UNIVERSITY OF NAIROBI

AN ASSESSMENT OF OCCUPATIONAL HEALTH AND SAFETY RISKS IN THE HOSPITALITY INDUSTRY: THE CASE OF SAROVA STANLEY HOTEL, NAIROBI, KENYA

BY

SHALINI TAK
(C50/64348/2013)

A RESEARCH PROJECT SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MASTER OF ARTS IN ENVIRONMENTAL PLANNING AND MANAGEMENT OF THE UNIVERSITY OF NAIROBI

Department of Geography and Environmental Studies

JUNE, 2016

Declaration

Declaration by Candidate

This project is my original work and has not been submitted for examination at any other institution.

Signed: _____ Date: 15/06/16

Ms. Shalini Tak
C50/64348/2013

Declaration by Supervisors

This research project has been submitted for examination with our approval as University Supervisors.

Signed: _____ Date: 16/6/2016

Prof. David N. Mungai
Wangari Maathai Institute for Peace and Environmental Studies
University of Nairobi

Signed: _____ Date: 15/06/2016

Dr. Martin Marani
Department of Geography and Environmental Studies
University of Nairobi

Acknowledgements

This research project would not have been possible without the generous support from the following. Foremost, I would like to express my sincere gratitude to my project supervisors, Prof. Mungai and Dr. Marani. They motivated me to be confident in my ability, and with their valuable guidance and immense knowledge, helped me produce a research project I am genuinely proud of.

My sincere thanks go to the directors, management and staff of the Sarova Stanley Hotel. They gave me the opportunity to mingle in their day-to-day activities with full openness and honesty that allowed me to study their reputable hotel. For their generosity, cooperation and all-round considerate and compassionate attitude, I am truly indebted.

Finally, I must express my profound gratitude to my wonderful family: my parents, siblings, in-laws, nephews, and my darling, loving husband! They provided me with unwavering patience, encouragement and support throughout my years of study, and through the process of researching and writing this project. This accomplishment would not have been possible without them.

My heartfelt thanks to you all!

Abstract

In Kenya, the hospitality industry is one of the main contributors to the nation's economy. However, there is a lack of information available on Occupational Health and Safety (OHS) risks in this industry. The main objective of this study was to carry out a risk assessment of the Sarova Stanley Hotel located in Nairobi, Kenya. The study sought to find out whether the Hotel had an effective Occupational Safety and Health Management System (OSHMS); to identify and map OHS hazards in the Hotel's Kitchen, Food & Beverage (F&B) service, Housekeeping, Health Club; and Front Office Departments; and to carry out a risk assessment of these Front of House Departments.

Stratified random sampling was used to collect data from 125 employees from the Kitchen (36), F&B (36), Housekeeping (30), Health Club (5) and Front Office (18) Departments using a semi-structured questionnaire. Hazards were identified and categorized using checklists from similar businesses, and the sample employees were asked to classify their frequency of occurrence as never, rarely, occasionally, frequently or very frequently. OHS risk types were classified into mild, moderate and major risks, and were assessed as low, medium, high or extreme level risks depending on their frequency of occurrence as per the employee survey. Direct observations of OHS processes and outcomes in the various Departments were made using a checklist. Key informant interviews were conducted with the Hotel General Manager, Hotel Nurse, members of the safety and health committee, Hotel Deputy Engineer, departmental managers, and human resources associates. Institutional documents which included clinical data on employee sick-offs, injuries and illnesses, and accident/incident reports were examined to complement the research findings.

The study found out that the hotel had a safety and health policy statement, a newly formed safety and health committee, had carried out annual safety and health audits, had an emergency planning and preparedness system, and an accident/incident management system. Results from the employee survey revealed that the most frequently identified OHS hazards by Department as perceived by the employees were as follows: working overtime in the Kitchen (97%); extreme temperature in F&B service (92%); cleaning agents in Housekeeping (96%); bodily fluids in the Health Club (100%); and extreme temperature in the Front Office (89%). The risks that caused most concern to the respective employees by Department were: fatigue in the Kitchen (38% perceived it as high risk); dizziness in F&B service (33% perceived it as low risk); skin dermatitis in Housekeeping (55% perceived it as medium risk); infections in the Health Club (60% perceived it as medium risk); and fainting in the Front Office (29% perceived it as low risk). A Kruskal Wallis H test found that there were significant differences in the types of physical risks experienced amongst the 5 Departments ($H(23.890) > \text{Critical Value}(9.488)$). However no significant differences were found in the types of psychosocial risks experienced amongst them ($H(6.391) < \text{Critical Value}(9.488)$).

The study concluded that both physical and psychosocial hazards and associated risks are experienced in the 5 Front of House Departments; therefore hotels such as the one studied should not be regarded as 'low-risk' work environments. In spite of an OSHMS at the Hotel, the numbers of annual accidents and incidences have remained on average the same. This may be due to inadequate implementation of the OSHMS and DOSHS audit recommendations, such as training and awareness creation of the employees regarding OHS. There is therefore need for the Hotel to strengthen its OSHMS to reduce the number of hazards and associated risks identified in this study, as it is clear that OHS is regarded as a non-core business issue in spite of the international trends and best practices. Therefore, to improve effectiveness, the study recommends the Sarova Stanley Hotel develop more effective monitoring and evaluation of their OSHMS by fully operationalizing its safety and health committee; and carrying out periodic risk assessments of the entire hotel operations and implementing recommendations thereof.

Table of Contents

Declaration....2

Acknowledgements....3

Abstract....4

List of Appendices....7

List of Figures....7

List of Tables....8

List of Plates....9

List of Abbreviations....10

Definition of Terms and Concepts....11

CHAPTER 1.0: INTRODUCTION....12

1.1 Background of the Study....12

1.1.1 History of Occupational Health and Safety....12

1.1.2 OSHMSs and the Importance of Risk Assessments....13

1.1.3 Occupational Health and Safety and Sustainable Development....14

1.1.4 Occupational Health and Safety and Human Rights....15

1.2 Statement of the Research Problem....16

1.3 Research Questions....17

1.4 Research Objectives....17

1.5 Research Hypotheses....17

1.6 Justification of the Study....18

1.7 Scope and Limitations of the Study....19

CHAPTER 2.0: LITERATURE REVIEW....20

2.1 The Concept of Occupational Health and Safety....20

2.2 Frameworks for Management of Occupational Health and Safety....21

2.2.1 International Frameworks....21

2.2.2 Regional Frameworks....24

2.2.3 National and Local Frameworks....26

2.3 Risk Assessments (with an emphasis on the provisions of OSHA, 2007)....29

2.4 Occupational Health and Safety in Hotels....34

2.5 Previous Studies on Occupational Health and Safety....37

2.6 Theoretical Framework....40

2.7 Conceptual Framework....44

2.8 Gaps in Knowledge 46
CHAPTER 3.0: STUDY AREA 47
3.1 Location and Setting 47
3.2 Descriptions of the Hotel's Front of House Departments 49
CHAPTER 4.0: METHODOLOGY 53
4.1 Research Design 53
4.2 Population and Sampling 53
4.3 Methods of Data Collection and Analysis 55
4.3.1 Employee Survey 55
4.3.2 Direct Observation 58
4.3.3 Key Informant Interviews 60
4.3.4 Document Review 61
4.4 Hypothesis Testing 62
4.5 Anticipated Outputs of the Study 62
CHAPTER 5.0: RESULTS AND DISCUSSION 63
5.1 Questionnaires Response Rate 63
5.2 Occupational Safety and Health Management System at the Sarova Stanley Hotel 64
5.2.1 Safety and Health Policy Statement 64
5.2.2 Safety and Health Committee 66
5.2.3 Safety and Health Audits, and Risk Assessments 68
5.2.4 Emergency Planning and Preparedness 69
5.2.5 Accident and Incident Management 72
5.3 Risk Assessment of OHS Hazards in the Hotel's Front of House Departments 73
5.3.1 Hazards Identification 73
5.3.2 Risks Assessment by Front of House Department 101
5.3.3 Precautionary Measures 123
5.4 Hypotheses Testing 134
CHAPTER 6.0: SUMMARY OF FINDINGS, CONCLUSION & RECOMMENDATIONS 137
6.1 Summary of Findings 137
6.2 Conclusion 141
6.3 Recommendations 142
REFERENCES 145

List of Appendices

Appendix 1: General Observation Checklist i
Appendix 2: Kitchen Observation Checklist v
Appendix 3: Food and Beverage Service Observation Checklist vii
Appendix 4: Housekeeping Observation Checklist viii
Appendix 5: Health Club Observation Checklist ix
Appendix 6: Front Office Observation Checklist xi
Appendix 7: OHS Employee Survey (Questionnaire) xvi
Appendix 8: Key Informant Interview Questions: General Manager xxii
Appendix 9: Key Informant Interview Questions: Hotel Nurse xxv
Appendix 10: Accident/Incidences Descriptions xxvi
Appendix 11: Common Hazards Amongst the Front of House Departments xxviii
Appendix 12: Kitchen Hazards xxix
Appendix 13: Food & Beverage Service Hazards xxx
Appendix 14: Housekeeping Hazards xxxi
Appendix 15: Health Club Hazards xxxii
Appendix 16: Front Office Hazards xxxiii
Appendix 17: Kitchen Risks xxxiv
Appendix 18: Food & Beverage Service Risks xxxv
Appendix 19: Housekeeping Risks xxxvi
Appendix 20: Health Club Risks xxxvii
Appendix 21: Front Office Risks xxxviii

List of Figures

Figure 1: The Deming Cycle 13
Figure 2: Six Step approach to conducting a Risk Assessment 30
Figure 3: Level of Risk matrix 32
Figure 4: Defence in Depth Accident Trajectory Model 41
Figure 5: Conceptual Framework 44
Figure 6: Location of the Sarova Stanley Hotel in Nairobi, Kenya, East Africa 48
Figure 7: Employee Awareness of Emergency Procedures 69
Figure 8: Sarova Hotels Accident/Incidence Investigation Flowchart 72
Figure 9: Hazards in the Front of House Departments (Employee Survey) 74

Figure 10: Hazards in the Front of House Departments (Checklists) 75
Figure 11: Kitchen Hazards (Employee Survey) 76
Figure 12: Kitchen Hazards (Checklists) 79
Figure 13: Food & Beverage Service Hazards (Employee Survey) 81
Figure 14: Food & Beverage Service Hazards (Checklists) 83
Figure 15: Housekeeping Hazards (Employee Survey) 87
Figure 16: Health Club Hazards (Employee Survey) 92
Figure 17: Front Office Hazards (Employee Survey) 97
Figure 18: January 2013-June 2015 Hotel Injury/Illness Records Analysis 101
Figure 19: Preference of Risk Controls in the Kitchen Department 125
Figure 20: Preference of Risk Controls in the F&B Service Department 127
Figure 21: Preference of Risk Controls in the Housekeeping Department 129
Figure 22: Preference of Risk Controls in the Health Club 131
Figure 23: Preference of Risk Controls in the Front Office Department 133

List of Tables

Table 1: Stratified Sample Sizes per Department 54
Table 2: Risk Assessment Matrix 57
Table 3: Terminology Defintions of Risk Assessment Matrix 57
Table 4: Response Rate to Questionnaires per Department 63
Table 5: Housekeeping Hazards (Checklists) 91
Table 6: Health Club Hazards (Checklists) 93
Table 7: Front Office Hazards (Checklists) 98
Table 8: January 2013-June 2015 Total Sick offs, Hospital Referrals and Admissions 101
Table 9: Kitchen Physical Risks Assessment 105
Table 10: Kitchen Psychosocial Risks Assessment 108
Table 11: F&B Service Physical Risks Assessment 110
Table 12: F&B Service Psychosocial Risks Assessment 112
Table 13: Housekeeping Physical Risks Assessment 113
Table 14: Housekeeping Psychosocial Risks Assessment 115
Table 15: Health Club Physical Risks Assessment 117
Table 16: Health Club Psychosocial Risks Assessment 119
Table 17: Front Office Physical Risks Assessment 120
Table 18: Front Office Psychosocial Risks Assessment 122

Table 19: Mean Ranks of Physical Risks per Department 135
Table 20: Physical Risks Hypothesis Test Summary 135
Table 21: Mean Ranks of Psychosocial Risks per Department 135
Table 22: Psychosocial Risks Hypothesis Test Summary 135

List of Plates

Plate 1: Sarova Stanley Hotel 47
Plate 2: Main Kitchen 49
Plate 3: Thorn Tree Kitchen 49
Plate 4: Pool Deck Kitchen 49
Plate 5: Thorn Tree Restaurant 50
Plate 6: Thai Chi Restaurant 50
Plate 7: Pool Deck Restaurant 50
Plate 8: Exchange Bar 51
Plate 9: Stanley Hotel Guest Room 51
Plate 10: Health Club Fitness Centre 52
Plate 11: Front Office Area 52
Plate 12: Quick instructions for Emergency Situations 71
Plate 13: Safe Work Practices Postings in the Kitchen (1) 80
Plate 14: Safe Work Practices Postings in the Kitchen (2) 80
Plate 15: Wet Floor Caution Sign in Thorn Tree Restaurant 84
Plate 16: Sunlight directly hitting Pool Deck Restaurant Computer order screen 84
Plate 17: Safe laundry Procedure Chart posted in Laundry area 89
Plate 18: Housekeeping MSDS File 90
Plate 19: Laundry Area Chemical 90
Plate 20: Low Ceiling in Plant Room 94
Plate 21: Swimming Pool Pump Room 94
Plate 22: No Lifeguard on Duty Sign 96
Plate 23: Swimming Pool Rules 96
Plate 24: Maintenance Works in Front Office back area 99
Plate 25: PPE worn by Engineering Contractor 99
Plate 26: Preventative Health Care Calendar 124

List of Abbreviations

AU	African Union
DDATM	Defence in Depth Accident Trajectory Model
DOSHS	Directorate of Occupational Safety and Health Services (Kenya)
EAC	East African Community
F&B	Food and Beverage
GOK	Government of Kenya
HSA	Hospitality and Safety Alliance (Australia)
HSA IE	Health and Safety Authority (Ireland)
HSE UK	Health and Safety Executive (United Kingdom)
IAPA	Industrial Accident Prevention Association (Canada)
ICOH	International Commission on Occupational Health
ILO	International Labour Organization
IRS	Internal Responsibility System
ISO	International Organization for Standardization
ITUC-Africa	International Trade Union Confederation-Africa
KAHC	Kenya Association of Hotel Keepers and Caterers
KNBS	Kenya National Bureau of Statistics
MSDS	Material Safety Data Sheet
NACOSH	National Council for Occupational Safety and Health (Kenya)
NEMA	National Environment Management Authority (Kenya)
OHS	Occupational Health and Safety
OSH	Occupational Safety and Health
OSHA	Occupational Safety and Health Act (Kenya)
OSHC	Occupational Safety and Health Committee
OSHMS	Occupational Safety and Health Management System
PPE	Personal Protective Equipment
SPSS	Statistical Package for the Social Sciences
UN	United Nations
WHO	World Health Organization
WIBA	Work Injury Benefit Act (Kenya)

Definition of Terms and Concepts

Occupational Health and Safety (OHS): The 1950 Joint ILO/WHO Committee provides the following definition of OHS:

"Occupational health should aim at the promotion and maintenance of the highest degree of physical, mental and social wellbeing in all occupations; the prevention amongst workers of departures from health caused by their working conditions; the protection of workers in their employment from risks resulting from factors adverse to health; the placing and maintenance of the worker in an occupational environment adapted to its physiological and psychological equipment and, to summarize: the adaptation of work to man and of each man to his job." (Muigua, 2012: 50)

Occupational Health and Safety Management System (OHSMS): OSHMSs "aim at providing a method to assess and improve performance in the prevention of workplace incidents and accidents via the effective management of hazards and risks in the workplace." (ILO, 2011:3)

Hazard: A hazard is "something or situation with the potential to cause injury or illness to people, damage to property or disruption to productivity" (HSA, 2003: 13); and can be found in both the physical and psychosocial work environments (Comcare, 2004; Burton, 2010).

Risk: Risk is the probability of occurrence of an adverse effect from a substance (hazard) on people or the environment combined with the magnitude of the consequence of that adverse effect (GOK, 2007). Therefore, the relationship between a hazard and risk is the level of exposure that determines the severity of the risk associated with the hazard (ILO, 2011).

Risk Assessment: Risk assessments involve the anticipation, recognition, evaluation and control of hazards arising from a workplace that could cause harm to workers, other people, property or the environment (ILO, 2011).

Hospitality Industry: The hospitality industry is a service based industry that encompasses accommodation, food, travel and tourism organizations which include hotels, restaurants, bars, nightclubs, airlines, and cruise lines (HSA, 2003; HSA IE, 2013).

CHAPTER 1.0: INTRODUCTION

1.1 Background of the Study

1.1.1 History of Occupational Health and Safety

The need for OHS can be traced back to the Industrial Revolution (the late 1700s), when most nations began to industrialize (Abrams, 2001; Share, 2012; Eves, 2014). During this period there were no health laws, regulations or safety codes obligating an employer to provide care or compensation for his employees. This led to widespread physical and moral harm suffered by workers (including children) who were generally forced to toil long hours for small wages under poor working conditions (Share, 2012; Eves, 2014). These occupational tragedies caused the public to put immense pressure on their governments to enact health and safety regulations for workplaces, especially factories; and this eventually led to the creation of Occupational Safety and Health Acts (OSHAs) in several countries (Abrams, 2001; Share, 2012; Eves, 2014).

The United Kingdom (UK) is said to be the first country to pass legislation on workers' health and safety with the enactment of the Health and Morals of Apprentices Act in 1802. Over time this was amended and strengthened until the enactment of the Health and Safety at Work Act in 1974, which continues to serve as the umbrella legislation for OHS in the UK (Abrams, 2001; Eves, 2014). With the enforcement of the OHS legislation, the UK reported significant decline in the number of work related fatalities and injuries. For example 148 workers were killed in the UK in 2012/2013 in comparison to 1500 workers killed in factories alone in 1915 (HSE UK, 2014).

In Africa, a 2004 World Health Organization (WHO) survey revealed that only 48% of the countries had OHS legislation (WHO, 2004). These included the Republic of South Africa and the Republic of Tanzania that enacted their OSHAs in 1993 and 2003 respectively (Elgstrand, 2010). However, initiatives for OHS in Africa can be traced to 1968 where Nigeria was the first country to host a seminar on Occupational Health for Developing Countries in Africa. In 2000, the WHO collaborated with the International Labour Organization (ILO) on the Joint Effort on OHS in Africa. And in 2005, Benin hosted a global meeting to review OHS in Africa (Puplampu, Quartey, 2012; WHO, 2004). Despite these initiatives OHS is not a priority in Africa's developmental agenda, even though it can help foster growth, productivity and profitability of struggling African economies (Puplampu, Quartey, 2012; WHO, 2004; Burton, 2010, Elgstrand, 2010, ITUC-Africa, 2013, ILO, 2013).

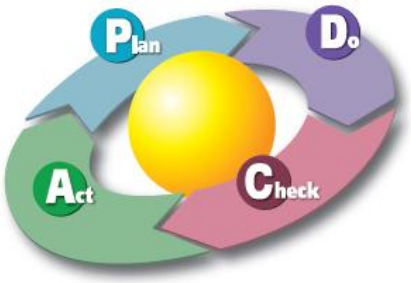
In Kenya OSHA was formally enacted in 2007, and provides a legal framework that employers and employees must comply with to ensure the health and safety of persons and the work environment (ILO, 2013; GOK, 2007). With OSHA 2007 the reporting and recording of OHS accidents improved significantly as in 2006/2007 only 355 accidents were recorded in comparison to 4812 in 2009/2010. This was attributed to

more work inspections being conducted by the Directorate of Occupational Safety and Health Services (DOSHS) who are mandated to administer the Act in the country (Elgstrand, 2010; ILO, 2013). However, OHS management in Kenya requires improvement as the DOSHS are underfunded and under staffed as they are only able to inspect approximately 4000 workplaces a year out of the estimated 140,000 which leaves most workers exposed to OHS hazards without intervention, and therefore majority of occupational accidents/diseases unregistered (Elgstrand, 2010; ILO, 2013, Muigua, 2012; GOK, 2007).

1.1.2 Occupational Safety and Health Management Systems and the Importance of Risk Assessments

According to ILO (2001), national legislation is important but may be insufficient to address OHS issues in specific organizations. Therefore, in 2001, the ILO published 'Guidelines on Occupational Safety and Health Management Systems' (ILO-OSH 2001) to assist organizations in tackling rapidly changing hazards and risks in their work environments. The Deming Cycle (also known as the 'Plan-Do-Check-Act' Principle) summarizes effectively the management steps defined in the ILO's Guidelines on OSHMS.

Figure 1: The Deming Cycle



Source: ILO (2011)

> "When applied to OSH, **"Plan"** involves the setting of an OSH policy, planning including the allocation of resources, provision of skills and organization of the system, hazard identification and risk assessment. The **"Do"** step refers to actual implementation and operation of the OSH programme. The **"Check"** step is devoted to measuring both the active and reactive performance of the programme. Finally the **"Act"** step closes the cycle with a review of the system in the context of continual improvement and the priming of the system for the next cycle." (ILO, 2011: 3)

Having an OSHMS does not only stand to benefit the worker and organization, but also helps protect the general environment as it helps create a sustainable safety culture within the enterprise and beyond (ILO, 2001). ILO (2011) adds that in order to have an effective OSHMS, regular risk assessments are required.

Stated in Section 6 (1) of OSHA 2007, is every occupier has the general duty to ensure the safety, health and welfare at work of all persons working in his workplace. Section 6(3) as well obligates the

occupier to carry out appropriate risk assessments of the work place, and on the basis of those results, adopt preventative and protective measures to ensure the safety and health of persons employed.

Carrying out risk assessments as well enables an occupier to effectively comply with his/her other duties specified in Section 6 (2) of OSHA 2007. These include provision of information, instruction, training and supervision to all persons employed to ensure their health and safety at work; and maintenance of the workplace in a condition that is safe and without risks to health. Occupiers are as well required to ensure that every person employed participates in the application and review of safety and health measures (Section 6 (2g)). It is important for employees to participate, as it not only helps them comply with their duties stated in Section 13 of OSHA 2007, but also enables them to understand and take ownership of the safety and health measures proposed in risk assessments (HSA IE, 2006).

Apart from the legal obligations to carry out risk assessments, there is also a moral and ethical obligation (a caring aspect) for employers to ensure that no harm or ill health befalls their employees while working in their care. HSA IE (2006) adds that evidence borne out of companies' practical experience proves that implementing effective safety and health management measures as well improves business efficiency and success. This is because accidents and ill health not only ruin life, but can lead to significant losses for businesses, which are often hidden and underestimated; through legal fees, fines, compensation, investigation time, lost production, lost good will from the workers, customers and sometimes the wider community (HSA IE, 2006; HSE UK, 2011). Carrying out regular risk assessments, and reviewing safety and health policies, cannot in themselves prevent accidents and ill health, but they are still important measures that are required in reducing their likelihoods (HSA IE, 2006, EC, 1996).

1.1.3 Occupational Health and Safety and Sustainable Development

When the World Commission on Environment and Development (Brundtland Commission) published its report 'Our Common Future' in 1987, it presented a relatively new concept – 'sustainable development'. The concept became one of the most successful approaches to be introduced in many years, as "it helped to shape the international agenda and the international community's attitude towards economic, social and environmental development" (Barlund, 2005).

In the 1992 Earth Summit in Rio de Janeiro, world leaders adopted the principles of the Rio Declaration on Environment and Development, and Agenda 21, as a route to achieving sustainable development. These principles highlighted the importance of investing in the development of human beings, their health and the environment as a prerequisite for sustainable development (Corvalan, Kjellstrom, Smith, 1999). Principle 1 of the Rio Declaration outlines the significance of human health in sustainable development: 'Human beings are at the centre of concerns for sustainable development. They are entitled to a healthy and productive life in harmony with nature" (UNCED, 1992b). Agenda 21 further links the

importance of workers and their trade unions in achieving sustainable development through promoting and maintaining a healthy work environment:

> "(...) (workers), trade unions are vital actors in facilitating the achievement of sustainable development in view of their experience in addressing industrial change, the extremely high priority they give to protection of the working environment and the related natural environment, and their promotion of socially responsible and economic development (...) The overall objective is poverty alleviation and full and sustainable employment, which contribute to safe, clean and healthy environments - the working environment, the community and the physical environment" (UNCED, 1992a: 29.1-2).

According to Amponsah-Tawiah (2013) and Taubitz (2010), OHS and sustainable development are inherently linked as they are based on the same interdependent and mutually reinforcing pillars: Economic development, Social Development and Environmental Protection; as both strive to achieve balance between these pillars and are therefore vital for one another. WHO (1995: 4) adds that "occupational health is a basic element and constitutes a social and health dimension of the principle of sustainable development," and helps to achieve such development through the activities practiced through the OHS discipline. According to WHO (1995) these OHS activities include implying a parsimonious use of resources, therefore minimizing the unnecessary loss of human and material resources; early identification of hazards and provision of preventative and protective measures, thereby minimizing harm to people and the environment; and last but not least promoting a healthy and productive life for all workers in a safe work environment, which is in tandem with Principle 1 of the Rio Declaration on Environment and Development.

1.1.4 Occupational Health and Safety and Human Rights

In relation to occupational health, several international human rights instruments have stressed on the right to a safe and healthy work environment as a key human right. For example, the preamble in the ILO's Constitution (1919) indicates "The protection of the worker against sickness, disease and injury arising out of his employment - is not only a labour right but a fundamental human right" The Universal Declaration on Human Rights (UN 1948) states that "Everyone has the right to life, to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment" (ILO, 2009a: 5). The Seoul Declaration on Safety and Health at Work (2008) expresses that "(...) the right to a safe and healthy working environment should be recognized as a fundamental human right and that globalization must go hand in hand with preventative measures to ensure the safety and health of all at work" (ILO, 2009a: 5). The protection of workers health and safety as a basic human right is as well advocated by former UN Secretary General Kofi Annan who stated in his Workers' Memorial Day speech in New York (28/04/02) that "(...) safety and health of workers is a part and parcel of human security (...) Safe work is not only sound economic policy, it is a basic human right" (GOK, 2012).

1.2 Statement of the Research Problem

All over the world, employers and employees have a responsibility to promote a safe and healthy work environment that minimizes or eliminates the risk of harm to any person or the environment, no matter the type or size of enterprise (Barlund, 2005; Amponsah-Tawiah, 2013).

In Kenya, hotels are part of the accommodation and food services activities industry which has one of the highest rates of employment, with figures reaching 73,700 employees in 2013 (KNBS, 2014) out of 2 million employed in the country's formal sector (ILO, 2013). However hotels also have one of the highest rates of employee turnover (Kuria, Wanderi, Ondigi, 2012; Kysilka, Csaba, 2013; Razzi, 2013). The top reasons this turnover trend is attributed to is poor organizational culture and leadership-in terms of long and unsociable hours of work, low wages, lack of consideration, respect and support from employers and management-which all cause an employee to have poor work-life balance and significant physical and mental stress, which eventually motivate them to seek other forms of employment (Lo, Lamm, 2005; Boardman, 2010; O'Neill, Davis, 2011; Kysilka, Csaba, 2013; Razzi, 2013). Dealing with customers on a daily basis, 'people pleasing' can as well cause a significant amount of physical and mental stress on even the most hardworking, career minded employee (Lo, Lamm, 2005; Kysilka, Csaba, 2013), as when it comes to customer service, employers and managers walk a fine line between keeping their customers happy and supporting their employees (Boardman, 2010). Lack of adequate training and precautions for dealing with hazardous machinery, equipment and chemicals, can as well cause employees to seek other forms of employment (HSA, 2003; HSA IE, 2013; Kysilka, Csaba, 2013).

In hotel work environments employees health and safety is further put at risk from wide scale manual handling, use of heavy machinery and equipment, dealing with hot surfaces and substances, cutting equipment, use of chemicals, risks of slips, trips and falls, exposure to communicable diseases from various customers and personal security put at risk from abusive customers, employers or criminals, amongst others (HSA IE, 2013). According to Buchanan *et al* (2010: 117), "hotel workers are nearly 40% more likely to be injured on the job than all other service sector workers. Hotel workers also sustain more severe injuries resulting in more days off work, more job transfers, and more medically restricted work compared to other employees in the hospitality industry".

There is unfortunately a lack of information readily available on OHS in this industry, especially in Africa, as it is considered a 'low risk' industry. However available literature from countries such as Australia, United Kingdom, Ireland and America show that OHS hazards and risks exist in this industry (Lo, Lamm, 2005; O'Neill, Davis, 2011; Ondieki, 2013; Gibbons, Gibbons, 2007; Mayhew, Quinlan, 2002; HSA IE, 2013). Most workplaces in Africa tend to as well just focus on physical hazards and not acknowledge the effects of the psychosocial work environment on employee wellbeing (Burton, 2010). This study thus aimed to identify the

types of physical and psychosocial OHS hazards and associated risks that are present in an African hotel work environment. The Sarova Stanley Hotel located in Nairobi, Kenya was purposely sampled as it is one of Kenya's largest hotels, was the first hotel built in the country in 1902, and ever since has maintained its 5 star status by winning several awards and attracting numerous travellers (Sarova Hotels, 2014; KAHC, 2014). Therefore it was considered the ideal study area to evaluate the hotel's Occupational Safety and Health Management System, and undertake a risk assessment of its Front of House Departments.

1.3 Research Questions

1. Does the Sarova Stanley Hotel have an Occupational Safety and Health Management System (OSHMS)? How is the OSHMS implemented?
2. What Occupational Health and Safety (OHS) hazards are employees exposed to in the hotel's Front of House Departments (Kitchen; Food & Beverage Service; Housekeeping; Health Club; and Front Office)?
3. What are the impacts of the hazards (the risks) to the hotel's employees?

1.4 Research Objectives

1.4.1 Overall Objective

The overall objective of the study was to carry out a risk assessment of the Sarova Stanley Hotel located in Nairobi, Kenya.

1.4.2 Specific Objectives

The specific objectives included the following:

1. To establish whether the Sarova Stanley Hotel has an effective OSHMS.
2. To identify and map OHS hazards in the hotel's Front of house Departments.
3. To carry out a risk assessment of these Front of House Departments.

1.5 Research Hypotheses

1. H_o: There is no difference in the type of physical risks experienced in each of the Front of House Departments.
   H_1: Physical risks experienced in the Front of House Departments differ from one another.

2. H_o: There is no difference in the type of psychosocial risks experienced in each of the Front of House Departments.
   H_1: Psychosocial risks experienced in the Front of House Departments differ from one another.

1.6 Justification of the Study

The study focuses on an established hotel in Nairobi as the capital city is the economic engine of the country as it employs a large percentage of the working population and generates much of the country's GDP (InterNations, 2013). The advancement of sustainable development and the protection of human rights are some of the vital underpinnings of this study, as it helps ensure best OHS practices are adhered to in the hotel work environment. Having a healthy and safe work environment lies in accordance with Principle 1 of the Rio Declaration on Environment and Development, and the 1919 ILO Constitution, amongst other international instruments on sustainable development and human rights.

Another fundamental advantage of this study is that it assists both the employer and employee to be compliant with Kenya's Occupational Safety and Health Act (OSHA) of 2007 as it uses the Act, as well as ILO guidelines, as a benchmark for implementation of a sound OSHMS at the study hotel.

From the literature reviewed there is a general notion that the hospitality industry, in particular hotels, are a 'low-risk' industry with few occupational risks, which unfortunately means little research has been done on OHS in this industry. However, this general perception may be the result of the lack of significant research done in this area (Lo, Lamm, 2005; O'Neill, Davis, 2011; Ondieki, 2013). Therefore, another advantage of this study is that it addresses this gap, which is especially important to a country like Kenya, as the contributions of the hospitality industry are very important to the economic development of the nation.

Overall this study contributes in making the hotel work environment cleaner, safer and healthier, which benefits the employer, employee and the business. Reduced illnesses, injuries and accidents do not only reduce costs of doing business but also motivate workers, bolster productivity and improve workplace relations. Without an effective OSHMS, these costs could be in the form of compensations for injury or death, legal fees, loss of manpower or tarnished business image and credibility (ILO, 1996; Workplace Corporation, 2000; Comcare, 2004; Mills, 2012). Leman, Hidayah A (2013: 34) summarize the importance of addressing OHS issues in the work environment:

> "Economically, morally, and legally, OSH has become an important issue. Companies are attempting to remain profitable in an ever competitive global economy. For companies, addressing safety, health and environmental programs, (…) may actually lean towards survival. (…) the amount of production required to cover costs associated with accidents in the workplace can be substantial and may far outweigh the expense of providing a safe and healthy working environment."

Finally the findings of this study can be used as a handy tool when designing integrated OSHMSs for new 5 star city hotels.

1.7 Scope and Limitations of the Study

The overall objective of this study was to carry out a risk assessment of OHS hazards and associated risks that are found in a hotel work environment, and how they are managed. The risk assessment procedure used in the study referred to the methods developed by the Health and Safety Authority of Ireland (HSA IE, 2006); UK Health and Safety Executive (HSE UK, 2011); Meng (2002); Government of South Australia (2009); and Queensland Government (2012).

Out of 14 '5 star' rated hotels located in the city of Nairobi (KAHC, 2014), the Sarova Stanley Hotel was purposefully sampled as the focus of this case study. This 5 star hotel has won numerous awards (such as the 2014 World Travel Award for Kenya's leading Hotel (Sarova Hotels, 2014)) and therefore was presumed to be an ideal case for this study. The target population of the study were the 12 main departments of the Sarova Stanley Hotel. From this, the hotel's 5 Front of House Departments were purposefully sampled as the focus of this case study: Kitchen, Food and Beverage service, Housekeeping, Health Club and Front Office; as from literature reviewed, these departments are the most susceptible to OHS hazards and associated risks (see e.g. Lo, Lamm, 2005; O'Neill, Davis, 2011; Bohle *et al*, 2004; Gibbons, Gibbons, 2007; Mayhew, Quinlan, 2002; Buchanan *et al*, 2010; HSA, 2003; Queensland Government, 2004; Workcover Corporation, 2000; HSA IE, 2013). Therefore, the study did not cover the hotels Back of House Departments, namely, Sales and Marketing, Repair and Maintenance, Security, Information Technology (IT), Purchasing and Receiving, Finance, and Human Resources.

OHS is a broad discipline that covers several health and safety issues, such as health and safety issues outlined in DOSHS's 2005 Code of Practice on Occupational Safety and Health Auditing (GOK, 2005). As this study was a risk assessment of a hotel work environment, the areas covered were limited to health and safety issues found in this industry. The following OHS issues were looked into:

- **General OHS Issues** (Workplace, Flooring and Stairways; Ventilation and Lighting; Cleanliness; Welfare Facilities; Mechanical/Electrical; Fire Safety; Hazardous Substances; PPE)
- **Kitchen OHS Issues** (Refrigeration and Storage; Hygiene; Others)
- **F&B Service Area OHS Issues** (Beverage (Bar) Area; Dining Area; Others)
- **Housekeeping OHS Issues** (Laundry Area; Cleaning Operations and Others)
- **Health Club OHS Issues** (Swimming Pool; Fitness Centre; Others)
- **Front Office OHS Issues** (Reception; Concierge)

The study mapped the types of physical and psychosocial hazards, and their associated risks, experienced in the 5 Departments under study. Finally, the study established the effectiveness of the implementation of the hotel's OSHMS, by enquiring into the following: safety and health policy; safety and health committee; any prior internal risk assessments; safety and health audits; emergency planning and preparedness; and accident/incident management.

CHAPTER 2.0: LITERATURE REVIEW

This section presents literature reviewed in relation to the study's elements, as well as findings of closely related previous studies and theories. It then explains a conceptual framework for the study. Finally, a summary of the gaps in knowledge are presented that form the focus of the study.

2.1 The Concept of Occupational Health and Safety

IAPA (2007: 20) defines the discipline of OHS as "the development, promotion, and maintenance of workplace policies and programs that ensure the physical, mental, and emotional well-being of employees". IAPA (2007) adds that these policies and programs should aim to maintain a safe work environment that is relatively free of actual or potential hazards that can harm employees; place employees in work environments that are suitable to their physical and mental make-up; and generally promote healthy lifestyles.

Therefore, the interlinking components of *health* and *safety* can be combined into one term, the *wellbeing* of workers, which is central to the definition of occupational health and safety. However, the meaning of this concept of wellbeing can be broad and may vary from physical, emotional, psychological and mental perspectives (Danna, Griffin, 1999). WHO defines health as a "state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity" (WHO, 1946: 1). In occupational health terms, this 'state' may vary from work related injuries and diseases such as industrial deafness and dermatitis to general health problems such as high blood pressure and stress (Muigua, 2012). Some occupational psychology perspectives, for example, associate a worker's wellbeing with mental health to ensure psychological wellbeing (Kelloway, Day, 2005), which is a viewpoint that based the definition of a psychologically healthy workplace by the American Psychological Association (APA):

> "an organization that (incorporates) health promotion activities, (offers) employee assistance programs, (has) flexible benefits and working conditions, (treats) employees fairly, and (offers) programs for employee development, health, safety, and the prevention of work stress" (Kelloway, Day, 2005: 223).

APA's definition emphasizes the aspects of employee development and a stress-free work environment, and is particularly useful when considering the effect of psychosocial hazards at the workplace.

Another component central to the definition of OHS is occupational injury/illness. The United States Bureau of Labor Statistics states that an injury or illness is considered to be work-related if an event or exposure in the work environment either caused or contributed to the resulting condition or significantly aggravated a pre-existing condition (Bureau of Labor Statistics, 2012). Ontario Ministry of Labor (1990) and

IAPA (2007) break down the term further by adding that occupational injury/illness is a harmful condition that results from exposure in the workplace to a biological, chemical, physical or ergonomic hazard to the extent that the normal physiological mechanisms are affected and the health of the worker is impaired. And so, "efforts in occupational health and safety must aim to prevent industrial accidents and diseases, and at the same time recognize the connection between worker health and safety, the workplace, and the environment outside the workplace" (ILO, 1996: 2).

In this study, the definition of occupational health and safety by the 1950 Joint International Labour Organization (ILO)/WHO Committee's definition on Occupational Health is applied as it incorporates the various components of OHS into one definition (outlined in Definition of Terms and Concepts). It is particularly interesting in the sense that it relates people and work, and how the two influence each other to produce certain desirable or undesirable outcomes. This definition can be considered complete as it stresses that OHS encompasses the social, mental, and physical well-being of workers, the 'whole person' (ILO, 1996). It also demonstrates how different perspectives (ILO and WHO) can fuse into each other to produce an all-round understanding of an otherwise complex concept of occupational health and safety.

2.2 Frameworks for Management of Occupational Health and Safety

2.2.1 International Frameworks

The role of the International Labour Organization (ILO) is to promote social justice and internationally recognized human and labour rights. Its main aims are to promote rights at work, encourage decent employment opportunities, enhance social protection and strengthen dialogue on work-related issues. They do this by bringing together their tripartite structure (government, employer and worker representatives of ILO member states-of which Kenya is a party to), that work together to set labour standards, develop policies and devise programmes that serve to meet the needs of working men and women (ILO, 2014). Agenda 21 supports tripartism as an important way of promoting and maintaining health and safety in the work environment, and achieving sustainable development, "The established principles of tripartism provide a basis for strengthened collaboration between workers and their representatives, Governments and employers in the implementation of sustainable development" (UNCED, 1992a: 29.1). Therefore, the ILO can be said to be one of the key international instruments that promotes and advises on OHS in all of its member states.

The ILO has established international labour standards in the form of Conventions and Recommendations, approximately 80 of which are in relation to OHS (ILO, 2009a). One of the most important international conventions held by the ILO regarding OHS was the 'Occupational Safety and Health Convention' (No.155) held in June 1981 whose purpose was the adoption of certain proposals in relation to safety and health and the working environment (ILO, 1981). Article 16.1 summarizes its purpose by stating

"Employers shall be required to ensure that, so far as reasonable practicable, the workplaces, machinery, equipment and processes under their control are safe and without risk to health" (ILO, 2009a: 5). In 2002 its protocol followed known as, the 'Protocol of 2002 to the Occupational Safety and Health Convention, 1981'; whose purpose was to strengthen recording and notification procedures for occupational accidents and diseases; and to promote the harmonization of these procedures with the aim of identifying their causes and establishing preventive measures (ILO, 2002). Apart from these, the ILO has developed several guidelines and codes of practices that help endorse worker wellbeing at both the national and organizational level. An example of an ILO developed Code of Practice related to the hospitality industry is the 'Code of Practice on Workplace Violence in Services Sectors and Measures to Combat this Phenomenon'. This was developed in 2003 and provides general guidance in addressing the problem of workplace violence in service sectors to both the national and organizational levels (ILO, 2003).

According to Normlex (2014) Kenya has ratified and adopted 49 ILO conventions, 43 of which are in force, and approximately 10 of which are related to OHS (ILO, 2013). Most of the OHS conventions adopted are either in regards to accident compensation, or associated with the agricultural and marine industries. Kenya, however, has not ratified to the important conventions regarding OHS such as the Occupational Safety and Health Convention of 1981 (No.155) or its Protocol of 2002. However according to ILO (2013), this convention and the '2006 Convention on the Promotional Framework for Occupational Safety and Health (No. 187)' have been identified and prioritized for ratification, but are still awaiting an Act of Parliament. Kenya, despite its high labour force in the Accommodation and Food Service Activities industry (KNBS, 2014), has unfortunately not ratified any ILO convention in relation to this industry, an important one being the 'Working Conditions (Hotels and Restaurants) Convention, 1991' (No. 172) which concerns adopting policies and practices to improve working conditions in the hospitality industry (ILO, 1991).

One of the most important guidelines developed regarding OHS was the 'ILO-OSH 2001: Guidelines on Occupational Safety and Health Management Systems' published in December 2001 by the ILO (ILO, 2011). This handbook provides practical approaches that assist national institutions, organizations, employers, workers and other social partners in establishing, implementing and improving OSHMSs, with the aim of reducing work-related injuries, ill health, diseases, incidents and deaths (ILO, 2001). The ILO-OSH 2001 guidelines were developed as a response to a growing need for a unified international standard, whose requirements organizations could base their OSHMSs upon (ILO, 2011; Leman, Hidayah A, 2013). However, the International Organization for Standardization (ISO) recognized this need earlier, and under the British Standards Institution (BSI) Group developed the OHSAS 18000 Series in 1999, which integrated the ISO 9001:2000 (Quality Standards) and ISO 14001:1996 (Environmental Management System Standards), with OSHMS standards(Leman, Hidayah A, 2013, BSI, 2014). However, according to ILO (2011), the ILO-OSH 2001 guidelines are the most suited and appropriate international standard for OSHMSs, as they were developed

under the tripartism system and reflect the principles of ILO OSH standards such as the Occupational Safety and Health Convention, 1981 (No. 155). To reaffirm their commitment and belief in the quality of ILO-OSH 2001, the Governing Body of the ILO in 2007 in fact asked the ISO to refrain from developing an international standard on OSHMSs (ILO, 2011).

Working in close partnership with the ILO on promoting OHS on a global scale, is the WHO. The Constitution of the WHO was adopted in 1946, in which Chapter 2 outlines the WHO's OHS functions, particularly Article 2h and i:

> "To promote, in co-operation with other specialized agencies where necessary, the prevention of accidental injuries; (and) to promote (...) the improvement of (...) economic or working conditions and other aspects of environmental hygiene." (WHO, 1946: Art.2h, i)

In May 2007, the 60th World Health Assembly was held, in which the Global Plan of Action on Workers' Health 2008-2017 was endorsed. The Plan of Action came out of concern that "there are major gaps between and within countries in the exposure of workers and local communities to occupational hazards and in their access to occupational health services" (WHO, 2007: 3). The WHO's work on OHS is currently governed by this Global Plan of Action, and it has been used to urge its Member States (of which Kenya is a part), that the health of workers is an essential prerequisite for a Nation's productivity and economic development, especially if workers' health is incorporated into "national and sectoral policies for sustainable development, poverty reduction, employment, trade, environmental protection, and education" (WHO, 2007: 4). The Plan of Action can be considered comprehensive as it deals with several aspects of workers' health such as primary prevention of occupational hazards, protection and promotion of health at work, employment conditions, and improving the performance of and access to occupational health services (WHO, 2007).

The WHO's activities are supported by its' network of Collaborating Centres around the world, some of which have been mandated to work on OHS issues in particular. For example the UK Government's Health and Safety Laboratory contributes to the achievement of WHO's Global Plan of Action on Workers' Health by working on specific occupational health projects, such as occupational respiratory disease, well-being and fitness for work, and emerging health issues associated with nanotechnologies (HSL, 2014). However, there is a major gap in the WHO addressing OHS in Africa, as out of the 52 Collaborating Centres for Occupational Health around the world, only one is found in Africa, which is in South Africa. Whereas the Collaborating Centre in Kenya has been mandated to conduct research in human reproductive health (WHO, 2014). This raises the question of whether or not WHO's Global Plan of Action on Workers' Health is really being implemented in Kenya, or Africa as a whole.

Another international institution that works closely with the ILO and WHO on promoting OHS on a global scale is the International Commission on Occupational Health (ICOH). ICOH is an international non-governmental professional scientific society whose main aims are to advance scientific progress, knowledge and development of all aspects of occupational health and safety. It has a membership of 2000 professionals from 93 countries, of which Kenya is a part of (ICOH, 2014). Even though there is an appointed ICOH National Secretary representing Kenya, there is lack of Kenyan representation in the elite group of ICOH Officers and Board members. In fact Africa has only two representatives in the group of Board members, both of whom are from South Africa (ICOH, 2012). This raises doubt as to whether ICOH activities are really being employed in Kenya or other parts of Africa.

2.2.2 Regional Frameworks

In 2000, the WHO and ILO formed the Joint Effort on OHS in Africa which aims at improving work conditions and environment in Africa by collaborating and cooperating with governments, employers and employees through various OHS activities (WHO, 2004). However, OHS management in general lacks priority in Africa's development agenda and is required to accelerate growth, productivity and profitability on the continent (WHO, 2004; Puplampu, Quartey, 2012; Burton, 2010, Elgstrand, 2010, ITUC-Africa, 2013, ILO, 2013).

The International Trade Union Confederation-Africa (ITUC-Africa) and the African Union (AU) are the other main international institutions that promote OHS on the African Continent through research, training and campaigns, as well as participating in trade union efforts on OHS issues (ITUC-Africa, 2014). ITUC-Africa's work on OHS has been particularly linked to new occupational challenges that have arisen due to rapid globalization, such as work related stress, violence at work, drug abuse and alcoholism (ITUC-Africa, 2013). ITUC-Africa, 2013: 9 adds that "globalization has opened the local markets to dangerous products from the developed world including nano-manufactured materials, cancer-causing agents, nuclear waste, electronic waste and other forms of products containing health threatening substances." To help tackle some of the emerging OHS issues, ITUC-Africa urges African governments to put into operation the 1991 Bamako Convention (of which Kenya is a party to), that prohibits the import into Africa of any hazardous waste, as well as the control of trans-boundary movement and management of hazardous wastes within Africa (ITUC-Africa, 2013; AU, 1998). Along with the lack of implementation of the Bamako Convention, ITUC-Africa is as well concerned with the lack of ratification of ILO OSH Conventions by the African Nations, which is impairing their ability to tackle OHS issues effectively. In particular the lack of ratification of the core ILO OSH Conventions: (C155 (1981) Occupational Safety and Health; C161 (1985) Health Services; and C187 (2006) Promotional Framework for OSH). Kenya is one of the many African nations that has not ratified to any of these core ILO OSH Conventions, and ITUC-Africa urges these Nations to prioritize the ratification of these conventions to help address OHS in their countries (ITUC-Africa, 2013; ILO, 2013; Normlex, 2014).

The East African Community (EAC) is one of the main entities that promotes OHS in the East African Region and is composed of Kenya, Uganda, Tanzania, Burundi and Rwanda (EAC, ILO, 2009). In collaboration with the ILO, the EAC has developed the EAC-DWP (Decent Work Programme) to bolster economic and social development in the region, through 3 Priorities, of which Priority 2 is the Extension of Social Protection. It focuses on improving OHS in the region, and helps constituents build their capacity in addressing OHS challenges by:

> "(creating) awareness on the dimensions and consequences of work-related accidents and injuries, to place health and safety of all workers on national and the sub-regional agenda and to stimulate and support practical action at all levels (...) (This helps constituents) embrace a systems approach for continuous improvement while also documenting impacts with links to national and social economic development" (EAC, ILO, 2009: 19).

Another programme that aims to develop OHS in the East African Region is the East African Regional Programme on Occupational Health and Safety (EARPOHS) developed by the Finnish Institute of Occupational Health (FIOH) in collaboration with the EAC. The programme's origins can be traced back to the late 1980s, and its activities support the achievement of the EAC objectives of harmonized labour policies and legislation on OHS, as well implementation of ILO's Global Strategy on OHS and WHO's Global Plan of Action for Workers' Health in the region (Lehtinen, 2009; Rantanen, Lehtinen, 2009; WHO, 2007). The programme was developed to address issues on occupational health services in the region, some of the issues noted included (Rantanen, Lehtinen, 2009):

- Great variations in the development of OHS systems between the countries (Kenya, Tanzania, and Uganda being substantially better developed than Burundi and Rwanda).
- Implementation and enforcement of OHS legislation weak in the entire region.
- Under-dimensioned or partially non-existent human resources for OHS. Leading to low practical coverage of OHS services, where limited health examinations and curative general health services are provided. Under-developed preventive activities.
- The countries suffer from weak systems for recognition and registration of occupational diseases and injuries.
- Under-developed collaboration mechanisms for collaboration and interaction between key partners and sectors such as the labour and health sectors, and the government and social partners in issues of occupational health.

However, Makhonge (2009) argues that it is not the absence of appropriate knowledge, but rather the inability to apply existing knowledge that leads to inadequate planning for the prevention of accidents, diseases and ill health at workplaces in these and other developing countries. Makhonge (2009) cites the business community in Kenya as an example whose common opinion is that implementation of safety and

health measures increases the costs of doing business, and as a result most organizations rarely mention OHS issues in their strategic plans. Therefore most OHS issues are relegated to a fire-fighting type of management, rather than if a proactive strategy was used at the planning stage which could have resulted in economic benefits that go with improved workplace safety and health. Burton (2010) adds another reason for inadequate planning for OHS is because most workplaces in Africa tend to focus on traditional OHS issues, that is, only addressing the physical work environment and not acknowledging the effects of the psychosocial work environment and work stressors on OHS. However, Makhonge (2009) states that under-developed preventive OHS activities in these countries is also due to lack of adequate data on accidents and diseases by the competent authorities, that could otherwise be used to facilitate proper planning for OHS issues at the enterprise and national level. Other reasons for lack of development of OHS in these and other African Nations include "inadequate human resources, insufficient level of collaboration between ministries of health and labour, weak policies, lack of essential preventive and curative services, and insufficient budget" (Burton, 2010: 17).

ITUC-Africa (2014) as well cites difficulties in implementing their activities effectively on the African continent, not only due to limited financial and logistical resources in several countries, but as well due to rampant political instability where workers rights and activities have been put under attack (such as denial of civil servants to freely join or form unions in Ethiopia; regular attacks on trade unions in Chad; and suppression of trade union rights and actions in Burundi, Swaziland and Zimbabwe). Humanitarian crises have as well hindered implementation of activities e.g. incidences of conflict, sectarian and extremist attacks in Mali, South Sudan, D.R. Congo, Central African Republic, Nigeria and Kenya (ITUC-Africa, 2014).

2.2.3 National and Local Frameworks

In August 2010, Kenya enacted a new Constitution, which is considered the supreme regulatory and legislation framework that lays the foundation for all other laws (ILO, 2013). Even though OHS is not specified in the Constitution, its principle is still advocated for in Part 2 of the Bill of Rights. In Article 41, the Constitution stipulates that every person has the right to fair labour practices and to reasonable working conditions; in Article 42, it states that everyone has the right to clean and healthy environment and in Article 69 it enjoins the State to eliminate processes and activities that are likely to endanger the environment (GOK, 2010). These Articles are therefore in tandem with Article 3 of Part 2 of the Environmental Management and Coordination Act (1999) (EMCA 1999) which also states that every person in Kenya is entitled to a clean and healthy environment and has the duty to safeguard and enhance the environment, by preventing, stopping or discontinuing any act or omission deleterious to the environment. EMCA 1999 is geared towards improving the quality of the environment including the working environment as it requires workplaces to develop the necessary institutional frameworks for environmental and occupational health and safety. Examples of other Kenyan laws and regulations that cover some aspects of OHS include the

Public Health Act CAP 242, the Radiation Protection Act CAP 243, and the Pest Control Products Act Cap 346 (GOK, 1999; Muchiri, 2005; GOK, 2010; Muigua, 2012; ILO, 2013).

OHS in Kenya can be traced back to 1950 when the colonial government found it necessary to have a legal instrument to manage the safety, health and welfare of people employed in factories; and so they enacted the British Factories Act of 1937. In 1990, after independence, this Act was amended to the Factories and Other Places of Work Act to broaden the scope of coverage to include agriculture and workplaces employing more than two persons, including the informal sector. Finally, to strengthen the process of OHS in Kenya, the Factories and Other Places of Work Act had been superseded by the enactments of the Occupational Safety and Health Act (OSHA) and the Work Injury Benefit Act (WIBA) in 2007; which are now the principal laws that govern OHS in the country (ILO, 2013; Muchiri, 2005).

> "The purpose of OSHA 2007, is to secure the safety, health and welfare of people at work, and to protect those not at work from risks to their safety and health arising from, or in connection with, the activities of people at work. The purpose of WIBA 2007 is to provide compensation to employees for work-related injuries and diseases contracted in the course of their employment, and for connected purposes" (ILO, 2013, p.3).

However, according to Muigua (2012), the duties outlined in OSHA 2007 are very extensive and broad and lack an effective enforcement mechanism which raises doubt as to whether employers or employees actually fulfil their obligations stated in the Act. Even though the Act does not directly refer to the hospitality industry, the broad nature of its provisions can be easily relatable to businesses in this industry. These include cleanliness, ventilation, and lighting provisions stated in Sections 47, 49, 50; fire safety in Sections 77 and 81; and welfare provisions such as accommodation for clothing, facilities for sitting and first aid in Sections 93-95 (Appendices 1-3 outline these and other OSHA 2007 provisions that are relatable to hotel work environments).

Institutions have been established to help administer OHS in Kenya. One of which is the Directorate of Occupational Safety and Health Services (DOSHS), which is a designated national authority under the Ministry of Labour, Social Security and Services that has a mandate to ensure compliance with the provisions of OSHA 2007 and WIBA 2007 (ILO, 2013). Some of the duties of DOSHS outlined in Section 23 of OSHA 2007 include promoting education and training, as well as collecting and disseminating information on OHS; conducting safety and health audits of workplaces as well as medical examinations of employees; and ensuring that employees who are injured in the course of their employment are compensated in accordance with the provisions of WIBA 2007. Section 24 of OSHA 2007 states that DOSHS shall establish a safety and health institute known as the Occupational Safety and Health Institute that will undertake research and training into all aspects of health and safety to occupational safety and health officers and other persons

(GOK, 2007). However, according to Muigua (2012) this said institute has not been established in line with section 24 of the Act.

The other body responsible for the administration of OHS in Kenya is the National Council for Occupational Safety and Health (NACOSH). NACOSH has 22 members which includes representatives of government ministries and agencies; the Federation of Kenya Employers (FKE), which is the national umbrella organization representing the interests of employers in Kenya; the Central Organization of Trade Unions (Kenya) (COTU-K), which is Kenya's most representative workers organization and has 35 affiliated members including the domestic and hotels industrial sector; and appointed practitioners in the field of OHS (ILO, 2013). The duties of NACOSH are outlined in Section 27 (1) of OSHA and include advising the Minister on the formulation and development of policy framework on national OHS; on legislative proposals on OHS; on strategic means of promoting the best practices in OHS; on the establishment, maintenance and development of a safety and health preventative culture; reviewing the provisions of the Act including rules and regulations, standards and industry codes of practice; the statistical analysis of work related deaths and injuries, and such other matters affecting the quality of working life in Kenya (GOK, 2007; Muigua, 2012; ILO, 2013).

The Government of Kenya (GOK), and particularly the Ministry of Labour, developed in 2012 the National Occupational Safety and Health Policy whose objectives are to establish national occupational safety and health systems and programs geared towards the improvement of the work environment; and to mainstream occupational safety and health issues into management systems of both private and public sectors. These objectives and the implementation of the policy will be in line with achieving the goals of Kenya's Vision 2030 which aims to develop Kenya into a globally competitive and prosperous country with a high quality of life by the year 2030; and so in order to achieve this, there is need to improve the safety and health of workers throughout the nation. However, this policy is yet to be implemented, as even though the draft has been submitted to the Cabinet, it is still awaiting discussion and approval (GOK, 2012; Kenya Vision 2030, 2014).

The challenges associated with implementing OHS in Kenya are largely due to lack of man power and funding. For instance out of 375 available posts in DOSHS, only 139 are filled, of which only 71 are OHS personnel and the rest are administrative support personnel. DOSHS are as well underfunded, for example during the financial year 2010-2011, DOSHS was allocated Ksh 327 million for all its activities against a budgeted sum of Ksh 683 million (ILO, 2013). For these reasons, DOSHS has only been able to inspect approximately 4000 workplaces a year out of the estimated 140,000, which leaves most workers (especially the 8.8 million that are estimated to work in the informal sector), exposed to OHS hazards without intervention (ILO, 2013; Muigua, 2012; Muchiri, 2005). There is also unequal representation of DOSHS officers throughout the country, as only 29 counties have DOSHS representation, leaving the remaining 18

counties with no officers. Rural areas, in particular, are insufficiently covered by DOSHS officers, and illiteracy levels in these areas tend to be high, and so these illiterate workers are left exposed to OHS hazards (ILO, 2013). Therefore, the achievement of OHS standards in Kenya still lacks capacity.

Overall good OHS management requires a tripartite approach: Government, Employer and Employee (ILO, 2011; ILO, 2001; GOK, 2013). The government's role is to provide a national framework for management of OHS, such as the rules stated in OSHA 2007; along with the DOSHS department that provides support for the promotion of OHS. The employer's role involves planning and implementation of a written safety and health policy, organization of safety and health functions, and constantly monitoring and reviewing performance of the policy and other health and safety systems. And the employee's role involves cooperating with the employer to ensure success of the policy and complying with all safe work procedures and practices. In summary, an effective and efficient institutional OSHMS should apply relevant OHS criteria, standards and performance; and should follow a continuous improvement cycle such as the Deming Cycle (Figure 1) which is based on the 'Plan-Do-Check-Act' Principle (ILO, 2011).

2.3 Risk Assessments (with an emphasis on the provisions of OSHA, 2007)

According to EC (1996) there is no single 'right' way of conducting a risk assessment as a variety of methods exist that vary according to the circumstance and type of environment where the assessment is being done. They however all incorporate similar elements/steps that involve identifying the hazards; evaluating the risks and deciding on precautions; recording and implementing the findings; and having regular reviews and updates of the assessment (EC, 1996; Workcover Corporation, 2000; HSA, 2003; HSA IE, 2006; HSE UK, 2011; ILO, 2011; HSA IE, 2013). They all as well agree that it is the responsibility of the occupier of the workplace to have regular risk assessments undertaken, but to involve all the employees as much as possible in the process, even if an external professional is hired to conduct the assessment (EC, 1996; Workcover Corporation, 2000; HSA, 2003; HSA IE, 2006; GOK, 2007; HSE UK, 2011; ILO, 2011; HSA IE, 2013).

The following six step approach to conducting a risk assessment was developed by the Health and Safety Authority of Ireland (HSA IE, 2006) and is a straightforward approach to risk assessment and management that incorporates their main elements. It can be considered the most suitable to use in a hotel work environment as HSA IE (2013); HSA (2003); and Workcover Corporation (2000) utilize similar steps for undertaking risk assessments in the hospitality industry. The steps are explained as follows.

Figure 2: Six Step approach to conducting a Risk Assessment

Source: HSA IE (2006)

STEP 1: SAFETY AND HEALTH POLICY

The risk assessment cycle begins and ends with the implementation of a safety and health policy which is a written statement of the safety and health measures taken to safeguard all in a particular work environment. The policy should be signed at senior, responsible management level on the employer's behalf. It should begin with a declaration stating the employer's commitment to ensuring that the "workplace is as safe and healthy as reasonably practicable, and that all relevant statutory requirements will be complied with" (HSA IE, 2006: 11).

It is the duty of occupiers, as per Section 7 of OSHA 2007, to prepare and, as often as may be appropriate, revise a written statement of his general policy with respect to the safety and health at work of his employees; and to bring the statement and any revision of it to the notice of all his employees. This is why this step marks the beginning and the end of the cycle, as the safety and health policy is used as a baseline to undertake a new risk assessment, and any new findings are reviewed and added to the policy, and so it is constantly revised and the cycle continues.

Section 9 (1) of OSHA 2007 as well states that every occupier shall establish a safety and health committee at the workplace in accordance with regulations prescribed by the Minister if, there are 20 or more persons employed at the workplace. The establishment of such a committee is not only necessary for the effective implementation of the safety and health policy, but also as a communication tool between senior managers and all employees on matters of safety and health at the workplace (HSA IE, 2006; GOK, 2013).

STEP 2: IDENTIFY HAZARDS

To safeguard safety and health in the workplace, it is crucial to identify the potential hazards from materials, equipment, chemicals and work activities. Identifying the root causes of risks (the hazards) is vital for an organization to be able to efficiently manage risks (HSA IE, 2006). The type of hazards in a workplace can vary from physical, chemical, biological, mechanical/electrical, ergonomic, to psychosocial hazards.

Types of hazards that can be found in a hotel work environment are discussed in Section 2.7: Conceptual Framework**.** Some hazards may be obvious such as working at heights or with electricity, but some may be less apparent such as excessive noise which may take a long time before any harm is realized (HSA IE, 2006; HSE UK, 2011; EC, 1996).

According to HSA IE, 2006; HSE UK, 2011; EC, 1996; Workcover Corporation, 2000; HSA, 2003, there are various approaches to identifying hazards in the workplace, the most important is to consult with the employees as they have firsthand experience on how they go about their duties, and therefore are able to advise on any difficulties, or their perceptions on any hazards and adverse effects; and they as well may have noticed things that are not immediately obvious to the assessor.

It is also important to walk around by examining systematically all aspects of the work to identify any area or activity that can be expected to cause harm. It is vital to look at what actually happens in the workplace or during the work activity, as actual practices may differ from any existing work manuals; and to particularly scrutinize situations involving new installations, maintenance and cleaning, and any changes in work production/process techniques (EC, 1996).

Checking manufacturers' instructions or datasheets for chemicals and equipment can immediately identify hazards and their precautionary measures. It is also important to look at the workplace's records of accidents, ill health, insurance claims, maintenance logs and training records as these may help to identify any less obvious hazards (HSA IE, 2006; HSE UK, 2011).

Last but not least, cross checking against any relevant legislation, regulations or standards covering particular hazards can help identify any potential hazards and their risks in the workplace, e.g. OSHA 2007 and its subsidiary legislations such as, 'The Factories (Electric Power Special) Rules', L.N. 340/1979; or 'The Factories and Other Places of Work (Hazardous Substances) Rules, 2007' (GOK, 2007).

STEP 3: ASSESS RISKS

After the hazards have been identified, there are 3 major aspects to consider when assessing their risks (HSA, 2003; HSA IE, 2006; HSE UK, 2011):

- What is the likelihood of the hazard to cause harm?
- What is the possible extent or severity of that harm?
- Who, including groups of persons, might be exposed to the hazard, and how often?

Using a hotel work environment as an example, the analysis of the hazard's likelihood to cause harm can be described as remote (not likely to occur); occasional (possible or known to occur); or frequent (common or repeating occurrence). While the analysis of the severity of the harm can be defined as minor (e.g. minor cuts/bruises, ill health that requires first aid treatment only); moderate (e.g. lacerations, burns,

sprains, minor fractures or dermatitis); or major (e.g. amputations, major fractures, poisoning, chronic ill health or fatal diseases) (HSA, 2003; Workcover Corporation 2000; HSA IE, 2013; Meng, 2002; EC, 1996). According to Meng (2002); Government of South Australia (2009); and Queensland Government (2012), descriptive statistics can be used to determine the results of the likelihood and severity which can then be tabulated into matrix form to determine the level of risk. Where high risk indicates immediate intervention is required to reduce the risk; medium risk requires interim risk control measures to be implemented; and low risk may not require any additional risk control measures but frequent monitoring to ensure it does not increase.

Figure 3: Level of Risk matrix

Likelihood / Severity	Remote	Occasional	Frequent
Major	Medium risk	**High risk**	**High risk**
Moderate	Low risk	Medium risk	**High risk**
Minor	Low risk	Low risk	Medium risk

Source: Meng (2002)

It is important to identify all those who might be exposed to the hazards whether directly or indirectly; for instance, a worker painting a surface is directly exposed to solvents, while other workers in the vicinity are indirectly exposed (EC, 1996). Particular attention should as well be given to people who may not be in the workplace all the time, but are still exposed to the hazards, such as visitors, contractors, suppliers and customers (HSA IE, 2006, HSE UK, 2011).

Lammerding, Fazil (2000); Coleman, Marks (1999); and Buchanan, Whiting (1998) concur on similar approaches for conducting microbial food safety risk assessments which involves hazard identification, exposure assessment, hazard characterization, and risk characterization. Therefore this approach can be considered suitable for analysing risks in a hotel work environment.

STEP 4: DECIDE PRECAUTIONS

Eliminating all risk would be an ideal situation, but not realistic, as life in general cannot be totally risk free (HSA IE, 2006). Occupiers, however, are still legally required by OSHA 2007 to ensure the safety, health and welfare of all persons in his workplace (Section 6). Therefore, there is need to take precautionary measures to control risks, in order to reduce their likelihood, spread, and level of severity.

Some aspects that should be taken into account include the severity of the risk, the likely outcome of an incident, the numbers who might be affected, and the time and cost required for taking certain precautionary measures (EC, 1996). The measures of controlling risks include (in order of preference): Elimination or Substitution; Engineering Controls; Administrative Controls; Personal Protective Equipment;

and Welfare Facilities (HSA, 2003; Queensland Government, 2004; HSA IE, 2006; MOM, 2006; Burton, 2010; HSE UK, 2011; HSA IE, 2013). These control measures are discussed further (with a focus on hotel work environments) in Section 2.7: Conceptual Framework.

STEP 5: RECORD THE FINDINGS

The results of the risk assessment should be recorded and integrated into the safety and health policy (HSA IE, 2006). The policy should be made available and accessible to all employees and be written in a form, manner and language that will be understood by all. HSA IE (2006) recommends that it is useful to keep a copy of the policy, or relevant extracts, available for inspection at or near every workplace to which it relates, in order for it to be effectively implemented.

According to the HSA IE (2006), the following are some of the areas that should be covered by a safety and health policy:

- The specific hazards identified and risks assessed, along with the preventive and protective measures taken to eliminate or control the risks.
- The resources provided by the employer to ensure the safety and health of employees such as time, personnel and finance.
- The plans and procedures to be used in the event of an emergency or serious danger.
- The procedures for monitoring safety and health performance in the workplace.
- The safety and health committee representatives, their names and responsibilities; including the channels of communication employees can use to consult with them on safety and health issues.
- Most importantly, the policy should clearly indicate the co-operation required from all employees to comply with the safety and health procedures, requirements and instructions given by a person having authority over him; to ensure his own safety and health and that of other persons who may be affected by his acts or omissions at the workplace; and at all times wear or use any protective equipment or clothing provided by the employer for the purpose of preventing risks to his safety and health (Section 13 of OSHA, 2007) (GOK, 2007).

Apart from legal requirements to prepare a safety and health policy statement (Section 7 of OSHA, 2007), there is an element of care that an occupier shows for the safety and health of his employees by writing down the policy and most importantly monitoring and implementing the measures stated in it. Therefore, he creates a safe and healthy work environment as he shows hazards have been identified and risks have been assessed, eliminated or controlled (HSA IE, 2006).

STEP 6: REVIEW AND UPDATE

The frequency of how often the safety and health policy should be reviewed and updated differs in opinion. According to HSA IE (2006) and HSE UK (2011), it should be formally reviewed every year, whereas

MOM (2006) recommends it to be reviewed at least once every three years. Ideally the safety statement should be reviewed and updated whenever there is an important change in the work environment. These include changes in work processes; organisational structure; number of workforce; equipment or substances used; technical knowledge or changes in legislation and standards (HSA IE, 2006); any of which can introduce significant new hazards and risks. Therefore, it is necessary to undertake frequent risk assessments, and review and update the safety and health policy, to ensure it remains relevant at all times. By periodically reviewing the policy, it helps the occupier to review how effective the safety and health management has been; and to ensure any proposed changes have been considered (HSA IE, 2006).

2.4 Occupational Health and Safety in Hotels

According to Buchanan *et al* (2010) injury rates for hotel workers are almost 40% higher than those in the service sector as a whole. They analysed the rates of OSHA-reported injuries within 71 US hotels for a 3 year period (2003-2005), for 4 leading hotel job categories (housekeepers; cooks/kitchen workers; stewards/dishwashers and banquet servers). They found that 2865 injuries were reported, in which housekeepers had the highest overall injury rate and the highest rate of musculoskeletal disorders (approximately 7.9 and 3.2 per 100 workers respectively). They also had the highest acute trauma rates along with cooks/kitchen workers, whereas banquet servers had the lowest injury rates. They concluded that the reasons why housekeepers are the most vulnerable to injuries is because "cleaning tasks(...) demand a high level of physical effort, including high aerobic strain and repetitive movements, high static muscular loads, high frequency of unsatisfactory postures, such as stooping and crouching, and subjective experience of strenuous work" (Buchanan *et al*, 2010: 120). However, this study is limited as it did not consider other vital job roles in a hotel, such as bar/restaurant servers, reception or office workers, grounds keepers or pool area attendants; and Buchanan *et al* (2010) add that there is a high tendency of workers who do not report their injuries especially if they are non-unionized, immigrants, or politically vulnerable.

The housekeeping department is indeed a job area that is vulnerable to health and safety risks, especially with the spread of infectious diseases. The housekeepers need to take special care when handling or cleaning anything that might have had contact with another person's blood or body fluids; such as razor blades, syringes, sanitary napkins, soiled sheets and towels, vomit or excreta (HSA, 2003). The substances they use to clean bathrooms, floors and laundry are potentially dangerous chemicals and may cause dermatitis and chemical burns. Laundry areas can as well be very damp, humid areas that can lead to health complications, especially with breathing (HSA IE, 2013). Other job roles that may also be exposed to infectious agents are pool and health club attendants. These workers are as well in frequent contact with chemicals and so it is important that only qualified, properly trained and instructed personnel deal with them (HSA IE, 2013).

Another occupational area that is particularly susceptible to health and safety risks is the kitchen and food preparation area. Different kinds of injuries and health implications can occur in workplaces where food is prepared and served, such as heat stress, strains, scalds, serious burns, lacerations, fractured bones and amputated limbs/fingers due to the kind of machinery and equipment used in these areas (e.g. knives, slicers, deep fat fryers, mincers, mixers, ovens, steam equipment etc) (HSA, 2003; HSA IE, 2013; Queensland Government, 2004). The risk of injury is made worse if the kitchen has a poor layout, for example if there's insufficient room to move safely around (move trolleys, carry trays) and avoid collision especially around exposed hot surfaces. Or if staff working with knives and other hand tools do not have adequate room to work safely and put themselves and others at risk of injury; or if simply, IN and OUT doors are not clearly marked, which can greatly elevate the risk of accidents (HSA, 2003).

The bar/restaurant service areas are as well associated with some occupational hazards. Slips, trips and falls, along with cuts from broken glass and injuries from manual handling are amongst the most common accidents in bar and restaurant areas; as well as risks from unsafe stacking of cases, kegs and gas cylinders-which may explode if stored incorrectly. These workers are also constantly collecting and disposing of waste, and so standards of safety and hygiene are of utmost importance to avoid putting the health and safety of customers, and other staff at risk (HSA, 2003; HSA IE, 2013). A unique hazard these workers are exposed to is environmental tobacco smoke, as they tend to work in close proximity to smokers. Exposure to this smoke can have mild health implications such as eye irritation to severe ones such as asthma, lung cancer, pneumonia and other chest infections (HSA, 2003).

Receptionists are as well exposed to occupational health and safety risks. Since receptionists tend to handle a high volume of enquiries, they are on their feet most of the time leading to strain, musculoskeletal disorders and stress. They as well generally spend many hours using a variety of keyboard and computer equipment which can lead to a range of injuries caused by overuse, poor posture and poor lighting. Because of the large volumes of people passing through, a reception area can become dirty and untidy very quickly, from dirty footprints, sticky finger marks, dust build up (which can affect the health of workers), stray items left in walkways, or furniture moved out of place which can cause obstruction and therefore increase risk of accidents. Receptionists as well tend to deal with large volumes of cash, and this puts them at risk of occupational violence from thieves and other dishonest people; terrorists; or violent and aggressive people (HSA, 2003; Hoel, Einarsen, 2003; ILO, 2009b).

A phenomenon that is experienced widely in the hotel industry, and threatens the safety and well being of workers, is sexual harassment (Hoel, Einarsen, 2003; HSA, 2003; ILO, 2009b). According to Hoel, Einarsen (2003: 18) ""sexiness" and "flirting" are encouraged as part of the job in the service industries, (...) (and) in many cases employees are not allowed to perceive themselves as victims of "harassment." Being exposed to unwanted sexually related attention is considered to be part of the job". The aspect of emotional

labour can be seen as a reason for this, as a hotel employee is expected to be gentle, caring, pleasant and accommodating, which can easily create a situation with a high risk of sexual harassment (Hoel, Einarsen 2003; Lo, Lamm, 2005). However, according to ILO (2009b), the levels of harassment can be significantly decreased through the implementation of strict policies that clearly define zero tolerance of sexual harassment; and having regular trainings for all staff on how to address this issue. According to Hoel, Einarsen (2003), the groups vulnerable to sexual harassment include women, part-time workers, and young workers (especially those on internships). However, they found that some men, especially waiters, are as well prone to sexual harassment, in form of obscene language and jokes, and sexually suggestive comments.

Another form of harassment that is widespread in the hotel work environment is bullying. This can be in form of intimidation or harassment, uncontrolled anger, frustration or irritation, verbal abuse, or physical assault (HSA, 2003). The assailants of these harassments can be a number of people, from the public and hotel guests, to supervisors, managers and other employees (HSA, 2003; Hoel, Einarsen, 2003). Hoel, Einarsen (2003) found that another form of bullying employees endure, is being undermined by their superiors, where they are given meaningless work; given work below their professional competencies; are put under undue pressure; or the efforts they have made are constantly devalued or under-appreciated.

Other forms of hazards and risks that are common in the hotel work environment include manual handling, which is one of the main causes of injury, as it accounts for over one third of all reported incidents in the hospitality sector (HSA IE, 2013). It involves any activity that requires the use of force exerted by a person to lift, lower, push, pull, carry or otherwise move any load; and can result in a number of injuries such as strains and sprains, neck and back injury, cuts, bruises, broken bones, and hernia. Manual handling is a requirement in almost all departments but especially in housekeeping, kitchen, and food and beverage service (HSA 2003, Queensland Government, 2004).

Slips, trips and falls as well account for a considerable proportion of work related accidents, and can occur anywhere in the hotel environment (HSA IE, 2013). People can slip and trip on slippery, rough, or uneven surfaces, or can fall down stairs or ladders. These can result in a number of injuries such as, broken bones, abrasions, strains, sprains or serious injuries to the back or spine (HSA, 2003). A number of factors can increase the risk of injury from slips, trips and falls, but they are mostly related to poor housekeeping, such as wet floors with no caution signs put up; inadequate floor washing methods leaving grease/detergent residue; a layer of fine dust on the floor; or unsecured matting/carpeting such as a loose mat or ripped carpet (HSA 2003, Queensland Government, 2004; HSA IE, 2013).

Finally, burns and cuts are also a frequent risk, in especially the kitchen and housekeeping departments. Burns can be caused by steam, irons and hot substances and equipment such as water, oil, stoves and ovens; as well from chemicals that are used for cleaning and gardening. Cuts are common risks

from the use of sharp tools such as knives, scissors; or appliances for cutting, shredding, and mincing (Queensland Government, 2004; HSA IE, 2013).

2.5 Previous Studies on Occupational Health and Safety

Many previous studies on OHS have focused on what are considered 'high-risk' industries, such as the construction industry, manufacturing industry, medical industry, agricultural industry and others. This unfortunately means that little research has been done on the so-called 'low-risk' industries, such as the hospitality industry; as there is a general notion that it has few occupational hazards and risks-however this general perception may be the result of the lack of significant research done in this area (Lo, Lamm, 2005; O'Neill, Davis, 2011; Ondieki, 2013). From reviewing literature, this seems to be especially the case for Africa, as most research and information available on OHS in the hospitality industry have been produced in developed countries such as Australia, New Zealand, UK and USA (see e.g. Lo, Lamm, 2005; O'Neill, Davis, 2011; Bohle *et al*, 2004; Gibbons, Gibbons, 2007; Mayhew, Quinlan, 2002; Buchanan *et al*, 2010; HSA, 2003; Queensland Government, 2004; Workcover Corporation, 2000; HSA IE, 2013). Therefore, there is need to address this issue, especially in Kenya where tourism is one of the top earners (approximately Ksh 93.9 billion in 2013) and is one of the country's highest employers (KNBS, 2014).

Global studies of OHS in the hospitality industry have mostly focused on occupational stress as a hazard in the industry, which affects a worker's wellbeing. These include Lo, Lamm (2005) who studied an employment relations perspective on occupational stress in the hospitality industry; Gibbons, Gibbons (2007) who studied occupational stress in the chef position; and O'Neill, Davis (2011) who researched on work stress and well being in the hotel industry. These studies found that there is a high level of occupational stress present in the hotel work environment from heavy workloads and hours (including shift work), employee/co-worker stressors (such as work arguments) and hotel guest stressors from intensive customer interaction.

Lo, Lamm (2005) point out that the intensive customer interaction is the reason for high level of 'emotional labour' required from hotel employees who have to "act in an empathetic, positive, and friendly manner at all times when dealing with customers in order to make them feel wanted and welcome" (Lo, Lamm, 2005: 24). This constant state of emotion may be unnerving and stressful for some and may lead to negative health implications (Hoel, Einarsen, 2003). However, Lo, Lamm (2005) found that there is widespread acceptance amongst employees that stress is an integral part of the job; that hospitality workers are expected to tolerate occupational stress and not challenge managerial decisions concerning conditions of their work, as to do so would result in disapproval by their managers. Kuria, Wanderi, Ondigi (2012) on their study on educational level and career growth in the hotel industry in Kenya, as well found similar results of employees reporting that they are not treated well by their management, describing them as

inflexible and unapproachable, making the employees work long hours causing them fatigue, stress and conflict in their work and personal life.

This lack of communication, and feeling undervalued by managers as a source of occupational stress, was also found by Gibbons, Gibbons (2007), along with bullying and threats of violence for some. Hoel, Einarsen (2003) in an interview with UK chefs reported that accounts of physical violence included kicking, pushing, throwing objects, and deliberately burning someone with hot equipment and food. They put these down to the negative characteristics of the work environment such as the heat and pressure to perform, which were seen to contribute to high levels of frustration among senior chefs. Gibbons, Gibbons (2007) found that not only does stress negatively affect the employee's well being but also resulted in some taking up unhealthy coping mechanisms to help with the stress such as smoking, consumption of alcohol and over/under eating, which further affects their health and wellbeing.

O'Neill, Davis (2011) found that there are no significant differences of stress levels by gender or marital status, however, hotel managers reported significantly more stressors than hourly employees, such as higher level of responsibility and longer working hours. Overall they found that there is a high level of stress and fatigue in the hotel work environment and this generally affected the physical and mental health of workers, led to low level of job satisfaction and high level of employee turnover, which on a whole affects the workers professional and personal life.

Other global studies on OHS in hospitality have related it to the high level of precarious employment found in this industry. Examples include Mayhew, Quinlan (2002) who conducted a research on OHS problems in relation to young, temporary workers in hospitality (particularly the fast food industry that practice fordist (mass production) systems); and Bohle *et al* (2004) who studied the impact of temporary employment in hospitality on working hours, work life conflict and health by comparing casual employees to full time ones. There are marked differences in the results of the two studies, whereby Mayhew, Quinlan (2002), contrary to expectations, found that temporary workers have the same amount of injuries as the full time workers, and excellent knowledge of risk control and the country's (Australia) OHS legislation. The researchers put these results down to the tightly controlled fordist system in their work environment, that specifies tasks and incorporates detailed risk assessments and control procedures; hence the low level of occupational accidents. However, Bohle *et al* (2004) found a significant difference between the reports of casual and full time employees in hotels. Casuals were more likely to work irregular hours over which they had little control; and this produced greater disruption to their family and social lives which caused them to have a poor work-life balance. All these led to health issues arising from this work-life conflict such as sleep disturbance, fatigue, and disrupted exercise and dietary regimes; therefore affecting their overall wellbeing.

Some of the studies conducted in Kenya on OHS have been done on sugar processing establishments, e.g. Mutuli, Onyoyo, Makhonge (2000) on the situation analysis of OHS in small-scale Kenyan sugar processing establishments; and a thesis on the influence of OHS practices on job satisfaction in Kenya's Chemelil Sugar Company by Indakwa (2013). Both these studies agree that there are high number hazards workers are exposed to in the sugar industry, especially in the agriculture and factory departments (field services and production). According to Mutuli, Onyoyo, Makhonge (2000), workers are forced to endure working environments that lack any consideration in terms of OHS and comfort, and management are often unaware of the poor working conditions and are oblivious to ways of improving productivity. This sentiment of managers' aloofness on OHS practices and familiarity with work safety legislation is shared by Mbakaya *et al* (1999) who found that 65% of workplaces in Kenya violated the mandatory legal requirement on the establishment of health and safety committees. Ongeri (2002) as well yielded similar results in his study on OHS policies in Kenyan tea factories, where he found that OHS issues were not fully understood and therefore not fully embraced, and these establishments as well lacked implementing a health and safety committee. However, the results of these studies may not be generalized to all workplaces as Mutuli, Onyoyo and Makhonge (2000) focused their study on small scale sugar processing establishments (the situation may be different in larger scale enterprises); and all three were done before the enactment of OSHA 2007.

Some studies that were conducted after the implementation of OSHA 2007 yielded different results. These studies show that majority of workers are satisfied with the OHS practices in their work environments; many had established health and safety committees in their work places (however, study by Sang (2010) found that employees find it difficult to balance committee duties with company duties, but still feel the committees have a positive impact on safety in the work place); but almost all feel the level of trainings on OHS are infrequent (although when done are useful (Indakwa, 2013)); and inspection and audits of their facilities by OSH officers are extremely low (see e.g. Nzuve, 2013; Gatithi, 2013; Sang, 2010; Ondieki, 2013; Indakwa, 2013).

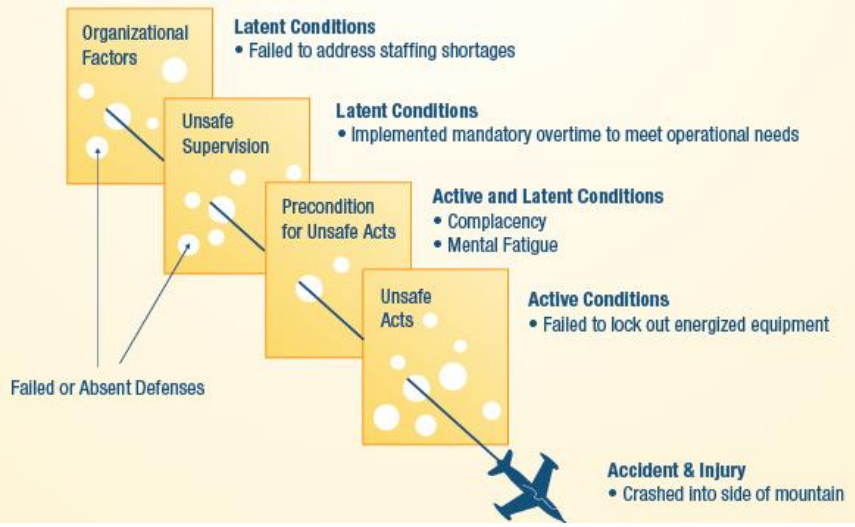
Gikonyo (2008) found that this lack of inspection and regulation by OSH officers is especially common in the informal sector, known in Kenya as the 'Jua Kali' sector. This leaves these workers exposed and vulnerable to OHS hazards which tend to be predominant in their environment (Gikonyo, 2008; ILO, 2013). Although Gikonyo's (2008) study was narrowly focused on the metal workers in the informal 'Kamakunji Jua Kali Market' in Nairobi, it is similar to the current research problem, as it as well investigated the types of hazards present in that work environment, their effects on the workers, and ways of improving the situation to reduce the risks of the hazards (although this aspect was vaguely touched as only one main solution was given to reduce the presence of hazards in this environment, which is to have a systematic and regular assessment of the OHS hazards, and this to be enhanced by a regulatory framework).

Few studies done in Kenya that relate to OHS in the hospitality industry include Wazir (2013) who researched the challenges of implementing health and safety programmes in Kenya Airways; and Ondieki (2013) who studied the implementation of 'Cleaner Production' in Nairobi hotels, where OHS was an aspect he looked into. Wazir (2013) found that even though a health and safety program exists in Kenya Airways, the employees are not aware of it nor are they part of the safety committee; there is no form of reporting accidents or identification of hazards; and the only time the program is reviewed is when there are major accidents involving aircrafts. Ondieki (2013) as well found that 85% of hotels in Nairobi have a department charged with the responsibility of OHS, and 70% had put in place some OHS requirements as prescribed by law such as insurance cover for staff, and emergency response equipment and procedures; however only 16% had written OHS policies and actually communicated these to their staff. Both these studies show that even though businesses in the hospitality industry comply with some aspects of OSHA 2007, such as setting up a health and safety committee, the problem lies in the implementation, actualization, and review of some of the OHS policies generated by this committee. As the previous studies have shown, audits and inspections done by official OSH officers are extremely low, and this may be one of the reasons for the lack of enforcement of OHS policies and measures in the hospitality industry in Kenya.

2.6 Theoretical Framework

In 1990, James Reason developed an OHS theory known as the 'Defence in Depth Accident Trajectory Model' (DDATM) (also known as the Swiss Cheese Model). He built on the idea that accidents in complex systems occur through a series of inter-connected factors, rather than a single causal condition. These conditions or vulnerabilities can be 'latent', present in the organization long before a specific incident is triggered (such as poor staffing, training, policy, managerial decisions, communication patterns or hierarchical relationships); or they can be real time errors, or 'active failures', usually by front line operators. These latent conditions and active failures can coexist within the workplace for a long time, however when they are allowed to come together it can lead to a possible trajectory for an accident (Reason, Hollnagel, Paries, 2006; Cassidy, 2012). Reason developed "a model of how accidents could be seen as the result of interrelations between real time 'unsafe acts' (active failures) by front line operators and (pre-existing) latent conditions (in an organization)" (Reason, Hollnagel, Paries, 2006: 2). According to Cassidy (2012: 1) "what Reason proposes is that risk has a trajectory, which passes through corresponding holes in the layers of defence, barriers and safeguards (an organization uses to protect them from failure/loss) and if it achieves a 'direct flow through', will result in a failure." The following is an illustration of the DDATM used in a scenario of an aeroplane crash.

Figure 4: Defence in Depth Accident Trajectory Model



Source: FAA, 2008

Cassidy (2012) gives an example of four critical health defence layers that can be applied to any organization or industry, including the hotel industry. The layers a hotel can use to protect themselves from failure or loss of productivity include:

- Pre-employment health screening
- Health management (including health-surveillance and assessments, wellbeing, and absenteeism)
- Injury management/rehabilitation (workers compensation)
- Exit medicals

Cassidy (2012) adds that the 'holes' arise when these layers are not used in a holistic manner, for instance separate departments managing different critical layers causing information gained to not be relayed effectively within the organization. Cassidy (2012: 3) further explains that by

> "Lining all of the health components (defence layers) up and having a conduit between them becomes the key to releasing valuable, risk-based information that can greatly enhance any organization's ability to identify health risk trends, and then use this information in a positive way to reduce the likelihood of poor health outcomes, and deliver measurable business and employee benefits" (Cassidy, 2012: 3).

For example Buchanan *et al* (2010) found that musculoskeletal disorders are rampant amongst housekeepers working in hotels. This information could be used at the pre-employment health screening layer for new housekeepers, to determine if the individual is prone/vulnerable to musculoskeletal disorders or is not the right 'fit' for the job. By hiring the wrong worker in the wrong occupation, the organization exposes itself to increased absenteeism, worker compensation claims and loss of productivity (Cassidy, 2012). Utilizing information gained at the different defence layers can help reduce these risks, for example analysing data from workers compensation and exit medicals can help capture the trending injuries in the

various departments and the hotel in general, such as musculoskeletal disorders, severe burns/lacerations, high blood pressure, anxiety etc. (HSA, 2003; HSA IE, 2013). This information can then be used not only at pre-employment screening, but as well to determine which health programs and interventions to introduce in the workplace that can help reduce the likelihoods of these injuries/disorders occurring, for instance back care programs, manual handling trainings, and dealing with stress trainings (Cassidy, 2012).

Reason's model shares similar components with other theories such as H.W. Heinrich's 1931 Domino Theory and the Safety Engineering Model developed by U.S researchers, where they advocate that it is a "chain of events and circumstances that ultimately lead to injury" (Cliff, 2012: 4) rather than a single condition or occurrence (Reason, Hollnagel, Paries, 2006). Like these theories, DDATM has been criticised for being too simplistic, as noted by Shappell & Wiegmann (2000) (in Reason, Hollnagel, Paries, 2006),

> "In many ways, Reason's 'Swiss cheese' model of accident causation has revolutionized common views of accident causation. Unfortunately, however, it is simply a theory with a few details on how to apply it in a real-world setting. In other words, the theory never defines what the 'holes in the cheese' really are, at least within the context of everyday operations". (Reason, Hollnagel, Paries, 2006: 12).

It is as well seen to focus more on barriers rather than hazards, giving the impression that it is more efficient to prevent accidents by strengthening system barriers than by eliminating causes. However it has been praised for being a valuable tool for accident analysis as it makes clear that accidents have complex causes, and it as well brings forward the effects of factors that may otherwise be hidden from view (latent conditions) (Reason, Hollnagel, Paries, 2006).

Dr. Peter Strahlendorf's Internal Responsibility System (IRS) theory as well agrees that different interrelated components can cause failures or accidents in an organization; however the rate of incidents or accidents depends on the 'safety culture' of the organization (Strahlendorf, 2013). Safety culture in the IRS theory states that it is everyone's (from the owner to top level directors to front line workers) responsibility to take steps to promote health and safety in the organization- action on health and safety should not be shrugged off as only the appointed management's responsibility (Thomason, 2005; Strahlendorf, 2013). Strahlendorf (2013) adds that if everyone took initiative to eliminate or control hazards, the rate of incidents would significantly decrease. However the IRS may work better in theory than practice as workers may avoid dealing with workplace health and safety issues. They may feel it is someone else's job; may not have enough time or resources to deal with the issue; or may feel they may offend someone or get into trouble if they attend to the issue themselves. Furthermore the IRS can be used by employees as an excuse to shirk legitimate work assignments thereby affecting productivity of the business (Thomason, 2005; Strahlendorf, 2013).

The Government of Western Australia as well agrees that it is everyone's responsibility to promote health and safety. As a result, in 1996, they developed a health and safety management philosophy known as ThinkSafe S.A.M. steps which involves (Government of Western Australia, 2014):

1. **S**pot the Hazard (Hazard Identification)
2. **A**ssess the Risk (Risk Assessment)
3. **M**ake the Changes (Risk Control)

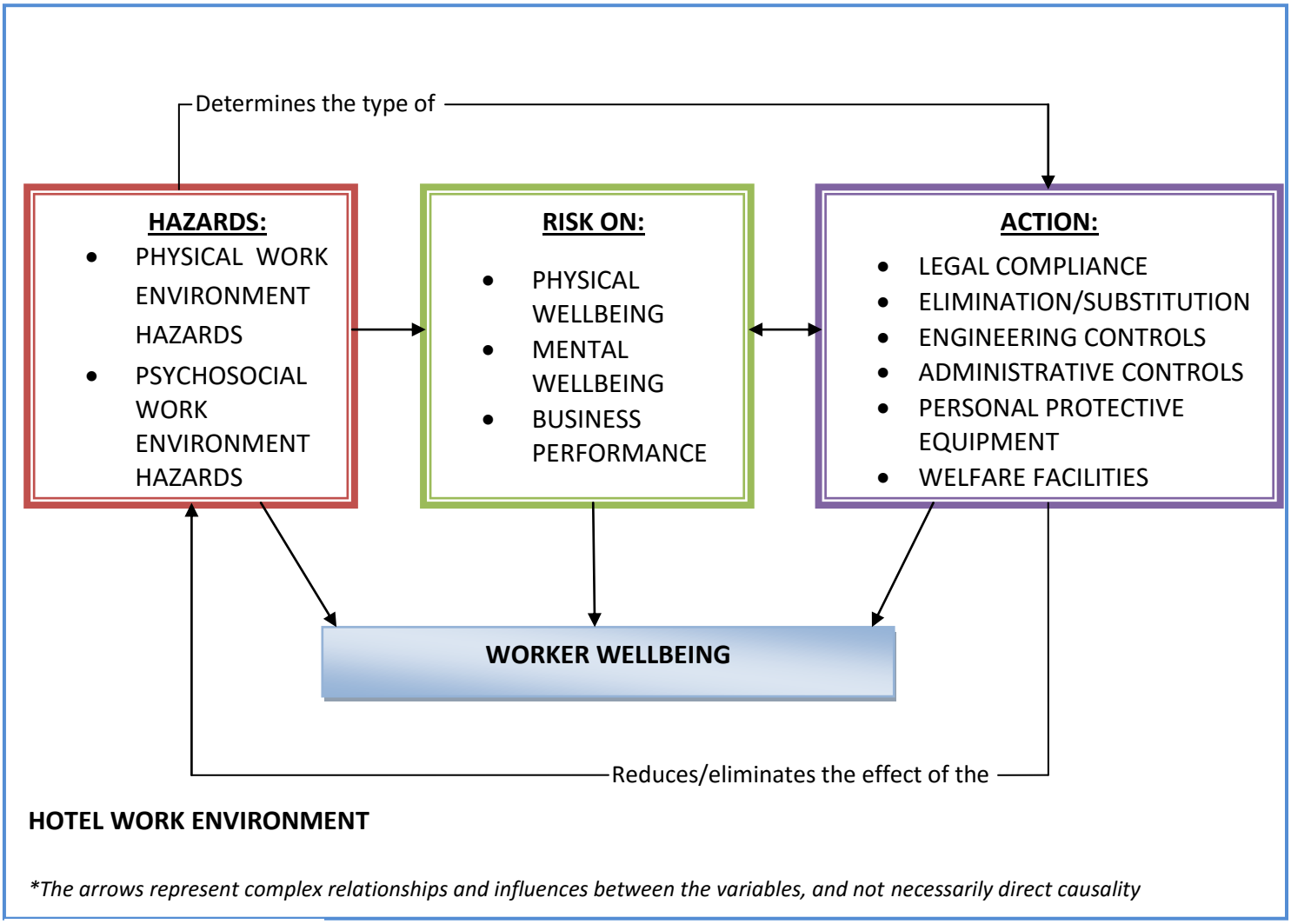
The aim of ThinkSafe was to bring about a 24hour safety culture amongst industries and the community through these three simple steps. They were taught in Western Australian school curriculums and their application was made compulsory in all workplaces to be performed by all employees (Government of Western Australia, 2014; Kierath, 1998; Borys, 2007). The philosophy proved to be successful, as just after two years of being introduced, a survey showed that Western Australia had the highest score of all Australian States for increased community awareness on safety. The survey also showed 93% recalled the ThinkSafe S.A.M. steps easily and 53% of the respondents said they apply the steps to their daily activities not just work (Kierath, 1998; Borys, 2007).

However its simplicity may be considered too basic to be able to conduct accurate risk assessments. The official document published by the Government of Western Australia (2014) explains each S.A.M. step in brief. For hazard identification it only lists some types of physical hazards (mechanical/electrical, chemical, ergonomic), with no mention of how to identify psychosocial hazards; even though research shows these hazards exist and have an effect on physical and mental wellbeing (Lo, Lamm, 2005; Burton, 2010; Comcare, 2004; Hoel, Einarsen, 2003; Borys, 2007). For risk assessment, Government of Western Australia (2014) lists two criteria for the assessor: how likely is it that the hazard could harm me or someone else and; how badly could I or someone else be harmed. This may be considered relatively basic as it does not take into account quantitative risk assessment methods which could otherwise provide more accurate results; it however allows the average employee a simple process to quickly assess safety risks in their environment (Marshall, 2004; Ingle, 2005). Finally for risk control, most effective methods to least effective methods are listed (elimination, substitution, isolation, safeguards, administrative, and use of personal protective equipment) which correlate with universal risk control methods (HSA IE, 2006; HSE UK, 2011; Meng, 2002; Government of South Australia, 2009).

Overall, the ThinkSafe S.A.M. steps philosophy provides necessary knowledge on conducting risk assessments which are easily comprehendible for persons at all levels. This therefore allows them to effectively manage health and safety in both their personal and work lives (Marshall, 2004; Ingle, 2005).

2.7 Conceptual Framework

Figure 5: Conceptual Framework



Source: Researcher (2014)

The conceptual model is designed by the researcher and is based on the Government of Western Australia's safety philosophy, ThinkSafe S.A.M. steps. It is divided into three key elements that have an implication on a hotel worker's wellbeing: the types of occupational **hazards**; the **risks** of these hazards on a worker; and the **actions** required that can reduce or eliminate the hazards and their associated risks.

The occupational hazards can be found in the physical work environment and the psychosocial work environment (workplace stressors). Some of the hazards in the physical hotel work environment can be physical (such as slippery surfaces, ladders, noise, excessive heat or cold); chemical (such as solvents, cleaning agents, pesticides); biological (bodily fluids, food or water borne pathogens, mould, pests); mechanical/electrical (from the use of electricity, machinery and equipment) or ergonomic (from manual handling, or poor lighting or ventilation). Whereas examples of workplace stressors in the psychosocial work

environment can be from poor work organization such as excessive work demands and loads, time pressure, or lack of reward and recognition and support from supervisors; or from poor organizational structure for instance lack of policies and practices related to the dignity or respect for all workers and their rights (e.g. maternity leave, hours of work, time off, vacation time, OHS rights etc.), or harassment and bullying, discrimination on the basis of HIV status, and other work stressors (HSA, 2003; Queensland Government, 2004; HSA IE, 2006; Lo, Lamm, 2005; Burton, 2010; HSA IE, 2013).

These hazards can then lead to risks to the physical and mental wellbeing of the worker. Some of the physical risks include illnesses and injuries, such as risks of infection from communicable diseases; musculoskeletal disorders; burns and cuts ranging in severity; skin diseases such as dermatitis; and respiratory diseases such as asthma, amongst others. The presence of hazards can as well affect the mental wellbeing of a worker. A worker experiencing psychosocial hazards may for example sleep badly; over medicate themselves; drink excessively and smoke; feel depressed; feel anxious or nervous; or feel angry and reckless. All these risks can impair the workers performance as they can become easily distracted or make serious errors in judgement, which affects theirs and others safety (Hoel, Einarsen, 2003; HSA, 2003; HSA IE, 2006; Gibbons, Gibbons, 2007; Lo, Lamm, 2005; Buchanan *et al*, 2010; Burton, 2010; O'Neill, Davis, 2011; HSA IE, 2013). Increased absenteeism from illnesses, injuries and accidents can affect a business's performance, not only from the loss of manpower, but from increased costs in the form of compensations for injury or death, or legal fees. If health and safety is not evidently promoted in the hotel's work environment, it can de-motivate workers and deteriorate workplace relations, which will ultimately affect the business's productivity. It can as well tarnish the hotel's image and credibility, which can lead to loss of customers, and therefore affect the hotel's performance and bottom line (ILO, 1996; Workplace Corporation, 2000; Comcare, 2004; Mills, 2012; Leman, Hidayah A, 2013).

In accordance with Reason's Defence in Depth Accident Trajectory Model (Cassidy, 2012), and Burton (2010), to prevent exposure to hazards and the resulting illnesses and injuries, hazards in the workplace must be recognized, assessed and controlled. The first and foremost action is to comply with the health and safety provisions outlined in OSHA 2007, which guides on standards and practices to promote health and safety in the work environment (GOK, 2007). The other actions of controlling hazards and their risks include (in order of preference) (HSA, 2003; Queensland Government, 2004; HSA IE, 2006; MOM, 2006; Burton, 2010; HSE UK, 2011; HSA IE, 2013):

- **Elimination or Substitution:** redesigning the workplace to eliminate the risk of injury (for example slip resistant flooring in a wet bar area); using less hazardous substances or chemicals; using mechanical aids to reduce or eliminate the need for manual handling; removing/retraining managers and supervisors in communication and leadership skills; or enforcing zero tolerance for harassment, bullying or discrimination in the workplace.

- **Engineering controls:** these include installing machine guarding; or ensuring proper ventilation in a work area (such as laundry room, kitchen) that removes excessive heat and maintains the circulation of fresh air (e.g. local exhaust system over cooking surface to remove steam, fumes or any contaminants).
- **Administrative controls**: ensuring good housekeeping to keep the work environment clear of rubbish, clutter and dangerous contaminants; performing preventative maintenance on machines and equipment; having easily available and noticeable work procedures to control the way work is done; use of safety signs and restricted areas; training and education, for instance training workers to use controls associated with specific hazards, to carry out emergency procedures (such as fire evacuation drills), change management trainings (for use of new equipment, new work procedures, new job roles) or trainings on stress management techniques and how to address conflict or harassment situations.
- Provision and use of suitable **personal protective equipment** such as protective clothing, footwear, goggles, and signs. However this measure should be used as a last resort after all other ways of eliminating the hazard have been explored.
- Provision of **welfare facilities** such as first aid and washing facilities for removal of any contamination; and access to safe, hygienic eating facilities, so workers are not forced to eat or drink in areas that maybe hazardous or exposed to contaminants (for example where cleaning chemicals are stored).

These actions therefore in turn loop back to reduce or eliminate the risks or the presence of the hazards; and all of the elements (hazard, risk, and action) affect the status of a workers' wellbeing.

2.8 Gaps in Knowledge

Many previous studies on OHS have focused mainly on what are considered 'high-risk' industries, This unfortunately means that little research has been done on the so-called 'low-risk' industries, such as the hospitality industry, as there is a general notion that it has few occupational hazards and risks-however this may be the result of the lack of significant research done in this area (Lo, Lamm, 2005; O'Neill, Davis, 2011; Ondieki, 2013). From reviewing literature, this seems to be especially the case for Africa, as most research and information available on OHS in the hospitality industry have been produced in developed countries such as Australia, New Zealand, UK and USA (see e.g. Lo, Lamm, 2005; Gibbons, Gibbons, 2007; Buchanan *et al*, 2010; HSA, 2003;; HSA IE, 2013). Therefore, there is need to address this issue, especially in Kenya where tourism is one of the top earners and one of the country's highest employers (KNBS, 2014).

Therefore, a risk assessment had been undertaken for this study that identified the type of hazards workers in a Nairobi city hotel are exposed to, and their effects on the employees' wellbeing. Other gaps of knowledge addressed by this study included focusing on hazards in the psychosocial work environment, not just the physical work environment. Finally, the study established the effectiveness of implementation of the hotel's OSHMS, by using OSHA 2007 and other established guidelines as a benchmark for implementation of a sound OSHMS.

CHAPTER 3.0: STUDY AREA

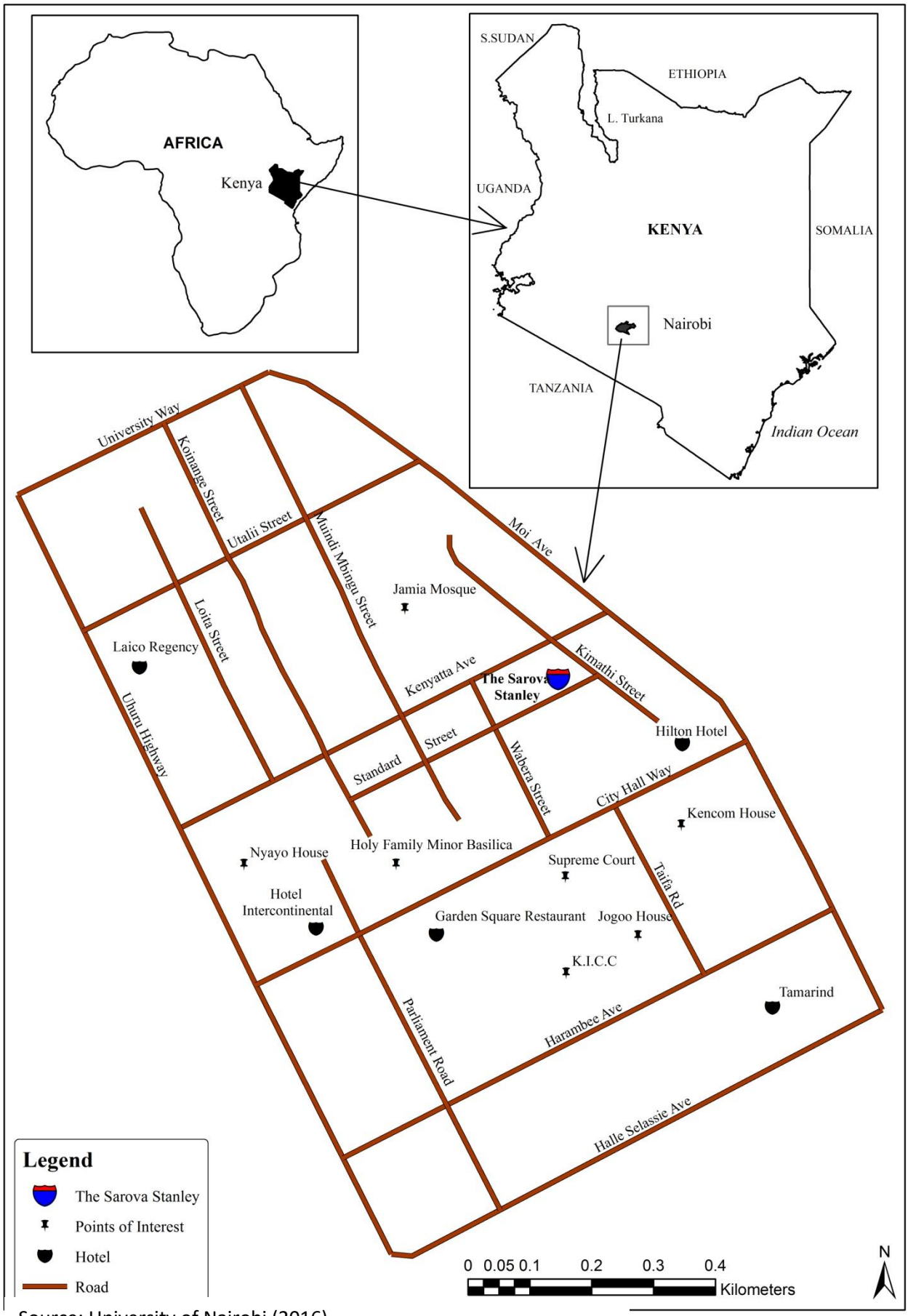
3.1 Location and Setting

The Sarova Stanley Hotel, built in 1902, is one of Kenya's pioneer hotels. It is located along the corner of Kenyatta Avenue and Kimathi Street in the Central Business District (CBD) of Nairobi, the capital city of Kenya, located in East Africa (Figure 6). It is a 9 storey building (excluding the basement area) that houses 217 guest rooms. Since its conception, the hotel has maintained its 5 star status throughout the years, and continues to do so as one of Nairobi's premier luxury business hotels. Its location in the capital city's CBD means it caters for several local and international business clienteles; however its rich history as one of Kenya's landmarks as well attracts several leisure travellers. The Stanley Hotel is part of the Sarova Group of Hotels whose portfolio in Kenya consists of 3 city hotels and 5 lodges (Sarova Hotels; 2014). The Stanley Hotel employs more than 300 employees consistent of both full time and casual employees working across its various departments. The Front of House Departments are the Kitchen, Food and Beverage service, Housekeeping, Health Club and Front Office. And the Back of House Departments are Sales and Marketing, Repair and Maintenance, Security, Information Technology (IT), Purchasing and Receiving, Finance, and Human Resources. This study focuses on the Front of House Departments that are described in the following section.

Plate 1: Sarova Stanley Hotel

Source: Sarova Hotels (2015)

Figure 6: Location of the Sarova Stanley Hotel in Nairobi, Kenya, East Africa



Source: University of Nairobi (2016)

3.2 Descriptions of the Hotel's Front of House Departments

3.2.1 Kitchen: *(as of January 2015, there are 54 employees working in the Kitchen Department)*

Main Kitchen: Located on the 1st floor of the hotel, the Main Kitchen is composed of the Thai Chi Kitchen, Room Service Kitchen, and Banqueting Kitchen (for functions/events), located alongside one another. There is as well a pastry kitchen, butchery, and staff canteen kitchen located a floor above the Main Kitchen area. As room service is a 24 hours operation, this part of the kitchen remains open throughout. The other parts of the kitchen are operational from approximately 0700hrs-2300hrs. The executive sous chef's and executive chef's offices are located in this area as well. Refrigerators and walk-in cold rooms are present in this kitchen.

Plate 2: Main Kitchen

Source: Field Data (2015)

Plate 3: Thorn Tree Kitchen

Thorn Tree Kitchen: The Thorn Tree Kitchen is located on the ground floor of the hotel, and is operational 24 hours where employees work 3 shift periods: (**1**) Day (0700hrs-1500hrs), (**2**) Evening (1500hrs-2300hrs) or (**3**) Overnight (2300hrs-0700hrs). This kitchen caters for the Thorn Tree Restaurant located on the same floor. The kitchen is divided into a hot food preparation area, a cold food preparation area, and a pizzeria section that houses a large clay oven for baking pizzas. Refrigerators and one walk-in cold room are present in this kitchen.

Source: Field Data (2015)

Plate 4: Pool Deck Kitchen

Pool Deck Kitchen: The Pool Deck Kitchen is located on the 5th floor of the hotel and caters for the Pool Deck Restaurant. It is considered a 'show kitchen' as its view is open to diners. The employees work two shifts split between the operating hours of 0900hrs-2300hrs. Due to limited spacing, there are no walk-in cold rooms in this kitchen but refrigerators are used.

Source: Field Data (2015)

3.2.2 **Food & Beverage Service:** *(as of January 2015, there are 54 employees working in the Food & Beverage service Department)*

Thorn Tree Restaurant: The Thorn Tree Restaurant is located on the ground floor of the hotel, and is operational 24 hours where employees work 3 shift periods: (**1**) Day (0700hrs-1500hrs), (**2**) Evening (1500hrs-2300hrs) or (**3**) Overnight (2300hrs-0700hrs). It is considered the main restaurant of the hotel as it serves breakfast and is open throughout. It is a bistro style pavement cafe and pizzeria that can seat up to 150 people and offers indoor and outdoor dining. Its outdoor terrace is adjacent to Kenyatta Avenue and Kimathi Street. The service staffs have a back area which they use for storage that is located within the Thorn Tree Kitchen.

Plate 5: Thorn Tree Restaurant

Source: Sarova Hotels (2015)

Thai Chi Restaurant: The Thai Chi Restaurant is located on the 1st floor of the hotel. It is the hotel's fine dining restaurant that serves authentic Thai cuisine and is open for lunch (1200hrs-1430hrs) and dinner (1900hrs-2230hrs). The restaurant can seat up to 50 people, and permits diners above the age of 12 years only. The employees work a 'split' shift between the two meal times (approximately 1130hrs-1500hrs and 1830hrs-2300hrs). The restaurant has a back area for staffs which is located within a hidden corner of the restaurant.

Plate 6 Thai Chi Restaurant

Source: Sarova Hotels (2015)

Pool Deck Restaurant: The Pool Deck Restaurant is located on the 5th floor of the hotel adjacent to the open air swimming pool. The restaurant is open from 0900hrs-2300hrs and serves snacks, lunch and dinner; if functions/events are occurring at the hotel, lunches are served in a buffet style. The employees work two shifts split between the operating hours of 0900hrs-2300hrs. The restaurant is partly open-air and partly covered and can seat up to 200 people. The service staffs have a back area which is used for storage that they share with kitchen staffs as it is adjacent to the Pool Deck Kitchen.

Plate 7: Pool Deck Restaurant

Source: Sarova Hotels (2015)

Plate 8: Exchange Bar

Exchange Bar: The Exchange Bar is the hotel's main bar which is located on the 1st floor. It is open from 1100hrs-2300hrs, and employees work two shifts split between 0900hrs-2300hrs. The bar offers alcoholic and non-alcoholic beverages, as well as bar snacks. Unaccompanied minors below the legal drinking age of 18 years are generally not permitted in this area. The bar is composed of the guest seating area which can seat up to 74 people, and the back staff area which includes a coffee preparation area, office, and dishwashing section.

Source: Sarova Hotels (2015)

3.2.3 **Housekeeping**: *(as of January 2015, there are 45 employees working in the Housekeeping Department)*

Plate 9: Stanley Hotel Guest Room

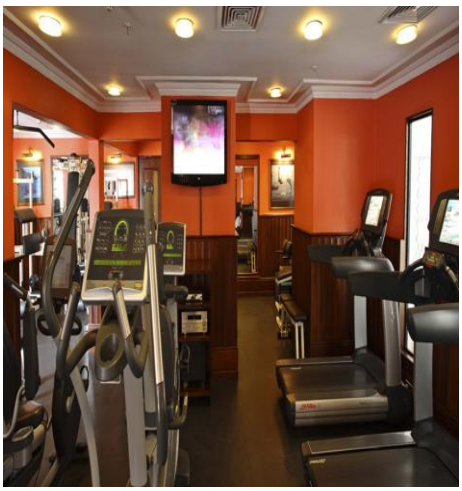
Employees working in the housekeeping department are split into four main groups: laundry attendants (handle the laundry cleaning operations); guest room attendants (handle the guest rooms cleaning operations); public area attendants (handle cleaning operations of the public areas of the hotel e.g. sanitary facilities, lobby area and restaurants); and mini bar attendants (control the mini bar consumptions from the guest rooms). The laundry area is in operation from 0700hrs-2300hrs and its attendants work two shifts split between these hours. The other housekeepers work 3 shift periods: (**1**) Day (0700hrs-1500hrs), (**2**) Evening (1500hrs-2300hrs) or (**3**) Overnight (2300hrs-0700hrs). The housekeeping office where the various housekeeping supervisors and management coordinate activities, is located on the 2nd floor of the hotel and is adjacent to the laundry area. There is a linen storage room located on the floor above where clean linen is transported to from the laundry area and stored.

Source: Sarova Hotels (2015)

3.2.4 **Health Club:** *(as of January 2015, there are 8 employees working in the Health Club)*

The health club is located on the 5th floor of the hotel. The health club area is split into two floors; the top floor is composed of the outdoor swimming pool (which is adjacent to the Pool Deck restaurant), and indoors the health club reception, fitness centre (gymnasium), aerobics studio, and guest sanitary facilities. Below this floor are two additional men and women guest changing rooms equipped with steam and sauna rooms. The swimming pool pump room is as well located on this floor. Employees working in the health club are divided into 2 main groups: Fitness Instructors (handle the gymnasium and swimming pool areas) and Therapists (provide therapies such as massages and spa treatments). The health club is open from 0600hrs-2200hrs and the employees work two shifts split between these hours.

Plate 10: Health Club Fitness Centre



Source: Sarova Hotels (2015)

3.2.5 **Front Office:** *(as of January 2015, there are 27 employees working in the Front Office Department)*

Employees working in the front office department are split into three main groups: receptionists (handle guest arrivals and departures); concierge attendants (handle guest luggage and travel enquiries); and switchboard attendants (handle the central telephone operations for the hotel). The front office area is located on the ground floor of the hotel and is composed of the concierge desk, lobby area, reception desks switchboard area and back office area for the staffs. The front office is operational 24 hours and the employees work 3 shift periods: (**1**) Day (0700hrs-1500hrs), (**2**) Evening (1500hrs-2300hrs) or (**3**) Overnight (2300hrs-0700hrs).

Plate 11: Front Office Area

Source: Sarova Hotels (2015)

CHAPTER 4.0: METHODOLOGY

4.1 Research Design

The overall aim of this study was to carry out a risk assessment with a focus on types of OHS hazards and associated risks that are found in a hotel work environment, and how they are managed. A case study research design was employed. Researcher Robert K. Yin defines a case study as an "empirical inquiry that investigates a contemporary phenomenon (e.g. a case) within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used" (Soy, 1997: 1).

Critics of case studies believe that they are only useful as an exploratory tool; and the intense focus on a 'case' can lead to biased findings and this therefore can offer no grounds for establishing reliability or generality of findings (Soy, 1997; Shuttleworth, 2008). However, enthusiasts of the case study approach to enquiry continue to use it to seek real-life situations to societal problems with the argument that it helps facilitate an understanding of complex real-life situations. Another key advantage for employing the case study design is that it allows the researcher to gather data from a variety of sources, and this therefore "ensures that the issue is not explored through one lens, but rather a variety of lenses which allows for multiple facets of the phenomenon to be revealed and understood" (Baxter, Jack, 2008: 544).

For this case study, multiple perspectives are gained about the OHS issues in the hotel (the employees' perspectives from the employee survey, the key informants' perspectives from the key informant interviews and from direct observation). It also allows for a collaboration of quantitative and qualitative approaches to be used in the study. For example data gathered from the employee survey and observation checklists are analysed quantitatively and qualitatively, which in turn supports the qualitative data gathered from the key informant interviews and from the document review. Therefore, the case study method, with its use of multiple data collection methods and analysis techniques, provided the researcher with the opportunity to converge the data which helps strengthen the research findings and conclusions (Soy, 1997; Baxter, Jack, 2008).

4.2 Population and Sampling

The Sarova Stanley Hotel, one of the pioneer five star hotels in Kenya, was the focus of this case study. The hotel continues to ascertain its prominence on the Kenyan market by winning numerous awards, such as the 2014 World Travel Award for Kenya's Leading Hotel (Sarova Hotels, 2014). Presumably, it should have one of the most functional OSHMSs and hence formed a good case for the study of good practices in OHS.

The study was based on a random sample of 125 employees drawn from a total of 188 employees that worked at the 5 Front of House Departments: Kitchen, Food and Beverage Service, Housekeeping, Health Club, and Front Office. As per literature reviewed, these departments experience the most physical and psychosocial work environment hazards and were therefore ideal areas for assessing the hotel's OHS hazards and associated risks (see e.g. Lo, Lamm, 2005; O'Neill, Davis, 2011; Bohle *et al*, 2004; Gibbons, Gibbons, 2007; Mayhew, Quinlan, 2002; Buchanan *et al*, 2010; HSA, 2003; Queensland Government, 2004; Workcover Corporation, 2000; HSA IE, 2013); and whose study was of greater relevance to the employee community of the hotel.

In order to select a sample for data collection, three steps were followed. Firstly the sample size was computed using formula by Creative Research Systems (2012):

$$ss = \frac{Z^2 * (p) * (1-p)}{c^2}$$

$$ss = \frac{1.96^2 * (0.5) * (1-0.5)}{0.05^2} = \underline{384.16}$$

Correction Formula for Finite Population:

$$\text{New ss} = \frac{ss}{1 + \frac{ss-1}{N}}$$

Where:

ss = sample size

Z = Z value (1.96 for 95% confidence level)

p = 0.5 (probability of picking a choice, expressed as decimal)

c = confidence interval, expressed as decimal (0.05 = ±5)

$$\textit{New ss} = \frac{384.16}{1 + \frac{384.16-1}{188}} = \mathbf{\underline{126.45}}$$

Secondly, the sample size was proportionally assigned to the 5 Front of House Departments, which were treated as strata. Table 1 shows the result of stratification of the sample size using a sampling fraction of 1.49 (N/n (188/126.45)). For example, Kitchen: 54/1.49=36 employees selected into the sample.

Table 1: Stratified Sample Sizes per Department

Front of House Department	**Population Size per Department**	**Number of Employees Selected into the Sample**
Kitchen	54	36
F&B Service	54	36
Housekeeping	45	30
Health Club	8	5
Front Office	27	18
TOTAL	**N=188**	**n=125**

Source: Researcher (2015)

Thirdly, and finally, using simple random sampling, actual members of the sample were selected from departmental employee lists obtained from human resources records. Consecutive numbers were first assigned to all employees of each study focus department. Then using the RANDBETWEEN function in Microsoft Excel random numbers were generated. The employees to whom the random numbers generated referred to became members of the sample for that department. The process was repeated for each department. The total selected members from each department constituted the study sample that was applied for the employee survey in section 4.3.1.

Direct observations were done by making randomized visits (using the RANDBETWEEN function in Microsoft Excel) to the study departments. The observation visits were synchronized with the official hotel work shifts: (**1**) Day (0700hrs-1500hrs), (**2**) Evening (1500hrs-2300hrs) and (**3**) Overnight (2300hrs-0700hrs). This allowed the researcher to observe various activities that can occur in the departments during the range of shifts. For each department and work shift, at least one random observation visit was made.

Key informant interviews drew from purposely selected participants (the Hotel General Manager, Hotel Nurse, members of the hotel's safety and health committee team, focus departments' managers, Hotel Deputy Engineer and human resources associates) due to their vital knowledge of OHS at the hotel.

4.3 Methods of Data Collection and Analysis

There were four methods of data collection used: employee survey, observation checklists, key informant interviews, and document review. These are detailed in sections 4.3.1-4.3.4, including how the data collected from each method was analysed.

4.3.1 Employee Survey

According to HSA IE, 2006; HSE UK, 2011; EC, 1996; Workcover Corporation, 2000; HSA, 2003, there are various approaches to identifying hazards in the workplace, the most important is to consult with the employees as they are the ones with firsthand experience on how they go about their duties, and therefore are able to advise on any difficulties, or their perceptions on any hazards and adverse effects. Therefore primary data for the employee survey was obtained by administrating a semi-structured OHS questionnaire to the sampled population of employees working across the study departments. The main aim of the questionnaire was to obtain the employees' perspectives on the types of OHS hazards and associated risks that are present in their work areas and their frequency of occurrences which helped determine the varying levels of risk. In regards to the hotel's OSHMS, the questionnaire enquired if the employees had encountered any accidents/incidents in relation to the hazards and risks and how they were handled; if they are aware of safety procedures instilled by the hotel; and in their opinion which precautionary measures work best to control risks in their work areas. The semi-structured questionnaire was designed by the researcher (see Appendix 7) where hazards and risks were identified and categorized using checklists and

other documents from similar businesses to the Sarova Stanley Hotel: Collins (2010a); WCB NS (2008); AIS (2013); VWA AU (2013a); VWA AU (2013b); VWA AU (2013c); VWA AU (2014a); VWA AU (2014b).

The questionnaire was designed to be self-completed by the respondent. The questionnaire was handed out to the sample population, and the respondents were asked to return the completed questionnaire within a week of being administered. This helped improve the response rate as the respondents/participants had sufficient time to complete the questionnaire at their own speed. According to Bryman (2012), having unsupervised self-completion questionnaires help reduce biased answers that can sometimes be influenced by the interviewer's characteristics (such as ethnicity, gender, social background) if they are present while the questionnaire is being filled out. The questionnaire is as well structured in an easy to follow design with majority closed ended questions that provide a list of alternatives for the participant to choose from. This helped improve response rate and reduce the chance of missing data (partially answered questionnaires) as the questions are straight forward and relatively easy to answer. The questionnaire was as well printed in a booklet form (both sides of the paper) to be a total of just three sheets of paper, this helped make the questionnaire look shorter, which according to Harper (1991) and Bryman (2012), tends to achieve better response rates than longer ones. To also help improve response rate and lessen the chance of missing data, the questionnaire contains a brief introduction that explains the research is for academic purposes and participants have been picked randomly and will remain anonymous. This should have instilled confidence in the participants to answer the questions to the best of their ability. Finally, respondents that did not return their completed questionnaires within a week, were followed up as much as possible (during the period of field research) to ensure they were completed.

DATA ANALYSIS: The first step involved data editing where the completed questionnaires were checked for any errors and missing data and were appropriately corrected. Data categories were pre-formed in the questionnaire:

- **Department** (Kitchen; F&B Service; Housekeeping; Health Club; Front Office)
- **Hazards** (Physical; Chemical; Biological; Mechanical/Electrical; Ergonomic; Workplace Stressors)
- **Risks** (Physical Risks: Mild, Moderate, Major; Psychosocial Risks: Mild, Moderate, Major)
- **Accident/Incidence Occurrence** (Type of Hazard; Type of Risk; Description of Incidence; Incidence Management)
- **Emergency Procedures** (Fire Emergency; Security Threat; Injury/Illness Emergency)
- **Risk Controls** (Elimination/Substitution; Engineering Controls; Administrative Controls; Personal Protective Equipment (PPE); Welfare Facilities).

Secondly, the data was coded into an acceptable format to be entered into the Statistical Package for the Social Sciences (SPSS) analysis system. The first question determined what department the employee

filling the questionnaire works in, so that the data obtained in that questionnaire was associated with that department. The departments were captured at the nominal level. Data in Part 1: Hazards and Part 2: Risks were collected at the ordinal level using a frequency scale whose frequencies were coded as follows: **Never** = 0; **Rarely** = 1; **Occasionally** = 2; **Frequently** = 3; **Very Frequently** = 4. 'Never' had been coded as 0 as it ascribes that the hazard/risk stated does not occur at all; and 'Very Frequently' had been coded the highest (4) as it ascribes that the hazard/risk stated occurs almost all of the time. Therefore the higher the frequency picked of the hazard/risk, the higher the overall level of risk.

Finally, the data obtained was used to help answer research questions 2 and 3, on the types of hazards and associated risks employees face per department. Descriptive statistics were used to analyse the data obtained for Part 1: Hazards and Part 2: Risks. These were first organized into separate tables that show the frequencies chosen for each variable per data category (e.g. physical hazards, chemical hazards, mild physical risks etc.) per department. These tables were then used to prepare bar charts to compare the percentages of hazards and risks in each department. The analysis was established on a cut off of 40% based on the participants that responded the stated hazard/risk occurs rather than 'Never' (does not occur).

The following risk assessment matrix was used to assess the levels of risks using the modal frequency of the data collected (rarely, occasionally, frequently or very frequently). It was designed in reference to Meng (2002); Government of South Australia (2009); and Queensland Government (2012):

Table 2: Risk Assessment Matrix

LIKELIHOOD / SEVERITY	RARELY	OCCASIONALLY	FREQUENTLY	VERY FREQUENTLY
MAJOR	MEDIUM RISK	HIGH RISK	EXTREME RISK	EXTREME RISK
MODERATE	LOW RISK	MEDIUM RISK	HIGH RISK	EXTREME RISK
MILD	LOW RISK	LOW RISK	MEDIUM RISK	MEDIUM RISK

Source: Researcher (2015)

Table 3 defines the terminologies used in the Risk Assessment Matrix (Table 2) in reference to Government of South Australia (2009); and Queensland Government (2012):

Table 3: Terminology Definitions of Risk Assessment Matrix

SEVERITY OF RISK	**LIKELIHOOD OF RISK OCCURRING**	**LEVEL OF RISK (*and related control Actions that can be implemented)***
MILD: Minor injuries requiring first-aid treatment.	**RARELY:** May occur but only in exceptional circumstances.	**LOW RISK:** Little likelihood that an injury would result. (***Action:*** *Monitor existing controls in place to make sure level of risk does not increase)*
MODERATE: Injuries requiring	**OCCASIONALLY:** Possible and likely	**MEDIUM RISK:** Some chance that

medical treatment, hospitalization, or lost time.	to occur at some time.	an injury requiring first aid would result. *(**Action:** Additional risk controls may be needed)*
MAJOR: Serious injuries requiring specialized medical treatment/hospitalization, permanent disability, or loss of life.	**FREQUENTLY:** Likely to occur frequently.	**HIGH RISK:** Likely that an injury requiring medical treatment would result. *(**Action:** Until elimination, substitution or engineering controls can be implemented; administrative or PPE controls should be instituted)*
	VERY FREQUENTLY: Almost certain to occur in most circumstances.	**EXTREME RISK:** Likely that a permanent, debilitating injury or death would result. *(**Action:** Elimination, substitution or engineering controls should be implemented immediately)*

Source: Researcher (2015)

Data obtained for Part 3: OSHMS was tabulated and used to add to the information on the types of hazards and risks experienced in each department. The data from Question 17 risk controls was tabulated and graphed to compare which controls are preferred by the employees to be implemented in the hotel. These were made as suggestions for improvements to the OSHMS. The overall data obtained from this Part was used to complement the findings from the key informant interviews.

4.3.2 Direct Observation

Primary data was as well obtained by direct field observation by examining systematically all aspects of the work per department, to identify any area or activity that can be expected to cause harm. Direct observation allows a researcher to enter into and better understand a situation or context. They also allow the researcher to learn about matters that participants may be unwilling to divulge in interviews or questionnaires. Therefore, when used with other methods of data collection, (in this case study: questionnaires, key informant interviews and document review) observation data helps complement and enhance the quality of research findings (Soy, 1997; Baxter, Jack, 2008; Bryman, 2012).

The field observation was conducted by the researcher with the aid of a checklist on identifying OHS processes and outcomes in each study department. The first part of the checklist examined general OHS matters that can occur in almost every work area. The second part looked at OHS matters that were more specific to the department under examination. As the Sarova Stanley Hotel has in total 3 kitchens and 4 Food

and Beverage Service areas, observations were made of all as it allowed the researcher to make comparisons between them and get a more comprehensive outlook of these departments.

The checklists as well drew on related provisions stated in OSHA 2007 that helped the researcher to cross-check if the hotel is complying with these rules and regulations. The checklists as well had a section for comments to enrich some of the findings, such as any possible impacts of particular hazards, and how often trainings are conducted and by whom. The additional use of field notes and a camera made the data collected more efficient and comprehensive. The checklists were designed by the researcher (see Appendices 1-6) with reference to checklists and other documents from similar businesses to the Sarova Stanley Hotel: Collins (2010a); Collins (2010b); Stover, Gallagher (2008); WCB NS (2008); VWA AU (2014a); VWA AU (2014b); GOK (2007).

DATA ANALYSIS: The completed checklists were firstly checked for any errors and missing data and were appropriately corrected. Data categories were as follows:

- **General OHS** (Workplace, Flooring and Stairways; Ventilation and Lighting; Cleanliness; Welfare Facilities; Mechanical/Electrical; Fire Safety; Hazardous Substances; PPE)
- **Kitchen OHS** (Refrigeration and Storage; Hygiene; Others)
- **F&B Service OHS** (Beverage (Bar) Area; Dining Area; Others)
- **Housekeeping OHS** (Laundry Area; Cleaning Operations and Others)
- **Health Club OHS** (Swimming Pool; Fitness Centre; Others)
- **Front Office OHS** (Reception; Concierge)

Data for the checklists was captured at the nominal level with a choice of Yes; No; or N/A to choose from for each OHS variable in the checklist. Where 'Yes' denoted a positive answer (there is no hazard/risk present); 'No' denoted a negative answer (there is a hazard/risk present); and 'N/A' denoted that the variable was not applicable for that department under observation. Therefore, the department that had more 'No' answers was assumed to have more OHS issues. Data obtained from the checklists was organized into tables per data category (Workspace, flooring and stairways; ventilation and lighting etc.). These tables were then used to prepare bar charts to show the total number of 'Yes' and 'No' answers per data group (e.g. General OHS; Kitchen OHS etc.) per department. These tables and charts were able to inform the researcher if any similarities of OHS matters occur across the departments. Therefore, this data helped answer research questions 2 and 3, on the types of OHS hazards and associated risks per department. Any 'No' answers to the OHS variables in the checklists were as well used as suggestions on ways to improve the hotel's OSHMS.

4.3.3 Key Informant Interviews

Key informant interviews were as well conducted as another form of primary data. According to Kumar (1989: 6) "key informant interviews involve interviewing select individuals who are likely to provide needed information, ideas, and insights on a particular subject (...) that usually cannot be obtained with other methods." For this case study, the key informants were the Hotel General Manager, Hotel Nurse, members of the hotel's safety and health committee team, focus departments' managers, Hotel Deputy Engineer and human resources associates to gauge their perception of OHS management at the hotel.

The General Manager, members of the safety and health committee (the Chief Engineer and the Chief Security Officer), focus departments' managers, Hotel Deputy Engineer and human resources associates were interviewed to gain valuable insight into how the hotel's OSHMS is implemented, and to determine its effectiveness (see interview guide in Appendix 8). The Hotel Nurse was interviewed to gain valuable insight into her experience of the nature of injuries and illnesses employees are likely to face in each department under study; and in her opinion, what kind of measures can be taken to prevent the injuries and illnesses (see Appendix 9). Overall research findings were strengthened as data gathered from these interviews helped complement the data obtained through the employee survey, hotel injury/illness records, and the data from the observation checklists, on the types of risks experienced in each department.

A voice recorder, pen and notebook were used as additional instruments to capture data for the interviews. The key informant interview questions were designed by the researcher with reference to the following: Collins (2010a); Stover, Gallagher (2008); WCB NS (2008); VWA AU (2013c); GOK (2004); GOK (2007).

DATA ANALYSIS: The data were firstly transcribed word for word, then cleaned and edited to be divided into pre-formed categories. Where data obtained from the interviews with the General Manager, safety and health committee members, focus departments' managers, Hotel Deputy Engineer and human resources associates were divided into **Safety and Health Policy Statement**; **Safety and Health Committee**; **Risk Assessments**; **Safety and Health Audit**; **Emergency Planning and Preparedness**; and **Accident/Incident Management**. These data were analysed qualitatively and helped answer research question 1 on the hotel's OSHMS and how it is implemented; and was as well used to make recommendations to the hotel on ways to improve their OSHMS.

The data obtained from the key informant interview with the Hotel Nurse was tabulated using Microsoft Excel to show the various types of **Injuries**, **Illnesses** and **Pre-Cautionary Measures** per study department. This table informed the researcher of any similarities across the departments. This data was used to complement the findings from the employee survey questionnaire, and accident/incident records, and therefore helped answer research questions 3 and 4 on the types of hazards and associated risks

employees face per department. The precautionary measures provided by the Nurse were used as suggestions on ways to improve the OSHMS.

4.3.4 Document Review

Published material on OHS in the hotel industry were reviewed for this study to identify the type of OHS hazards and risks that are present in a hotel work environment, and the types of precautionary measures that can be taken to control the risks (e.g. Workcover Corporation, 2000; HSA, 2003; Queensland Government, 2004; HSA IE, 2013; Collins, 2010a; Collins, 2010b; Stover, Gallagher, 2008). Reviewing documents are a useful source of data as they are relatively inexpensive, usually unobtrusive and they provide the researcher with a good source of background information that they can use to complement their overall research findings (Bryman, 2012).

Other secondary sources of data were obtained by reviewing some of the hotel's documents: safety and health policy, clinical data on employee sick-offs, injuries and illnesses, accident/incident reports, duty manager compendium, DOSHS safety and health audit conducted in 2014, and NEMA environmental audit conducted in 2014. These helped identify any less obvious hazards, as well as possible impacts of the hazards.

DATA ANALYSIS: Hotel accident/incident reports were examined for incidences that occurred in the Front of House Departments and for matters related to OHS. The incidences were then summarized into year, type, area of incident, and how it was managed (Appendix 10).

The Hotel Nurse's clinical records of occurrences of employee injuries/illnesses for the period of January 2013 to June 2015 were examined and divided into broad categories per condition in relation to OHS (burns, cuts, musculoskeletal, slips/trips/falls, respiratory, skin infections, eye infections, food/water borne illnesses, gastrointestinal, hypertension, and neurological illnesses). The frequencies for each condition were then presented into graphs showing the total number of cases of the various injuries/illnesses per department per year (January-December 2013; January-December 2014; and January-June 2015). The Nurse's records showing total number of employee sick-offs, hospital referrals and hospital admissions for this period were as well summarized and tabulated.

These data helped complement the findings from the other methods of data collection as they helped determine the effectiveness of the hotel's OSHMS, as well as the nature of hazards and associated risks employees face per department.

4.4 Hypothesis Testing

Data gathered from Part 2 of the employee survey questionnaire was used to test the hypotheses:

1. H_o: There is no difference in the type of physical risks experienced in each of the Front of House Departments.
2. H_o: There is no difference in the type of psychosocial risks experienced in each of the Front of House Departments.

Kruskal Wallis H Test was used to test these hypotheses at a 0.05 level of significance. This statistical test had been chosen as it is a rank-based non-parametric test that can be used to determine if there are statistically significant differences between two or more groups of an independent variable (the departments) on a continuous or ordinal dependent variable (the risks measured on the 5-point frequency scale) (Lund Research Ltd, 2013). As it is a non-parametric test it has less stringent assumptions (unlike parametric tests), one of which is that it does not assume a normally distributed population. The other assumptions that the data from Parts 1 and 2 of the questionnaire meet include (Lund Research Ltd, 2013):

- The dependent variable should be measured at the ordinal level (the risks measured on the 5-point frequency scale).
- The independent variable should consist of two or more categorical, independent groups (the 5 departments).
- There should be independence of observations-no relationship between the observations in each group (the questionnaires were filled in by different employees-there was no overlap of participants as no employee works in more than one department).

The data was entered into SPSS, and the mean average physical and psychosocial risk 'score' per participant was calculated in order to perform the Kruskal Wallis H test (Lund Research Ltd, 2013). Using a chi square table of critical values, if the calculated test statistic (H) is greater than the critical value at 0.05 significance level, then the null hypothesis can be rejected, or fail to be rejected if it is less (Sullivan, 2013).

4.5 Anticipated Outputs of the Study

- A research project report to be submitted to the University of Nairobi as partial fulfilment of the requirements for the award of the degree of Master of Arts (M.A) in Environmental Planning and Management.
- Possible journal publication to disseminate the findings of a risk assessment of OHS hazards in a Nairobi city hotel work environment.

CHAPTER 5.0: RESULTS AND DISCUSSION

This chapter presents the findings and discusses them in accordance with the study's research objectives. The results are based on data collected over a period of 6 weeks between January-March 2015.

5.1 Questionnaires Response Rate

Table 4: Response Rate to Questionnaires per Department

Front of House Department	Number of Questionnaires Administered	Number of Filled Questionnaires Returned	Response Rate (%)
Kitchen Employees:			
Banqueting	5	5	100%
Pastry	5	5	100%
Staff Canteen	2	1	50%
Pool Deck Restaurant	3	3	100%
Room Service	4	4	100%
Thai Chi Restaurant	4	3	75%
Thorn Tree Restaurant	13	12	92.3%
Total	**36**	**33**	**91.7%**
F&B Service Employees:			
Exchange Bar	4	4	100%
Pool Deck Restaurant	5	5	100%
Room Service	5	5	100%
Thai Chi Restaurant	3	3	100%
Thorn Tree Restaurant	19	19	100%
Total	**36**	**36**	**100%**
Housekeeping Employees:			
Laundry	6	6	100%
Guest Rooms	13	10	77%
Public Area	8	8	100%
Mini Bar	3	2	66.6%
Total	**30**	**26**	**86.7%**
Health Club			
Therapist	2	2	100%
Fitness Instructor	3	3	100%
Total	**5**	**5**	**100%**
Front Office			
Concierge	6	6	100%
Reception	12	12	100%
Total	**18**	**18**	**100%**
TOTAL	**125**	**118**	**94.4%**

Source: Field Data (2015)

Table 4 presents the response rate to the employee survey questionnaire for each of the 5 Departments. A total of 118 duly filled questionnaires were returned out of 125 distributed to employees working in the Front of House Departments' various work areas constituting a response rate of 94.4%. Researcher T.W. Mangione classifies response rates above 85% as excellent, and therefore representative of a population (Bryman, 2012). This response rate as well "falls within (researchers') Mugenda and Mugenda's prescribed significant response rate for statistical analysis which they established at a minimal value of 50%" (Oben, 2013: 84). Generally, there was a high response rate from all 5 Departments, with the lowest from the Housekeeping Department (86.7%). This was probably due to the scattered nature of where the housekeeping employees work, and so not all questionnaires administered to them were returned within the time period.

5.2 Occupational Safety and Health Management System (OSHMS) at the Sarova Stanley Hotel

In relation to research objective 1, the findings show that the Sarova Stanley Hotel has established some aspects of the components of an effective OSHMS. These are discussed in the following sub-sections.

5.2.1 Safety and Health Policy Statement

There is a written safety and health policy for the Sarova Hotels Group overall which has been in effect since February 2013. It has been signed at the most senior, responsible management level on the employer's behalf (The Sarova Group Directors); and begins with the employer's declaration of commitment to safety and health which is in tandem with the literature reviewed on these policy statements (e.g. HSA IE, 2006; GOK, 2005; GOK, 2013; Kabaka, 2014).

The policy outlines general safety and health objectives that apply to all of Sarova's properties. These include ensuring compliance with all the statutory requirements in relation to safety and health; ensuring health and safety considerations are incorporated into business decision making and job planning at all levels; and stating that managers and employees are all responsible for health and safety in their work places and should cooperate in implementing the policy, amongst several others. According to HSA IE (2006) and GOK (2013), these objectives are pertinent as they give direction and show how the safety and health policy will influence activities such as the selection of competent people, equipment and materials; and the way work is done.

A significant part of a safety and health policy is outlining the details of the company's safety and health committee (HSA IE, 2006; GOK, 2005; GOK, 2013). The Sarova policy states that each of its properties will establish an Occupational Safety and Health Committee (OSHC) that will guide and support the continuous development and improvement of health and safety compliance and performance. The specific functions and duties of the OSHC are listed in the policy and comply with OSHA 2007's subsidiary legislation,

'The Factories and Other Places of Work (Safety and Health Committees) Rules, 2004'. As the policy is generally written for all the Sarova properties, specific details of the Stanley OSHC are not given such as the committee members names, job titles and responsibilities, or the channels of communication employees can use to consult with them on safety and health issues, which according to HSA IE (2006) and GOK (2005) are important details to put in a safety and health policy.

Other sections covered in Sarova's safety and health policy include an OSHC checklist (that checks how well prepared they are for emergencies); details of how incidents and injuries should be investigated including a flowchart of activities and blank incident report formats; new employee safety and health induction checklist that makes sure new employees are aware of the hazards and risks in their work area, how to perform their job safely and who their safety and health representatives are; and general emergency procedures concisely written for evacuation, armed robbery, earthquake and fire. The policy becomes more property specific in the fire drill and evacuation procedure section, as each property is unique in its physical makeup. For the Sarova Stanley Hotel these procedures have been well detailed outlining the duties of the different employees relevant to these situations, the different assembly points depending on the severity of the situation, and how to handle the hotel guests.

The Sarova safety and health policy is otherwise quite generally written, whereby some details required for a safety and health policy statement are not available or are not clearly stated. An important section missing from the policy is lack of details on risk assessments. Therefore there is no information on specific hazards identified and risks assessed, along with any preventive and protective measures taken to control the risks, which according to EC (1996); HSA IE (2006); HSE UK (2011) and GOK (2013) are vital components of a safety and health policy. Other details not clearly stated in the policy include information on the resources provided by the employer to ensure safety and health such as time, personnel and finance; although there is a brief, ambiguous statement written in the policy stating that "the management will provide sufficient resources for the implementation of this policy" (Sarova Hotels, 2013).

Since its implementation in 2013, the number of employee sick offs per year have been more or less the same, with an average of 140 sick offs from January 2013 to June 2015 (Table 8); and in just half a year 2015 already had 124 sick offs. Over the 2.5 years, with less than 200 employees working in the Front of House Departments, there was on average 329 cases of injuries/illnesses reported to the Nurse from these departments (Figure 18). These are an indication the policy may not be very effective and requires improvement in order for these cases to reduce. The policy states it will be reviewed every year, however this is not the case as just the safety systems such as fire safety are looked into as part of an annual internal general audit of operations. The organization should implement the clauses stated in the policy such as reviewing accident/incident reports, conducting regular internal and external safety and health inspections, along with regular employee medical examinations; in order to better equip the hotel to monitor and

measure the performance of the safety and health system in place, and therefore review the effectiveness of the safety and health policy.

The effectiveness of the implementation of the policy can be considered lacking as the awareness of its existence was very low amongst departmental managers and employees, where some were vaguely aware of its existence and majority had never seen it (even though it is mentioned in the employee handbook which is given to every associate). According to the Chief Security Officer, there are plans for the OSHC to create more employee awareness of this policy, as well as review and update it to include more specific information on hazards and risks. To help improve awareness, the 2014 DOSHS Sarova Stanley safety and health audit recommended the policy be posted in prominent places of the workplace, (which unfortunately the researcher found was still not implemented); this audit as well found no training records of the implementation of this policy, both of which are areas of improvement (Kabaka, 2014). Bringing the safety and health policy statement, and any revision of it, to the notice of all employees is a requirement of section 7 (1b) of OSHA 2007 (GOK, 2007).

Overall the Sarova safety and health policy covers important areas such as the employer's commitment to safety and health, the functions and duties of the OSHC, details on incident/injury management, new employee safety and health induction checklist, and fire drill and evacuation procedures which are well detailed. However the policy is too general and should be more relatable for each property, such as contain more specific details of the property's OSHC, and very importantly details on risk assessments that identify specific hazards and the assessment of risks, as well as the preventive and protective measures taken to eliminate or control the risks. The policy as well needs to specify how the performance of safety and health systems will be monitored, and the procedures of how the policy will be reviewed. Finally, there is need to improve employee awareness of the policy by posting it, or relevant extracts of it, at or near every workplace to which it relates, in order for it to be effectively implemented (as recommended by HSA IE, 2006); along with regular trainings on its implementation.

5.2.2 Safety and Health Committee

The Sarova safety and health policy states that each of its properties will establish an OSHC. This complies with Section 9 of OSHA 2007 and Section 3 of its subsidiary legislation (2004 Safety and Health Committee Rules) (GOK, 2007; GOK, 2004).

According to the General Manager, Chief Engineer and Chief Security Officer, a new OSHC had been recently formed for the Sarova Stanley Hotel in the last quarter of year 2014. The committee has a total of 14 members which is in accordance with Section 4 (2b) of GOK (2004). The Stanley OSHC meets the terms of GOK (2005) and Section 5 of GOK (2004) as it is composed of 5 women and 9 men consisting of key department heads such as the Chief Engineer; Chief Security Officer; Human Resources Manager; Executive

Chef; Chief Steward, Hotel Nurse, and representatives from each department at the supervisory and line staff level. These members are the health and safety 'champions' of their respective departments. At the time of research they were no specific roles assigned to the Stanley OSHC members apart from the Chief Engineer whose role is set as the head of the committee. He is assisted in his duties by the Chief Security Officer (who is as well the custodian for incident reports and emergency procedures), and can be considered the secretary to the OSHC. According to the Chief Engineer, the specific roles and duties for the other committee members will be defined after their initial training phase is over and they are in full operation.

As the Stanley OSHC is fairly young, at the time of research, they were still not fully operational. The Stanley DOSHS 2014 safety and health audit, and the NEMA 2015 environmental audit as well found that a safety and health committee had been established for the Stanley Hotel but required reconstituting to comply more with OSHA 2007 and GOK (2004) (Kabaka, 2014; Amollo, 2015). According to the Stanley Human Resources department, an OSH officer from DOSHS had trained the OSHC at the end of 2014. During the time of research the OSHC were going through bi-monthly-monthly internal trainings and exercises to learn how to perform their duties accurately such as learning how to compile accident/incidences reports, and how to perform risk assessments. According to the Chief Security Officer, these meetings as well involve discussing the OSHC's agenda and plans for the future. These include training heads of departments on the importance of health and safety, so that they may support the motives of their respective representative in the OSHC. They as well plan to come up with a health and safety inspection checklist, that will be done 2-3 times a year for all departments; as well as devise a procedure that will determine possible hazards in all departments. This will then be part of a new employee's induction program, where the head of that department will take the employee through all the possible hazards and risks in that work area; which departmental managers agreed will be a useful and important step in integrating new employees on safe work procedures, as well as reminding the old employees.

The functions and duties of the OSHC are listed in the Sarova safety and health policy. These are in line with Section 6 of GOK (2004) however with a few minor differences. For instance the provision of Section 6 (b) in GOK (2004) states that safety and health inspections should be conducted at least once in every 3 months, while in the Sarova policy it states they will be conducted once in every 6 months. There is as well no provision given in the policy of how effective communication channels will be established on matters of health and safety between the management and workers as stated in Section 6 (h) of GOK (2004). As the Stanley OSHC is new, not all functions stated in policy are adhered to such as performance of bi-annual safety and health inspections, and compilation of accident, incidents and ill-health statistics. Although some functions are already in-force such as workers education programs on health and safety (these include health talks on fatigue, rheumatism, stress management, nutrition and fitness), and conducting periodic fire drills to sensitize associates, guests and any other personnel.

No definite date was given to the researcher of when the Stanley Hotel OSHC will be fully operational. However, according to the General Manager, Chief Engineer, and Chief Security Officer, they will be in the near future, once the members have finished their initial trainings and are confident in how to perform their functions and duties. The lack of an operational OSHC was found as a vital component missing for an effective and efficient OSHMS. Therefore, the hotel should put into operation this committee without delay in order to improve this fundamental aspect of their OSHMS.

5.2.3 Safety and Health Audits, and Risk Assessments

The Sarova group performs its own internal safety and health audits (as part of their annual general audit) of safety systems such as fire safety and mechanical and electrical safety. In addition, an annual safety and health audit for the Sarova Stanley is conducted by an OSH officer from the DOSHS which complies fully with Section 11 of OSHA 2007 (GOK, 2007). Apart from the audits, other services provided by the DOSHS have included trainings on general safety and health management for all of the Sarova properties, and a recent training for the newly formed Stanley OSHC. Another audit conducted recently in 2015 included a NEMA Environmental Audit. Having these regular audits helps the hotel monitor the performance of their health and safety system, and therefore continually improve the efficiency of their OSHMS.

However, according to the 2014 DOSHS Sarova Stanley safety and health audit report, and the researcher's findings, an occupational safety and health risk assessment for the facility and operations had not been conducted. This is a vital component missing which therefore affects the effectiveness of the hotel's OSHMS as risk assessments determine the efficiency of control measures in place, and help identify and regularly review hazardous conditions and assess risks (Kabaka, 2014). This is indeed an area for improvement as Section 6 (3) of OSHA 2007 requires the occupier to carry out appropriate risk assessments of the workplace, and on the basis of those results, adopt preventative and protective measures to ensure the safety and health of persons employed (GOK, 2007).

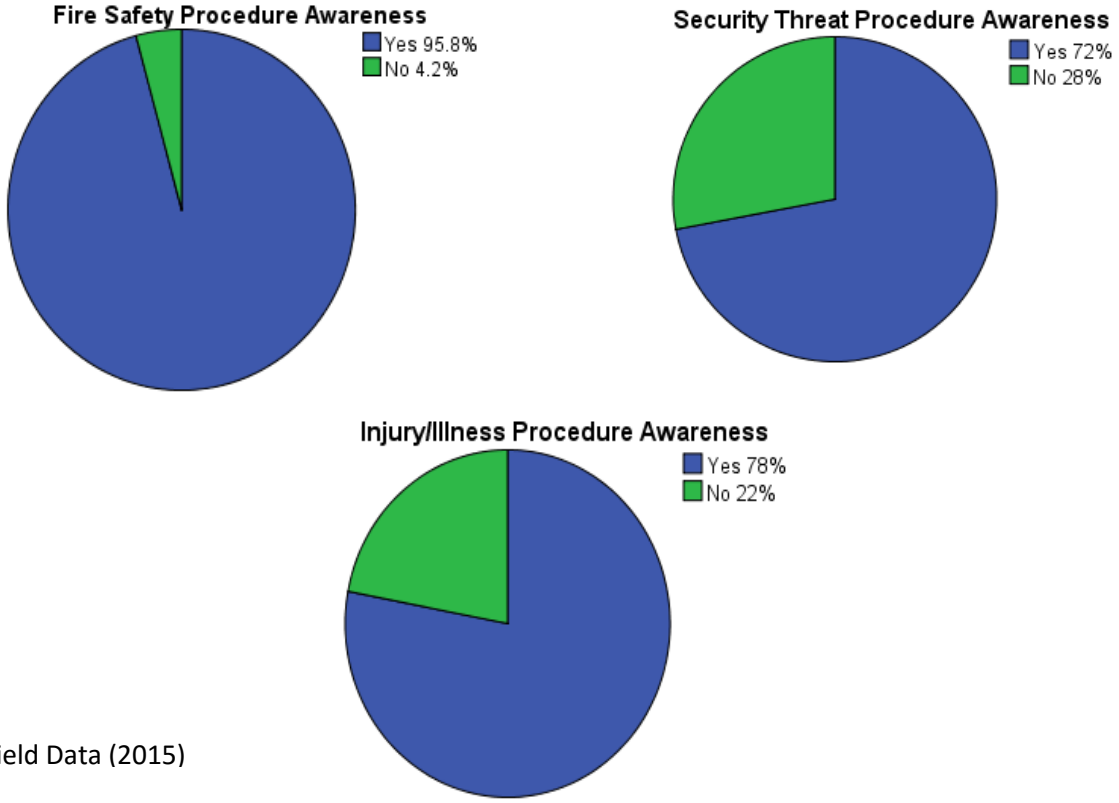
However, according to the General Manager, internal officers have been carrying out risk assessments approximately once a year at the hotel; and in the near future will be collaborating with the hotel's OSHC. This will help the assessments of each department to be conducted more efficiently, as each department has a knowledgeable representative in the committee. The Chief Security Officer adds that the OSHC are planning to devise a procedure that will determine possible hazards in all departments, as well as come up with a health and safety inspection checklist that will be done 2-3 times a year for all work areas of the hotel. When in operation, these plans should help advance the overall management of occupational safety and health in the hotel, through improved risk assessment procedures.

5.2.4 Emergency Planning and Preparedness

The Sarova Stanley Hotel has some written emergency plans and procedures that can be found in the Sarova safety and health policy, the duty manager's compendium (handbook), and with the Chief Security Officer and Hotel Engineer, who are in charge overall of these plans and procedures. The emergency procedures that are found in the safety and health policy are procedures for evacuation, armed robbery, earthquake and fire. As these procedures can apply to any Sarova property, they are briefly written with only the important points outlined. Only the fire safety procedure provides detailed instructions in relation to the Sarova Stanley Hotel. The duty manager compendium provides instructions to the manager on how to handle certain emergency situations, mostly in relation to hotel guests. At the time of research this handbook was being revised to include more types of emergency situations, and provide more details for the current ones.

The outlining of emergency plans and procedures is a vital component of an OSHMS (GOK, 2013). However, it appeared only management level employees had access to this crucial information as no plans/procedures were posted on any Front of House Department notice boards (despite this being an immediate recommendation in the Sarova Stanley DOSHS 2014 safety and health audit). This could affect employees awareness on what to do in emergency situations and therefore reduce the overall effectiveness of the organization's OSHMS. The following charts depict employee survey results on employee emergency awareness knowledge, which the researcher found differed from face to face discussions with the employees.

Figure 7: Employee Awareness of Emergency Procedures



Source: Field Data (2015)

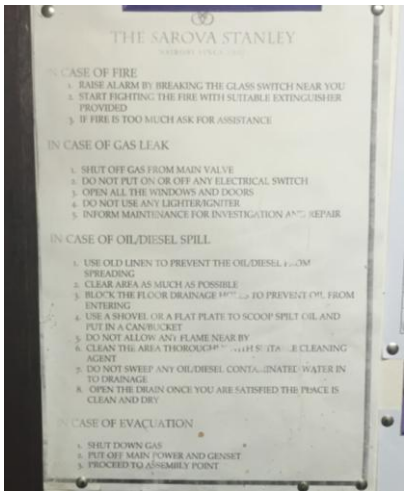
According to the data, employee knowledge on fire safety procedures is relatively high, with only 5 out of the 118 participants responding that they are unaware of what to do in these situations (these 5 participants work in the housekeeping and kitchen departments). However, during observation, when the researcher asked department managers and other employees if they are aware of fire evacuation routes and how to use fire fighting equipment, some answered confidently (mostly the kitchen employees), while the others were hesitant and appeared unsure (mostly the food and beverage service staff). According to the General Manager fire safety trainings were an area of improvement for the hotel, but in the last half of 2014 they rapidly progressed, and a successful fire drill was carried out in December 2014, with future fire drills to be conducted twice a year. Throughout the hotel all means of escape are properly maintained and kept free from obstruction, which complies with Section 81 (3) of OSHA 2007 (GOK, 2007). The hotel fire systems are tested and inspected regularly; the fire alarms, smoke detectors and fire fighting equipment (hoses, extinguishers, blankets) are regularly maintained by a contractor (approximately every 4 months); while other inspections, for example the fire doors and emergency lighting are done by the internal hotel engineering team. According to the internal maintenance team some improvements can be made in this area. The functioning of fire doors are mostly only checked when required, however, spot checks are at times done. Therefore, there is need to have regularly scheduled, and documented inspections. The emergency lights are checked every end of month while the generator on-load is being tested. According to the Deputy Engineer, emergency lights should last 20 minutes and there are plans in motion to test these lights for longer as at the moment they are tested for approximately only a couple of minutes. Documentation of these tests is as well required.

According to the data collected from the employee survey, 33 out of the 118 participants (ranging across all departments except health club) are not confident in security threat emergency procedures. This result is in line with the researcher's findings from direct observation and impromptu discussions with the department managers and other employees. The employees agree that security trainings are conducted in the hotel, but if a real life threat emerged they would be too fearful to remember what to do; this is a sentiment especially felt by the switchboard telephone operators. The employees in general feel they require extra confidence and training on security due to the rising insecurity in the country and the hotel's sensitive location in the central business district such as how to define suspicious characters, procedure for dealing with suspicious packages, and how to act in an armed holed up, robbery or hostage situation. Some security trainings (e.g. on combating terrorism) are already implemented in the hotel. The researcher found that even though these trainings are given, attention and attendance to them needs to improve, as when random security personnel were asked on how they handle unattended luggage, and if security checks are done on stored luggage, they came across hesitant and unsure of themselves. Regular refresher trainings may be required for these personnel.

26 out of the 118 employee survey participants (ranging across all departments except health club) answered they are unaware of the emergency procedure to follow in case a co-worker suffers an injury/illness. This shows that there is need to post guidelines on these processes (in reference to the incident/injury procedure provided in the safety and health policy) either on employee notice boards, or where they can be easily accessed and noticed by them. According to the General Manager, each department has 2 trained first-aider representatives; and there are plans to have all duty managers trained in first-aid so that there's always a first-aider available in the hotel, along with the Hotel Nurse. In most departments, first-aid kits are available, which conforms to Section 95 of OSHA 2007 (GOK, 2007). However, from direct observation and impromptu discussions with employees, the researcher found there is need to create wider first-aider awareness as some employees are unsure of who their first-aider representatives are. This can be improved by having a list of all the hotel first-aiders displayed on the employee notice boards in all work areas; as the researcher found that only the front office department had posted the names of their two first-aider representatives on their notice board. There is as well need to have more control over the first-aid kit use, as some kits are easily accessible and left unlocked (such as in the Main Kitchen and Health-Club), and so some personnel may abuse this privilege (by utilizing more items than required), or some may not use the items correctly by taking incorrect dosage of medication. The first-aid kits are taken by the department first-aider representatives to the Nurse to be replenished as required, they use checklists for this. However, the representatives do not provide proper records of kit use, which is vital in order to improve control. According to the Nurse this is meant to be done, but not, due to laxity.

Overall, employee awareness on handling emergency situations requires improvement in order for the hotel's OSHMS to be more efficient and effective. Even though the researcher found evacuation route plans posted in guest rooms; and quick instructions for fire, gas leak, oil/diesel spill and evacuation emergencies posted on the staff cafeteria corridor notice board, and the human resources office notice board, these are not enough to create and maintain employee knowledge on these situations. Emergency plans and procedures should be posted or easily available in every work area in order to reduce panic and disarray amongst workers, and therefore enable smoother handling of emergency situations (HSA IE, 2006).

Plate 12: Quick instructions for Emergency Situations

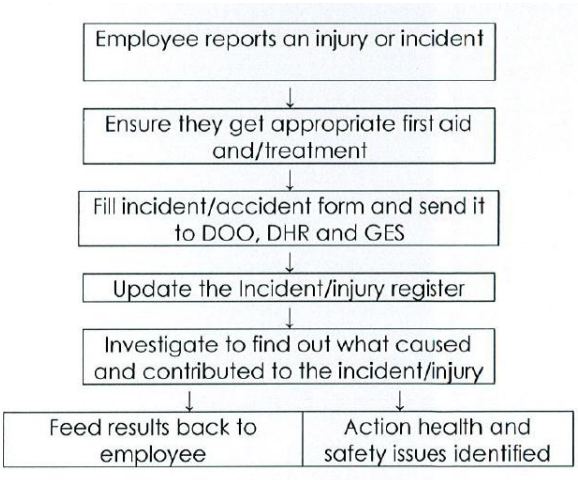


Source: Field Data (2015)

5.2.5 Accident and Incident Management

The Sarova Stanley Hotel has established a formal system for the reporting and investigation of accidents and incidences, which is in line with the provisions of OSHA 2007 and the DOSHS code of practice on OSH auditing (GOK, 2007; GOK, 2005). The processes for these are mentioned in the Sarova Group safety and health policy, and in the Stanley Hotel duty manager's compendium. The sequence of procedures at the time of an accident/incidence has been depicted in a flow chart available in the Sarova safety and health policy:

Figure 8: Sarova Hotels Accident/Incidence Investigation Flowchart



Source: Sarova Hotels (2013)

There is an official reporting template available for accidents and incidences that include details such as type, description and cause of the incident; as well as what corrective action has been recommended/taken to prevent reoccurrences of similar incidences. These incidence reports are filled in by the highest in hierarchy (at the time of incidence) of the department in concern, in conjunction with hotel security who are called in to inspect the scene at the time of incidence. The Chief Security Officer is the overall custodian of the accident/incidences reports.

From reviewing the hotel's accident/incidences reports (Appendix 10), and from the General Manager and Chief Security Officer, the reporting of incidences has greatly improved in the last year or so. Previous reporting used to be relatively inconsistent with different formats being used and not all incidences being reported or recorded. Incidences are now reported more consistently using the official Sarova accident/incidence reporting template. However, follow up reports need to be done to see if the recommendations made were implemented and to inspect what happened after the incident (e.g. did the employee return to work? Was the employee given a different job role? How many days of sickness absence was the employee given? What was the insurance claim?) There is also need to create more employee awareness of these reports and the findings, as recommended in the 2014 DOSHS Sarova Stanley safety and health audit, to help avoid similar incidences in the future (Kabaka, 2014). From impromptu discussions, some supervisors are unaware of, or are unconcerned with these reports, shrugging them of as part of their manager's duties. This finding is in line with Dr. Strahlendorf's Internal Responsibility System (IRS) theory

where workers may avoid dealing with health and safety issues as they feel it is someone else's job (Thomasen, 2005; Strahlendorf, 2013). Therefore there is need to train these employees on the importance of these reports to help improve the efficiency of accident/incidence investigation and management.

Overall the effectiveness of the hotel's accident/incident management requires improvement. This can be done by introducing an official incident/injury register (as mentioned in the Sarova safety and health policy) to improve the record keeping of the accident/incident reports. At the time of research, the only information available on this was the Hotel Nurse's clinical records of injuries/illnesses employees visited her for (Table 8 and Figure 18). The Stanley OSHC should collaborate with the Nurse by compiling this information into monthly statistics showing the various conditions experienced per department. They should also keep specific records of the nature of injuries/illnesses employees are referred or admitted to hospital for, as well as the reasons for sick offs, along with insurance claims reports. This information can "greatly enhance (the) organization's ability to identify health risk trends, and then use this information in a positive way to reduce the likelihood of poor health outcomes, and (therefore) deliver measurable business and employee benefits" (Cassidy, 2012: 3) as depicted in Reason's 'Defence in Depth Accident Trajectory Model'. Compilation of these reports is as well recommended by GOK (2005); GOK (2013) and Kabaka (2014) as an important way of monitoring the performance and efficiency of an organization's OSHMS. As since 2013 the annual number of employee sick-offs, injuries and illnesses are relatively the same; an indication the hotel's OSHMS is not very effective and requires some improvement.

5.3 Risk Assessment of Occupational Health and Safety (OHS) Hazards in the Hotel's Front of House Departments

This section identifies the types of hazards and associated risks in the hotel's Front of House Departments. From the research findings, it as well suggests precautionary measures the hotel can take to help control the risks identified.

5.3.1 Hazards Identification

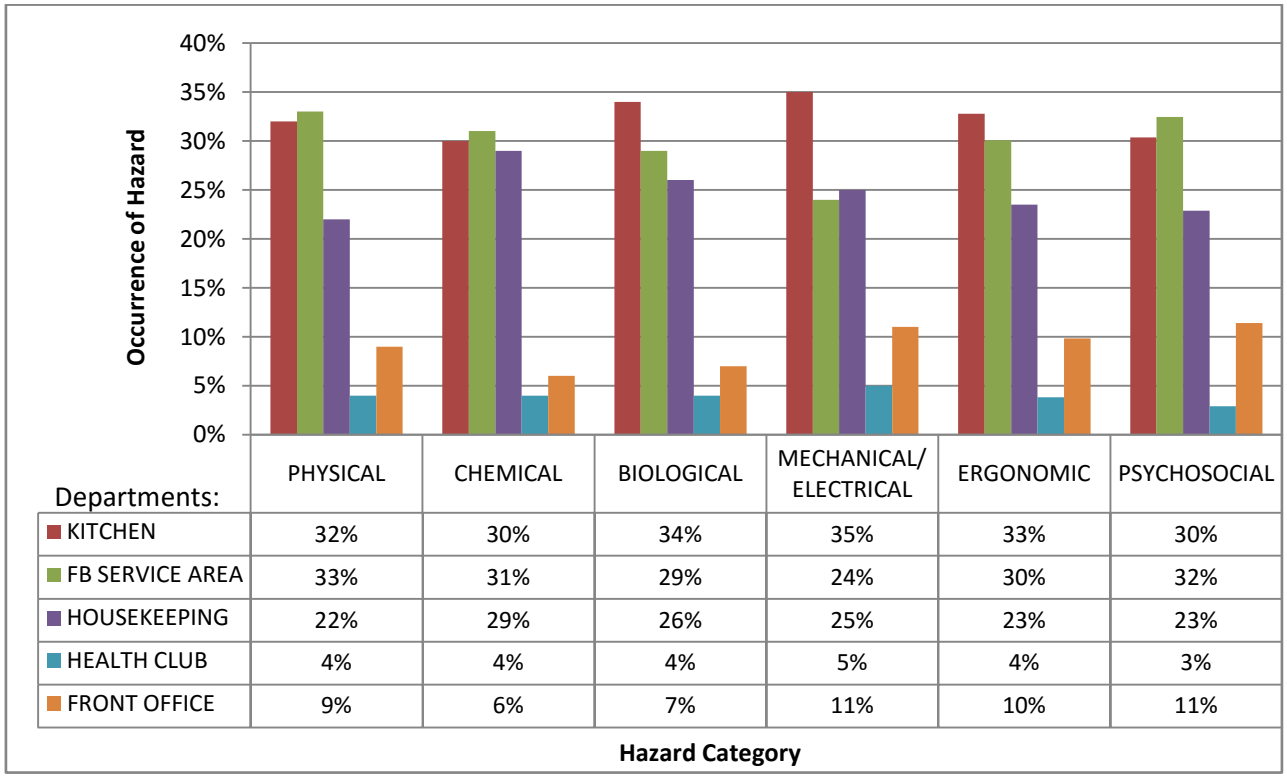
5.3.1.1 Common Hazards in the Front of House Departments:

Figure 9 summarizes the occurrences of hazards amongst all 5 departments under study as per the employee survey (see Appendix 11 for breakdown of these hazards). Notable hazards that are widely experienced, with more than 3/4s of the participants answering that they occur, include extreme temperature (88%), slippery surfaces (74%), pests (84%) and lack of sitting (90%). Some participants have as well reported accidents/incidents that have occurred in relation to some of these hazards: 9 participants reported slipping/falling due to slippery floor surfaces, and 4 reported feeling unwell due to extreme temperatures in their work area. These findings are in line with information received from the Hotel Nurse

and departmental managers as they state employees are often treated for injuries from slips and falls, for dizziness, and for musculoskeletal disorders from prolonged standing and manual handling.

It is interesting to note that the psychosocial hazards (or workplace stressors) received more responses of occurrence than the other groups of hazards. These findings coincide with some studies. For example, more than 60% said they experience overall conflict with their superiors which include lack of support, guidance, feedback and recognition. More than 65% as well said they do not participate in decision making and are not given the opportunity to express their views or opinions. This is similar to studies from Lo, Lamm (2005); Hoel, Einarsen (2003); Gibbons, Gibbons (2007); O'Neill, Davis (2011) and Kuria, Wanderi, Ondigi (2012) who found that hotel workers experience a high level of stress, much of which is contributed from conflicting with management as they are expected not to challenge managerial decisions and tend to not be treated well by inflexible and unapproachable management. Lo, Lamm (2005) and Hoel, Einarsen (2003) as well found that hotel workers experience a high level of conflict with clients and verbal bullying from co-workers, management and clients. This is somewhat in line with the current research findings as only 47% answered they experience client conflict, and 50% said they experience verbal bullying. These studies along with Gibbons, Gibbons (2007) and Bohle *et al* (2004), as well found that hotel workers work long and odd hours, and usually have heavy workloads with few breaks due to the customer satisfaction nature of the job. This is in line with the current research's findings as more than 65% of participants said they are given excessive workloads, work overtime and unsocial hours with lack of rest breaks.

Figure 9: Hazards in the Front of House Departments (Employee Survey)

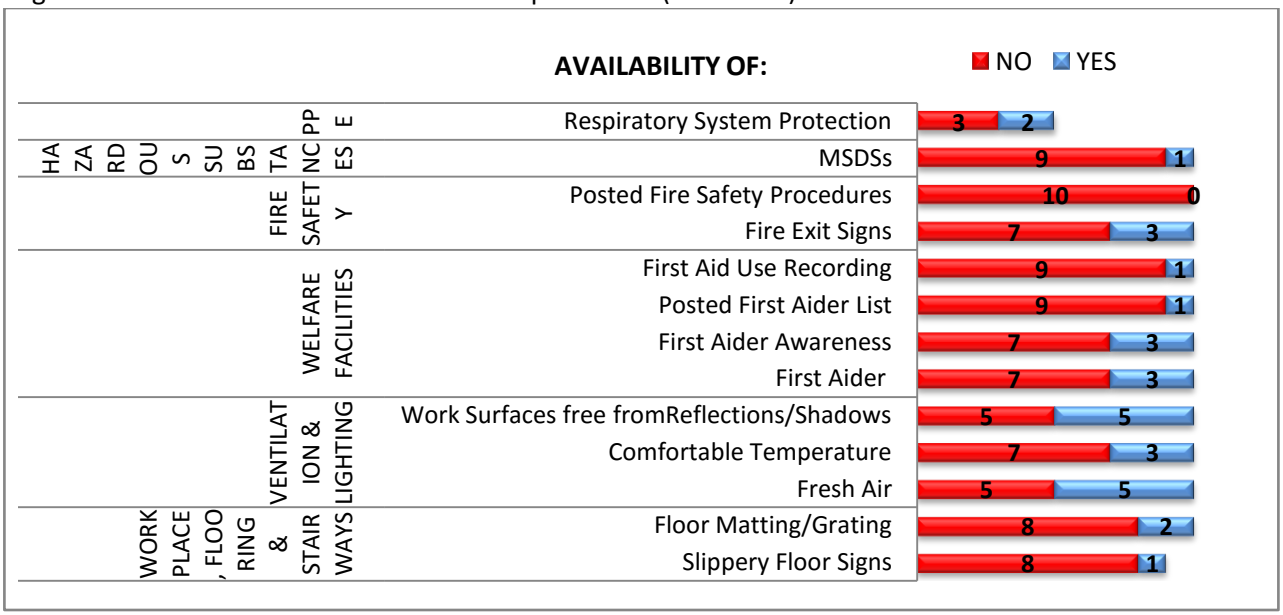


Departments:	PHYSICAL	CHEMICAL	BIOLOGICAL	MECHANICAL/ ELECTRICAL	ERGONOMIC	PSYCHOSOCIAL
KITCHEN	32%	30%	34%	35%	33%	30%
FB SERVICE AREA	33%	31%	29%	24%	30%	32%
HOUSEKEEPING	22%	29%	26%	25%	23%	23%
HEALTH CLUB	4%	4%	4%	5%	4%	3%
FRONT OFFICE	9%	6%	7%	11%	10%	11%

Source: Field Data (2015)

Figure 10 summarizes the OHS matters from the direct observation checklists that received more 'No' responses than 'Yes' out of the 10 areas observed; therefore indicating presence of a hazard. These findings complement the above employee survey findings on common hazards in all the departments. For example, 8 out of the 10 areas observed lacked slippery floor caution signs (even when floors were being cleaned) and floor matting/grating, which is in line with 74% of the participants stating there are slippery floor surfaces in their work areas. Other notable hazards observed directly by the researcher include lack of visible, posted fire safety procedures and first aider information, which would otherwise be able to guide associates in times of emergencies. Last but not least, lack of availability of MSDSs (housekeeping was the only department with them) in all the work areas is another area of concern, especially since more than 65% of participants of the survey reported that they work with chemicals/solvents. The 2014 DOSHS Sarova Stanley safety and health audit as well found that MSDSs were only available in one department and recommended they should be easily accessible in all as a vital information guide during a chemical emergency (Kabaka, 2014).

Figure 10: Hazards in the Front of House Departments (Checklists)

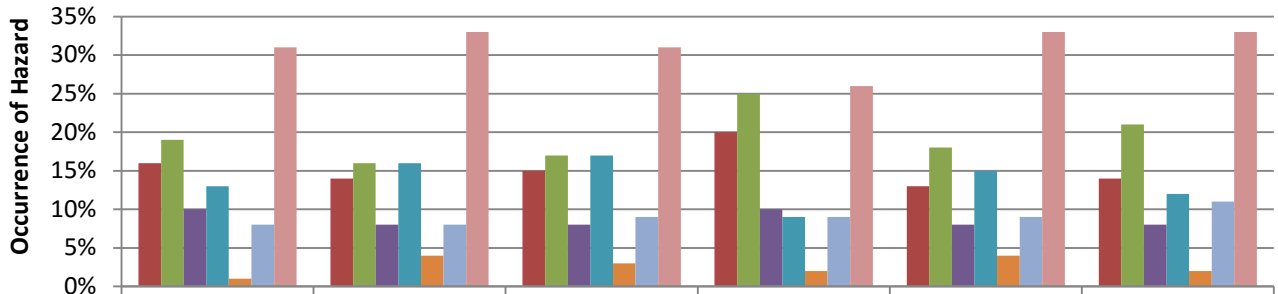


Source: Field Data (2015)

Hazards identification per department is discussed in the following sections.

5.3.1.2 Kitchen Hazards:

Figure 11: Kitchen Hazards (Employee Survey)



Kitchen Work Areas	PHYSICAL	CHEMICAL	BIOLOGICAL	MECHANICAL/ ELECTRICAL	ERGONOMIC	PSYCHOSOCIAL
BANQUETING	16%	14%	15%	20%	13%	14%
PASTRY	19%	16%	17%	25%	18%	21%
POOL DECK	10%	8%	8%	10%	8%	8%
ROOM SERVICE	13%	16%	17%	9%	15%	12%
STAFF CANTEEN	1%	4%	3%	2%	4%	2%
THAI CHI	8%	8%	9%	9%	9%	11%
THORN TREE	31%	33%	31%	26%	33%	33%

Hazard Category

Source: Field Data (2015)

Figure 11 summarizes the occurrences of hazards in the various kitchen work areas as per the employee survey (see Appendix 12 for breakdown of these hazards). 22 out of the 26 listed psychosocial hazards in the questionnaire received positive responses of occurrence, indicating a high presence of these workplace stressors in the kitchen work areas. This is in line with the studies by Gibbons, Gibbons (2007) and Hoel, Einarsen (2003) who found that kitchen staffs experience a great deal of occupational stress. Contributors of this stress include lack of communication, feeling undervalued, and being bullied and intimidated both physically and verbally by superiors. The current research findings tally with these studies as 67% of the kitchen employees responded that they experience conflict with their superiors, and more than 67% responded they lack openness, participation, guidance, support, recognition and feedback from their superiors. Even though, only 18 out of the 33 kitchen participants responded they experience verbal bullying and only 11 responded they experience physical bullying, these were still the highest responses to these variables from all the departments under study. Hoel, Einarsen (2003) concluded that the occupational stress is due to the negative characteristics of the kitchen work environment, such as the heat and pressure to perform, causing a high level of frustration. This explains why 64% of the kitchen participants responded they experience conflict with their co-workers; in fact incidences have been logged in the Stanley Hotel's accident/incident records of chefs verbally and physically fighting with one another. Other sources of occupational stress in the kitchen work environment include excessive workload, working overtime and

unsocial hours, with lack of rest breaks as indicated by almost all the kitchen participants. According to the General Manager, Hotel Nurse, and kitchen management, the kitchen staffs are some of the busiest workers in the entire hotel due to working banqueting functions and outside caterings which can run overtime and be back to back, along with conducting normal restaurant duties.

All of the kitchen participants (except 1) responded that there are slippery surfaces in their work areas; and 9 reported incidents that have occurred in relation to slippery floors, such as slips/trips, neck/back injury and fractures. Direct observation of the 3 main kitchen areas revealed similar findings. The flooring in all 3 kitchens, including in the cold rooms, were observed to be quite slippery, especially when wet (particularly the pot wash areas), and so chefs and stewards are provided with non-slip safety boots. However serving staffs are constantly passing through the kitchens and are at risk of slips, trips or falls as they are not provided with non-slip shoes. There are some ramps located within the Thorn Tree Kitchen, which although small are quite steep and slippery; when wet, persons have to be particularly careful on them not to slip. Similarly, in the Main Kitchen the ramp leading into one of the cold rooms is very steep and very slippery. These ramps are missing sturdy handrails which can otherwise help assist persons along them. It was as well observed that while the floors were being cleaned, caution 'slippery floor' signs were not placed in any of the kitchens (although according to the stewards they are available), thus becoming a risk to any unobservant persons. A chef in fact reported an incident of when they did not realise the floor was being cleaned which caused them to slip on the wet floor and strain their back.

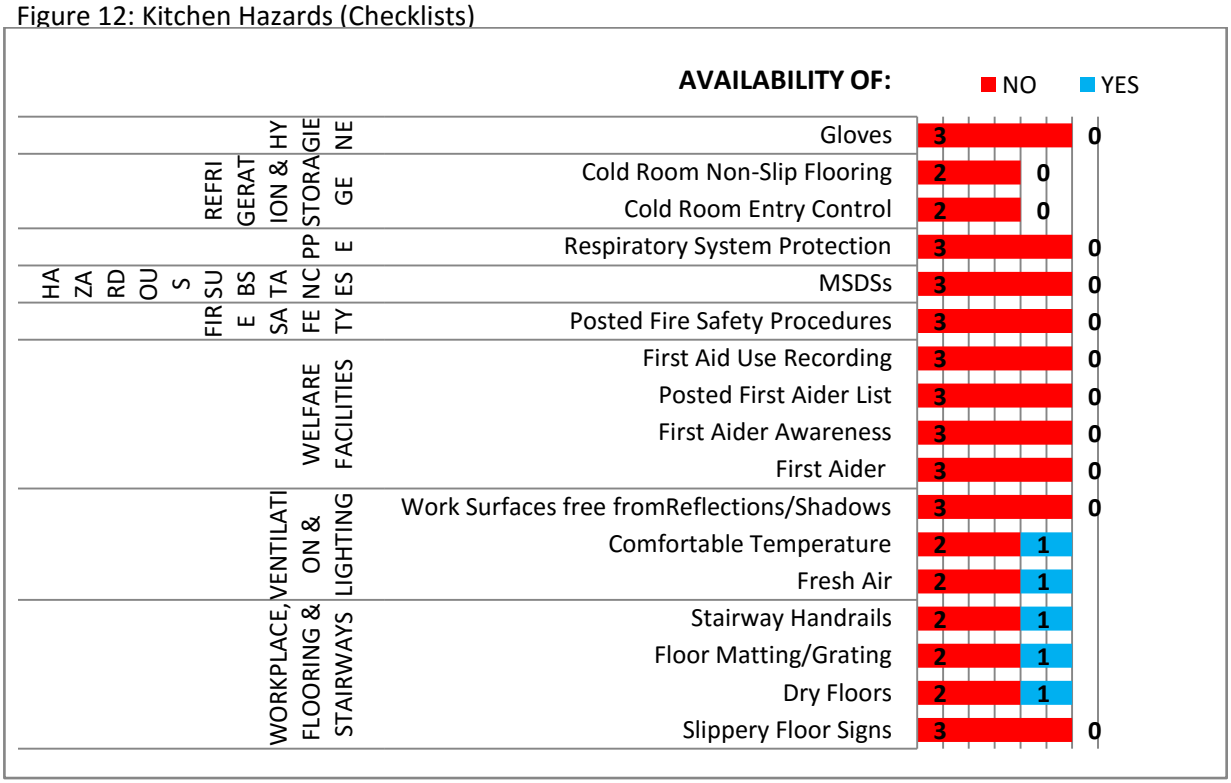
32 out of the 33 kitchen participants responded there are extreme temperatures in their work areas and 21 said there's lack of fresh air; 3 as well reported dizziness, fatigue and difficulty breathing from constantly moving between hot kitchens and cold walk in fridges. From direct observation, the researcher noted that all 3 of the kitchens were installed with overhead ventilation ducts for air circulation and the Main Kitchen as well has 3 large open able windows; however they could still get hot and stuffy especially when busy. This is the case for the Pool Deck kitchen as well which is an open kitchen located at the pool side, and it's air temperature and freshness is dependent on the outside weather, therefore it can get extra hot and stuffy if it is a hot and busy day.

Almost all Pool Deck kitchen participants responded that they are exposed to fumes. This could be in relation to the griddle oven which was observed by the researcher, and confirmed by employees, to get quite smoky; enough for some to complain of dry eyes and breathing difficulty. This could be the reason for kitchen employees reporting 36% of cases of eye infections and 28% of respiratory illnesses to the Hotel Nurse from January 2013-June 2015. As a response the hotel has installed an air extractor fan above this oven, and ovens in the other kitchens to reduce smoke fumes. In total 61% of the kitchen participants responded they are exposed to fumes. From observation, these are mostly the stewarding staffs who are exposed to chemical fumes as they are the ones who are responsible for, and deal mostly with the chemicals

in use in the kitchen. According to the stewarding team, there are two particular chemicals that give off strong fumes that affect their respiratory system; one steward even complained that he has developed asthma due to these chemicals: oven cleaner and terrazzo floor cleaner. The stewards wear gloves, aprons, head coverings and safety shoes as PPE, but unfortunately do not wear masks or safety goggles that could otherwise protect them from irritating fumes. Another area of concern was the lack of MSDSs in any of the kitchens, despite more than 70% of the kitchen participants responding that they deal with chemicals/solvents and cleaning agents. When asked, the stewarding team were unaware they had ever seen a MSDS, but said they get regular trainings from the chemical supplier companies. The chemicals were otherwise observed to have the basic supplier warning labels on the containers and were stored securely in the stewarding store.

Figure 12 summarizes the OHS matters from the direct observation checklists that received more 'No' responses than 'Yes' out of the 3 kitchen areas observed. As kitchen employees are in constant contact with food and water, 87% of the participants responded that they are exposed to possible food or water borne pathogens. However, the Nurse's records show that only 21% of food/water borne illnesses treated from January 2013-June 2015 was from the kitchen department. This highlights a strength in the hotel's OSHMS, as the hotel organizes health screening for all the food handlers every 6 months, as part of their preventative health care. Another positive feature noted was all dustbins are non-hand operable, therefore helping prevent possibilities of contamination. In terms of cleanliness all 3 kitchens were relatively clean, as the stewards wipe work surfaces, mop the kitchen floor, empty the dustbins after every shift, and deep clean the kitchens and equipment overnight. However, the main kitchen was observed to have become messy and cluttered after a particularly busy shift, and was left that way for at least half an hour before being cleaned. Better organization and planning may be required in anticipation of busy shifts to avoid attracting dirt and pests as a couple of cockroaches were spotted by the researcher during this time. 94% of participants responded there are pests in their work area, even though the kitchens are pest proofed as there are flying insect 'zappers' located in each of them, and according to the kitchen management, the pest control contractor visits the establishment 1-2 times a month to pest proof the entire hotel.

Figure 12: Kitchen Hazards (Checklists)



Source: Field Data (2015)

According to 67% of the kitchen participants the machinery/equipment is in poor condition. However, the Hotel Deputy Engineer states the appliances are serviced every 3 months by the suppliers; otherwise the in-house maintenance team have a weekly schedule for maintenance of all the electrical equipment. He added that there is rarely 'hand-in-hand' inspection done of the equipment and work area with the chefs. This is an area of improvement and needs to be done on a weekly/monthly basis, and documented, to ensure proper preventative maintenance and functioning of equipment. It is as well important to have refresher trainings on how to safely operate equipment, as there was an incident of a steward who crushed his fingers while trying to clean a juicing machine that was still on. It was observed that slight reflections come off the metallic work tops in the kitchens from the overhead artificial lighting, however when asked, employees said it does not irritate them and they are able to work comfortably.

As in all areas observed, information on fire safety procedures was not available. This needs to be posted on the work area notice boards to better prepare for emergencies. In the Thorn Tree and Main Kitchen, fire fighting equipment, such as fire blankets, extinguishers and fire alarms are easily available; fire exit routes are as well clearly marked with self-latching fire doors. However, in the Pool Deck Kitchen, there are no signs to direct staff within the kitchen to the fire exit route, although it is located just outside of the kitchen storage area. Old employees may be aware of this, but with no signs to direct them, new employees may not be aware of this in a time of emergency. According to Collins (2010a) fire doors should be self-latching to help stop the spread of fire/smoke. This is an area of improvement for the Pool Deck Kitchen, as

the door leading from inside the kitchen directly to the fire exit route is a normal lockable door that is left open during operation hours.

In terms of employee welfare, drinking water is readily available in all the kitchens, and there are as well hand washing stations located in all kitchens for staffs to sanitize, which are in line with Sections 91 and 92 of OSHA 2007. First aid kits are as well easily available in the Main and Pool Deck Kitchens. However, one was not easily available in the Thorn Tree Kitchen and staffs said they usually go up one floor to use the ones available in the Main Kitchen. The kitchen staffs were as well not confident in answering who their first aid representatives are, saying they normally help themselves to the kits for minor incidents, and visit the hotel Nurse for major ones. Information on the hotel first aiders needs to be posted on the notice boards in times of emergency when the Nurse may not be available. Lack of sitting is one of the welfare hazards with 79% of participants saying it occurs very frequently. This was as well observed by the researcher and confirmed by the Nurse, General Manager and kitchen management who said that the nature of kitchen staffs jobs require them to be on their feet majority of the time. There is a staff cafeteria in the hotel where employees can sit when needed, which complies with Section 94 of OSHA 2007.

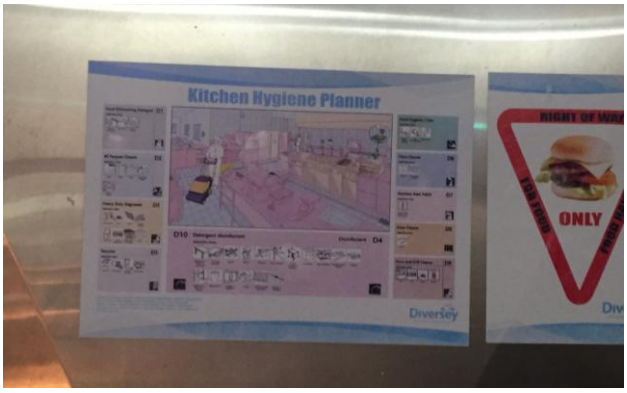
A positive aspect noted is that hygiene is of utmost importance in the kitchen, as employees are trained approximately every fortnight in personal and food hygiene practices either by the chemical supplier company, or by the Executive or Sous Chef. It was as well observed that even though gloves are not worn for hand-to-plate service operations, tongs and other utensils are used for sensitive foods such as salads. Items in the cold rooms, refrigerators, and storage areas were properly covered and dated, and neatly stored with cooked and raw items stored separately. 'Best by' dates are regularly checked by chefs on duty, and they as well have a schedule to deep clean all the cold rooms and refrigerators at least once a week. An area of improvement observed was that entrance into the cold rooms was not officially controlled, as any chef on duty can enter them. The cold room doors are however lockable, and for safety they can be easily opened from the inside.

The findings show there are some areas for improvement in the kitchen to eliminate or minimize the possibility of hazards; but there are as well some positive aspects in the kitchen that already do this such as safe work procedures posted in the work areas and bi-annual medical screenings for the employees.

Plate 13: Safe Work Practices Postings in the Kitchen (1)

Source: Field Data (2015)

Plate 14: Safe Work Practices Postings in the Kitchen (2)

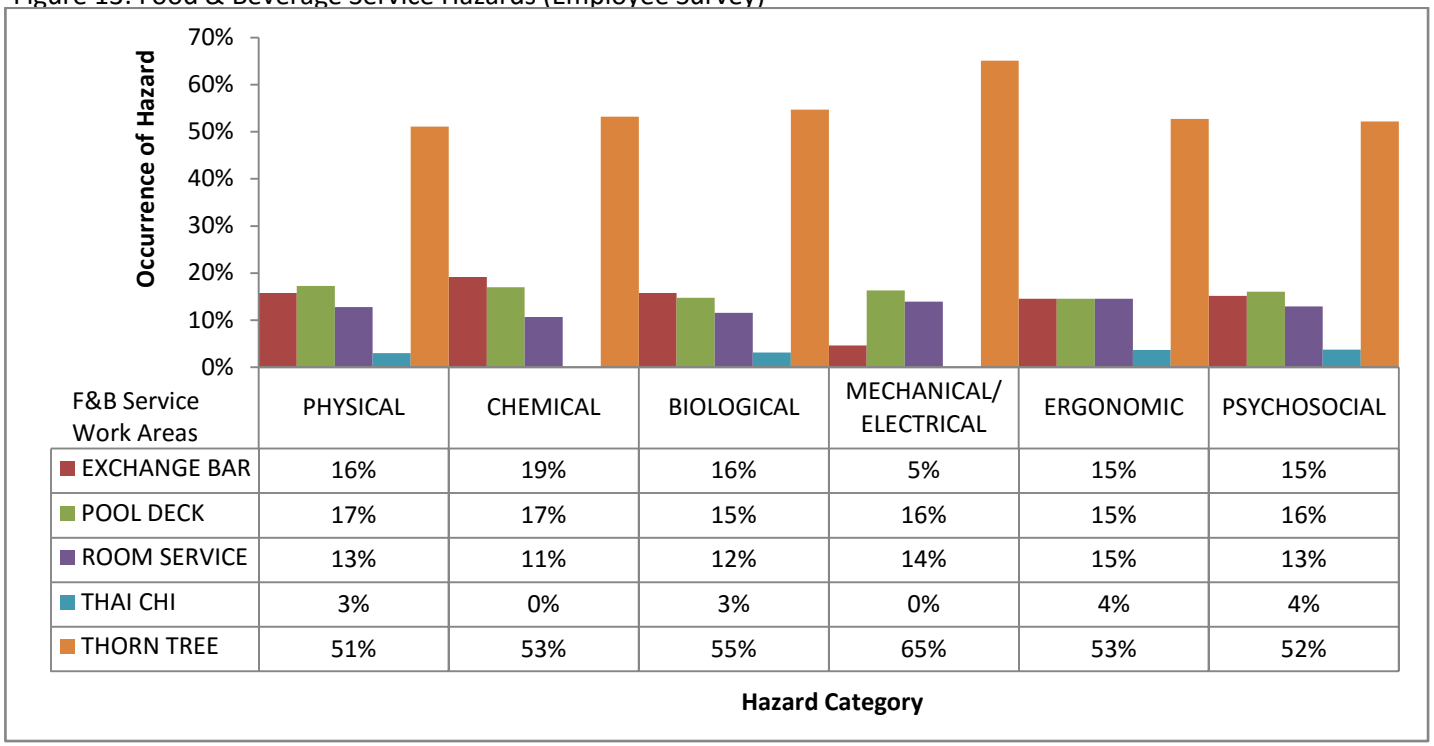


)

Source: Field Data (2015)

5.3.1.3 Food and Beverage Service Hazards:

Figure 13: Food & Beverage Service Hazards (Employee Survey)



F&B Service Work Areas	PHYSICAL	CHEMICAL	BIOLOGICAL	MECHANICAL/ ELECTRICAL	ERGONOMIC	PSYCHOSOCIAL
EXCHANGE BAR	16%	19%	16%	5%	15%	15%
POOL DECK	17%	17%	15%	16%	15%	16%
ROOM SERVICE	13%	11%	12%	14%	15%	13%
THAI CHI	3%	0%	3%	0%	4%	4%
THORN TREE	51%	53%	55%	65%	53%	52%

Source: Field Data (2015)

Figure 13 summarizes the occurrences of hazards in the various F&B service work areas as per the employee survey (see Appendix 13 for breakdown of these hazards). Similar to the kitchen findings, workplace stressors received a high number of responses of occurrence from the F&B service participants, indicating a high level of psychological hazards. Like the kitchen participants, F&B employees have some of the most active and demanding jobs in the hotel, especially on a busy day. As a result almost all of the F&B participants responded they lack rest breaks, work unsocial hours, and at times work overtime. As well similar to the kitchen participants, 67% of the F&B participants responded that they experience conflict with their superiors. They encounter lack of openness, participation, guidance, support, recognition and support from their superiors; and more than half responded that at times they have no control over how to perform their duties, or have choice over their days off/leave time. These findings are similar to Lo, Lamm (2005), hotel managers "tend towards a unitarist approach in managing employment relations (...) Employees are not expected to challenge managerial decisions (...) as to do so would result in (their) disapproval" (Lo, Lamm, 2005: 18).

Hoel, Einarsen (2003) and Lo, Lamm (2005) point out that the intensive customer interaction nature of a service worker's job leads to high level of stress; and the expectance of the employee to always be gentle, caring, pleasant and accommodating makes them vulnerable to criminals and possible sexual harassment. These are in line with the current research's findings as 61% responded they experience conflict with clients, 50% say they are exposed to criminals, and 33% responded they experience sexual harassment

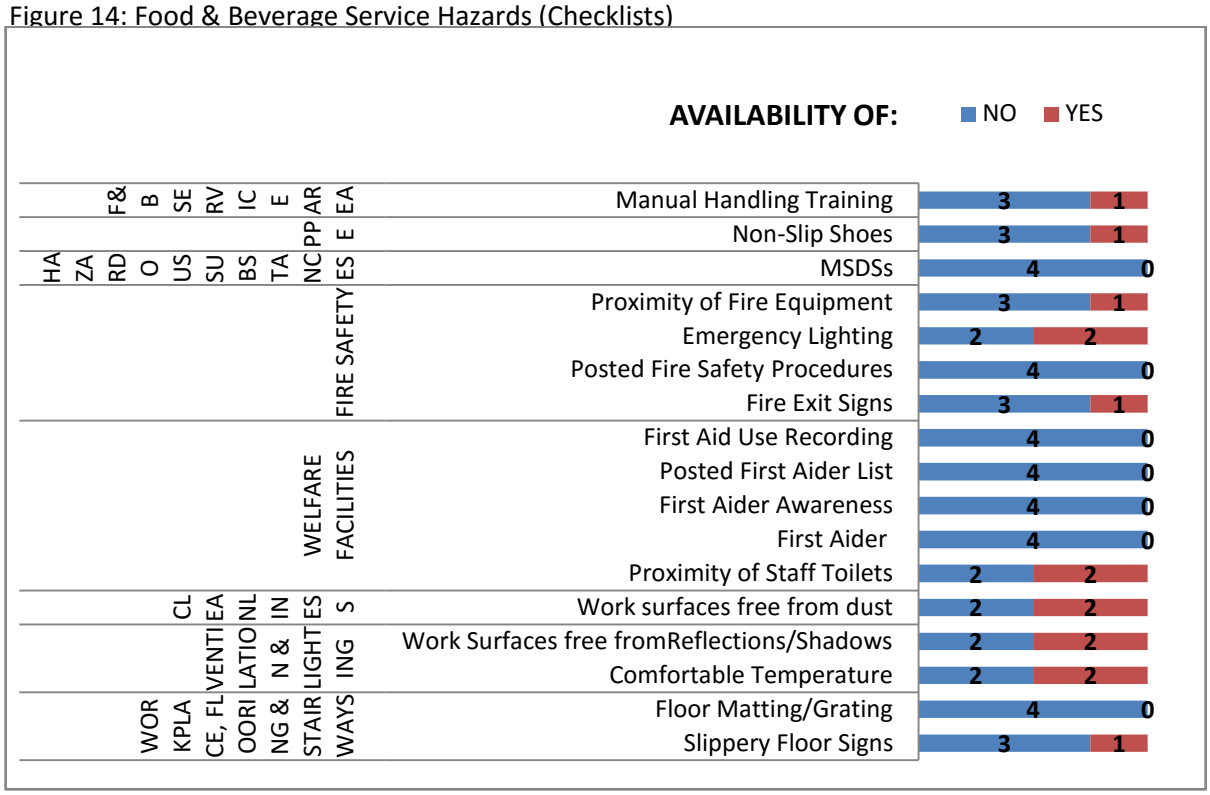
in their work area. The Hotel Nurse concurs that employees expected to interact with customers are vulnerable to sexual harassment, and as a result the hotel has regular sexual harassment talks, and has developed a sexual harassment policy; she adds that it is unfortunately rare for employees to officially come forward with these complaints as they feel embarrassed.

Another common hazard shared with the kitchen, as indicated by 92% of the F&B participants, is extreme temperature in their work areas. The temperatures in the Exchange Bar and Thorn Tree restaurant were observed as relatively comfortable. However, if it is a particularly hot day they can get warm; as the Exchange Bar is surrounded by large windows that let in direct sunlight, and the Thorn Tree restaurant is partly al fresco (open air). This was as well noticed at the Pool Deck as it is a majority al fresco restaurant, and so it can get uncomfortably hot or cold dependant on the day's weather. In the Thai Chi restaurant extreme temperatures were noted: as the Air Conditioner is on throughout opening hours, employees complained that it can get quite cold; and there is a sharp contrast for when they have to enter the hot kitchen, which they frequent to collect food and drop off dishes.

Ergonomic hazards of lack of sitting and manual handling are also common with the kitchen. The nature of the F&B service staff jobs require them to be constantly on their feet. However, lack of seating for staff was especially observed at the Thorn Tree Restaurant, and concurred by 94% of the Thorn Tree F&B participants, as employees would have to go all the way up to the staff cafeteria or staff washrooms to rest. In the other three F&B areas, a chair and table are available in their back areas in case an employee needs to sit. There is a high level of manual handling amongst service staff, as they constantly have to lift and move loads such as full trays, crates, furniture and heavy equipment (HSA, 2003), as concurred by 70% of participants who responded they handle large, heavy, awkward objects. It was observed by the researcher that trolleys are available in most areas to help transport crates, except in the Exchange Bar, where associates complained they lack a trolley and have to transport the crates by hand which can cause muscle strain and other injury. The researcher as well noted that there is no official training for safe manual handling practices done at the hotel, although the Pool Deck restaurant manager said that associates are immediately corrected if they are observed to be unsafely/incorrectly lifting objects. Another common hazard that had a high level of response as the kitchen is 83% of the F&B participants who said there are occurrences of pests in their work areas. According to the Executive Housekeeper there is a pest control contractor who comes at least once a month to pest proof the entire hotel; however at times some pests may be spotted as they are particularly attracted to food preparation areas. The researcher noticed some cockroaches and ants in the back area of the Exchange Bar. According to the bar manager this is because the flooring is due to be fixed in this area as some tiles are cracked which give way to these pests. Cracked tiling as well poses as a trip hazard as indicated by 58% of the F&B participants (except Thai Chi) who responded

there is worn out flooring in their work area; however from direct observation, the researcher found there is adequate flooring in all areas, apart from the back area of the Exchange Bar.

Figure 14: Food & Beverage Service Hazards (Checklists)



Source: Field Data (2015)

Figure 14 summarizes the OHS matters from the direct observation checklists that received more 'No' responses than 'Yes' out of the 4 F&B Service areas observed. 81% of F&B participants responded there are slippery surfaces in their work areas. From the Nurse's clinical records, 41% of cases of slips/trips/falls were from the F&B department, the highest of the 5 departments. The flooring in the 4 F&B areas were observed to be quite slippery especially when wet, as the flooring is more or less smooth without matting/grating. Only the Thorn Tree restaurant was noted to display a 'caution wet floor' sign in the guest terrace area, as it was raining at the time of observation and the terrace flooring had become wet. The researcher observed that caution slippery floor signs are only displayed in guest areas and not staff areas when they are being cleaned. This is a hazard as some staffs may not be aware that floors are being cleaned and therefore are at risk of slipping/falling. It was as well noted that since the Pool Deck restaurant is partly open air, the exposed flooring can get wet and very slippery when it rains. Pool Deck management stated that caution signs are usually not displayed to alert persons, but agreed it is an area for improvement. Staffs are as well constantly passing through kitchens and behind bar areas whose floorings can easily get wet, unfortunately apart from the bar tenders (with an exception of the Pool Deck bar tenders), service staffs wear normal work shoes and not anti-slip safety boots. The service staffs are as well in danger of falling objects in the kitchens and bar areas such as crates, bottles, knives, utensils and other heavy items; and so it is important to have the safety boots as they are steel-toed for protection from foot injury.

Plate 15: Wet Floor Caution Sign in Thorn Tree Restaurant (*due to rain*)

Source: Field Data (2015)

Plate 16: Sunlight directly hitting Pool Deck Restaurant Computer order screen

Source: Field Data (2015)

16 out of the 17 Thorn Tree F&B participants responded there is loud noise in their work area, and 65% responded they are exposed to fumes. According to the Thorn Tree staffs, they are not only exposed to smoke in the kitchen, but as well as fumes from the vehicular traffic located right outside the restaurant, which can get noisy. 4 out of the 5 Pool Deck F&B participants as well responded that they are exposed to fumes. The researcher observed that the source of the fumes is not only from the smoky griddle in the kitchen, but as well from cigarette smokers permitted to smoke at the Pool Deck bar area; this is in line with HSA (2003), that states a unique hazard F&B servers are exposed to is environmental tobacco smoke. Chemical hazards were otherwise observed to be relatively low in the F&B service areas, as mostly mild cleaning agents are used. However, according to the label on the chlorinated detergent powder used for sanitizing utensils, rubber gloves are recommended to be worn for prolonged use as the chemical can cause skin irritation, which is minded by most employees.

In terms of fire safety, the Pool Deck restaurant fire exit door is clearly marked and self-latching. Fire fighting equipment such as extinguisher and fire blanket are as well easily accessible to the service staff as they are located in the restaurants adjacent open-kitchen. However, fire safety measures were noted to be lacking in the other 3 F&B areas observed. In the Thorn Tree restaurant, even though one of the fire assembly points is located in the foyer just outside the restaurant, there are no signs to direct persons to this area, as persons would have to exit the restaurant through the hotel lobby and out through the main entrance. Employees may be aware of this route, but customers would not be. Similarly in the Thai Chi restaurant and Exchange Bar, there are no fire exit signs displayed in the vicinities and therefore no fire exit routes marked, although available. Persons in the Thai Chi restaurant can access the fire exit route through the adjacent Main Kitchen. However, in a panic it can get confusing as two doors are available in the access between the restaurant and kitchen, and neither is marked to direct persons clearly to the fire exit route. In

the Exchange Bar, the guest area is quite open; however, the back area of the bar is relatively secluded and squeezed, with narrow, oddly angled walkways and only one access door. Due to the seclusion, associates located in this back area may not immediately realise if a fire is occurring in the front, and when they do, may not be able to easily exit the area due to its narrowness. This area is also vulnerable as according to the Deputy Engineer, the hotel plant room is located directly above it, and there are volatile equipment located here such as a pressurized container, glass washer and ice machine. Both the Exchange Bar and Thai Chi restaurant lack emergency lighting, which is an important fire safety element as both these areas can get quite dark. Proximity of fire fighting equipment was as well noted to be lacking in both these areas and the Thorn Tree restaurant; with no equipment available in the restaurants themselves and the closest one's being either in the kitchens or outside the restaurants-either of which are relatively far in a time of emergency. All areas however were observed to have overhead sprinklers. When directly asked if they are confident in their knowledge on fire safety (equipment use and fire exit route), several of the staff seemed unsure and were hesitant in answering. This contradicts the data collected from the questionnaire, as 100% of the F&B service participants responded they are confident in their knowledge of fire safety procedures.

All the F&B service areas were observed to be non-smoking; with the exception of the Pool Deck Bar area. No smoking regulation sign is displayed in all areas except in the Thai Chi restaurant. The restaurant as well lacks the liquor licensing body signage regarding the sale of alcohol/cigarettes to minors; this alcohol warning sign was as well observed to be missing at the Exchange Bar. According to these area managers, minors are generally not permitted within the bar area and children below 12 years of age are not permitted in the Thai Chi restaurant. The alcohol sign is however clearly displayed at the Thorn Tree and Pool Deck restaurants. A positive point noted by the researcher is that all servers are trained in responsible alcohol service at least 2-3 times a year by management or external trainers. Access to alcohol storage is as well strictly controlled in all the F&B service areas by the bar tender on duty as they are responsible for the stock. All beverage refrigerators are as well lockable to restrict access. However, in the hotel accident/incident records, 2 cases of alcohol theft by staffs occurred overnight from the Pool Deck restaurant storage. This situation has improved as access to this area is strictly monitored, especially overnight, and no situations of alcohol theft have been reported in the last couple of years.

Some hazards unique to particular F&B service areas were observed by the researcher as follows:

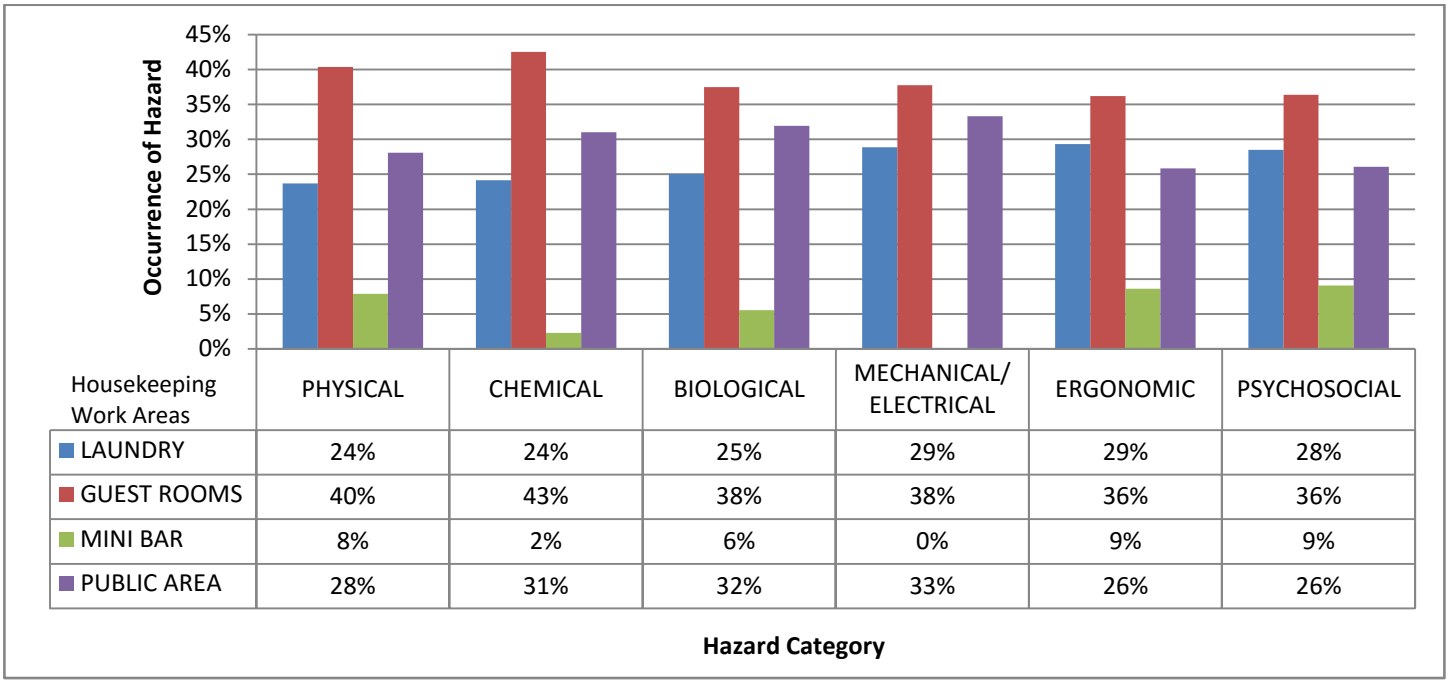
- No drinking water was available for the Thai Chi staff, who said they normally have to go all the way to the staff cafeteria for water. Space is however available to place a 20litre bottle of drinking water. Even though there is a 20litre bottle of drinking water available for the Exchange Bar staff, it is not placed on a dispenser and staffs have to tip the bottle to pour into a glass; this can be heavy and difficult for some staff. All other areas had drinking water easily accessible for staff.

- As the Pool Deck is an open air restaurant, when there is bright sunlight it can impair vision of the servers. The Pool deck servers add that it can sometimes be very difficult to see the computer screen to handle orders as the sunlight reflects directly off it, causing strain to the eyes.
- Staffs in the Exchange Bar and Thorn Tree restaurant complain that they constantly have to wipe dust off surfaces and floors. They state dust in the Exchange Bar collects on work surfaces due to the large carpet located in its guest area. Whereas dust collects in The Thorn Tree terrace in particular as a busy road is located just outside of it.
- There is a pressurized container located in the Exchange Bar that is connected to the wine cooler refrigerators. This container is only handled by the in-house maintenance team, however as a precautionary measure, bar staffs should as well be trained in the safe handling of this container to avoid any dangerous occurrences.
- There is a sharps container available in all the F&B areas for broken glass. However, the researcher noted that during the Thorn Tree observation, broken glass was dangerously kept on a shelf with other items in storage. It was assumed that the server who kept them there may have been in a hurry to close shift and forgot to place them in the sharps container. Precaution must be taken to place precarious items such as these properly.

According to HSA (2003) and HSA IE (2013), servers are constantly collecting and disposing of waste, and so hygiene standards are very important to protect the health of persons. This was a positive aspect observed by the researcher. Surfaces and floors of the F&B areas are cleaned at least 3 times a day, dustbins are emptied regularly, and the entire area and equipment are deep cleaned overnight. Hand washing stations are as well easily accessible in all the F&B areas so staffs can regularly sanitize. Like the kitchen staff, F&B servers as well have regular trainings on personal and food hygiene practices; and are as well subjected to bi-annual health screenings. Finally all the areas were observed to be kept neat and organized, with items such as crates stacked safely which is in line with Sections 47 (1a,b) of OSHA 2007.

5.3.1.4 Housekeeping Hazards:

Figure 15: Housekeeping Hazards (Employee Survey)



Housekeeping Work Areas	PHYSICAL	CHEMICAL	BIOLOGICAL	MECHANICAL/ ELECTRICAL	ERGONOMIC	PSYCHOSOCIAL
LAUNDRY	24%	24%	25%	29%	29%	28%
GUEST ROOMS	40%	43%	38%	38%	36%	36%
MINI BAR	8%	2%	6%	0%	9%	9%
PUBLIC AREA	28%	31%	32%	33%	26%	26%

Source: Field Data (2015)

Figure 15 summarizes the occurrences of hazards in the various housekeeping work areas as per the employee survey (see Appendix 14 for breakdown of these hazards). Psychosocial hazards are prominent in the housekeeping department as 16 out of the 26 hazards listed in this category had more responses of occurrences than 'Never'. Similar to the kitchen and F&B service departments, occurrences of conflict with superiors ranked high with 17 out of the 26 housekeeping participants responding this. More than 62% of the participants said they lack feedback, recognition, support, participation and openness from their superiors; however, less than half of the participants responded they lack guidance from their superiors which is dissimilar to the kitchen and F&B service area responses. 50% of housekeepers as well responded they experience conflict with their co-workers. This is in line with information received from the Nurse as she said housekeepers are stressed as they complain about conflicts with their management and colleagues, pressure of their work load, and the lack of staffing in their department. This information as well coincides with more than 58% of the housekeepers who responded they are given excessive workload, work overtime, not given enough time to complete their tasks, have lack of rest breaks, and work unsocial hours due to shift work. The Nurse added that housekeepers, along with many other hotel employees have job insecurity (of being transferred or employment being terminated) due to the low business performance of the hotel in relation to the dwindling tourism industry of the country in the last couple of years. A unique workplace stressor with a high response, unlike the kitchen and F&B service areas, is 65% of the housekeepers responding that their job tasks are mundane; they find them boring and unfulfilling. This is in line with Hoel, Einarsen (2003) who found that being given meaningless work is a source of stress in the workplace.

According to Buchanan *et al* (2010) housekeepers are some of the most vulnerable to injuries as the nature of their jobs demand a high level of physical effort such as " (...) repetitive movements, high static muscular loads, (and) high frequency of unsatisfactory postures" (Buchanan *et al*, 2010: 120). This statement corresponds with 53% of the housekeepers responding they deal with heavy manual handling in their job tasks. Four of the housekeeping participants reported having muscular strains and sprains from carrying and pushing heavy loads, such as heavy furniture and full carts. This is supported by the Hotel Nurse's clinical data as housekeeping had the 2nd most cases of musculoskeletal injuries since 2013 with 27%. The Nurse states she regularly treats housekeepers for muscular injuries from manual handling such as carrying heavy linen bundle bags over the shoulder. Unfortunately official trainings on safe lifting techniques are rarely done, and should be conducted more often to help the employees avoid these injuries. Two of the housekeepers add that strains and tiredness as well occur due to lack of sitting. 92% of the housekeeping participants responded that the nature of their jobs require them to be frequently/very frequently on their feet, from constantly walking around the hotel.

77% of the housekeepers responded there are slippery surfaces in their work area, 58% of which are the guest room and public area attendants. Although, since 2013, only 4 cases of slips/trips/falls were reported to the Nurse from housekeeping. The Nurse states that guest room and public area attendants tend to slip/trip while cleaning floors, especially wet bathroom floors. One guest room attendant in fact reported mild physical injury from slipping while cleaning a bathroom floor. The same employee as well reported slipping from having to constantly walk up and down stairs to the laundry room to pick or drop off linen, especially when the service elevator is out of order or busy. This is in line with 81% of the participants responding there are steep surfaces in their work area. The mini bar attendants add that sometimes they have to rush up and down the stairs to verify mini bar consumptions when there are many guests checking out. The researcher as well noted that the laundry and adjacent housekeeping office areas are relatively squeezed and is generally busy with people. There are many activities that occur here, the main ones include washing, drying, collecting dirty laundry, linen folding, and pressing; with several machinery in use that take up much of the available space. However due to the nature of the building, spacing is generally limited, with some walk ways being quite narrow. During the time of observation the laundry and housekeeping office were very busy as the hotel was at full occupancy, and the area had become relatively cluttered with items kept in ways such as linen carts and laundry piles. This is a hazard as it hinders easy escape in a time of emergency, or an unobservant person may trip over these haphazardly kept items. Otherwise it was observed that on a less busy day, paths were kept clear and the areas were organized.

According to the Nurse, laundry attendants in particular suffer from dizziness and tiredness due to the high temperature in their work area. This is in line as 73% of the housekeepers responded there are high temperatures in their work area, of which all 6 laundry attendants responded occurs frequently. All of the laundry attendants as well responded there is lack of fresh air in their work area, with one reporting they get

dizziness from this. The researcher noted the laundry area is located in the centre of the hotel building and therefore has no windows to let in fresh air and natural light. Supply and extraction ventilation ducts are installed in this area, but it still gets very hot and stuffy around the machines when in use. The Nurse adds that this a main cause of respiratory illnesses amongst housekeepers with 46% of cases since 2013. There were low responses of occurrence of high temperatures and lack of fresh air from the other participants, as they have access to cool, fresh air from moving around the hotel. Drinking water is available in the laundry area for the attendants; however it is located in a corner behind the calendar ironer machine, which can make it relatively difficult to get to. During the period of observation, the water container was empty. When asked, the housekeepers said it is usually full but as that the day was very busy no one had time to refill it. This was noted as a hazard, as according to the Nurse, water should always be available to maintain the wellbeing of the attendants working in the hot, physically demanding environment.

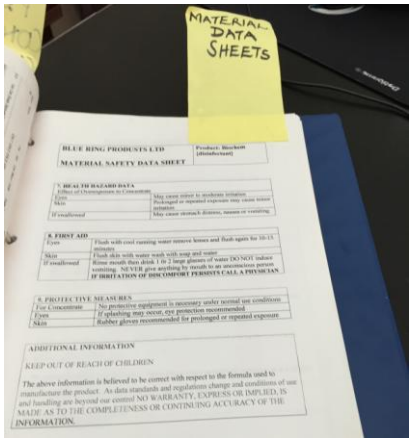
According to HSA (2003) housekeepers are some of the most vulnerable to biological hazards as they are constantly dealing with dirt, bodily fluids, and are exposed to pathogens from handling water and soiled items. More than 58% of the participants responded they are exposed to these biological hazards; and similar to the other departments under study, almost all responded there are pests in their work area. It was observed that even though gloves are available, they are seldom worn by the housekeepers when handling soiled linen, and especially not when they are busy. This exposes them to potential biological hazards. According to Collins (2010a) soiled linen barrels should be lined with removable plastic bags along the inside surface and should be covered at all times to avoid bacterial contamination. These were noted to be missing. The barrels are otherwise cleaned and sanitized daily at opening time, along with the washers and dryers and linen folding surfaces; the ventilation ducts also provide forced air exhaust for the soiled linen. To avoid contamination, dirty linen is kept separate from clean linen at all times and strict clothing and linen handling procedures are as well followed. According to the managers, trainings on safe handling procedures for biologically contaminated objects e.g. soiled linen, sanitary napkins, vomit are as well given 3-4 times a year by management or an external hygiene professional.

Plate 17: Safe Laundry Procedure chart posted in Laundry Area

Source: Field Data (2015)

25 out of the 26 housekeeping participants responded their job require them to use cleaning agents, and 85% said they use chemicals/solvents; which is in line with HSA IE (2013). Several types of chemicals are used by the laundry attendants such as surfactant boosters, alkali builders, chlorine bleach, and peracid bleach amongst others. Whereas the guest room and public area attendants use disinfectants, detergents, cleaning agents and furniture and floor polishes. The chemicals in the laundry area are stored in their proper supplier containers; however they are all kept together and mostly stored behind the washing machines. This is hazardous as the machines could malfunction and blow, and since the area is relatively confined, it may be difficult for persons to escape in time. 77% of the housekeepers as well responded they are exposed to fumes. 9 out of the 10 guest room attendants responded that they are exposed not only to fumes coming off some strong solvents, but as well to cigarette smoke from cleaning the smoking permissible guest rooms. According to the laundry attendants, some of the chemicals, such as chlorine bleach, give off strong fumes that cause dry eyes and irritation to their respiratory system. Although masks and gloves are worn, safety goggles are not. The goggles are recommended to be worn according to the MSDS for the chlorine bleach, to protect the eyes from irritation. It was noted that the housekeeping department was the only area under study to have a MSDS file readily available for all the chemicals in use. The provision of MSDS is in line with Section 84 (3) of OSHA 2007. However, refresher trainings on the safe use of the chemicals are not done and should be introduced, as trainings are only done when new chemicals are introduced. This can be hazardous for new employees who may not be made aware of the dangers of the chemicals. Most of the chemicals were noted to cause skin irritation and chemical burns; however the housekeepers wear protective clothing and gloves when they use them. They are as well exposed to non-chemical burns, as the steam press ironing machine, the calendar machine and even hot laundry coming straight out of the washer/dryer can be hot enough to cause mild to severe burns. There was in fact a critical incident in 2011 where a housekeeper's fingers got severely burnt and had to be amputated as he was not careful while using the hot calendar ironing machine. However, since 2013 no cases of burns were reported from housekeeping.

Plate 18: Housekeeping MSDS File



Source: Field Data (2015)

Plate 19: Laundry Area Chemical

Source: Field Data (2015)

Table 5: Housekeeping Hazards (Checklists)

OHS CATEGORY	LACK OF AVAILABILITY OF:
WORKPLACE, FLOORING and STAIRWAYS	• Work Space • Equipment Space • Walkway Space • Clear Paths
VENTILATION and LIGHTING	• Comfortable Temperature • Employees free from Dry Eyes • Natural Lighting
CLEANLINESS	• Tidy Work Area
WELFARE FACILITIES	• Proximity of Drinking Water • Posted First Aider List • First Aid Use Recording
FIRE SAFETY	• Fire Exit Signs • Posted Fire Safety Procedure • Emergency Lighting
LAUNDRY AREA	• Protective Clothing for Soiled Linen • Covered Soiled Linen Barrel • Interior Plastic lining in Soiled Linen Barrel

Source: Field Data (2015)

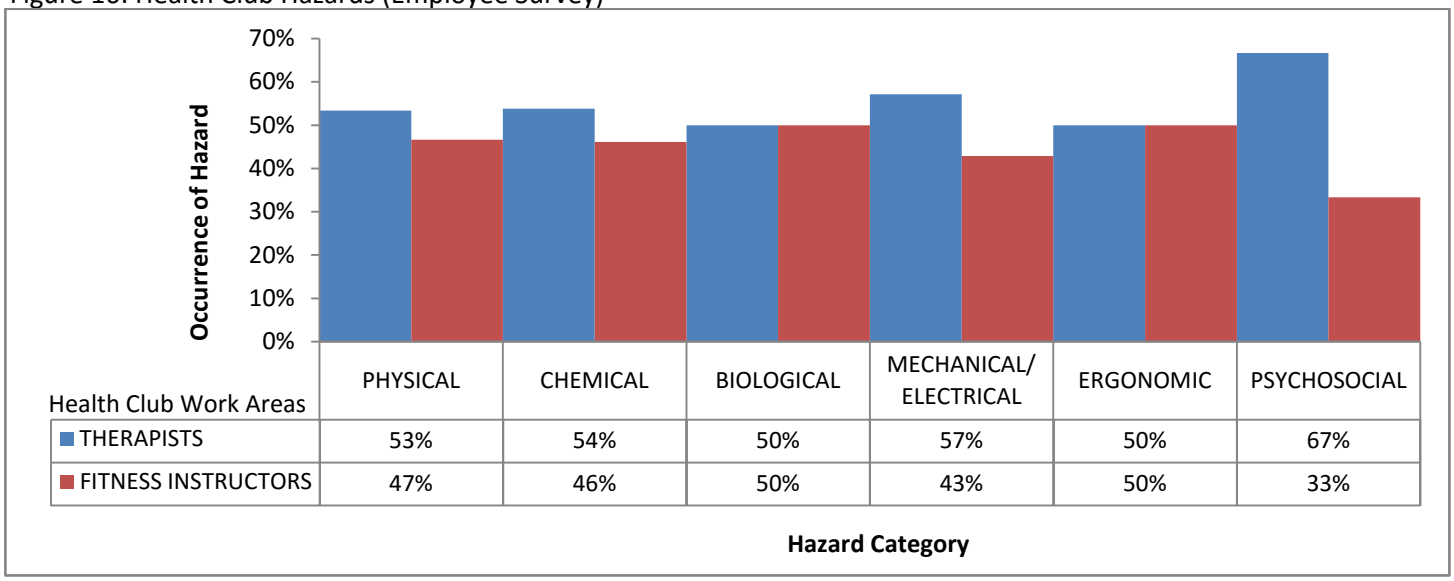
Table 5 shows the OHS matters that were found to be lacking during the time of direct observation of the housekeeping department. In terms of fire safety, the housekeeping office and laundry area are directly connected to the fire escape route. However, there are no fire exit signs within this area to direct persons to the correct route, as there are three possible paths. This can be a source of confusion for persons in a panic, or new employees. There are as well no emergency lights in this area, apart from the guest room corridors. When the laundry area is busy, laundry piles and other items may block the way of the narrow paths for ease of escape. There are fire exit signs in the guest room corridors that direct persons to the fire exit route. Fire exit maps are as well posted in guest rooms directing the persons to the nearest fire exit route. It was however noted that one of the 3rd floor fire exit doors was kept locked shut (due to security and noise concerns), however a fire exit sign was still hung above this door, and fire exit maps in the guest rooms in this vicinity still direct persons here. The maps and sign should be changed around to direct persons to the alternative fire exit route available. In terms of fire fighting equipment, sprinklers are installed in the laundry area, and there is an extinguisher available in this area and another in the office area. There is as well a fire alarm and fire hose reel located outside these areas. When, asked employees appeared confident in how to use the equipment.

Inspection and cleanliness of equipment and machinery was noted as a positive point. The machines are serviced 4 times a year by a contractor, as well as being inspected regularly by the in-house maintenance team. The filters for the washers and dryers are cleaned every morning, and lint is removed from the washers after approximately two washes. Pipes, ducts and overhead fixtures are cleaned every week by the

maintenance team. Other positive points included clean linen being transported to a store room a floor above the laundry area, where they are kept neat and organized. The allocation of housekeeping keys (for guest rooms) are recorded and kept securely. And for public area and room cleaning operations, cleaning items are placed neatly where no one can trip/fall over them. Areas for improvement include the need for better organization during busy periods so that safety and welfare aspects are not compromised such as keeping items in a neat and organized matter, maintaining cleanliness of the area and ensuring drinking water is available at all times. Similar to the other areas of study, the use of first aid items needs to be recorded to ensure better control, and a list of the hotel first aiders needs to be posted to help in a time of emergency.

5.3.1.5 Health Club Hazards:

Figure 16: Health Club Hazards (Employee Survey)



Health Club Work Areas	PHYSICAL	CHEMICAL	BIOLOGICAL	MECHANICAL/ ELECTRICAL	ERGONOMIC	PSYCHOSOCIAL
THERAPISTS	53%	54%	50%	57%	50%	67%
FITNESS INSTRUCTORS	47%	46%	50%	43%	50%	33%

Source: Field Data (2015)

Figure 16 summarizes the hazards that occur in the health club work areas as per the employee survey (see Appendix 15 for breakdown of these hazards). An interesting finding is that conflict with superiors, lack of feedback, recognition, support, guidance and participation had less responses of occurrence than the other departments under study; making it seem that these psychosocial hazards do not occur in the health club. However, according to the Nurse, the health club associates are usually under stress as they regularly complain about conflicts with their superiors and co-workers. From the survey, the 2 therapists responded that they experience conflict with their superiors and co-workers frequently, including other psychosocial related hazards ranging from rarely to very frequently; whereas all 3 of the fitness instructors responded that these never occur. These findings could be in relation to the 3 participants (2 therapists and 1 fitness instructor) that responded they experience lack of openness, indicating they are not able to honestly express their views or opinion. They as well responded they experience unfulfilling or boring job tasks. This is in line with information received from the Nurse. She has noted that these associates are

sometimes idle which causes them to gossip, which in turn leads to conflicts. When asked about exposure to criminals, the associates responded that they are at times wary of the backgrounds of new health club members due to the insecurity situation in the country, and so they have to be vigilant when signing up new clients.

Table 6: Health Club Hazards (Checklists)

OHS CATEGORY	LACK OF AVAILABILITY OF:
WORKPLACE, FLOORING and STAIRWAYS	• Slippery Floor Signs • Slippery Floor Matting/Grating
VENTILATION and LIGHTING	• Comfortable Temperature • Fresh Air
CLEANLINESS	• Dust Free Work Area
WELFARE FACILITIES	• Posted First Aider List • First Aid Use Recording
FIRE SAFETY	• Fire Exit Signs • Posted Fire Safety Procedure • Emergency Lighting • Safe Means of Exit from all Work areas
HAZARDOUS SUBSTANCES	• MSDS
SWIMMING POOL	• Barrier Restricting Access to Swimming Pool
FITNESS CENTRE	• Posted Fitness Centre Rules • Posted Age Restrictions • Emergency Shut-off Switch for Steam/Sauna • Posted Time-Limit for Steam/Sauna Use

Source: Field Data (2015)

Table 6 shows the OHS matters that were found to be lacking during the time of direct observation of the health club. 3 of the participants responded there are slippery and steep surfaces in their work area. It was observed that the poolside and general health club flooring are quite slippery-especially if someone is coming directly from the swimming pool dripping water. According to the employees a few incidents have occurred where people have slipped on the poolside flooring; such as in 2014 a client slipped on the wet floor near the poolside shower area, but no injuries were reported. A caution slippery floor sign is yet to be put up to alert persons. Non-slippery ridged tiling is however used in the changing rooms; rubber matting in the fitness centre; and wooden flooring in the aerobics studio. In terms of steep surfaces, there are two flights of stairs leading from the health club down to the guest changing rooms. According to the Nurse, she has had incidences of persons falling on these stairs, especially if they are rushing down them, or if they are wet from people returning from the swimming pool. However, since 2013 she has only had 2 incidences of slips/trips/falls by health club employees reported to her. Matting/grating can be put on these stairs to reduce the slipperiness. The stairs however were observed to be in good condition and with a sturdy handrail which are in line with Sections 77 (1,5) of OSHA 2007.

4 out of the 5 health club participants responded extreme temperatures occasionally occur in their work area, as well as lack of fresh air. This was noted to be caused by the health club air conditioner which frequently breaks down making the air hot and stuffy; however when it is working, the atmosphere is at a comfortable level. The health club is as well surrounded by large windows that let in plenty of natural light, but can as well make the area fairly hot from the direct sunlight. In terms of workspace, there is adequate spacing throughout the health club, enough for persons to use the fitness equipment comfortably. However, the swimming pool pump room located directly below the pool was observed to be very confined. There are two accesses to the pump room; if one cannot access the pump room using the back door of the men's changing room, the alternative route is to cross the adjacent plant room hunch backed due to the constricted spacing and low ceiling. It feels confined as old mattresses and towels, and used dispenser water bottles are stored here. The chemicals for the swimming pool are as well kept in this area. This area is further hazardous as it is dark, slightly damp and dusty; and in a time of emergency, one may not be able to escape easily from this area.

Plate 20: Low Ceiling in Plant Room

Source: Field Data (2015)

Plate 21: Swimming Pool Pump Room

Source: Field Data (2015)

According to HSA (2003) and HSA IE (2013), spa and fitness centre workers are exposed to pathogens and infectious diseases as they are in constant contact with bodily fluids such as perspiration from clients. This is in line as almost all responded they are exposed to bodily fluids and pathogens. However, since 2013 only 9 cases of skin infections were reported to the Nurse. She adds that it is particularly the therapists as they cannot wear gloves while giving treatments such as massages, manicures, and pedicures. The low number of cases can be due to hand washing stations being located throughout the health club and so employees can regularly sanitize and protect themselves. Sanitizers are as well used to wipe the fitness equipment regularly after use to stop the spread of germs. The floors, surfaces and in particular the steam/sauna are cleaned three times a day to maintain hygiene. According to the employees, the poolside and fitness centre areas are prone to dust and dirt due to the heavy movements of people, and so they have to be constantly cleaned.

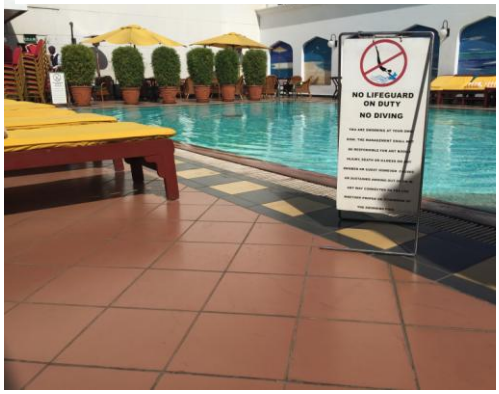
According to HSA IE (2013), like the housekeepers, health club attendants are as well in frequent contact with chemicals. It was noted that the swimming pool attendants are especially in contact with strong chemicals but have been trained and instructed in the safe handling of them. Some of the strong chemicals include chlorine 90%, chlorine 65% and swimming pool algaecide; all of which according to their supplier warning labels, require the user to wear gloves, masks and safety goggles. The attendants wear gloves and masks but not safety goggles even though the chlorine in particular gives off harmful fumes, as indicated by the 3 who responded they are exposed to them. According to an attendant, swimming goggles are at times worn to protect the eyes from this irritant, especially when the pool drain covers are being scrubbed; however these are still not safety goggles which are required. It was as well noted that a file containing the chemicals MSDS used to be present at the health club, as indicated in the 2014 Sarova Stanley safety and health audit (Kabaka, 2014), but is no longer there according to the employees who are unaware of its location. The chemicals were otherwise observed to be securely stored in the swimming pool pump room in their supplier containers.

In terms of fire safety, some areas were found to be potentially hazardous. All fire doors were noted to be self-latching, and there is a safe means of exit from all areas except the plant room. It was as well observed that there is no direct exit from the men's changing room. When persons come out through the main door of the changing room there is no sign directing to the quickest access to the fire exit route, which is through the ladies changing room located opposite. There is as well confusion with the fire exit signs located in the ladies changing room, as one points directly to the fire exit route, while the other points to the main door which is in the opposite direction and leads to a longer way to reach the same fire exit route. This sign can be turned around to point to the one that leads directly to the route, and therefore help persons escape faster. It was noted that the fire exit door in the aerobics studio is kept locked, and is in fact blocked by pool beds on the other side of it. The fire exit sign however still points to this door, it should be changed around to instead point to the main door, which leads straight out to the fire exit access near the fitness centre. Firefighting equipment is available, such as sprinklers, fire hoses and extinguishers. However, near the changing rooms, persons may be unaware that a cabinet with a hose reel and extinguisher is available just inside the first door of the men's changing room. There is space outside both changing rooms where this cabinet can be moved and therefore be less hidden; helping persons act quicker in a time of emergency. Similar to the other departments, there is no fire evacuation map posted, and emergency lights have not been installed; that could otherwise help direct persons safely.

Positive aspects were noted in regards to OHS in the swimming pool area. The drain covers are flat surfaced, secure and in good condition to eliminate trip hazards. Swimming pool rules are posted, and a life safety ring is available for swimmers safety. There are clear separations of shallow and deep areas of the pool as the depths are marked on the sides in metres. According to the attendants, the pool chemical quality

checks are done twice a day; as well as the temperature of the pool to maintain it at 29°C (when the weather is hot) and 32°C (when the weather is cool). It was as well noted that drink services to the pool area are done in plastic glasses; however food is still served on ceramic plates, which poses a sharps hazard to swimmers in case the plates break. There is as well no official life guard on duty, although the health club attendants have been trained in life guarding techniques in case of emergency. Finally, it was noted that there are no barriers erected that restrict access to the pool; this poses a danger for unaccompanied minors, or swimmers that may come after closing hours and therefore would be unsupervised. However, after closing hours the door to the main pool deck area is shut, and a guard is posted on duty.

Plate 22: No Lifeguard on Duty Sign



Source: Field Data (2015)

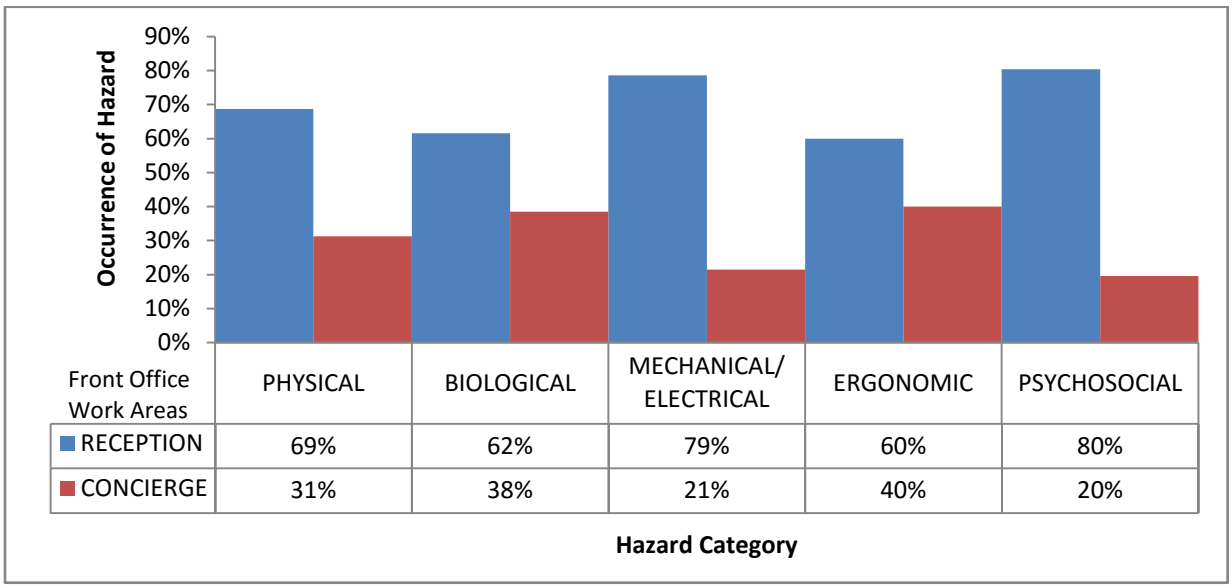
Plate 23: Swimming Pool Rules

Source: Field Data (2015)

Positive OHS aspects were as well noted in the fitness centre (gym area). There are instructions posted for specific equipment use, including medical advisories; and clients are supervised at all times. It was however observed that there are no overall rules posted for the use of the fitness centre, as well as no postings of minimum age restrictions. There is although a disclaimer posted absolving management from responsibility in regards to equipment use; and according to the health club manager, there is an established understanding amongst the associates that persons under 14 years are not permitted to use the gym, and persons under 18 years are not permitted in the steam/sauna rooms. There are rules posted for the use of the steam/sauna rooms, however they do not contain advisories on the maximum time one should use them in terms of health and safety. The steam/sauna rooms are not equipped with an emergency cut off switch (as suggested by Collins (2010a)), but rather a normal on/off switch. They however are equipped with a timer and temperature control system. The steam/sauna rooms were noted to be kept neat and clean, to eliminate biological hazards; and the flooring of the rooms were observed to be textured in order to eliminate slip/trip hazards.

5.3.1.6 Front Office Hazards:

Figure 17: Front Office Hazards (Employee Survey)



Source: Field Data (2015)

Figure 17 summarizes the hazards that occur in the front office work areas as per the employee survey (see Appendix 16 for breakdown of these hazards). Unlike the other departments, participants had a low response to conflict with superiors as only 6 out of the 18 participants stated that this occurs. However, similar to the other departments, over 56% of the participants responded they experience lack of recognition, lack of participation in decision making, and have no control over their days off. Over 61% of the participants responded they work overtime and unsocial hours; due to shift hours, which includes working overnight. Front office staffs handle a high volume of enquiries, and are at the centre of customer service, and at times this leads them to work overtime (Lo, Lamm, 2005; HSA, 2003). Lo, Lamm (2005) add that constant 'people pleasing' leads to high amount of stress, which can lead to conflicts arising not only with clients (as indicated by 44% of participants), but as well co-workers and management; which can give rise to verbal bullying (as indicated by 44% of participants). According to the employees, the receptionists in particular experience a lot of stress as they tend to be the first ones to deal with guest complaints, or handle complicated requests. They have to maintain a fine balance between what's best for the business and how to keep the customer happy (Lo, Lamm, 2005; Boardman, 2010). According to Hoel, Einarsen (2003) and ILO (2009b), a psychosocial hazard receptionists are prone to are criminals, as they tend to deal with large volumes of cash. Even though only 44% of the participants responded they are exposed to criminals, from direct conversations, there have been attempts in the past to con cashiers for their till money by persons pretending to be guests. Handling large volumes of cash is a source of stress for the cashiers as they are responsible and accountable for all the monies in their till. Table 7 shows the OHS matters that were found to be lacking during the time of direct observation of the front office department.

Table 7: Front Office Hazards (Checklists)

OHS CATEGORY	LACK OF AVAILABILITY OF:
WORKPLACE, FLOORING and STAIRWAYS	• Slippery/Uneven Floor Caution Signs • Flooring free from Trip Hazards • Slippery Floor Matting/Grating
VENTILATION and LIGHTING	• Comfortable Temperature • Fresh Air
CLEANLINESS	• Dust Free Work Area
WELFARE FACILITIES	• Sanitizers • Workstations/Equipment Set Up to Reduce Awkward Postures • Workstations Suitable for a Range of Users with Different Heights
MECHANICAL/ELECTIRICAL	• Cables Kept in a Neat, Organized Manner
RECEPTION AREA	• Employee Confidence on Knowledge of Security Emergency Procedures • Adjustability of Visual Display Units
CONCIERGE AREA	• Employee Confidence on Knowledge of how to Handle Abandoned Luggage • Trainings for Safe Lifting Techniques

Source: Field Data (2015)

A positive aspect is there is adequate work space throughout the front office area. The marble flooring in the lobby area was observed to be quite slippery, especially when wet, and for persons wearing shoes vulnerable to slip such as high heels and grip-less shoes. However, according to the concierge attendants, no incidences of slipping/falling have occurred, but they themselves have slipped on slippery/steep floors in the hotel as they say their shoes lack grip. Incidences have as well occurred of people tripping over the small step that leads to the lobby seating area. According to the staffs, people tend to misstep as they do not notice that the seating area is slightly raised from the general flooring, even though it is carpeted a different colour, and a gold metal plating runs across the step. Similar incidences have occurred on the first step of the main staircase that leads to the upper floor. There is matting put on this first step, however according to staffs when it was black in colour people used to misstep often and trip. The matting has since been changed to red and fewer incidences have occurred. A 'mind the step' sign can be posted for both these steps to alert persons. Another vulnerable area observed by the researcher is the heavy door that leads to the back office area. This door only opens inwards and has no window to alert if someone is behind it, or a control lever to ensure it opens gently. Therefore if someone opens the door with force from the outside, it can make a person on the inside vulnerable to getting knocked or injured.

Even though a ventilation system is installed in the lobby, 89% of the participants responded there are extreme temperatures in the front office. When asked, the staffs said that when the weather is hot, or

when the lobby area is crowded, it can make the reception area hot and stuffy. The researched observed that there are large windows in the lobby area that let in natural light, however when there is direct sunlight it can make the area hot. The area is made further warm as the windows do not open to let in fresh air.

In terms of cleanliness the front office area can get dusty and dirty due to heavy movements of people, and fumes coming from vehicular traffic just outside. The area is therefore cleaned thoroughly twice a day, or as required. The dirt can affect the health of the workers in this area, as well as being in constant contact with a variety of different people, making them exposed to possible pathogens (HSA, 2003). Sanitizers can be introduced in this area so that the workers are able to protect themselves, as hand washing stations are located relatively far. The data collected from the questionnaire however does not tally with this, as only 5 participants responded they are exposed to bodily fluids and pathogens. The researcher observed that the area is generally tidy apart from some cables/wires behind the reception desk that appeared cluttered. They are however kept hidden under the workstations and out of the walkways to eliminate trip hazards. At the time of observation, there was a maintenance issue being worked on in the back office that caused a thick cloud of dust to accumulate in this area including the switchboard. This dust and the electrical and chemical fumes coming off the machinery and 'filler' being used made it very difficult to breathe. PPE should have been provided to the employees working in this vicinity, as a dust mask and safety goggles were only worn by the engineering contractor performing the duties. According to the switchboard attendants similar incidences of difficulty in breathing and headaches occur when painting is done in the area. PPE should be provided to the switchboard attendants to protect them from the paint fumes as they cannot leave their workstation when this is being done.

Plate 24: Maintenance Works in Front Office back area

Source: Field Data (2015)

Plate 25: PPE worn by Engineering Contractor

Source: Field Data (2015)

In terms of welfare, drinking water is readily available in the back office for the front office staff. The front office is as well the only department where the names of the front office first aid representatives are posted on the notice board; and where the use of the first aid items are controlled, as they are recorded and reported to the Nurse. However, a list of all the hotel first aiders should be posted at the switchboard as this

is a central point of communication, especially in an emergency. According to HSA (2003), front office staffs are on their feet majority of the time, and spend many hours using a variety of keyboard and computer equipment causing strain and musculoskeletal disorders. This is in line with the findings as 83% of the participants responded that their job requires them to be on their feet, and so they lack time to sit. One participant even reported an incident of fainting due to fatigue from long hours of standing. The researcher observed that one of the reception workstations had been lowered to accommodate for new laptops being installed. This however causes the staffs to bend in an awkward posture in order to use the equipment, leading to possible strains. The other reception workstation is at a level that is comfortable for a range of users with different heights; however, its Visual Display Unit is sunken into the workbench and so the screen cannot be adjusted to suit different users, causing neck strain.

In terms of fire safety, the researcher observed that there is a lack of fire exit signs to direct persons in an emergency. One of the fire assembly points is however located just outside the lobby. Unlike the other departments under study, there is a posting on fire safety instructions displayed in the switchboard area. It informs the attendant on how to deal with fire alarms when they go off and whom to call. Additional information should as well be posted for other staffs for instance, responsibilities at a time of a fire emergency and the different evacuation/fire assembly points. The researcher observed that there is a safe means of exit from all areas apart from the cashier's office. The cashier may not realize immediately if there is a fire as this office is kept locked for security purposes and is a relatively confined space. The researcher as well observed that there is a lack of fire fighting equipment in this office, as well as the reception, switchboard and back office areas. The nearest equipment is one fire hose reel located relatively far in the lobby. Sprinklers have however been installed in the reception and lobby area, but not in the switchboard or back area corridor.

As stated by Hoel, Einarsen (2003) and ILO (2009b), the reception area is exposed to criminals and other dishonest people such as terrorists. 17 out of the 18 participants responded they are aware of the emergency procedure to follow in case of a security threat. However when asked directly, the staffs admitted they are not confident in how they are supposed to act in case of a security emergency, even though they have received trainings on this. Refresher trainings on security may be required for these staffs, as well as information postings on their notice boards so they can retain the information better.

Positive aspects noted by the researcher include importance of guest privacy issues. Associates have been trained to be discrete with guest details, and not say names or room numbers out loud. The concierge as well follows a strict receipt system when handling storage of luggage for guests; and the security team oversees this to make sure nothing hazardous/dangerous is stored. Finally as an area of improvement, safe lifting techniques trainings for the concierge attendants should be introduced, as they are constantly handling heavy, awkward items, and these trainings can help protect them from physical injuries.

5.3.2 Risks Assessment by Front of House Department

5.3.2.1 Sarova Stanley Hotel Injury/Illness Analysis:

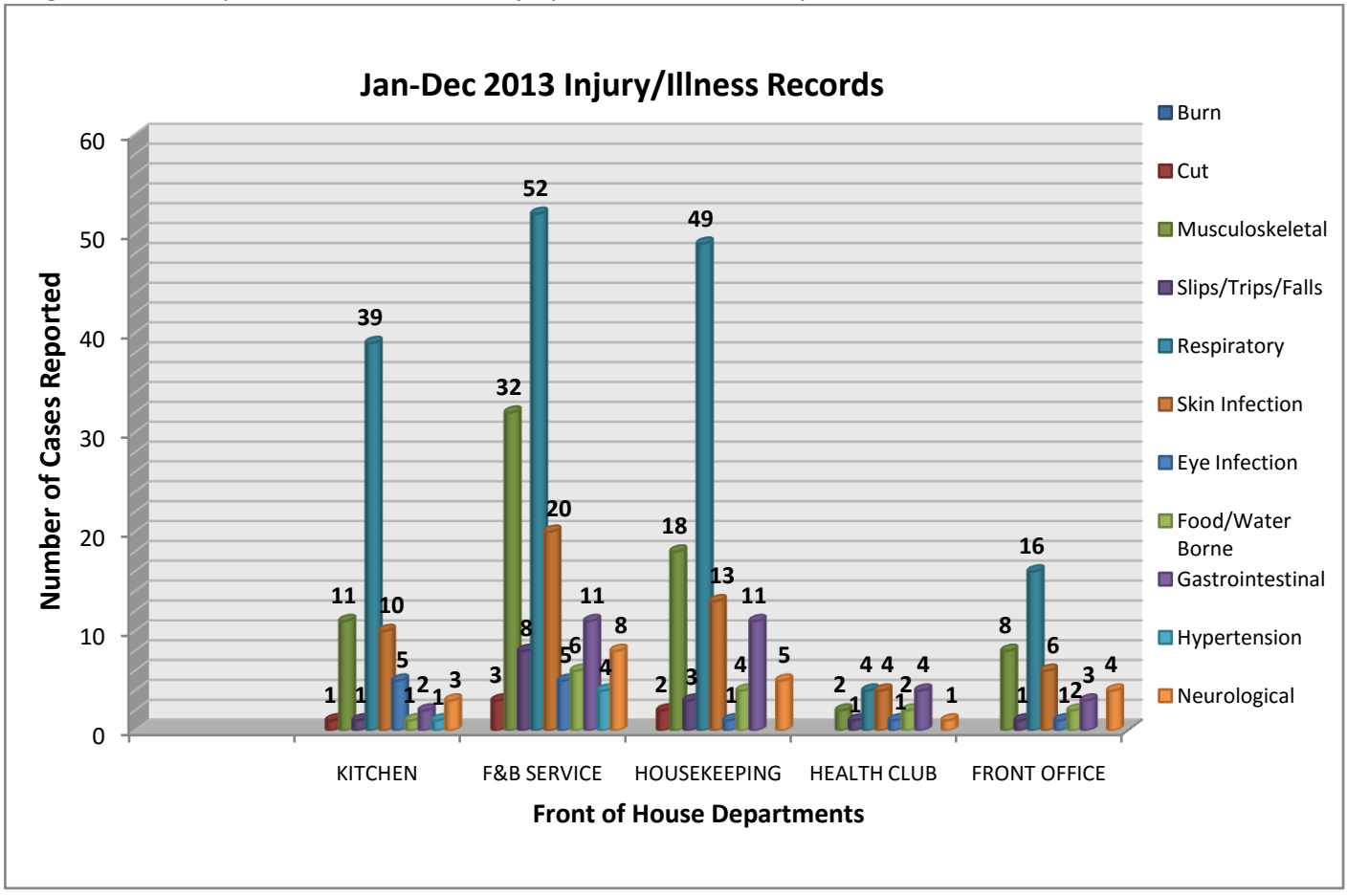
The Hotel Nurse keeps records of injuries/illnesses employees visit her for. The researcher has analysed this data into the following graphs (Figure 18) that show annually the number of cases reported for the various injuries/illnesses by Front of House Department during the period of January 2013 to June 2015. From hotel clinical records, Table 8 summarizes for this period the total number of sick offs taken by employees, as well as total number that were referred to hospital for further diagnosis, and total number number that were admitted in hospital.

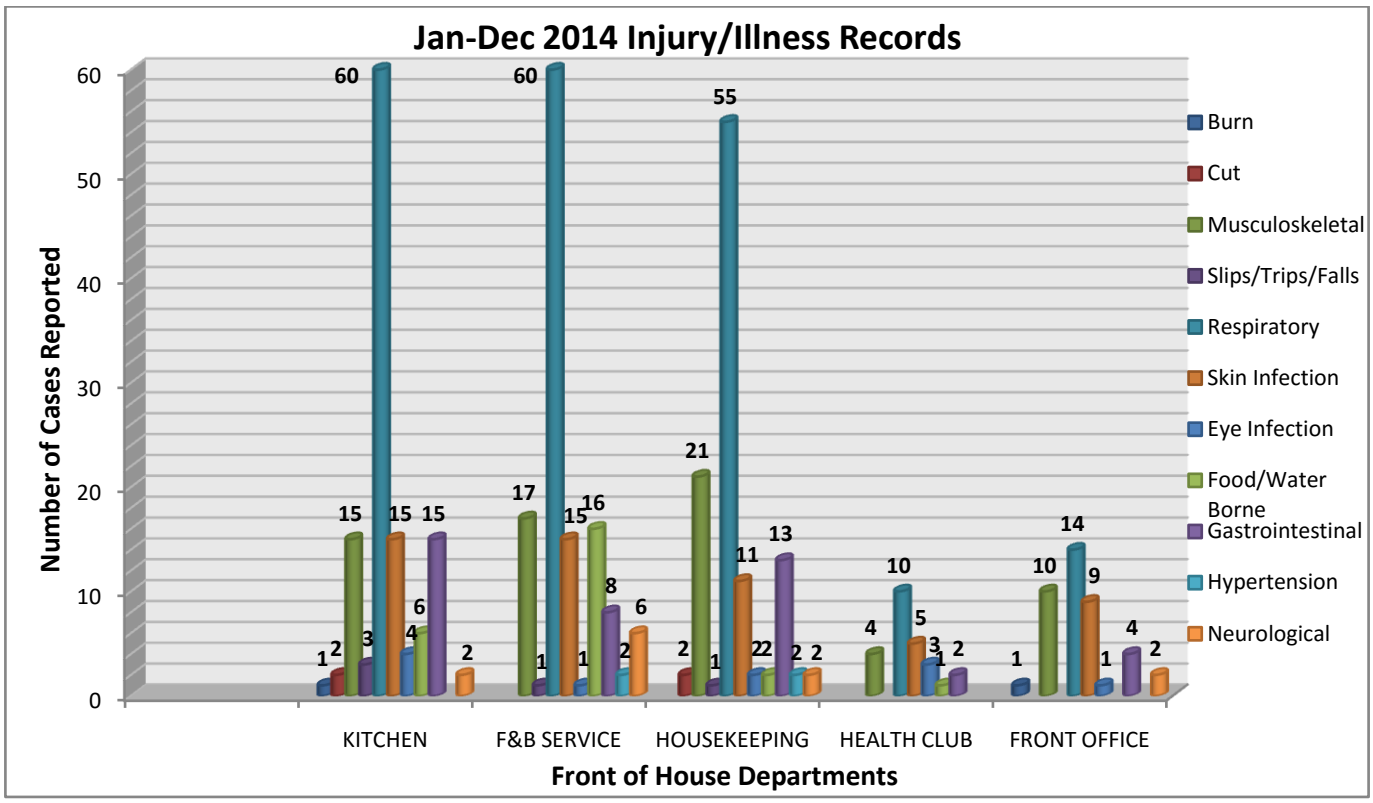
Table 8: January 2013-June 2015 Total Sick offs, Hospital Referrals and Admissions

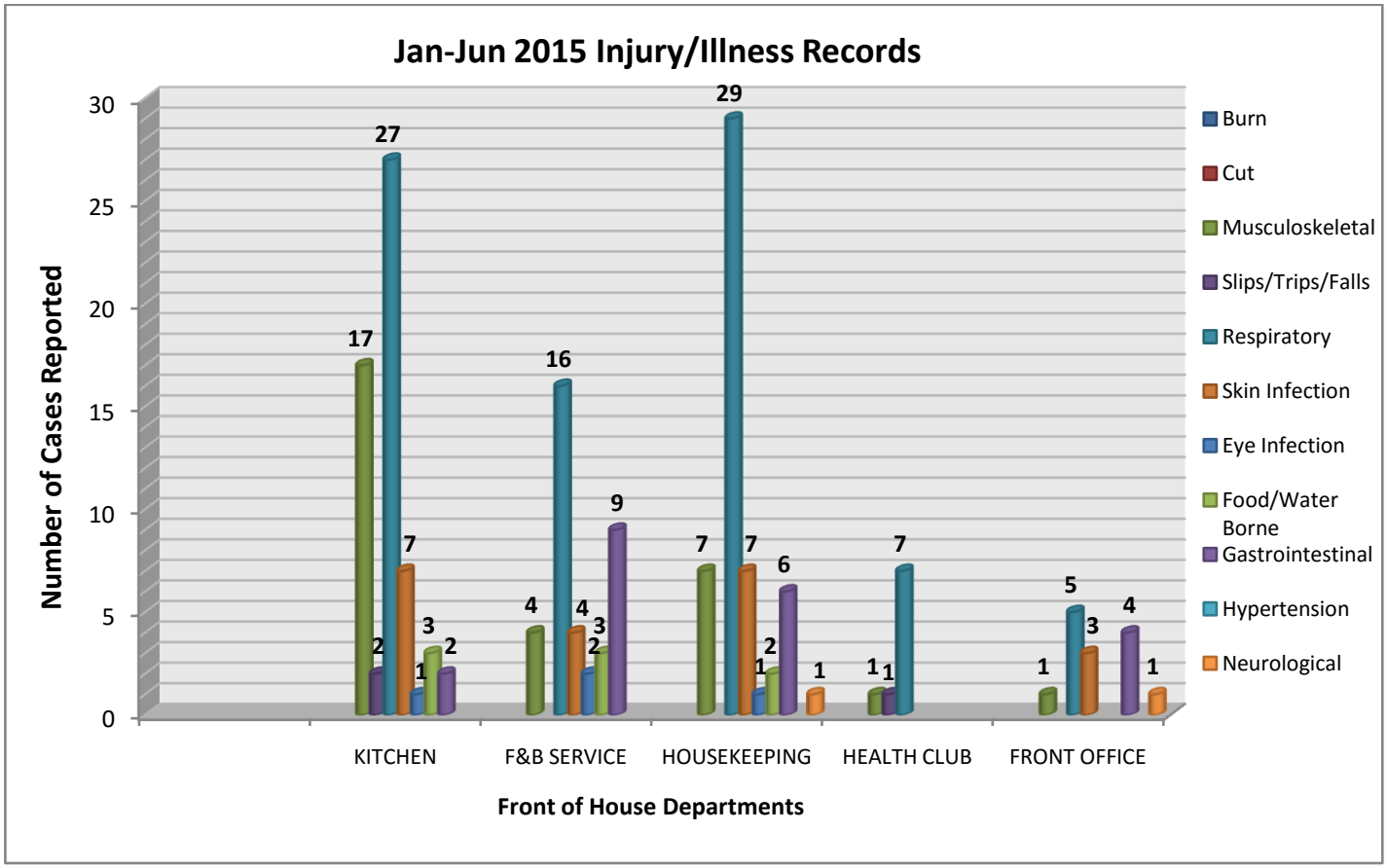
	Number of Sick-offs	Number of Hospital Referrals	Number of Hospital Admissions
Jan-Dec 2013	151	39	11
Jan-Dec 2014	145	36	16
Jan-Jun 2015	124	19	2

Source: Field Data (2015)

Figure 18: January 2013-June 2015 Hotel Injury/Illness Records Analysis







Source: Field Data (2015)

In all departments, the most reported illnesses to the Hotel Nurse were cases of respiratory illnesses (45%). These varied from cough and colds to pneumonia and asthma. The top 3 departments with the highest number of these cases over the 2.5 years were kitchen, F&B service, and housekeeping. This is somewhat in line with the employee survey findings as 37% of all participants responded they experience respiratory problems with the highest responses from these three departments. However 'fatigue' had the highest response of occurrence from the employee survey with 85%. According to the Nurse, HSA (2003) and HSA IE (2013), these employees are prone to respiratory illnesses as they are exposed to extreme temperatures, are in direct contact with guests with communicable illnesses, and handle contaminated items such as waste tissue, dirty utensils, and used linen. 2014 had the highest number of respiratory illnesses with 47% of the cases reported.

Musculoskeletal disorders such as strains, sprains, aches, myalgia (muscle fatigue) and lumbago (back ache) were the second most reported illness over the 2.5 years (17% of the cases). The employee survey revealed a higher response with 54% responding they experience musculoskeletal problems. According to the Nurse and HSA (2003), these are common amongst all employees due to widespread manual handling, long periods of standing and poor postures. 2013 had the highest reports of musculoskeletal disorders (71 cases); followed closely in 2015, where in just half a year 17% of the cases reported were musculoskeletal.

Skin infections were the 3rd highest reported illness. These varied from fungal infections, dermatitis, boils and rashes, with majority of cases from the kitchen, F&B service and housekeeping departments. This is in line with employee survey findings, as from 35% of positive responses of skin infections, the highest were from these 3 departments. According to the Nurse, employees can get skin infections from direct contact with infected guests or not wearing proper PPE when handling unsanitary items such as used linen. 2014 had the highest number of skin infections with 55 cases reported; majority from the F&B service department.

Gastrointestinal illnesses were the 4th most reported illnesses across all the departments over the 3 years. They varied from indigestion, hyperacidity, abdominal pain to peptic ulcer. The employee survey as well revealed a high response of occurrence of these illnesses (65%). The Nurse states that many of these cases are due to the stressful nature of the job, and many employees developing poor diets; some may over indulge in order to keep their energy levels up; and those who work overnight shifts eat at odd, late hours which affects their digestive systems. 2014 had the highest number of gastrointestinal illnesses over the 2.5 years with 42 cases reported, with majority of cases from the kitchen, F&B service and housekeeping departments.

Food/water borne illnesses (food poisoning, amoeba, typhoid) and neurological illnesses (headache, migraine, neuritis) were other common illnesses reported to the Nurse across the departments. The Nurse states that many of the neurological cases are a result of stress for example from long, odd work hours,

constant 'people pleasing', and work-life conflict (see Lo, Lamm, 2005; Hoel, Einarsen, 2003; O'Neill, Davis, 2011; Bohle *et al*, 2004). However, a higher response of occurrence of headaches was found from the employee survey (80%). According to the Nurse headaches are a common condition but majority of the cases are not reported to her, as the employees treat themselves using medication provided in the first aid boxes. This is similar for minor cases of burns, cuts, and slips/trips which yielded high responses of occurrence from the employee survey (49%; 61%; and 55% respectively). The use of first aid items should be reported, no matter how minor the incident, so that trends in these incidences can be identified and the hotel's OSHMS can improve.

From the clinical data, the total number of cases of injuries/illnesses per department, in order from most to least, was as follows: F&B service department (313)> housekeeping (270)> kitchen (256)> front office (96)> health club (53). Overall, 2014 had the highest cases of illnesses/injuries reported over the 2.5 years (426); with majority from the F&B service department mainly for respiratory illnesses and musculoskeletal disorders. However 2013 had the highest number of sick offs and hospital referrals, with 394 reported cases of injuries/illnesses. Records on hospital referrals and admissions showing the specific injury/illness should be included in order to better understand and manage these incidences, not just be kept as a general statistic. In 2013 and 2014, majority of cases of illnesses/injuries were reported from the F&B service department (38% and 30% respectively). However in 2015, in just half a year, majority of the cases reported were from the kitchen and housekeeping departments (34% and 31% respectively), mainly for respiratory illnesses, musculoskeletal disorders and skin infections. All the conditions reported can be related to OHS; however, it is as well likely they were contracted outside the hotel but aggravated by the workplace environment such as hypertension, severe musculoskeletal disorders and neurological illnesses.

The following sections discuss and assess the risks faced by employees working in each of the hotel's Front of House Departments.

5.3.2.2 Kitchen Risks:

Table 9: Kitchen Physical Risks Assessment

SEVERITY \ LIKELIHOOD		RARELY	OCCASIONALLY	FREQUENTLY	VERY FREQUENTLY
MAJOR PHYSICAL RISKS	Major burns	MEDIUM RISK			
	Lacerations	MEDIUM RISK			
	Major falls	MEDIUM RISK			
	Musculoskeletal	MEDIUM RISK			
	Electric Shock	MEDIUM RISK			
	Broken Bones	MEDIUM RISK			
MODERATE PHYSICAL RISKS	DifficultyHearing	LOW RISK			
	Fractures	LOW RISK			
	Fainting		MEDIUM RISK		
	BreathingPrblms		MEDIUM RISK		
	Skin Dermatitis	LOW RISK			
	Infections	LOW RISK			
	Neck/BackInjury		MEDIUM RISK		
	Falls		MEDIUM RISK		
MILD PHYSICAL RISKS	Mild Burns		LOW RISK		
	Mild Cuts		LOW RISK		
	Bruises		LOW RISK		
	Muscular Strains			MEDIUM RISK	
	Dizziness			MEDIUM RISK	
	Slips/Trips				MEDIUMRISK

Source: Field Data (2015)

Table 9 shows the assessment of physical risks that occur in the kitchen department as per the employee survey (Reference Appendix 17).

Major physical risks exist in the kitchen, and have been assessed at medium level as majority of the participants responded they rarely occur. The most common major physical risk in the kitchen are musculoskeletal disorders, as 55% of the participants responded they occur. This is the second most reported condition to the Nurse with 26% of the cases from the kitchen department. According to the Nurse and kitchen employees, these disorders, as well as neck/back injuries and muscular strains (which almost all participants responded occur, 41% of which responded occur occasionally), are the result of constant bending, lifting and pushing heavy awkward loads (manual handling), and as well from standing for long periods; usually affecting their neck, back, arms and legs. The lack of sitting hazard (as responded by 97% of

the kitchen participants) as well leads to risks of varicose veins and haemorrhoids developing, as per the General Manager and Nurse. The Nurse states she as well has many cases of kitchen workers suffering from calcaneal spur, which is caused when a foot bone is exposed to constant stress (from continual standing) leading to calcium depositing in the heels, which causes pain. Another major physical risk that 55% of participants responded occurs (although mostly rarely) are electric shocks. However, according to the Nurse these may be mild/superficial shocks from slight electric malfunctions of sockets or machinery, as no employee as of yet had officially reported these injuries.

According to the Nurse, friction burns, especially occurring in between the thighs, are as well a common risk amongst kitchen workers due to the long periods of standing, and the extreme heat in their work areas. Extreme temperatures hazard in the kitchen work areas received a high response of occurrence from 97% of the participants. 5 participants reported incidences of dizziness, and at times fainting occurring due to the heat in their work areas. 36% of participants responded that dizziness occurs frequently and so it has been assessed at a medium level of risk. Fainting has as well been assessed as medium risk, as although majority of participants responded it occurs occasionally, it is ranked as a moderate severe risk. Additional risk controls may be required to control these risks such as trainings on wellbeing. The Nurse states that many of the kitchen workers do not eat a balanced nutritious meal or drink enough water, which could otherwise help avert these incidences. 28% of cases of respiratory illnesses reported to the Nurse were from kitchen employees. According to the General Manager and Nurse, kitchen workers are prone to these (cough, cold, sore throat) as they tend to move in between areas of extreme temperatures (from freezing walk in fridges to hot kitchens). This finding is in line as 44% responded having breathing problems occasionally, and so this risk has as well been assessed at a medium level.

According to the Nurse another hazard that causes respiratory illnesses is being exposed to fumes; smoke and chemical (especially the stewards). 61% of the kitchen workers responded they are exposed to fumes. The kitchen stewards reported that some of the chemicals they use give off strong fumes, which make it very difficult to breathe. One steward said he had developed asthma due to this. Additional risk controls such as the provision of masks to protect the stewards' respiratory system, or substituting the chemicals to less harmful ones may be required. 2 participants from the Thorn Tree and Pool Deck kitchen as well reported incidences of having difficulty breathing due to the excessive smoke that can occur in their work areas, especially when they are busy. The participants added that the smoke as well causes dizziness.

According to the Nurse; HSA (2003); HSA IE (2013); burns from heat such as hot surfaces, hot oils (mostly chefs) and chemicals (mostly stewards) are as well a common risk in the kitchen. This is in line as 50% responded that mild burns occur occasionally, and 50% responded major burns occur rarely. The mild burns have been assessed as a low level of risk as they are minor injuries that can usually be treated with first aid. However, the major burns have been assessed at medium level as they are injuries that usually

require specialized medical treatment or hospitalization. The use of chemicals, and being exposed to biological hazards such as food or water borne pathogens, can as well lead to risks such as skin dermatitis and fungal infections. 45% of participants responded this occurs rarely, which is in line with 25% of skin infection cases reported to the Nurse from kitchen employees; and therefore has been assessed as low risk. The Nurse states that fungal infections especially occur in between toes due to wearing closed shoes for long hours and being exposed to heat. The Nurse adds that if stewards do not wear gumboots (which are provided) while cleaning, their shoes can soak through which puts their feet at risk of infections.

The Hotel Nurse, HSA (2003); HSA IE (2013); and Queensland Government (2004) state that cuts and lacerations are another common risk faced by kitchen employees due to the sharp tools and equipment used such as knives, slicers and mincers. 91% of the participants responded that mild cuts occur and 73% responded that major lacerations as well occur, however rarely; which corresponds with the Nurse's records as only 3 cases of cuts from the kitchen were reported to her from 2013. Major lacerations have been assessed at a medium level of risk. For example, there was a major laceration incident that occurred in 2014 where a steward's fingers got trapped in a sugarcane crusher machine while he was cleaning it and it was still switched on, causing the skin on his hands to be severely lacerated. The steward was hospitalized and received special medical treatment, and eventually returned to work healed.

Another physical risk that received a high response of occurrence are slips/trips, which 76% of participants responded occur. In relation to slips/trips, are falls and major falls, which more than 58% of the participants as well responded occur. All of these have been assessed at a medium level of risk, indicating additional risk controls may be required to control them. 8 participants reported incidences of slipping/falling as they did not realise the floor was wet, leading to muscular strains, neck/back injuries, or even fractures or broken bones. 97% responded that slippery surfaces are a hazard in their work area, and 55% responded there are steep surfaces. These figures do not correspond with the Nurse's clinical records as out of 22 cases of slips/trips/falls reported to her from 2013, only 6 were from the kitchen; indicating some of the incidences reported by participants may have been minor and self-treated. The researcher however did observe that the floors in the kitchen areas are generally slippery, especially the ramps, and even more so when they are wet. It was as well observed that there was a lack of 'caution slippery floor' signs displayed when these staff areas were being cleaned, therefore putting an unobservant person at risk of slipping/falling.

Table 10 shows the assessment of psychosocial risks that occur in the kitchen areas as per the employee survey.

Table 10: Kitchen Psychosocial Risks Assessment

SEVERITY \ LIKELIHOOD		RARELY	OCCASIONALLY	FREQUENTLY	VERY FREQUENTLY
MAJOR PSYCHOSOCIAL RISKS	Depression	MEDIUM RISK			
MODERATE PSYCHOSOCIAL RISKS	Unable to meet Personal Needs		MEDIUM RISK		
	UnableToMeet Family/SocialNds		MEDIUM RISK		
	Medication Reliance		MEDIUM RISK		
	Fatigue			HIGH RISK	
	No Confidence		MEDIUM RISK		
	Emotionless	LOW RISK			
	Disorientation	LOW RISK			
	Anger	LOW RISK			
	Under eat	LOW RISK			
MILD PSYCHOSOCIAL RISKS	Headaches		LOW RISK		
	Indigestion		LOW RISK		
	Restless Sleep		LOW RISK		
	Alcohol Consumption		LOW RISK		
	Caffeine Reliance		LOW RISK		

Source: Field Data (2015)

Moderately severe psychosocial risk 'Fatigue' has been assessed as high risk in the kitchen area, as 88% of the participants responded this occurs, with 38% responding it occurs frequently. The General Manager, Nurse and kitchen management state that kitchen workers are prone to fatigue as they are some of the busiest workers in the entire hotel (from working banqueting functions and outside caterings which can run overtime and be back to back, along with conducting normal restaurant duties). Excessive workload, working unsocial hours, with lack of rest breaks had a high response of occurrence by almost all the kitchen participants, with 97% responding they work overtime. 6 participants even reported having incidences of extreme fatigue, disorientation, restless sleep and muscular aches due to these workplace stressors. According to the Nurse, instead of eating balanced, nutritious diets and exercising, many kitchen workers have developed a reliance on caffeine, and even drugs and some medication, to help keep alert and their energy levels up.

The Nurse adds that anxiety/stress is widely felt amongst the kitchen workers. This is not only due to the work hours or work load, but as well due to conflicts with superiors and co-workers. This concurs as 67%

of participants responded they experience conflict with their superiors, where more than 67% responded they lack openness, participation, guidance, support, recognition and feedback from their superiors. 64% of participants as well responded they experience conflict with their co-workers, as shown in some arguments/fights that have been logged into the hotel accident/incident records. According to the Nurse, anxiety/stress causes symptoms (or risks) of headaches, hyperacidity (indigestion), restless sleep, feeling emotionless or anger, or having lack of confidence. All of these risks have been assessed as low level, apart from lack of confidence which has been assessed as medium as majority of the participants responded that this occurs occasionally. These symptoms have been assessed as low level risks as they can usually be treated using first-aid; as even though there was a high response of occurrence of headaches (91%) and indigestion (79%) from participants, only 14% and 20% of these cases respectively were reported from the kitchen to the Nurse since 2013.

Worse cases of anxiety/stress can develop depression. According to the Nurse, no one officially reports having depression (as indicated by only 39% of participants responding they feel depressed), she however adds that it is mostly mild depression rather than severe that is experienced. In the questionnaire, 2 participants report feeling depressed due to superior and co-worker conflicts, but as well due to not being able to meet their personal or family/social obligations, mostly as they have no control over their days/time off (as indicated by 82% of the participants). This shows as more than 82% of the participants responded that these two moderately severe risks occur occasionally, and so they have been assessed at a medium level of risk. The Nurse adds that a unique illness that many chefs have reported to her is sexual dysfunction. She adds that these may be due to prolonged standing, but as well due to feeling excessively stressed.

According to the Hotel Nurse and Gibbons, Gibbons (2007) many develop unhealthy coping mechanisms to help deal with the stress which includes drug use. Alcoholism as well develops as a coping mechanism. According to the Nurse this is especially rampant amongst chefs as alcohol is easily accessible to them as they use it for cooking. Other coping mechanisms include under and over eating. The Nurse states that she treats some kitchen workers for anaemia as they under eat; but at the same time many suffer obesity from over eating, especially eating too much sugary/salty/fatty foods as they are easily accessible, and chefs tend to over indulge while they cook.

The kitchen department has several physical and psychosocial risks as shown above. Majority of which have been assessed as medium level risks indicating there is some chance an injury/illness can result, and the hotel may need to implement additional risk controls to help control them.

5.3.2.3 Food and Beverage Service Risks:

Table 11: F&B Service Physical Risks Assessment

SEVERITY \ LIKELIHOOD		RARELY	OCCASIONALLY	FREQUENTLY	VERY FREQUENTLY
MODERATE PHYSICAL RISKS	Infections	LOW RISK			
	Neck/BackInjury	LOW RISK			
	Falls		MEDIUM RISK		
MILD PHYSICAL RISKS	Mild Burns	LOW RISK			
	Mild Cuts		LOW RISK		
	Bruises	LOW RISK			
	Muscular Strains			MEDIUM RISK	
	Dizziness	LOW RISK			
	Slips/Trips			MEDIUM RISK	

Source: Field Data (2015)

Table 11 shows the assessment of physical risks that occur in the F&B service department as per the employee survey (Reference Appendix 18). Similar to kitchen employees, muscular strains are a common moderate physical risk amongst F&B service workers; with 48% of the participants responding they occur frequently, and so this risk has been assessed at a medium level. From the employee survey, kitchen had the highest occurrence of musculoskeletal conditions; however the Nurse's clinical records show that overall F&B department had the majority of these cases reported to her with 32% in comparison to the kitchen with 26%. According to the Hotel Nurse; HSA (2003); and HSA IE (2013), these risks are attributed to the high level of manual handling amongst service staff (as concurred by 70% of the participants); as they have to lift and move loads such as full trays, crates, furniture, and heavy equipment. Neck, back, arms and leg strains/aches as well occur due to lack of sitting, as the nature of the F&B service jobs require them to be constantly on their feet (as indicated by 83% of the participants). Standing for long hours and constant strain, can as well lead to varicose veins and haemorrhoids developing, which is similar to the kitchen employees.

Muscular strains and sprains, along with bruises and neck/back injuries, as well occur from slips/trips or falls; which are a common risk amongst F&B service workers, as indicated by 64% of the participants, and concurred by HSA (2003) and HSA IE (2013). Slips/trips and falls have been assessed at a medium level of risk, as most of the participants responded these occur frequently and occasionally respectively. This concurs with the Nurse's records as majority (41%) of cases of slips/trips/falls reported to her since 2013 were from F&B. According to the Nurse, slips/trips or falls tend to occur when the service workers are in a hurry; or on wet floors-especially when they pass through the kitchens as they wear normal shoes unlike the non-slip

safety boots worn by kitchen workers. Slippery and steep surfaces in all 4 F&B service areas were as well observed by the researcher, along with lack of caution signs put up, that could otherwise help alert persons of wet floors.

According to the Hotel Nurse; HSA (2003); and HSA IE (2013), mild cuts especially from broken glass are common amongst F&B service workers. This is indicated by 61% of the participants; the Exchange Bar participants responded mild cuts occur frequently in their work area, as they are especially exposed to broken glass. Mild heat burns from e.g. handling hot plates are as well a common risk. Both these risks have been assessed at a low level, as they are usually minor injuries that can be treated with first-aid.

92% of the participants responded there are extreme temperatures in their work areas; which the researcher observed is from the hot kitchens, as well as the restaurants, which can get hot and stuffy depending on the day's weather (apart from the Thai Chi restaurant). It was interesting to note that all 5 Pool Deck service participants responded they get headaches varying from occasionally to very frequently, which is probably due to the direct sunlight they are exposed to, that as well causes eye strain. The hot temperatures can lead to dizziness, as indicated by 67% of the participants, however it's been assessed at a low level as majority of participants responded it occurs rarely. According to the Nurse, and concurred by HSA (2003) and HSA IE (2013), moving in and out of hot kitchens can as well lead to respiratory illnesses, such as sore throats, cold, flues and other viral infections from handling waste and serving infected guests (47% in fact responded they are exposed to bodily fluids and pathogens). Her clinical records as well show that F&B department had the second highest number of cases of respiratory illnesses with 29%. The employee survey however yielded less occurrences of these risks as only 47% of the participants responded infections occur (with majority stating rarely), and only 33% responded occurrences of breathing problems.

Table 12 shows the assessment of psychosocial risks that occur in the F&B service department as per the employee survey. According to the Nurse, anxiety/stress is widely felt amongst the F&B service employees as she regularly treats them for gastrointestinal and neurological illnesses (30% and 40% of the cases since 2013 respectively); and 6 out of 9 cases of hypertension are from the F&B department. This can as well be seen from the high responses of occurrences of psychological hazards by the F&B survey participants. For example 67% of participants responded they experience conflict with their superiors, where more than 61% responded they lack openness, participation, guidance, support, recognition and feedback from their superiors. The existence of conflict with management as well shows from the 55% who responded they have no control over how to perform their job tasks. The intensive customer interaction nature of the job as well causes the workers to experience conflict with the clients, exposes them to criminals, and to harassment such as sexual and verbal bullying. All of these workplace stressors contribute to anxiety/stress; which can manifest itself in forms of headaches, hyperacidity, restless sleep, feeling emotionless or anger, or having lack of confidence; all of which have been assessed at a low risk level.

Depression received a high response from 50% of the participants; the highest response rate from all 5 departments. Depression has been assessed as a medium risk level as majority of participants responded it occurs rarely. However, 5 participants responded they have suicidal thoughts, varying from rarely to very frequently (the highest responses of this risk from all the departments under study); and 8 participants responded that they have violent tendencies. Similar to the kitchen, depression can as well be linked to over 70% of the participants responding they are not able to meet their personal, family/social needs, and in relation, the 72% responding they have no control over their days off. Therefore, the relatively high occurrence of these major psychosocial risks may require additional risk controls to be implemented, such as stress management talks and counselling.

Table 12: F&B Service Psychosocial Risks Assessment

LIKELIHOOD / SEVERITY		RARELY	OCCASIONALLY	FREQUENTLY	VERY FREQUENTLY
MAJOR PSYCHOSOCIAL RISKS	Depression	MEDIUM RISK			
MODERATE PSYCHOSOCIAL RISKS	Unable to meet Personal Needs		MEDIUM RISK		
	UnableToMeet Family/SocialNds	LOW RISK			
	Medication Reliance	LOW RISK			
	Fatigue		MEDIUM RISK		
	No Confidence	LOW RISK			
	Disorientation	LOW RISK			
	Anger	LOW RISK			
	Under eat	LOW RISK			
MILD PSYCHOSOCIAL RISKS	Headaches		LOW RISK		
	Indigestion	LOW RISK			
	Restless Sleep	LOW RISK			
	Alcohol Consumption	LOW RISK			
	Caffeine Reliance	LOW RISK			

Source: Field Data (2015)

Similar to the kitchen findings, moderate psychosocial risk 'fatigue' received a high response of occurrence from 86% of the participants. It has been assessed as a medium risk level as 32% responded it occurs occasionally. According to the Nurse, like the kitchen employees, F&B service workers are some of the busiest in the hotel, with 72% responding they have excessive workload, and more than 78% responding they lack rest breaks, work unsocial hours and at times work overtime. All of which contribute to

anxiety/stress, fatigue and disorientation. Like the kitchen workers, the Nurse states that F&B employees utilize unhealthy mechanisms to cope with the fatigue and stress. Caffeine, drugs and some medication reliance develop to help keep alert and energetic. Drug and medication use as well helps cope with stress, along with alcoholism, over and under eating (which can cause obesity and anaemia). Anaemia occurs when servers do not take the time to eat, or they lose their appetite from stress. The Nurse adds that alcoholism is especially common among bar tenders due to easy access to alcohol; and over eating is common as servers are always around food and tend to indulge in sugary, fatty, unhealthy foods. The Nurse advises the servers to drink enough water, take time to eat a balanced diet and exercise regularly to help combat fatigue, stress and other physical and psychosocial risks.

Similar to the kitchen, the F&B service department has several physical and psychosocial risks as shown above. Majority of which have been assessed as low level risks, however some risks such as muscular strains, slips/trips/falls, anxiety/stress and fatigue may require additional risk controls to be implemented in order to help control them.

5.3.2.4 Housekeeping Risks:

Table 13: Housekeeping Physical Risks Assessment

LIKELIHOOD / SEVERITY		RARELY	OCCASIONALLY	FREQUENTLY	VERY FREQUENTLY
MAJOR PHYSICAL RISKS	Musculoskeletal Disorders	MEDIUM RISK			
MODERATE PHYSICAL RISKS	Fractures	LOW RISK			
	Breathing Problems	LOW RISK			
	Skin Dermatitis		MEDIUM RISK		
	Infections		MEDIUM RISK		
	Neck/Back Injury		MEDIUM RISK		
	Falls	LOW RISK			
MILD PHYSICAL RISKS	Mild Burns		LOW RISK		
	Mild Cuts	LOW RISK			
	Bruises		LOW RISK		
	Muscular Strains			MEDIUM RISK	
	Dizziness	LOW RISK			
	Slips/Trips			MEDIUM RISK	

Source: Field Data (2015)

Table 13 shows the assessment of physical risks in the housekeeping department as per the employee survey (Reference Appendix 19). Buchanan *et al* (2010), states the nature of housekeeping jobs demand a high rate of manual handling (as concurred by 53% of the participants), which makes them some of the most vulnerable to musculoskeletal injuries. From the Nurse's records housekeeping is the 2nd department with the most of these cases with 27% since 2013. From the survey, muscular strains and disorders have been assessed at a medium level of risk as majority responded they occur frequently (55%) and rarely (35%) respectively. According to the Nurse bruises and sprains ranging from mild to severe are as well incurred by housekeepers e.g. from knocking into furniture such as bed corners. 92% responded their job requires them to be constantly on their feet, which as well causes strain, varicose veins and haemorrhoids developing similar to the kitchen and F&B service employees.

Muscular injuries, as well as fractured bones can as well be caused from slips/trips/falls, which are common amongst housekeepers (HSA, 2003; HSA IE, 2013). This can be seen from the 77% that responded there are slippery surfaces in their work area, and the 65% that responded slips/trips occur frequently. However, since 2013 only 4 cases of slips/trips/falls have been reported. The questionnaire findings show that 94% of the guest room and public area attendant participants responded slips/trips occur ranging from rarely to very frequently, which the Nurse states is usually when they are cleaning, such as slipping on wet bathroom floors. 81% of participants responded there are steep surfaces in their work area which can as well cause slips/trips or falls, as some participants report slips occur especially when one rushes up and down stairs. Falls have been assessed as low risk as majority of participants responded it occurs rarely; however slips/trips have been assessed as medium risk as majority responded it occurs frequently, indicating additional measures may need to be implemented in order to control this risk.

More than 58% of the housekeeping participants responded they are exposed to biological hazards such as dirt, bodily fluids and pathogens; as concurred by HSA (2003). The Hotel Nurse states these hazards expose housekeepers to bacterial and fungal infections especially when they handle soiled linen and other unsanitary items bare handed. Since 2013, housekeeping had 24% of cases of skin infections reported. Infections have been ranked as a medium level risk as 50% of the participants responded they occur occasionally; according to the Nurse with the use of gloves and constant sanitizing, the level of risk can reduce.

According to HSA IE (2013), laundry areas tend to be damp, humid areas that can cause breathing complications. 38% of the housekeeping participants responded they have breathing problems and 58% responded they experience dizziness. Since 2013 housekeeping had the most cases of respiratory illnesses reported with 30%. According to some participants these usually occur due to fatigue; however some laundry participants reported they occur due to the extreme temperature and lack of fresh air in their work area. 4 out of the 6 laundry attendants responded that they experience breathing problems (of which

majority responded rarely), therefore it has been ranked as a low level risk. However, some additional risk controls may need to be implemented as it was observed to get very hot and stuffy around the laundry machinery (of which there are several) when they are in use.

Chemicals/solvents are commonly used by housekeepers (as indicated by 85% of the participants). According to the laundry attendants, fumes that come off some chemicals cause dry eyes and irritation to their respiratory system. Although masks and gloves are worn, safety goggles are not which could otherwise help protect against these irritating fumes. According to the Nurse, skin dermatitis from cleaning agents, and some chemical burns can as well occur, especially if housekeepers do not wear gloves. Non-chemical burns can occur from handling hot surfaces/items such as hot laundry coming straight out of the washer/dryer, to more severe burns from hot machinery such as the steam press, calendar ironer machine. There was a major burn incident when a laundry attendant was not careful while using the hot calendar ironer machine causing his fingers to get severely burnt that they eventually had to be amputated. According to the participants, major burns are a rare phenomenon as only 6 out of the 26 participants responded they occur. 42% responded mild burns occur occasionally, but have been ranked as a low level risk as they are usually injuries that can be treated with first-aid. Since 2013, no occurrences of burns were reported to the Nurse.

Table 14: Housekeeping Psychosocial Risks Assessment

LIKELIHOOD / SEVERITY		**RARELY**	**OCCASIONALLY**	**FREQUENTLY**	**VERY FREQUENTLY**
MAJOR PSYCHOSOCIAL RISKS	Depression	MEDIUM RISK			
MODERATE PSYCHOSOCIAL RISKS	Unable to meet Personal Needs		MEDIUM RISK		
	UnableToMeet Family/SocialNds		MEDIUM RISK		
	Medication Reliance		MEDIUM RISK		
	Fatigue		MEDIUM RISK		
	No Confidence	LOW RISK			
	Disorientation	LOW RISK			
	Anger	LOW RISK			
MILD PSYCHOSOCIAL RISKS	Headaches		LOW RISK		
	Indigestion	LOW RISK			
	Restless Sleep	LOW RISK			
	Caffeine Reliance	LOW RISK			

Source: Field Data (2015)

Table 14 shows the assessment of psychosocial risks that occur in the housekeeping department as per the employee survey. Similar to the other departments under study, psychosocial hazards are highly experienced in the housekeeping department, as indicated by 16 out of the 26 listed psychosocial hazards receiving more responses of occurrence than 'Never'.

According to the Hotel Nurse, there is a high amount of anxiety/stress amongst the housekeepers. This can be seen from the 65% that responded they experience conflict with their superiors; 50% experience conflict with co-workers; 77% experience job insecurity; and 65% find their job tasks are unfulfilling (they are boring and mundane), which are all a source of anxiety/stress (Hoel, Einarsen; 2003). Similar to the other departments, headaches, hyperacidity (indigestion) or restless sleep can manifest. All of which have been assessed as low level risks as they can usually be treated with first aid. This is in line as since 2013only 8 cases of neurological illnesses (headaches, migraines) have been reported to the Nurse; however, housekeeping had the most cases of gastrointestinal illnesses with 30%. Depression, however, has been assessed as medium level risk, as although majority of participants responded it occurs rarely, it is a major psychosocial risk that requires specialized treatment. According to the Nurse, symptoms of depression include mood swings, feeling emotionless, or lacking confidence, along with other symptoms of anxiety/stress. Similar to the other departments, some participants report depression due to not being able to meet their personal, family or social needs. More than 77% responded these risks occur, and so they have been assessed as medium level risks; as not being able to meet these needs causes distress to the workers and therefore affects their mental wellbeing; as concurred by Kelloway, Day (2005).

More than 58% of the participants responded they are given excessive workload, work overtime, work unsocial hours, are not given enough time to complete their tasks, and have lack of rest breaks. All of these contribute to fatigue which 88% responded occurs, of which 39% said occurs occasionally; therefore fatigue has been assessed as a medium level risk. Similar to the kitchen and F&B service employees, housekeepers develop unhealthy mechanisms to cope with the stress and fatigue, which include caffeine and medication reliance, as well as drug use. Medication reliance received a high response from 65% of the participants; as per the Nurse, this is as well to cope with pain from injuries/strains sustained from manual handling. She adds that obesity is common, as housekeepers tend to over indulge in sugary, fatty foods, as they believe it will keep their energy up in order to perform their physically demanding labours.

The housekeeping physical and psychosocial risks have a mixture of assessments of low and medium level. Indicating some risks such as muscular strains, slips/trips, infections, skin dermatitis, anxiety/stress and fatigue may require additional risk controls to be implemented in order to help control them.

5.3.2.5 Health Club Risks:

Table 15: Health Club Physical Risks Assessment

SEVERITY \ LIKELIHOOD		RARELY	OCCASIONALLY	FREQUENTLY	VERY FREQUENTLY
MAJOR PHYSICAL RISKS	Musculoskeletal Disorders	MEDIUM RISK			
	Electric Shock	MEDIUM RISK			
MODERATE PHYSICAL RISKS	Breathing Problems	LOW RISK			
	Skin Dermatitis	LOW RISK			
	Infections		MEDIUM RISK		
	Neck/Back Injury	LOW RISK			
	Falls		MEDIUM RISK		
MILD PHYSICAL RISKS	Mild Burns	LOW RISK			
	Mild Cuts	LOW RISK			
	Bruises		LOW RISK		
	Muscular Strains		LOW RISK		
	Dizziness		LOW RISK		
	Slips/Trips		LOW RISK		

Source: Field Data (2015)

Table 15 shows the assessment of physical risks that occur in the health club as per the employee survey (Reference Appendix 20). According to the Nurse, health club employees are generally fitter than others in the hotel; as they tend to be more knowledgeable about healthy lifestyles involving regular exercise and eating nutritionally balanced meals. However, they are still prone to muscular strains and musculoskeletal disorders, similar to the other departments. These occur from the physically demanding nature of the job such as assisting guests to exercise, swim, lack of sitting, and awkward bending while providing spa treatments (HSA IE, 2013). Muscular strains have been assessed as low level risks as they can usually be treated with first aid. Neck/Back injuries have as well been assessed as low level risks as majority of the participants responded they occur rarely. However musculoskeletal disorders have been assessed as medium level risk as it is a long term major physical injury, although majority of the participants responded they occur rarely. These correlate with the Nurse's records as since 2013 only 7 cases of musculoskeletal injuries were reported to her. Another major physical risk that participants responded occurs, although rarely, are electric shocks. This may be in relation to the participants who responded there are loose sockets and machinery in poor condition in their work area. However, the researcher observed that the equipment and sockets were in good condition and were regularly inspected. Similar to the kitchen employees, the

Nurse states that the shocks may be superficial from a malfunctioning equipment/socket as she has had no official report of electric shocks.

3 out of the 5 participants responded there are slippery and steep surfaces in their work area; and it was noted that the poolside and general health club flooring are quite slippery. According to the associates, there have been incidences of people slipping, especially if the flooring is wet. As of now no major injuries have occurred, and since 2013 only 2 cases slips/trips/falls were reported to the Nurse. The Nurse states she has treated mild to moderate injuries for employees who have fallen on the stairs that lead down to the guest changing rooms; especially if they are taken in a rush or if they are wet. Participants responded that slips/trips and falls occur occasionally; however slips/trips have been assessed as low risk as the injuries can usually be treated with first aid, whereas falls have been assessed as medium risk as they can cause injuries that may require specialized medical treatment.

4 out of the 5 participants responded that extreme temperatures occasionally occur in their work area, as well as lack of fresh air. Hot temperatures and stuffiness in the health club was as well observed by the researcher. This was observed to be due to the large windows that let in direct sunlight, as well as being exposed to direct sunlight by the poolside, and the air conditioner, which according to the employees, frequently breaks down making the atmosphere hot and stuffy. These can lead to dizziness and breathing problems which have been assessed as low level risks as majority of the participants responded they occur occasionally and rarely respectively. This is correlates with the Nurse's records as since 2013 she has only had 21 cases of respiratory illnesses reported to her from the health club.

Health club attendants are in frequent contact with chemicals (HSA IE; 2013); some of which are so strong they give off harmful fumes. A participant reported an incident where he accidentally inhaled chlorine fumes which caused him difficulty in breathing for many hours. According to the employees, the fumes from the chemicals as well cause irritation to their eyes. Similar to the housekeepers, the health club attendants wear masks and gloves as PPE, but not safety goggles which can otherwise help protect them from the harmful fumes. The use of safety goggles is as well recommended on the chemical container labels. Some chemicals can cause skin dermatitis and chemical burns; however these have been assessed as low level risks as majority of the participants responded they occur rarely as they are normally very careful to wear their PPE when handling chemicals.

According to HSA (2003) and HSA IE (2013), health club attendants are vulnerable to biological hazards as they are in constant contact with bodily fluids making them exposed to pathogens and infectious diseases, which almost all participants responded they are exposed to. However, since 2013 there have only been 9 cases of skin infections reported. According to the Nurse, these occur from being exposed to bodily fluids such as sweat, for instance when fitness instructors are assisting customers with their exercise; and

therapists tend to get fungal infections on their fingers or hands as they cannot wear gloves while giving treatments such as massages, manicures and pedicures. She as well treats eye infections (however only 4 cases since 2013) which can be caused from chemical fumes or from not wearing swimming goggles while in the swimming pool. Infections have been assessed as a medium level risk as all the participants responded they occur, with 3 responding they occur occasionally.

Table 16: Health Club Psychosocial Risks Assessment

LIKELIHOOD / SEVERITY		RARELY	OCCASIONALLY	FREQUENTLY	VERY FREQUENTLY
MAJOR PSYCHOSOCIAL RISKS	Insomnia	MEDIUM RISK			
	Violent Tendencies	MEDIUM RISK			
	Depression	MEDIUM RISK			
MODERATE PSYCHOSOCIAL RISKS	Unable to meet Personal Needs		MEDIUM RISK		
	Unable to Meet Family/ Social Needs	LOW RISK			
	Fatigue		MEDIUM RISK		
	Emotionless	LOW RISK			
	Disorientation	LOW RISK			
	Anger	LOW RISK			
MILD PSYCHOSOCIAL RISKS	Headaches		LOW RISK		
	Indigestion	LOW RISK			
	Restless Sleep	LOW RISK			

Source: Field Data (2015)

Table 16 shows the assessment of psychosocial risks that occur in the health club as per the employee survey. Unlike the other departments, there were fewer responses of psychosocial hazards from the health club participants; giving the impression that there are not many workplace stressors in the health club. However, the Hotel Nurse differs stating health club attendants experience a high amount of anxiety/stress as they regularly place complaints about conflicts with their superiors, co-workers, and at times difficult clients. The few responses of psychosocial hazards may be in relation to the 3 participants that responded they experience lack of openness, indicating they cannot be honest about their views/opinions. Similar to the other departments, anxiety/stress can manifest itself in mild forms such as headaches, indigestion, restless sleep-all of which have been assessed as low risks as they can usually be treated with first aid; and major cases occur rarely as since 2013 only 1 case of neurological illnesses and 6 of gastrointestinal illnesses were reported to the Nurse. However, dissimilar to the other departments, are that

2 therapists and 1 fitness instructor responded they experience moderate psychosocial risks such as anger, and major psychosocial risks of insomnia and violent tendencies. All responded they occur rarely, however insomnia and violent tendencies have been assessed as medium level risks as they are serious risks where there is likelihood that an accident/injury/illness can occur that may incur in lost time or require specialized treatment (Government of South Australia, 2009; Queensland Government, 2012).

Similar to housekeeping, majority of participants responded they find their job tasks boring (unfulfilling and mundane) and as 2 out 5 responded they feel emotionless in their job; which is a source of anxiety/stress (Hoel, Einarsen, 2003). The Nurse has observed that the health club attendants are at times idle which leads them to gossip, which in turn causes them to have conflicts and at times depression. Depression has been assessed as a medium level risk, as 3 out of the 5 participants responded it occurs, although mostly rarely. Depression may as well be due to not having enough time to meet personal, family or social needs- which could be related to the 3 participants responding they have excessive workload and work overtime. These are similar findings to the other departments under study, as well as occurrences of disorientation and fatigue-which has been ranked as a medium level risk as majority of participants responded that it occasionally occurs.

According to the Nurse, as health club attendants tend to be more health conscious than the other hotel employees, they are less likely to take up unhealthy coping mechanisms to deal with the fatigue, anxiety and stress. However, as seen above, the anxiety/stress can come out in forms of major psychosocial risks such as anger, violent tendencies and insomnia. Therefore, these and other risks such as falls, muscular strains, musculoskeletal disorders and infections, may require additional measures to be implemented in order to control the occurrence of these risks.

5.3.2.6 Front Office Risks:

Table 17: Front Office Physical Risks Assessment

LIKELIHOOD / SEVERITY		RARELY	OCCASIONALLY	FREQUENTLY	VERY FREQUENTLY
MODERATE PHYSICAL RISKS	Fainting	LOW RISK			
	Infections		MEDIUM RISK		
MILD PHYSICAL RISKS	Bruises	LOW RISK			
	Muscular Strains		LOW RISK		
	Dizziness	LOW RISK			
	Slips/Trips	LOW RISK			

Source: Field Data (2015)

Table 17 shows the assessment of physical risks that occur in the front office department as per the employee survey (Reference Appendix 21). Similar to the other departments, front office employees are inclined to get muscular strains and in major cases, musculoskeletal disorders (only 1 participant responded that this occurs, although rarely). 83% of the participants responded that they experience muscular strains, 60% of which responded they occur occasionally, and so this risk has been assessed as a low level risk. Receptionists spend many hours on their feet using a variety of keyboard and computer equipment causing poor posture and strains to their neck, arms, back and legs; concierge as well get similar strains from constant manual handling (e.g. handling heavy luggage) (HSA, 2003). Front office had 19 cases of musculoskeletal injuries reported to the Nurse since 2013, the 4th highest of the study departments. The Nurse adds that prolonged standing (as indicated by 83% of participants) can as well lead to varicose veins and haemorrhoids developing, similar to the kitchen, F&B and housekeeping employees. She states that switchboard attendants are as well likely to develop back problems, however from prolonged sitting; as well as some hearing difficulties due to the nature of their job. 5 out of the 6 concierge participants responded that slips/trips and bruises occur in their work area, however mostly rarely, therefore they have been assessed as low level risks; as since 2013 only 1 case of slip/trip/fall was reported to the Nurse.

The front office department is prone to becoming dirty due to the large volumes of people passing through. The dirt and constant interaction with different people puts the front office employees at risk of contracting infections (HSA, 2003). This is in line as 12 out of the 18 participants responded that they suffer infections, of which 9 responded they occur occasionally; and from the Nurse's records, front office is the 4th highest department for skin infections and communicable respiratory illnesses, with 18 and 35 cases respectively since 2013. Therefore, infections have been assessed as a medium level risk, as additional controls may be required in order to control this risk, such as the provision of sanitizers for the employees.

89% responded there are extreme temperatures in their work area. The warm and stuffy atmosphere in the front office was as well observed by the researcher, especially if it is a busy or hot day. This can cause dizziness and at times fainting; however both of these have been assessed as low level risks as majority of participants responded they occur rarely. A participant reported that some incidents of fainting have occurred, however mostly due to prolonged standing and fatigue. According to the Nurse some of the employees do not drink enough water, or take time to eat well balanced meals, which can cause these incidents.

Table 18: Front Office Psychosocial Risks Assessment

SEVERITY \ LIKELIHOOD		RARELY	OCCASIONALLY	FREQUENTLY	VERY FREQUENTLY
MAJOR PSYCHOSOCIAL RISKS	Depression	MEDIUM RISK			
MODERATE PSYCHOSOCIAL RISKS	Unable to meet Personal Needs		MEDIUM RISK		
	UnableToMeet Family/SocialNds	LOW RISK			
	Fatigue		MEDIUM RISK		
	No Confidence	LOW RISK			
	Disorientation	LOW RISK			
	Anger	LOW RISK			
	Under eat	LOW RISK			
MILD PSYCHOSOCIAL RISKS	Headaches	LOW RISK			
	Indigestion	LOW RISK			
	Restless Sleep		LOW RISK		
	Alcohol Consumption		LOW RISK		
	Caffeine Reliance				MEDIUM RISK

Source: Field Data (2015)

Table 18 shows the assessment of psychosocial risks that occur in the front office department as per the employee survey. Similar to the other departments, fatigue is a common risk faced by front office employees; as indicated by 78% of the participants; 50% of which responded that they experience it occasionally. Therefore fatigue has been ranked as a medium level risk, as according to some receptionists, it has led to some incidences of fainting. Similar to the other departments, fatigue may be related to the over 61% of participants that responded they work overtime and unsocial hours.

The front office employees experience a high amount of anxiety/stress; especially from the 'people pleasing' nature of the job and from handling large volume of enquiries and complaints (Lo, Lamm, 2005; Boardman, 2010; HSA, 2003). Similar to the other departments, fatigue and anxiety/stress can manifest itself in forms of headaches, indigestion, restless sleep, lack of confidence, lack of concentration (disorientation), and mood swings such as anger. All of which have been assessed as low risk; however monitoring of existing risk controls maybe required as majority of participants responded they occasionally have restless sleep (one of the highest responses of this risk, along with the kitchen employees). In major cases of fatigue or anxiety/stress, depression can develop. Similar to the other departments, this can be linked to the 67% that responded that due to their job, they are unable to meet their personal needs, and the 78% that are unable to meet their family/social needs; both of which have been assessed as medium and low level risks

respectively. Depression, like all the departments under study, has as well been assessed as a medium level risk, as even though majority of participants responded it occurs rarely, it is ranked as a major psychosocial risk as it can significantly impact an employee's wellbeing (Kelloway, Day, 2005).

According to the Nurse, front office employees as well develop unhealthy coping mechanisms to deal with the fatigue, and anxiety/stress. These include caffeine reliance, medication reliance, some drug use, alcohol consumption, and under and over eating. An interesting finding is that 72% of participants responded they rely on caffeine, 46% of which responded very frequently (the highest response of this risk from the 5 departments under study). The high dependency of caffeine may as well be related to the 61% that responded they have restless sleep. This risk has therefore been assessed as a medium level risk, as additional controls may be required to reduce the level of dependency the employees have on caffeine; e.g. health talks on the risks of caffeine. The Nurse adds that anaemia is common amongst the front office employees, as they usually don't take the time to eat, or some lose their appetite from stress. She adds that when they do eat, they tend to over indulge in especially sugary/fatty foods to satiate their hunger and keep their energy up; which can lead to obesity and other gastrointestinal illnesses developing (from the Nurse's records front office is the 4th highest department for gastrointestinal illnesses, with 11 cases since 2013).

From the findings, there are more psychosocial risks than physical risks in the front office department, indicating that there are a high number of workplace stressors in this environment. Majority of risks have been assessed as low level risks, however some such as infections, anxiety/stress, fatigue, and caffeine reliance have been assessed as medium level risks; indicating the need for additional measures to be implemented in order to control them.

5.3.3 Precautionary Measures

The following describes precautionary measures the hotel is already implementing, and suggestions of others it can implement, in order to control the risks identified per Front of House Department.

5.3.3.1 Common Precautionary Measures for all Front of House Departments:

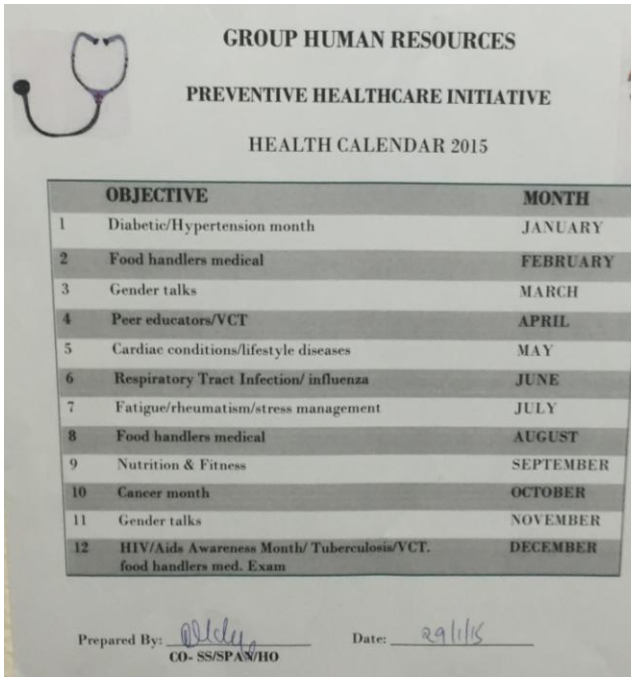
As per the employee survey, the most preferred risk controls to be implemented in the hotel are: Health and Safety Trainings (81%); Provision of First-Aid Equipment (75%); Emergency Procedure Trainings (71%); Stress Management Trainings (70%); Emergency/Safety Procedures to be Posted in their work areas (69%); More Flexibility over Choice of Shift Schedules/Time-off (53%) and the Availability of Sanitizers in their work areas (51%). From impromptu discussions, employees admitted they do not feel confident on the procedure to follow in case of a fire, security, or injury/illness emergency; even though majority of the participants in the questionnaire responded that they are knowledgeable about these procedures (Figure 7). Having regular trainings and visual prompts in their work areas can help build their confidence (as indicated by more than 69% of the participants).

According to the Hotel Nurse, the following are some precautionary measures the employees can take in order to better protect themselves from accidents, injuries or illnesses:

- Have occasional rest breaks (sit down) to avoid injuries/illnesses developing from prolonged standing such as strains, varicose veins, haemorrhoids.
- Exercise regularly to develop fitness and muscle-as standing is not a form of exercise it is a strain. Exercising regularly as well helps reduce anxiety/stress.
- Have occasional massages done to ease sore muscles.
- Drink plenty of water, and eat a regular balanced, nutritious diet to maintain strength and overall physical and mental wellbeing.
- Control the use of first-aid items through recording and reporting to make sure items (such as medicines) are used correctly and not over-consumed than is advised. Display a list of the first-aid representatives per department.
- Attend the fatigue and stress management talks held regularly at the hotel.

Apart from fatigue and stress management talks, the hotel has other regular health talks it has scheduled in a 'Preventative Health Care Calendar' to help the employees maintain their health, safety and wellbeing.

Plate 26: Preventative Health Care Calendar



GROUP HUMAN RESOURCES

PREVENTIVE HEALTHCARE INITIATIVE

HEALTH CALENDAR 2015

	OBJECTIVE	MONTH
1	Diabetic/Hypertension month	JANUARY
2	Food handlers medical	FEBRUARY
3	Gender talks	MARCH
4	Peer educators/VCT	APRIL
5	Cardiac conditions/lifestyle diseases	MAY
6	Respiratory Tract Infection/ influenza	JUNE
7	Fatigue/rheumatism/stress management	JULY
8	Food handlers medical	AUGUST
9	Nutrition & Fitness	SEPTEMBER
10	Cancer month	OCTOBER
11	Gender talks	NOVEMBER
12	HIV/Aids Awareness Month/ Tuberculosis/VCT. food handlers med. Exam	DECEMBER

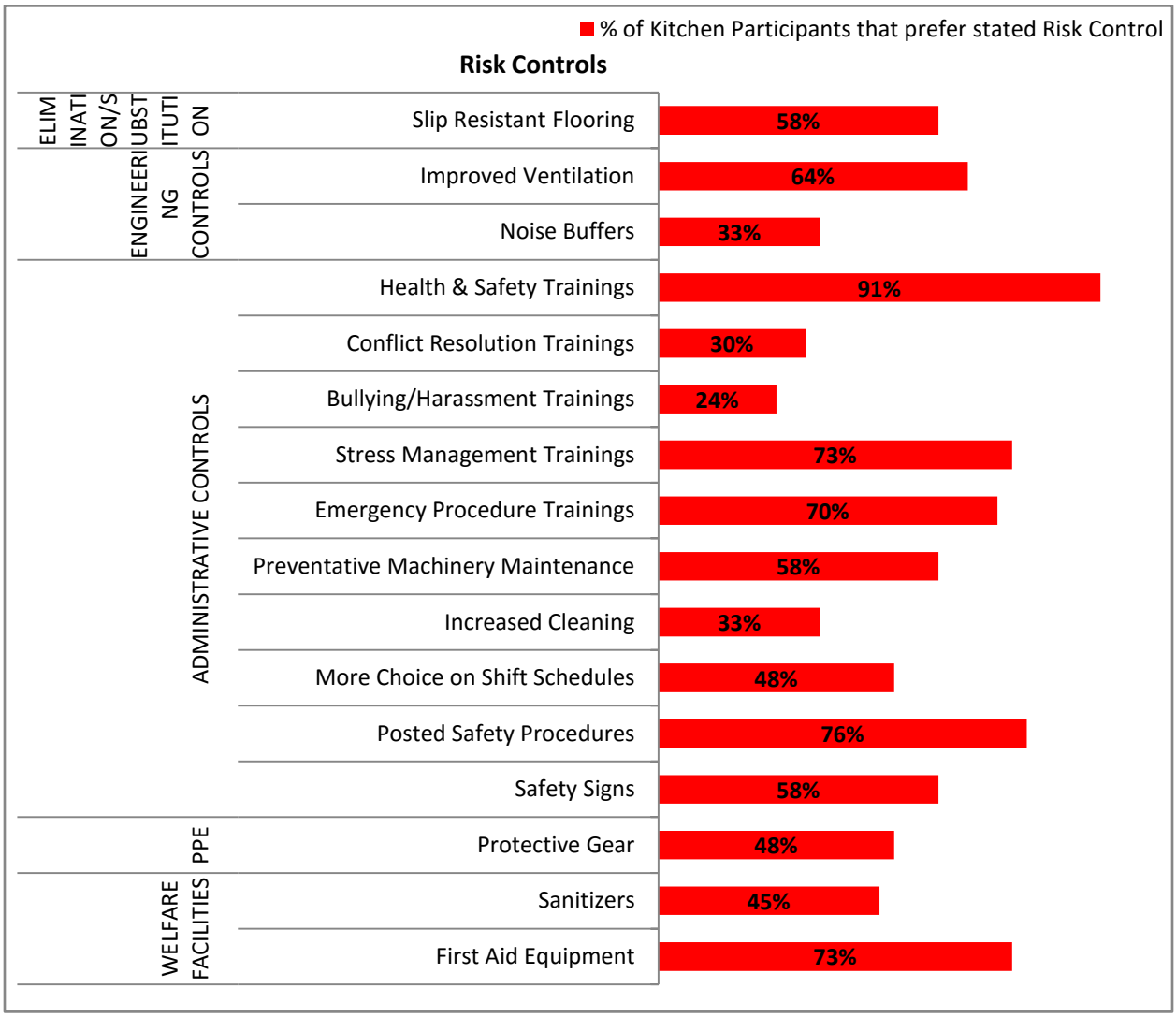
Prepared By: _____ Date: 29/1/15

CO- SS/SPAN/HO

Source: Field Data (2015)

5.3.3.2 Kitchen:

Figure 19: Preference of Risk Controls in the Kitchen Department



Source: Field Data (2015)

As per the employee survey, the following are the top 5 risk controls preferred to be implemented in the kitchen department: Health and Safety Trainings; Emergency/Safety Procedures to be posted in their work areas; Stress Management Trainings; Provision of First-Aid Equipment; and Improved Ventilation in their work areas.

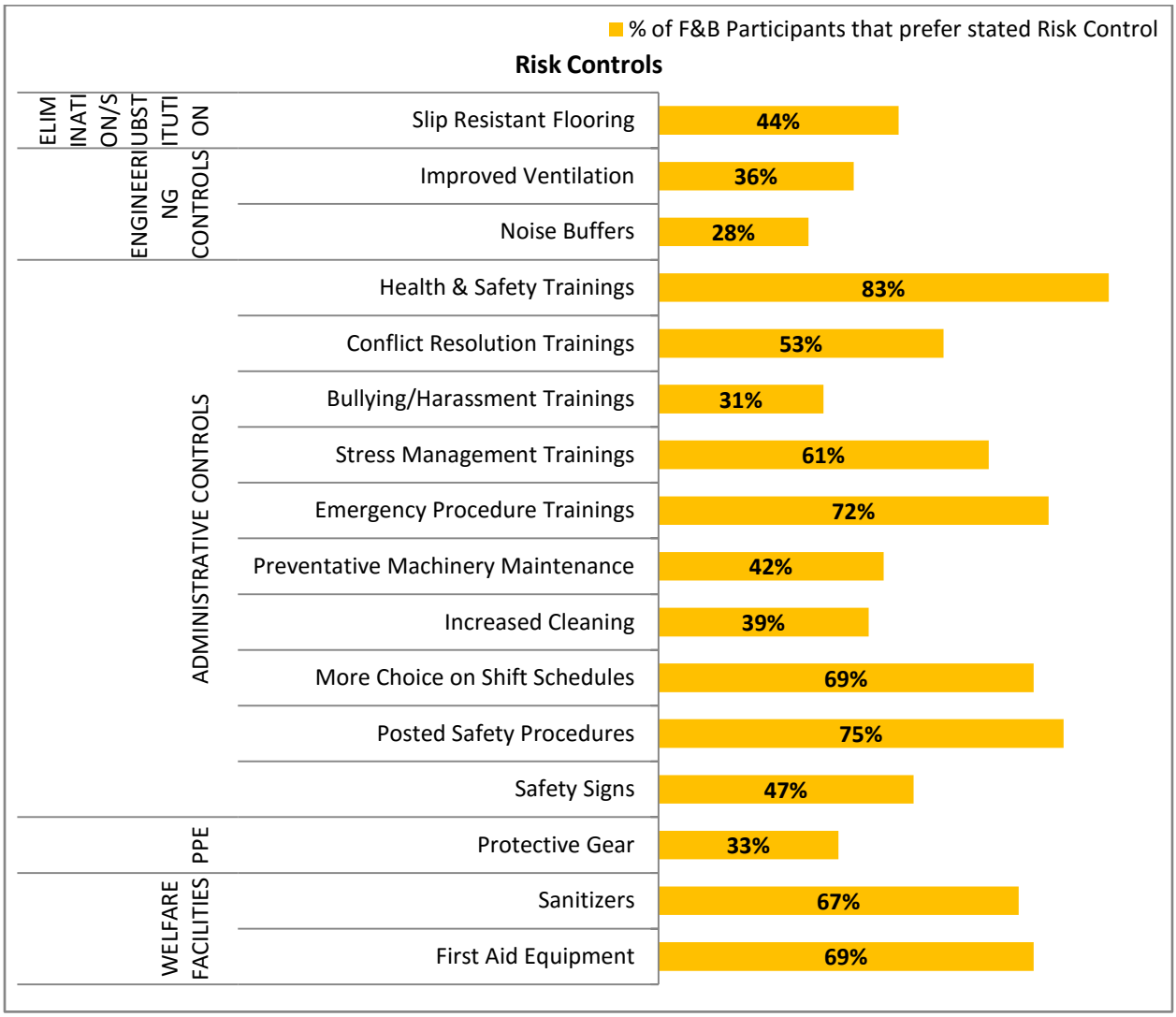
From the research findings, other precautionary measures that can be taken to control risks in the kitchen work areas include:

- Retraining managers and supervisors in communication and leadership skills to reduce risks associated with conflicts with superiors (HSE UK, 2011).
- Attend the talks on alcoholism which are conducted by external professionals at the hotel (as recommended by Hotel Nurse).

- Make sure feet are always clean and dry; and always wear clean socks (cotton not nylon) to avoid fungal infections (as recommended by Hotel Nurse).
- Wear non-absorbent shoes such as gumboots when cleaning to avoid risk of infections (as recommended by Hotel Nurse).
- Wear soft insoles in shoes to reduce pressure on feet (as recommended by Hotel Nurse).
- Use trolleys to transport heavy loads (as recommended by Hotel Nurse).
- Have trainings on safe manual handling practices e.g. safe lifting techniques for heavy, awkward objects to minimize injuries sustained by employees from manual handling.
- Non-slip flooring to be used especially on ramps (e.g. in Thorn tree Kitchen) and in the walk-in cold rooms; 'caution slippery floor signs' to be displayed during wet cleaning operations.
- According to the General Manager coats are provided for associates entering the walk-in cold rooms (but are seldom worn). They should be worn to protect against upper respiratory tract infections.
- Frequently sanitize/wash hands to prevent infections.
- Always use masks and gloves when handling chemicals-to avoid exposure to fumes and chemical burns. Safety goggles should as well be worn for chemicals that cause irritation to eyes.
- MSDSs for the chemicals to be readily available in all the kitchens.
- Refresher trainings on the safe handling of chemicals should be regularly conducted.
- The Deputy Engineer recommends regular 'hand-in-hand' inspections to be conducted with the maintenance team and chefs in tandem, to ensure proper preventative maintenance and functioning of equipment; chefs can as well get a chance to refresh their memory on how to safely operate the equipment.
- Fire exit signs to be displayed in the Pool Deck kitchen, which can especially benefit new employees. The fire exit door leading from the Pool Deck kitchen to the fire exit route to be changed to self-latching/closing to help stop the spread of fire/smoke.

5.3.3.3 Food and Beverage Service:

Figure 20: Preference of Risk Controls in the F&B Service Department



Source: Field Data (2015)

As per the employee survey, the following are the top 5 risk controls preferred to be implemented in the F&B service department: Health and Safety Trainings; Emergency/Safety Procedures to be posted in their work areas; Emergency Procedure Trainings; More Flexibility over Choice of Shift Schedules/Time-off; and Provision of First-Aid Equipment. The availability of sanitizers in their work areas, and stress management trainings, as well had a high response of preference from the participants.

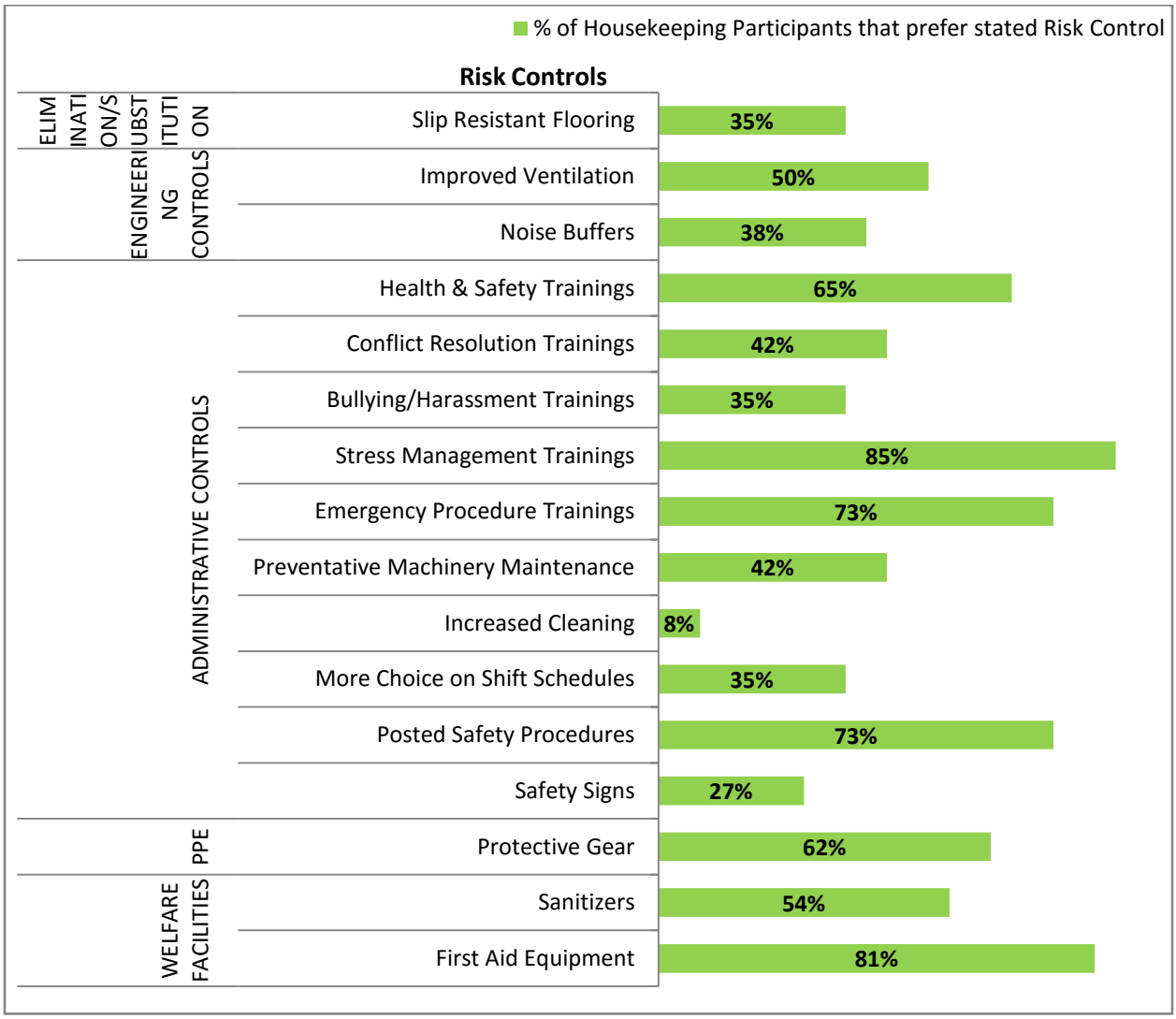
From the research findings, other precautionary measures that can be taken to control risks in the F&B service work areas include:

- Retraining managers and supervisors in communication and leadership skills to reduce risks associated with conflicts with superiors (HSE UK, 2011).
- Attend security trainings held at the hotel to develop tactics on how to handle exposure to criminals.

- Attend talks held at the hotel on sexual harassment; and utilize the hotel sexual harassment policy to report cases of harassment.
- Attend the talks on alcoholism which are conducted by external professionals at the hotel (as recommended by Hotel Nurse).
- Shoe specification for the servers should be reconsidered to be non-slip (to have better grip)-but not necessarily the safety boots worn by the kitchen workers as they are considerably heavy and so maybe impractical for the servers (as recommended by Hotel Nurse).
- Frequently sanitize/wash hands to prevent infections.
- Display 'caution slippery floor signs' during wet cleaning operations of the staff areas; and also when it rains at the Thorn Tree and Pool Deck Restaurants as the flooring exposed to open-air can get slippery when wet.
- Have trainings on safe manual handling practices such as safe lifting techniques for heavy, awkward objects to minimize injuries sustained by employees from manual handling.
- Fire exit signs to be displayed at the Thorn Tree and Thai Chi Restaurants, as well as the Exchange Bar to direct persons to the nearest fire exit routes. Similarly, fire exit doors to be clearly marked in these F&B service areas. Fire fighting equipment such as extinguishers as well should be available within the restaurants as the closest ones are located relatively far in the kitchens. Extinguishers can be placed in the volatile back area of the Exchange Bar as the closest fire fighting equipment are located relatively far from it. Emergency lighting should be installed at the Exchange Bar (especially the back area) and Thai Chi restaurants as both these areas can get quite dark.
- A visor can be placed over the computer order screen at the Pool Deck Restaurant to reduce eye strain from sunlight reflecting directly off the screen.
- Drinking water can be placed in the back area of the Thai Chi restaurant so that staffs don't have to go all the way to the staff cafeteria for water. The 20ltr drinking water available in the back area of the Exchange Bar should be provided with a dispenser so that staffs don't have to lift the heavy bottle to pour water.
- Fix broken and cracked tiling in the back area of the Exchange Bar as it poses as a trip hazard and as well gives way to some pests emerging such as cockroaches and ants.
- In-house maintenance team should as well train the Exchange Bar staffs in the safe handling of the pressurized container located in the back area of the bar, as a precautionary measure to avoid any dangerous occurrences.

5.3.3.4 Housekeeping:

Figure 21: Preference of Risk Controls in the Housekeeping Department



Source: Field Data (2015)

As per the employee survey, the following are the top 5 risk controls preferred to be implemented in the housekeeping department: Stress Management Trainings; Provision of First-Aid Equipment; Emergency Procedure Trainings; Emergency/Safety Procedures to be Posted in their work areas; and Health and Safety Trainings. The availability of Personal Protective Equipment, and improved ventilation in their work areas (selected by almost all Laundry Attendants), as well had a high response of preference from the participants.

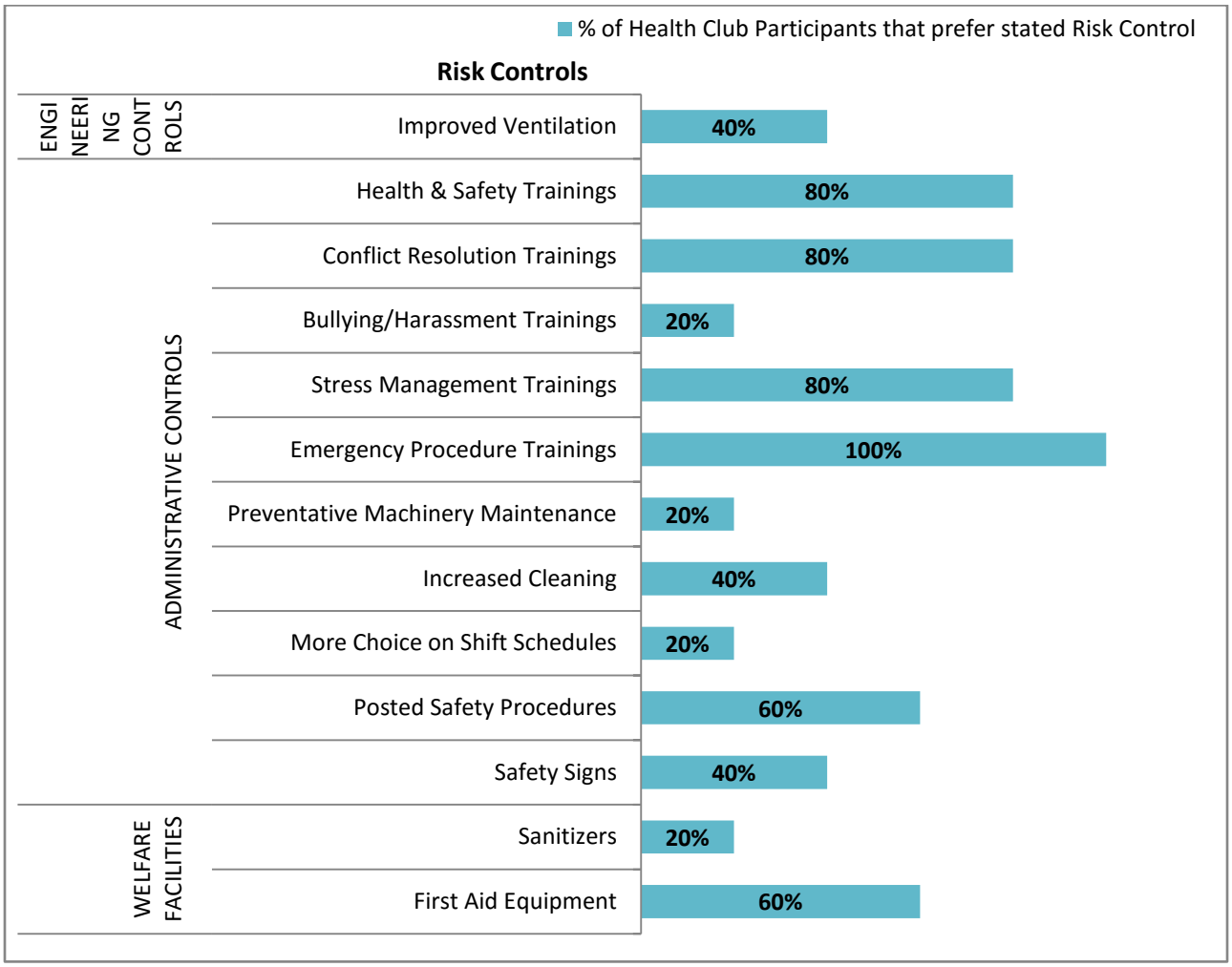
From the research findings, other precautionary measures that can be taken to control risks in the housekeeping work area include:

- Retraining managers and supervisors in communication and leadership skills to reduce risks associated with conflicts with superiors (HSE UK, 2011).

- Have trainings on safe manual handling practices such as safe lifting techniques for heavy, awkward objects; how to bend when making beds, to minimize injuries sustained by employees from manual handling.
- Use trolleys to transport heavy loads.
- Shoe specification for especially the guest room and public area attendants should be reconsidered to be non-slip (to have better grip) to reduce the likelihood of slipping when cleaning e.g. bathroom floors.
- Always use masks and gloves when handling chemicals-to avoid exposure to fumes and chemical burns. Safety goggles should as well be worn for chemicals that cause irritation to eyes.
- Refresher trainings on the safe handling of chemicals should be regularly conducted.
- A separate lockable storage area for the laundry chemicals can be considered so that access to them is restricted, and they are kept far from the laundry machines in case they malfunction, which can otherwise lead to a dangerous occurrence.
- Frequently sanitize/wash hands to prevent infections.
- Always use gloves when handling unsanitary items such as soiled linen.
- Soiled linen barrels should be lined with removable plastic bags along the inside surface and should be covered at all times to avoid bacterial contamination (Collins, 2010a).
- As the spacing in the laundry area is limited, better care needs to be taken on busy days to keep the area neat and organized, and walkways clear, in case of emergency evacuations, and to prevent trip hazards.
- Additional fans can be installed in the laundry area, especially near the machines to keep the air cool and fresh, and therefore reduce risks associated with extreme temperatures and lack of fresh air.
- The drinking water dispenser in the laundry area can be moved to the adjacent housekeeping office area so that it can be easily reached by all housekeeping workers.
- Fire exit signs should be clearly displayed in the second floor back area stairway to direct persons quickly to the fire exit route, which can be beneficial for new employees and guests who are on this floor; emergency lighting should as well be installed in this area.
- The fire evacuation maps in the 3rd floor guest rooms should be edited to direct persons to the alternative fire exit route for this floor and not to the fire exit door that is kept locked. The fire exit sign above this door should as well be changed round to direct persons to the alternative route.

5.3.3.5 Health Club:

Figure 22: Preference of Risk Controls in the Health Club



Source: Field Data (2015)

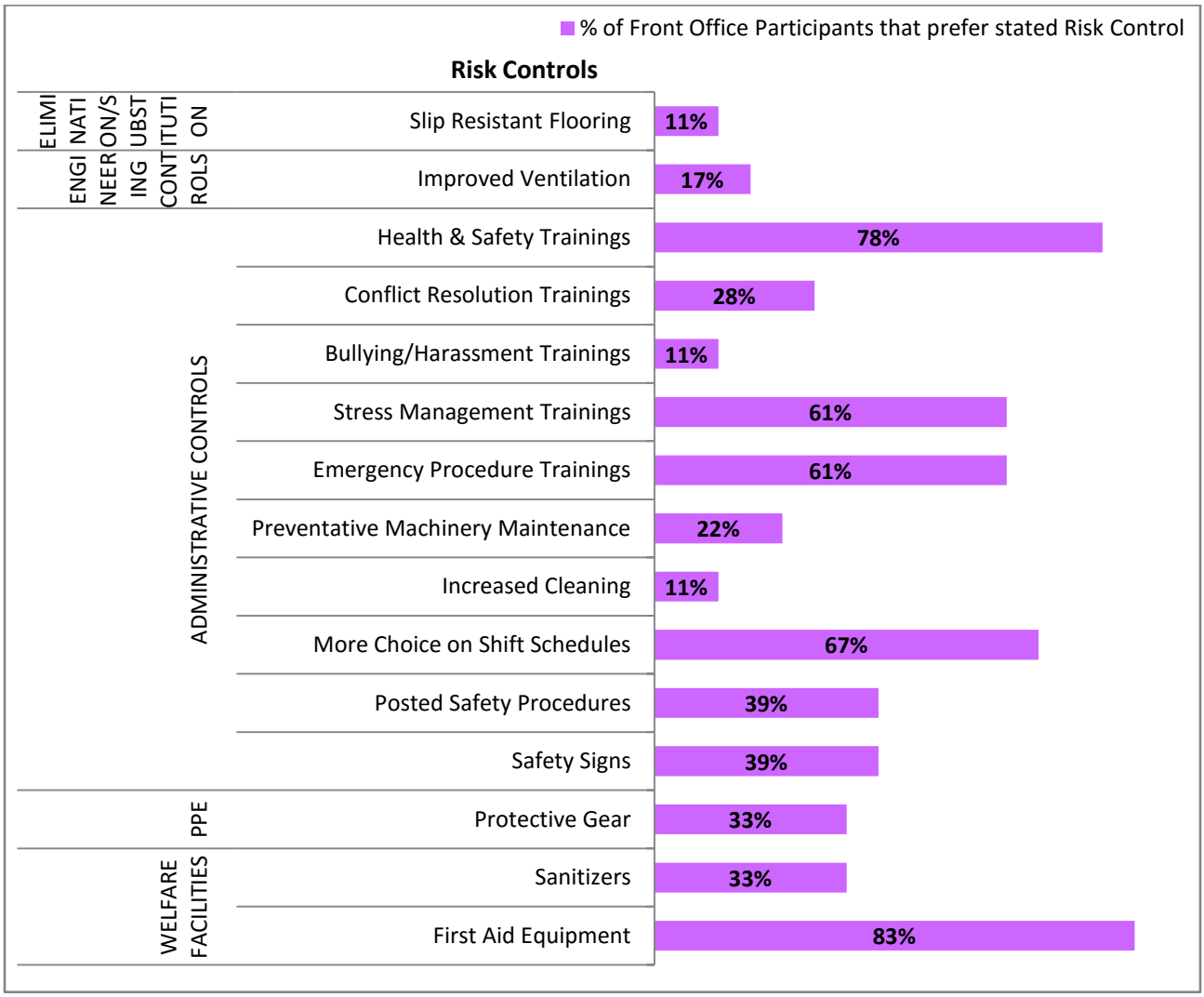
As per the employee survey, the following are the top 5 risk controls preferred to be implemented in the health club: Emergency Procedure Trainings; Health and Safety Trainings; Conflict Resolution Trainings; Stress Management Trainings; (and jointly) Emergency/Safety Procedures to be Posted in their work areas and Provision of First-Aid Equipment. An interesting finding is that no participant responded that they would like slip resistant flooring to be put in their work area-even though they have reported incidences of slipping/falling due to slippery flooring especially by the pool side. Similarly no participant responded that they would prefer the provision of PPE -even though they handle a large number of chemicals. However, apart from safety goggles, PPE is already provided to the health club employees, and according to the Nurse, they are the most careful to wear them when handling chemicals. Another interesting finding is that all the participants responded that they would like trainings done on emergency procedures; even though in Part 3 of the employee survey all the health club participants responded that they are knowledgeable about the emergency procedures to follow for fire, security threat and injury/illness.

From the research findings, other precautionary measures that can be taken to control risks in the health club work area include:

- Retraining managers and supervisors in communication and leadership skills to reduce risks associated with conflicts with superiors (HSE UK, 2011).
- Always use masks and gloves when handling chemicals-to avoid exposure to fumes and chemical burns. Safety goggles should as well be worn for chemicals that cause irritation to eyes.
- MSDSs for chemicals should be readily available to the employees.
- Refresher trainings on the safe handling of chemicals should be regularly conducted.
- Frequently sanitize/wash hands to prevent infections.
- Swimming goggles should be worn while in the swimming pool to prevent eye infections.
- A 'caution slippery floor' sign can be displayed near the pool side to alert persons of possible wet flooring.
- Food and drinks services to the poolside should be served in non-breakable receptacles rather than glass/ceramic that could otherwise pose a sharps hazard to swimmers in case they break.
- Install lights in the swimming pool pump room and plant room; have the rooms regularly cleaned and items kept neat and organized to ensure there's adequate spacing to move comfortably.
- General rules for the fitness centre use, which includes minimum age restrictions, should be clearly displayed.
- A maximum time limit for the steam/sauna use should be established and displayed in the steam/sauna rules as health advisories for clients.
- Fire safety: There is no direct access to the fire exit route from the men's changing room and the quickest access to it is through the ladies changing room. A sign/map can be displayed to direct the patrons of this-however this may be considered controversial. The fire exit sign that points to the main door in the ladies changing room should be changed around to point to the door that leads directly to the fire exit route, therefore helping persons escape faster. Similarly the fire exit sign above the locked fire exit door in the aerobics studio should be changed around to point to the main door that then leads directly to the fire exit route. In the men's changing room, the cabinet with the fire fighting equipment can be moved to the space available outside both changing rooms so that it is less hidden to especially the ladies who may be unaware, therefore helping persons to act quicker in a time of emergency.

5.3.3.6 Front Office:

Figure 23: Preference of Risk Controls in the Front Office Department



Source: Field Data (2015)

As per the employee survey, the following are the top 5 risk controls preferred to be implemented in the front office department: Provision of First-Aid Equipment; Health and Safety Trainings; More Flexibility over Choice of Shift Schedules/Time-off; Stress Management Trainings; and Emergency Procedure Trainings.

From the research findings, other precautionary measures that can be taken to control risks in the front office work area include:

- Retraining managers and supervisors in communication and leadership skills to reduce risks associated with conflicts with superiors (HSE UK, 2011).
- Complaint handling trainings, to equip front office associates with tactics on how best to handle guest complaints.

- Attend talks held at the hotel on sexual harassment; and utilize the hotel sexual harassment policy to report cases of harassment.
- Attend security trainings held at the hotel to develop tactics on how to handle exposure to criminals.
- Have trainings for the concierge attendants on safe manual handling practices such as safe lifting techniques for heavy, awkward objects to minimize injuries sustained by the employees from manual handling.
- Shoe specification for the concierge attendants should be reconsidered to be non-slip (to have better grip) to reduce their likelihood of slipping.
- A 'mind the step' sign can be posted near the two steps in the lobby where incidences of tripping/miss-stepping have occurred.
- Frequently sanitize/wash hands to prevent infections.
- In the reception area, have adjustable computer screens, and workstations at a comfortable height, to reduce neck/back strain and to suit a range of users with varying heights.
- A list of all the hotel first aid representatives, as well as fire marshals should be displayed in the switchboard area, as this is a central point of communication, especially in an emergency.
- Fire fighting equipment such as extinguishers should be available in the reception, switchboard area and cashier's office, as the nearest fire fighting equipment (hose reel) is located relatively far in the lobby area.

5.4 Hypotheses Testing

Data gathered from Part 2 of the employee survey questionnaire was used to test the following hypotheses:

1. H_o: There is no difference in the type of physical risks experienced in each of the Front of House Departments.
2. H_o: There is no difference in the type of psychosocial risks experienced in each of the Front of House Departments.

As the researcher sought to determine if there are statistically significant differences in physical and psychosocial risks (dependent variables) between the 5 Front of House Departments (independent variables), a Kruskal Wallis H Test, at a significance level of 0.05, was run to test these hypotheses. The degrees of freedom have been calculated as 4 (K-1; number of samples – 1 (5-1)), and therefore the chi square critical value has been determined as 9.488 (Sullivan, 2013). The hypotheses test results are as follows.

1. **H_o: There is no difference in the type of physical risks experienced in each of the Front of House Departments**

Table 19: Mean Ranks of Physical Risks per Department

	Department	N	Mean Rank
Physical risk score	**Kitchen**	33	79.65
	Food and Beverage Service	36	52.07
	Housekeeping	26	63.50
	Health Club	5	51.20
	Front Office	18	33.94
	Total	118	

Source: Field Data (2015)

Table 20: Physical Risks Hypothesis Test Summary

Total N	118
Calculated Test Statistic (H)	23.890
Degrees of Freedom	4
Asymptotic Sig. (2-sided test)	.000

Source: Field Data (2015)

The above hypothesis test result shows that there are statistically significant differences in the distribution of physical risks among the 5 Front of House Departments. Therefore the null hypothesis is rejected and the alternative hypothesis is adopted, as the calculated value of H (23.890) is greater than the critical value (9.488). This result demonstrates that the hotel employees do not experience the same types of physical risks; instead they face different types of physical risks depending on the department they work in. This finding is in line with HSA (2003); Queensland Government (2004); HSA IE (2013); Gibbons, Gibbons (2007); and Buchanan *et al* (2010); which all state that unique types of physical risks are experienced in each hotel work area (such as cuts and burns in the kitchen, and risks associated with keyboard and computer use in the front office such as eye strain and carpel tunnel).

2. **H_o: There is no difference in the type of psychosocial risks experienced in each of the Front of House Departments**

Table 21: Mean Ranks of Psychosocial Risks per Department

	Department	N	Mean Rank
Psychosocial risk score	**Kitchen**	33	69.35
	Food and Beverage Service	36	60.28
	Housekeeping	26	57.81
	Health Club	5	44.50
	Front Office	18	46.50
	Total	118	

Source: Field Data (2015)

Table 22: Psychosocial Risks Hypothesis Test Summary

Total N	118
Calculated Test Statistic (H)	6.391
Degrees of Freedom	4
Asymptotic Sig. (2-sided test)	.172

Source: Field Data (2015)

The above hypothesis test result shows that the distribution of psychosocial risks is similar amongst the 5 Front of House Departments. Therefore the null hypothesis has failed to be rejected, as the calculated value of H (6.391) is less than the critical value (9.488). This result demonstrates that the hotel employees experience similar types of psychosocial risks. This finding is however in line with Hoel, Einarsen (2003); HSA (2003); Queensland Government (2004); HSA IE (2013); Lo, Lamm (2005); Gibbons, Gibbons (2007); O'Neill, Davis (2011) and Burton (2010); which state that some workplace stressors are similar amongst all the hotel work areas (such as conflicts arising with clients, co-workers, and management; working odd and long hours; and verbal and sexual harassment), all of which cause the hotel employee to feel a high amount of anxiety and stress, as well as fatigue; therefore affecting their mental wellbeing (Kelloway, Day, 2005).

CHAPTER 6.0: SUMMARY OF FINDINGS, CONCLUSION & RECOMMENDATIONS

This chapter summarizes the findings of the study in accordance with the research's objectives and hypotheses. It finally draws conclusions and makes recommendations based on the findings.

6.1 Summary of Findings

Objective 1: To establish whether the Sarova Stanley Hotel has an effective Occupational Safety and Health Management System (OSHMS)

The Sarova Stanley Hotel has established some aspects of the components of an effective OSHMS in terms of having a safety and health policy statement; a newly formed safety and health committee; conducting annual safety and health audits; and having an emergency planning and preparedness system; and an accident/incident management system.

There is an overall written safety and health policy for the entire Sarova Hotels group. Some of its components are in tandem with literature reviewed on an effective and appropriate safety and health policy statement (e.g. HSA IE, 2006; GOK, 2005; GOK, 2007; GOK, 2013; Kabaka, 2014). Such as employers signed declaration of commitment to safety and health including compliance to related statutory requirements; statements that managers and employees are as well responsible for the implementation of the policy; details on incident/injury management and information on emergency procedures. However, the policy is too generally written and should be more relatable for each hotel property in order for it to become more effective and be in line with the literature reviewed. Review of annual clinical data shows that number of employee sick offs, injuries and illnesses have remained relatively the same since the policy's implementation in 2013; an indication it is not very effective and requires improvement. These include providing details on specific property risk assessments (specific hazards identified, risks assessed, and risk controls implemented); specific details of the hotel's OSHC; details on how the employer plans to measure the performance of the OSHMS in place, and how the effectiveness of the policy will be reviewed; finally there is need to increase employee awareness of the policy.

The hotel has established an Occupational Safety and Health Committee (OSHC) which complies with the requirements of GOK (2004) and GOK (2007). At the time of research, the Stanley OSHC had been recently formed and the members were still undergoing training. Therefore, not all OSHC functions stated in the safety and health policy and GOK (2004) were in operation such as performance of bi-annual safety and health inspections, and compilation of accident, incidents and ill-health statistics. Although some functions were already in-force such as some workers education programs on health and safety, and conducting periodic fire drills. The lack of an operational OSHC was found as a vital component missing for an effective and efficient OSHMS.

Annual safety and health audits are conducted at the hotel both internally (as part of a general audit), and externally by an OSH officer from DOSHS which complies with OSHA 2007 and helps the hotel monitor the efficiency of their OSHMS. However, a risk assessment for the facility and operations had not been conducted (Kabaka, 2014). According to the hotel management, risk assessments to identify and regularly review hazardous conditions and assess risks, as well determine the efficiency of control measures in place, will be part of the functions and duties of the OSHC once they are fully operational.

The Sarova Stanley Hotel has some written emergency plans and procedures that can be found in the Sarova safety and health policy, the duty manager's compendium (handbook), and with the Chief Security Officer and Chief Engineer, who are responsible for them. From the employee survey, 95.8% of the participants responded they are aware of the fire safety procedures instilled by the hotel; 72% responded they are aware of the security threat procedures; and 78% responded they are aware of the injury/illness emergency procedures. However from impromptu discussions, very few appeared confident on what to do in these emergency situations despite trainings being conducted in these areas, therefore reducing the overall effectiveness of the organization's OSHMS. Having these emergency procedures visibly posted on employee notice boards in the respective work areas may help to improve their confidence and awareness of them.

The Stanley Hotel has established a formal system for the reporting and investigation of accidents and incidences which complies with GOK (2007) and GOK (2005). However, an official incident/injury register needs to be introduced to improve the record keeping of the accident/incident reports. The Stanley OSHC should collaborate with the Nurse by compiling her records of injuries/illnesses employees visit her for into monthly statistics showing the various conditions experienced per department. They should also keep specific records of the nature of injuries/illnesses employees are referred or admitted to hospital for, as well as the reasons for sick offs, along with insurance claim reports. These are an important way of monitoring the performance and efficiency of an organization's OSHMS (GOK, 2005; GOK, 2013; Cassidy, 2012; Kabaka, 2014). As since 2013 the annual number of employee sick-offs, injuries and illnesses are relatively the same; an indication the hotel's OSHMS is not very effective and requires some improvement.

Objective 2: To identify and map Occupational Health and Safety (OHS) hazards in the hotel's Front of House Departments

The following are the top ten hazards per department that received the highest responses of occurrence from the participants of the employee survey; the figures represent the percentage of participants that responded that the hazard occurs in their respective work areas.

KITCHEN: Working Overtime (97%); Lack of Sitting (97%); Slippery Surfaces (97%); Extreme Temperature (97%); Pests (94%); Cleaning Agents (91%); Working Unsocial Hours (85%); Manual Handling (85%); *and tied*

responses of: No Control over Days off (82%); Lack of Rest Breaks (82%); Lack of Participation (82%); Pathogens (82%); and Loud Noise (82%). Other hazards observed in the kitchen areas included lack of availability of: respiratory system protection when using chemicals; MSDSs; caution slippery floor signs; manual handling trainings; first aid use recording; posted first aider list and posted fire safety procedures.

F&B SERVICE: Extreme Temperature (92%); Working Unsocial Hours (83%); Lack of Sitting (83%); Pests (83%); Working Overtime (81%); Cleaning Agents (81%); Slippery Surfaces (81%); Lack of Rest Breaks (78%); *and tied responses of:* No Control over Days off (72%); Lack of Openness (72%); and Excessive Workload (72%). Other hazards observed in the F&B Service areas included lack of availability of: manual handling training; MSDSs; caution slippery floor signs; proximity of fire equipment; first aid use recording; posted first aider list and posted fire safety procedures.

HOUSEKEEPING: Cleaning Agents (96%); Lack of Sitting (92%); Working Unsocial Hours (85%); Chemicals/Solvents (85%); Working Overtime (81%); Lack of Participation (81%); Excessive Workload (81%); Pests (81%); Steep Surfaces (81%); *and tied responses of:* Job Insecurity (77%); Lack of Recognition (77%); Fumes (77%); Pesticides (77%); and Slippery Surfaces (77%). Other hazards observed in the housekeeping area included lack of availability of: interior plastic lining in soiled linen barrel; covered soiled linen barrel; protective clothing for soiled linen (gloves available but seldom worn); manual handling trainings; first aid use recording; posted first aider list and posted fire safety procedures.

HEALTH CLUB: Lack of Sitting (100%); Bodily Fluids (100%); Loud Noise (100%); Poor Machinery (80%); Pests (80%); Chemicals/Solvents (80%); Extreme Temperature (80%); *and tied responses of:* Exposure to Criminals (60%); Working Overtime (60%); Lack of Openness (60%); Excessive workload (60%); Unfulfilling Tasks (60%); Lack of Fresh Air (60%); Loose Sockets (60%); Pathogens (60%); Fumes (60%); Pesticides (60%); Cleaning Agents (60%); Steep Surfaces (60%); and Slippery Surfaces (60%). Other hazards observed in the health club area included lack of availability of: posted fitness centre rules; posted age restrictions; posted time limit for steam/sauna use; MSDSs; caution slippery floor signs; first aid use recording; posted first aider list and posted fire safety procedures.

FRONT OFFICE: Extreme Temperature (89%); Lack of Sitting (83%); No Control over Days off (72%); Working Overtime (72%); Pests (72%); Lack of Recognition (67%); Working Unsocial Hours (61%); Job Insecurity (56%); and Lack of Participation (56%). Other hazards observed in the front office area included lack of availability of: manual handling trainings; sanitizers; and slippery/uneven floor caution signs.

Objective 3: To carry out a risk assessment of these Front of House Departments

The risks per department are assessed into low, medium, high or extreme level risks in accordance with the modal frequency results of the employee survey questionnaire (rarely, occasionally, frequently, or

very frequently). The top 5 most preferred risk controls (precautionary measures) according to the participants of the employee survey are as well summarized.

KITCHEN: *Low Risk*: (*Physical Risks)* Difficulty Hearing; Fractures; Skin Dermatitis; Infections; Mild Burns; Mild Cuts; Bruises. (*Psychosocial Risks*) Feeling Emotionless; Disorientation; Anger; Under Eating; Headaches; Indigestion; Restless Sleep; Alcohol Consumption; Caffeine Reliance.
Medium Risk: (*Physical Risks*) Major Burns; Lacerations; Major Falls; Musculoskeletal Disorders; Electric Shock; Broken Bones; Fainting; Breathing Problems; Neck/Back Injury; Falls; Muscular Strains; Dizziness; Slips/Trips. (*Psychosocial Risks)* Depression; Unable to meet Personal Needs; Unable to meet Family/Social Needs; Medication Reliance; Lack of Confidence.
High Risk: (*Psychosocial Risks*) Fatigue.
***Precautionary Measures*:** Health and Safety Trainings (91%); Emergency/Safety Procedures to be posted in their work areas (76%); Stress Management Trainings (73%); Provision of First Aid Equipment (73%); and Improved Ventilation in their work areas (64%).

F&B SERVICE: *Low Risk*: *(Physical Risks*) Infections; Neck/Back Injury; Mild Burns; Mild Cuts; Bruises; Dizziness. (*Psychosocial Risks*) Unable to meet Family/Social Needs; Medication Reliance; Lack of Confidence; Disorientation; Anger; Under Eating; Headaches; Indigestion; Restless Sleep; Alcohol Consumption; Caffeine Reliance.
Medium Risk: (*Physical Risks*) Falls; Muscular Strains; Slips/Trips. (*Psychosocial Risks*) Depression; Unable to meet Personal Needs; Fatigue.
***Precautionary Measures*:** Health and Safety Trainings (83%); Emergency/Safety Procedures to be posted in their work areas (75%); Emergency Procedure Trainings (72%); More Flexibility over Choice of Shift Schedules/Time-off (69%); and Provision of First-Aid Equipment (69%).

HOUSEKEEPING: *Low Risk*: *(Physical Risks*) Fractures; Breathing Problems; Falls; Mild Burns; Mild Cuts; Bruises; Dizziness. (*Psychosocial Risks*) Lack of Confidence; Disorientation; Anger; Headaches; Indigestion; Restless Sleep; Caffeine Reliance.
Medium Risk: (*Physical Risks*) Musculoskeletal Disorders; Skin Dermatitis; Infections; Neck/Back Injury; Muscular Strains; Slips/Trips. (*Psychosocial Risks*) Depression; Unable to meet Personal Needs; Unable to meet Family/Social Needs; Medication Reliance; Fatigue.
***Precautionary Measures*:** Stress Management Trainings (85%); Provision of First-Aid Equipment (81%); Emergency Procedure Trainings (73%); Emergency/Safety Procedures to be posted in their work areas (73%); and Health and Safety Trainings (65%).

HEALTH CLUB: *Low Risk*: *(Physical Risks*) Breathing Problems; Skin Dermatitis; Neck/Back Injury; Mild Burns; Mild Cuts; Bruises; Muscular Strains; Dizziness; Slips/Trips. (*Psychosocial Risks*) Unable to meet Family/Social Needs; Feeling Emotionless; Disorientation; Anger; Headaches; Indigestion; Restless Sleep.

Medium Risk: (*Physical Risks*) Musculoskeletal Disorders; Electric Shock; infections; Falls. (*Psychosocial Risks*) Insomnia; Violent Tendencies; Depression; Unable to meet Personal Needs; Fatigue.

***Precautionary Measures*:** Emergency Procedure Trainings (100%); Health and Safety Trainings (80%); Conflict Resolution Trainings (80%); Stress Management Trainings (80%); (and jointly) Emergency/Safety Procedures to be posted in their work areas (60%); and Provision of First-Aid Equipment (60%).

FRONT OFFICE: *Low Risk*: *(Physical Risks*) Fainting; Bruises; Muscular Strains; Dizziness; Slips/Trips. (*Psychosocial Risks*) Unable to meet Family/Social Needs; Lack of Confidence; Disorientation; Anger; Under Eating; Headaches; Indigestion; Restless Sleep; Alcohol Consumption.

Medium Risk: (*Physical Risks*) Infections. (*Psychosocial Risks*) Depression; Unable to meet Personal Needs; Fatigue; Caffeine Reliance.

***Precautionary Measures*:** Provision of First-Aid Equipment (83%); Health and Safety Trainings (78%); More Flexibility over Choice of Shift Schedules/Time-off (67%); Stress Management Trainings (61%); and Emergency Procedure Trainings (61%).

Hypotheses Testing Kruskal Wallis H Test was run to test the following hypotheses:

1. *H_o: There is no difference in the type of physical risks experienced in each of the Front of House Departments.*

(H=23.890>Critical Value=9.488) this test result shows that there are statistically significant differences in the distribution of physical risks among the 5 Front of House Departments; therefore the null hypothesis is rejected and the alternative hypothesis is adopted as the calculated value of H is greater than the critical value.

2. *H_o: There is no difference in the type of psychosocial risks experienced in each of the Front of House Departments.*

(H=6.391<Critical Value=9.488) this test result shows that the distribution of psychosocial risks is similar amongst the 5 Front of House Departments; therefore the null hypothesis has failed to be rejected as the calculated value of H is less than the critical value.

6.2 Conclusion

The demand for physical and emotional labour is relatively high in the hotel industry, and leads to the development of physical and psychosocial OHS risks. Therefore in order to manage and control these risks, a hotel requires an effective and efficient OSHMS.

The OSHMS at the Sarova Stanley Hotel was found to not be very effective, and therefore requires strengthening. Although some components of an effective OSHMS have been established (such as a written

safety and health policy, annual safety and health audits and written emergency plans and procedures); the annual number of employee sick offs, injuries and illnesses have remained relatively the same since 2013. This can be explained by inadequate implementation of the requirements of the OSHMS and DOSHS audit recommendations, such as training and awareness creation of the employees regarding OHS. It is as well clear that OHS is regarded as a non-core business issue in spite of the international trends and best practices. Therefore monitoring and evaluating the performance of the OSHMS by fully operationalizing the safety and health committee; and carrying out periodic risk assessments of the entire hotel operations and implementing recommendations thereof, can improve the OSHMS's efficiency and effectiveness. This is in line with studies by Ondieki (2013); and Wazir (2013), who found that even though Kenyan businesses in the hospitality industry comply with some aspects of OSHA (2007), the problem lies in the implementation, actualization, and review of their OSHMSs.

The study concluded that both physical and psychosocial hazards and associated risks are experienced in the 5 Front of House Departments. They ranged from physical, chemical, biological, mechanical/electrical, ergonomic and workplace (psychosocial) stressors. The comparison of mean ranks of the frequency of occurrence of risks showed that some departments experienced more physical risks than others (in decreasing order): Kitchen (79.65)> Housekeeping (63.50) > F&B Service (52.07) > Health Club (51.20) > Front Office (33.94). However, the mean ranks of psychosocial risks were more or less the same showing that employees in all 5 departments experience similar occurrences of psychosocial risks. These findings are in line with literature reviewed on hazards and risks in the hotel industry (e.g. Lo, Lamm, 2005; O'Neill, Davis, 2011; Bohle *et al*, 2004; Gibbons, Gibbons, 2007; Mayhew, Quinlan, 2002; Buchanan *et al*, 2010; HSA, 2003; Queensland Government, 2004; Workcover Corporation, 2000; HSA IE, 2013). Overall the findings were in line with hotel clinical data of injuries and illnesses where the top 3 departments with the most conditions (risks) are kitchen, F&B service and housekeeping. Therefore, hotels similar to the Sarova Stanley Hotel should not be regarded as 'low-risk' work environments.

6.3 Recommendations

The following recommendations are based on the findings of the study. They are made for the government, employer and employee as according to ILO (2011); GOK (2013); and Kabaka (2014), good OHS management requires a tripartite approach.

For the Government/Policy Makers

- The study found that OHS hazards and associated risks are present in the hotel work environment and should not be considered as low-risk work areas. To further knowledge, the Government of Kenya should encourage more research to be done on OHS in the hospitality industry. The research can be used to

produce guidebooks/handbooks that advise employers in this industry on how to identify and manage OHS effectively in their businesses.

- The findings showed that both physical and psychosocial hazards and risks are experienced in the hotel work environment. Therefore, when conducting safety and health audits, DOSHS should address not only the physical work environment but as well the effects of the psychosocial work environment. The Government of Kenya should as well introduce provisions for addressing workplace stressors in OSHA 2007 and in the DOSHS Code of Practice on Occupational Safety and Health Auditing (GOK, 2007; GOK, 2005).
- The Accommodation and Food Services Activities industry in Kenya has one of the highest rates of employment and is a significant contributor to the country's GDP (KNBS, 2014). Despite this, Kenya has not ratified any ILO convention in relation to this industry, an important one being the 'Working Conditions (Hotels and Restaurants) Convention, 1991' (No. 172). This is an important convention the Government should consider as it concerns adopting policies and practices to improve working conditions in the hospitality industry (ILO, 1991).
- To increase the Government's ability to tackle OHS issues effectively throughout the Kenyan region, the core ILO OHS conventions should be ratified to namely: C155 (1981) Occupational Safety and Health; C161 (1985) Health Services; and C187 (2006) Promotional Framework for OSH (ITUC-Africa, 2013; ILO, 2013).

For the Employer

To address the physical and psychosocial hazards and associated risks found in the hotel's front of house departments, the study recommends the Sarova Stanley Hotel fully implement the requirements of its OSHMS by applying the following:

- The safety and health policy available at the hotel is too general as it is written for the overall Sarova Hotels group. It should contain specific information in relation to each particular property (in this case the Stanley Hotel), in order to make it more relatable, and its implementation to be more effective. These include information on risk assessments undertaken; specific details of the hotel's OSHC; details on how the employer plans to measure the performance of the OSHMS in place, and how the effectiveness of the policy will be reviewed. Increase employee awareness of the policy by making it visible in all work areas. Let them cooperate and participate in its review and implementation which complies with Sections 6 and 13 of OSHA 2007; and creates a sense of understanding and ownership in the employees to ensure more effective implementation of the safety and health measures provided (HSA IE, 2006).
- Fully operationalize the Occupational Safety and Health Committee (OSHC). Assign specific roles to the OSHC and ensure functions and duties stated in Section 6 of GOK (2004) and Section 2 of the Sarova safety and health policy are adhered to. Employees should as well be made aware of who the safety and health representatives are; and what communication channels they can effectively use to report matters of health and safety (GOK, 2004; HSA IE, 2006).

- Fully implement recommendations provided in DOSHS audits such as conducting periodic OHS risk assessments. These assessments should take into account the effect of workplace stressors on the wellbeing of the employees. Employees should as well be consulted as they are the ones with firsthand experience on how they go about their duties, and therefore are able to advise on any hazardous conditions, risks, and the risk controls that work best (HSE UK, 2011; EC, 1996).
- Increase employee awareness on OHS matters by conducting regular trainings in this area. 69% of the employee survey participants responded they would like the written emergency plans/procedures to be visibly posted in their respective work areas e.g. for fire, security, and accident/illness/injury. Having these visibly displayed can improve employee confidence and knowledge on what to do in these situations, along with regular trainings on these emergency procedures, which 71% responded they prefer.
- Introduce an official incident/injury register to improve the record keeping of the accident/incident reports. Statistics and reports of ill health while at work, sickness absence and insurance claims needs to as well be introduced. These reports are an important way of monitoring the performance and efficiency of the OSHMS (GOK, 2005; GOK, 2013; Kabaka, 2014); and are in line with the defence layers in Reason's Defence in Depth Accident Trajectory Model (Cassidy, 2012).

For the Employee

To increase the effectiveness of The Stanley Hotel's OSHMS and control the hazards and associated risks identified, the study recommends the employees to:

- Cooperate with the employer and participate in the implementation of the safety and health policy. This complies with duties stated in Section 13 of OSHA 2007; and enables better understanding and ownership of the safety and health measures instilled in the hotel (HSA IE, 2006).
- Comply with all safe work procedures and practices instilled in the hotel, including use of the Personal Protective Equipment provided.
- Attend the health and safety talks and events scheduled in the hotel's preventative health care calendar.
- Be interested in learning and developing skills on OHS by attending the relative trainings; and reporting all unsafe conditions, acts and practices noted which is in line with Strahlendorf's Internal Responsibility System (IRS) theory (Strahlendorf, 2013).

Recommendations for Further Research

- A risk assessment of OHS hazards of the back of house departments of a hotel establishment (Sales and Marketing, Repair and Maintenance, Security, Information Technology (IT), Purchasing and Receiving, Finance, and Human Resources).
- A comparison of the level of implementation of OSHMSs amongst '5-star' Hotels in Nairobi.
- OHS measures implemented in '5-star' Hotels in Nairobi and their effect on business performance.

REFERENCES

ABRAMS, H.K. (2001) *A Short History of Occupational Health.* Journal of Public Health Policy. Vol. 22, No.1, pp. 34-80.

AIS (2013) *Workplace Stress Survey* [Online] The American Institute of Stress. Available From: http://www.stress.org/wp-content/uploads/2011/08/Workplace-Stress-Survey.pdf [Accessed: 30/10/14]

AMOLLO, D. (2015) *Sarova Stanley Annual Environmental Audit Report*. Ref No.: NEMA/EA/5/2/6078. National Environment Management Environment Authority (NEMA) Kenya.

AMPONSAH-TAWIAH, K. (2013) *Occupational Health and Safety and Sustainable Development in Ghana.* International Journal of Business Administration. Vol. 4, No. 2, pp. 74-78.

AU (1998) *Bamako Convention* [Online] African Union, Bamako, Mali, January 1991. Available From: http://www.unep.org/delc/BamakoConvention/tabid/106390/Default.aspx [Accessed: 19/9/14]

BARLUND, K. (2005) *Sustainable Development: Concept and Action* [Online] United Nations Economic Commission for Europe. Available From: http://www.unece.org/oes/nutshell/2004-2005/focus_sustainable_development.html [Accessed: 6/8/14]

BAXTER, P., JACK, S. (2008) *Qualitative Case Study Methodology: Study Design and Implementation for Novice Researchers*. The Qualitative Report. Vol. 13, No. 4, pp. 544-559.

BOARDMAN, T. (2010) *Staff Turnover in Hospitality* [Online] Inside Business 360. Available From: http://www.insidebusiness360.com/index.php/staff-turnover-in-hospitality-10131/ [Accessed: 12/8/14]

BOHLE, P., QUINLAN, M., KENNEDY, D., WILLIAMSON, A. (2004) *Working hours, work-life conflict and health in precarious and "permanent" employment.* Rev.Saúde Pública. Vol. 38, pp. 19-25.

BORYS, D.M. (2007) *Exploring Risk Awareness as a Cultural Approach to Safety: An Ethnographic Study of a Contract Maintenance Environment.* PhD Thesis. School of Science and Engineering, University of Ballarat, Australia.

BRYMAN, A. (2012) *Social Research Methods*. 4th Ed. Oxford: Oxford University Press.

BSI (2014) *About BSI* [Online] British Standards Institution. Available From: http://www.bsigroup.com/en-GB/about-bsi/our-history/ [Accessed: 15/9/14]

BUCHANAN, R.L., WHITING, R.C. (1998) *Risk Assessment: A Means for Linking HACCP Plans and Public Health*. Journal of Food Protection. No. 11, pp. 1531-1534.

BUCHANAN, S., KRAUSE, N., MORIARTY, J., FRUMIN, E., SHIMEK, J.A., MIRER, F., ORRIS, P., PUNNETT, L. (2010) *Occupational Injury Disparities in the US Hotel Industry* [Online] American Journal of Industrial Medicine. Vol. 53, pp.116-125.

BUREAU OF LABOR STATISTICS (2012) *Occupational Safety and Health Definitions* [Online] United States Department of Labor. Available From: http://www.bls.gov/iif/oshdef.htm [Accessed: 9/9/14]

BURTON, J. (2010) *WHO Healthy Workplace Framework and Model: Background Document and Supporting Literature and Practices*. Geneva: WHO Headquarters.

CASSIDY, M. (2012) *Applying Risk Theory to Occupational Health* [Online] Return to Work Matters Pty Ltd. Available From: http://www.rtwmatters.org/article/article.php?id=1710 [Accessed: 29/9/14]

CLIFF, D. (2012) *The Management of Occupational Health and Safety in the Australian Mining Industry* [Online] International Mining for Development Centre. Available From: http://im4dc.org/wp-content/uploads/2012/01/UWA_1698_Paper-03.pdf [Accessed: 29/9/14]

COLEMAN, M.E., MARKS H.M. (1999) *Qualitative and Quantitative Risk Assessment.* Food Control. Vol. 10, No. 4-5, pp. 289-297.

COLLINS, D. (2010a) *Comprehensive Generic Checklist for Hotels and Resorts* [Online] Public Liability Insurance Information and Resources. Available From: http://www.publicliability.net.au/2010/09/29/comprehensive-hotel-resort-risk-management-checklist/ [Accessed: 30/10/14]

COLLINS, D. (2010b) *Public Liability and Hazard Evaluation Checklist: Hotels and Clubs* [Online] Public Liability Insurance Information and Resources. Available From: http://www.publicliability.net.au/2010/10/02/club-and-hotel-hazard-evaluation-checklist/ [Accessed: 16/3/14]

COMCARE (2004) *Identifying Hazards in the Workplace*. Commonwealth of Australia. Canberra: Australian Government

CORVALAN, C.F., KJELLSTROM, T., SMITH, R.S. (1999) *Health, Environment and Sustainable Development. Identifying Links and Indicators to Promote Action.* Epidemiology Resources Inc. Vol. 10, pp. 656-660.

CREATIVE RESEARCH SYSTEMS (2012) *Sample Size Calculator* [Online] Available From: http://www.surveysystem.com/sscalc.htm [Accessed: 14/1/15]

DANNA, K., GRIFFIN, R.W. (1999) *Health and Well-Being in the Workplace: A Review and Synthesis of the Literature*. Journal of Management. Vol. 25, No. 3, pp. 357-384.

EAC, ILO (2009) *The East African Community Decent Work Programme 2010-2015* [Online] ILO Office for Kenya, Somalia, Tanzania and Uganda. Available From: http://www.ilo.org/public/english/bureau/program/dwcp/download/eacfinal.pdf [Accessed: 19/9/14]

EC (1996) *Guidance on Risk Assessment at Work*. European Commission. Luxembourg: Office for Official Publications of the European Communities.

EECKELAERT, L., STARREN, A., SCHEPPINGEN, A., FOX, D., BRUCK, C. (2011) *Occupational Safety and Health Culture Assessment-A Review of Main Approaches and Selected Tools.* Working Environment Information Working Paper. European Agency for Safety and Health at Work (EU-OSHA). Luxembourg: Publications Office of the European Union.

ELGSTRAND, K., ed. (2010) *OSH & Development: OSH Needs in Developing Countries.* Stockholm: Swedish Association for Occupational and Environmental Health & Development (UFA) in cooperation with the International Commission of Occupational Health (ICOH). No. 10, pp. 52,69,78.

EVES, D. (2014) *A brief history of the origins, development and implementation of health and safety law in the United Kingdom, 1802–2014* [Online] History of Occupational Safety and Health. Available From: http://www.historyofosh.org.uk/brief/index.html#chapter01 [Accessed: 2/7/14]

FAA (2008) *Reason's (1990) "Swiss Cheese" Model of Organizational Accidents* [Online] U.S Department of Transportation: Federal Aviation Administration. Available From: http://www.hf.faa.gov/hfguide/07/07_win_fig_7_3.html [Accessed: 5/10/14]

GATITHI, A.W. (2013) *The Extent of Compliance with Occupational Safety and Health Regulations at Manufacturing Companies in Mombasa County*. MBA Thesis. College of Humanities and Social Sciences, University of Nairobi.

GIBBONS, R.M., GIBBONS, C. (2007) *Occupational Stress in the Chef Position*. International Journal of Contemporary Hospitality Management. Vol. 19, No. 1, pp. 32-42.

GIKONYO, E. (2008) *The Impact of Occupational Hazards on the Health of Metal Workers in Kenya's Jua Kali Sector: A Case Study of Kamukunji Metal Work Cluster in Nairobi*. MA Research Project. Department of Sociology, University of Nairobi

GOK (1999) *Environmental Management and Co-ordination Act.* Chapter 387. Revised Edition 2012 (1999). Republic of Kenya: National Council for Law Reporting.

GOK (2004) *The Factories and Other Places of Work (Safety and Health Committees) Rules*. Republic of Kenya: National Council for Law Reporting.

GOK (2005) *Code of Practice on Occupational Safety and Health Auditing*. Directorate of Occupational Safety and Health Services. Republic of Kenya: Ministry of Labour and Human Resources Development.

GOK (2007) *The Occupational Safety and Health Act No. 15 of 2007*. Revised Edition 2010 (2007). Republic of Kenya: National Council for Law Reporting.

GOK (2010) *Constitution of Kenya.* Revised Edition 2012 (2010). Republic of Kenya: National Council for Law Reporting.

GOK (2012) *The National Occupational Safety and Health Policy*. Republic of Kenya: Ministry for Labour

GOK (2013) *Occupational Safety and Health Manual: for the Safety and Health Committee Members*. Directorate of Occupational Safety and Health Services. Republic of Kenya: Ministry of Labour, Social Security and Service.

GOVERNMENT OF SOUTH AUSTRALIA (2009) *Risk Assessment Matrix: Determining the Level of Risk.* Australia: Department of Education and Children's Services.

GOVERNMENT OF WESTERN AUSTRALIA (2014) *Hazard Identification, Risk Assessment and Risk Control*. Safe@Work Modules. Western Australia: WorkSafe, Department of Commerce.

GULDENMUND, F.W. (2010) *Understanding and Exploring Safety Culture*. Thesis (PhD) Delft University, The Netherlands.

HARPER, W.M. (1991) *Statistics*. Frameworks. 6th Ed. Harlow: Pearson Education Ltd.

HOEL, H., EINARSEN, S. (2003) *Violence at Work in Hotels, Catering and Tourism*. Sectoral Activities Programme Working Paper WP.211. Geneva: International Labour Office.

HSA (2003) *Occupational Health and Safety in Hospitality. Supervisors Training Manual*. Hospitality Safety Alliance. New South Wales (AU): WorkCover.

HSA IE (2006) *Guidelines on Risk Assessments and Safety Statements*. Dublin: Health and Safety Authority.

HSA IE (2013) *Safety, Health and Welfare in Hotels, Restaurants, Catering and Bars*. Dublin: Health and Safety Authority.

HSE UK (2011) *Five Steps to Risk Assessment.* United Kingdom: Health and Safety Executive.

HSE UK (2014) *Health and Safety Statistics* [Online] UK: Health and Safety Executive. Available From: http://www.hse.gov.uk/statistics/ [Accessed: 5/7/14]

HSL (2014) *World Health Organization* [Online] Health and Safety Laboratory: An Agency of the Health and Safety Executive (HSE) UK. Available From: http://www.hsl.gov.uk/centres-of-excellence/centre-for-workplace-health/world-health-organisation [Accessed 15/9/14]

IAPA (2007) *Glossary of Occupational Health and Safety Terms* [Online] Industrial Accident Prevention Association. Available From: http://www.iapa.ca/pdf/iapa_glossary.pdf [Accessed: 9/9/14]

ICOH (2012) *Minutes of the 2nd General Assembly.* 2nd General Assembly of the International Commission on Occupational Health, Cancun, 23rd March 2012.

ICOH (2014) *About ICOH* [Online] International Commission on Occupational Health. Available From: http://www.icohweb.org/site_new/ico_about.asp [Accessed: 16/9/14]

ILO (1981) *Occupational Safety and Health Convention, 1981 (No. 155).* Geneva: International Labour Office.

ILO (1991) *Working Conditions (Hotels and Restaurants) Convention, 1991 (No. 172).* Geneva: International Labour Office.

ILO (1996) *Introduction to Occupational Health and Safety*. In: Your Health and Safety at Work: A Collection of Modules. Geneva: International Labour Office.

ILO (2001) *ILO-OSH 2001: Guidelines on Occupational Safety and Health Management Systems.* SafeWork-ILO InFocus Programme on Safety and Health at Work and the Environment. Geneva: International Labour Office.

ILO (2002) *Protocol of 2002 to the Occupational Safety and Health Convention, 1981*. Geneva: International Labour Office.

ILO (2003) *Code of Practice on Workplace Violence in Services Sectors and Measures to Combat this Phenomenon.* International Labour Organization, Sectoral Activities Programme. Geneva: International Labour Office.

ILO (2009a) *Health and Life at Work: A Basic Human Right*. Geneva: International Labour Office.

ILO (2009b) *Occupational Safety and Health Manual for Tourism*. SafeWork-ILO InFocus Programme on Safety and Health at Work and the Environment. Geneva: International Labour Office.

ILO (2011) *OSH Management System: A Tool for Continual Improvement*. International Labour Organization. Turin: International Training Centre of the ILO.

ILO (2013) *National Profile on Occupational Safety and Health- Kenya*. International Labour Organization. Geneva: International Labour Office.

ILO (2014) *About the ILO* [Online] International Labour Organization. Available From: http://www.ilo.org/global/about-the-ilo/lang--en/index.htm [Accessed: 4/3/14]

INDAKWA, D.O. (2013) *Perceived Influence of Occupational Health and Safety Practices on Job Satisfaction among Employees in Chemelil Sugar Company Limited, Kenya.* MBA Research Project. School of Business, University of Nairobi

INGLE, B. (2005) *If You're Not Managing Risk You're Not Managing Safety*. Western Australia Journal of Occupational Safety and Health. IFAP Safety WA. Issue: July 2005.

INTERNATIONS (2013) *Working in Nairobi* [Online] InterNations GmbH. Available From: http://www.internations.org/nairobi-expats/guide/working-in-nairobi-15858 [Accessed: 3/2/14]

ITUC-AFRICA (2013) *Report to The African Union Labour and Social Affairs Commission, April 2013*. International Trade Union Confederation-Africa.

ITUC-AFRICA (2014) *Activity Report to 3rd World Congress 2010-2014.* International Trade Union Confederation-Africa.

KABAKA, E.A. (2014) *Health and Safety Audit Report for Sarova Stanley*. June 2014. Directorate of Occupational Safety and Health Services. Republic of Kenya: Ministry of Labour, Social Security and Service.

KAHC (2014) *KAHC Members Directory-Nairobi* [Online] Kenya Association of Hotel Keepers. Available From: http://www.kahc.co.ke/kahc-members-directory.php?reg=Nairobi [Accessed: 15/12/14]

KELLOWAY, E.K., DAY, A.L. (2005) *Building Healthy Workplaces: What We Know So Far.* Canadian Journal of Behavioural Science. Vol. 37, No. 4, pp. 223-235.

KENYA VISION 2030 (2014) *Development and Implementation of a National Occupational Safety and Health Policy* [Online] Available From: http://www.vision2030.go.ke/index.php/pillars/project/Social/64 [Accessed: 10/3/14]

KIERATH, G.D. (1998) *Workplace Safety Campaign*. Minister for Labour Relations. Government of Western Australia Legislative Assembly, 23rd June 1998.

KNBS (2014) *Kenya Facts and Figures 2014.* Nairobi: Kenya National Bureau of Statistics.

KUMAR, K. (1989) *Conducting Key Informant Interviews in Developing Countries*. A.I.D Program Design and Evaluation Methodology Report No. 13. Agency for International Development.

KURIA, S.K., WANDERI, P.M., ONDIGI, A. (2012) *Hotel Employment in Kenya; Contingent Work or Professional Career?* International Journal of Academic Research in Business and Social Sciences. July 2012, Vol.2, No.7.

KYSILKA, D., CSABA, N. (2013) *Employee Turnover in the Hospitality Industry.* Economic Science Series. Vol. 19, pp. 378-384.

LAMMERDING, A.M., FAZIL, A. (2000) *Hazard Identification and Exposure Assessment for Microbial Food Safety Risk Assessment*. International Journal of Food Microbiology Vol. 58, No. 3, pp. 147-157.

LEHTINEN, S. (2009) *Planning the East African Regional Programme on Occupational Health and Safety*. African Newsletter on Occupational Health and Safety. Vol.19, No.2, pp.42-44.

LEMAN, A.M., HIDAYAH A, N. (2013) *Occupational Safety and Health: Workers and Industrial Safety Monitoring for Sustainable Work Environment Development* [Online] In: Health and Safety. Environmental Technology Online AET April/May 2013. Country? Available From: http://www.envirotech-online.com/articles/health-and-safety/10/a.m_leman_and_nor_hidayah_a/occupational_safety_and_health_workers_and_industrial_safety_monitoring_for_sustainable_work_environment_development/1414/ [Accessed: 9/9/14]

LO, K., LAMM, F. (2005) *Occupational Stress in the Hospitality Industry - an Employment Relations Perspective*. New Zealand Journal of Employment Relations, Vol. 30, No. 1, pp. 23-47.

LUND RESEARCH LTD (2013) *Kruskal Wallis H Test using SPSS Statistics* [Online] Laerd Statistics. Available From: https://statistics.laerd.com/spss-tutorials/kruskal-wallis-h-test-using-spss-statistics.php [Accessed: 24/11/14]

MAKHONGE, P.W. (2009) *Planning of Occupational Safety and Health Activities*. African Newsletter on Occupational Health and Safety. Vol.19, No.2, pp.27.

MARSHALL, G. (2004) *Raising Risk Management Competency*. 22nd Annual Conference of the Australian Institute of Occupational Hygienists, Fremantle, Australia.

MAYHEW, C., QUINLAN, M. (2002) *Fordism in the Fast Food Industry: Pervasive Management Control and Occupational Health and Safety Risks for Young Temporary Workers*. Sociology of Health & Illness. Vol. 24, No. 3, pp. 261-284.

MBAKAYA, C.F., ONYOYO, H.A., LWAKI, S.A., OMONDI, O.J. (1999) *A Survey on Management Perspectives of the State of Workplace Health and Safety Practices in Kenya*. Accident; Analysis and Prevention. Vol. 31, No. 4, pp. 305-312.

MENG, Y.C. (2002) *Risk Assessment and Management*. Ministry of Man Power. Singapore: Occupational Safety and Health Division.

MILLS (2012) *Setting up a Health and Safety System in your Small Business*. Landscaping and Growers. Closing the Loop. Ontario (CA): Workplace Safety and Prevention Services.

MOM (2006) *A Guide to the Workplace Safety and Health (Risk Management) Regulations.* Ministry of Man Power. Singapore: Occupational Safety and Health Division.

MUCHIRI, F.K (2005) *Do Occupational Health Services Really Exist in Kenya?* Challenges to Occupational Health Services in the Regions: the National and International response. WHO/ICOH/ILO Workshop. Helsinki, Finland.

MUIGUA, D.K. (2012) *Realising Occupational Safety and Health as a Fundamental Human Right in Kenya.* Mount Kenya University Law Journal, pp. 47-74.

MUTULI, D.A., ONYOYO, H.A., MAKHONGE, P.W. (2000) *Situation Analysis of Occupational Safety and Health in Small-Scale Sugarcane Processing Establishments in Kenya.* Proceedings of the Human Factors and Ergonomics Society Annual Meeting July 2000 vol. 44 no. 22. pp. 670-673.

NORMLEX (2014) *Ratifications of ILO Conventions: Ratifications for Kenya* [Online] International Labour Organization. Available From: http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:11200:0::NO::P11200_COUNTRY_ID:103315 [Accessed: 27/2/14]

NZUVE, S.N. (2013) *The Extent of Compliance with Occupational Safety and Health Regulations at Registered Workplaces in Nairobi*. Centre for Promoting Ideas USA. Nairobi: University of Nairobi.

OBEN, T.E.A. (2013) *Greening Construction of Mega Sports Venues and Facilities: The Case of the London 2012 Olympic Games*. MA Research Project. Department of Geography and Environmental Studies, University of Nairobi

ONDIEKI, J.M. (2013) *Assessment of the Adoption and Level of Implementation of Cleaner Production by Star Rated Hotels in Nairobi County, Kenya.* MA Research Project. Department of Geography and Environmental Studies, University of Nairobi.

O'NEILL, J.W., DAVIS, K. (2011) *Work Stress and Well-being in the Hotel Industry*. International Journal of Hospitality Management. Vol. 30, No. 2, pp. 385-390.

ONGERI, Z. (2002) *The Effects of Occupational Health and Safety Policies in Tea Factories in Kenya*. MA Research Project. Department of Sociology, University of Nairobi

ONTARIO MINISTRY OF LABOUR (1990) *Occupational Health and Safety Act*. Revised Statutes of Ontario, Chapter 0.1. Ontario: Queen's Printer for Ontario.

PUPLAMPU, B.B., QUARTEY, S.H. (2012) *Key Issues on Occupational Health and Safety Practices in Ghana: A Review.* International Journal of Business and Social Science. Vol.3, No. 19, pp. 151-156.

QUEENSLAND GOVERNMENT (2004) *Workplace Health and Safety Student Program. Hospitality and Tourism Industry.* Australia: Queensland Department of Industrial Relations

QUEENSLAND GOVERNMENT (2012) *Risk Assessment Template*. Australia: Department of Education, Training and Employment.

RANTANEN, J., LEHTINEN, S (2009) *Basic Occupational Health Services in East Africa*. GOHNET (Global Occupational Health Network) No.15-Spring 2009. Reports from the WHO Regions and from ILO.

RAZZI, K. (2013) *High Turnover in Hospitality* [Online] TNS Employee Insights. Available From: http://blog.tnsemployeeinsights.com/high-turnover-in-hospitality/ [Accessed: 12/8/14]

REASON, J., HOLLNAGEL, E., PARIES, J. (2006) *Revisiting the Swiss Cheese Model of Accidents*. Bretigny-sur-Orge: Eurocontrol Experimental Centre.

SANG, M.C. (2010) *A Description of Safety and Health Committees among Selected Industries in Nairobi.* MPH Thesis. College of Humanities and Social Sciences, University of Nairobi.

SAROVA HOTELS (2013) *Safety and Health Policy*. Sarova Group of Hotels, Kenya.

SAROVA HOTELS (2014) *Sarova Stanley* [Online] Available From: http://www.sarovahotels.com/stanley/ [Accessed: 9/12/14]

SAROVA HOTELS (2015) *Sarova Stanley Gallery* [Online] Available From: http://www.sarovahotels.com/stanley/gallery.aspx [Accessed: 20/8/15]

SHARE (2012) *History and Legislative Framework of Occupational Health and Safety in Canada* [Online] Shareholder Association for Research and Education. Available From: http://www.share.ca/files/12-7-17_History_of_OHS_in_Canada.pdf [Accessed: 2/7/14]

SHUTTLEWORTH, M. (2008) *Case Study Research Design* [Online] Explorable.com. Available From: https://explorable.com/case-study-research-design?gid=1582 [Accessed: 18/11/14]

SOY, S.K. (1997) *The Case Study as a Research Method* [Online] Unpublished paper, University of Texas at Austin. Available From: https://www.ischool.utexas.edu/~ssoy/usesusers/l391d1b.htm [Accessed: 18/11/14]

STOVER, J., GALLAGHER, A.J. (2008) *Safety and Security Self Inspection for Hotels*. American Hotel and Lodging Association (AHLA).

STRAHLENDORF, P. (2013) *A Theory of Incidents: You are Your Brother and Sister's Keeper*. Ontario: Workplace Safety North; A Health & Safety Ontario Partner.

SULLIVAN, M. (III) (2013) *Confidence Intervals for a Population Standard Deviation* [Online] In: Statistics: Informed Decisions Using Data. 4th Ed. Boston: Pearson Education Inc.

TAUBITZ, M. (2010) *How Safety Fits with Sustainability* [Online] Occupational Health and Safety Online: September 2010 Issue. Available From: http://ohsonline.com/Articles/2010/09/01/How-Safety-Fits-with-Sustainability.aspx [Accessed: 6/8/14]

THOMASON, T. (2005) *Economic Incentives and Workplace Safety*. In: Roberts, K., Burton, J.F., Bodah, M.M. (eds.) Workplace injuries and diseases: prevention and compensation: essays in honor of Terry Thomason. Michigan: W.E. Upjohn Institute for Employment Research.

UNCED (1992a) *Strengthening the Role of Workers and their Trade Unions.* In: Agenda 21. United Nations Conference on Environment and Development. Rio de Janeiro, 3-14 June 1992.

UNCED (1992b) *Rio Declaration on Environment and Development.* United Nations Conference on Environment and Development. Rio de Janeiro, 3-14 June 1992.

UNIVERSITY OF NAIROBI (2016) *Location of the Sarova Stanley Hotel in Nairobi, Kenya, East Africa*. Department of Geography and Environmental Studies, University of Nairobi

VAN VLIET, V. (2014) *Organizational Culture Model (Schein)* [Online] ToolsHero: Organizational Theories and Methods. Available From: http://www.toolshero.com/organizational-culture-model-schein/ [Accessed: 10/10/14]

VWA AU (2013a) *Risk Assessment for Stress*. Australia: Victorian WorkCover Authority

VWA AU (2013b) *Stress Questionnaire*. Australia: Victorian WorkCover Authority

VWA AU (2013c) *Workplace First Aid Checklist*. Australia: Victorian WorkCover Authority

VWA AU (2014a) *General Workplace Inspection Checklist*. Australia: Victorian WorkCover Authority

VWA AU (2014b) *Workplace Inspection Checklist: Hazard Identification-Office*. Australia: Victorian WorkCover Authority

WAZIR, A.W. (2013) *Challenges of Implementing Health and Safety Programmes in Kenya Airways (KQ)* [Online] MBA Research Project. School of Business, University of Nairobi.

WCB NS (2008) *Workplace Health and Safety Survey for Small Businesses*. Nova Scotia (CA): Workers Compensation Board

WHO (1946) *Constitution of the World Health Organization*. International Health Conference, New York, 19 June to 22 July 1946. World Health Organization.

WHO (1995) *The Workplace and Sustainable Development.* In: Global Strategy on Occupational Health for All: The Way to Health at Work. World Health Organization.

WHO (2004) *Occupational Health and Safety in the African Region: Situation Analysis and Perspectives.* Report of the Regional Director. Regional Committee for Africa, 54th Session, Brazzaville, Republic of Congo, 30 August-3 September 2004.

WHO (2007) *Workers' Health: Global Plan of Action 2008-2017*. 60th World Health Assembly, Geneva, 14-23 May 2007. World Health Organization.

WHO (2014) *WHO Collaborating Centres* [Online] World Health Organization. Available From: http://apps.who.int/whocc/Default.aspx [Accessed 15/9/14]

WORKCOVER CORPORATION (2000) *Managing Occupational Health and Safety in the Hospitality Industry; Small Businesses*. South Australia: Safer Industries

APPENDIX 1: **GENERAL OBSERVATION CHECKLIST**

	GENERAL OHS:				
PROVISIONS STATED IN OSHA 2007	**1. WORKSPACE; FLOORING AND STAIRWAYS**	**YES**	**NO**	**N/A**	**COMMENT**
Overcrowding (48 (1)): • An occupier shall ensure that his workplace shall not, while work is carried on, be so overcrowded as to cause risk of injury to the health of the persons employed therein.	a) Is there sufficient space for tasks to be carried out with ease?				
	b) Is there sufficient space for the equipment and the operator?				
	c) Is there sufficient space for walkways through an area?				
	d) Are there signs available to advise patrons and staff of slippery/uneven surfaces?				
Safe Means of Access and Safe Place of Employment (77 (1,5)): • All floors, steps, stairs, passages and gangways in a workplace shall be of sound construction and be properly maintained.	e) Are all signage and other items kept well clear of pedestrian paths?				
	f) Are all stairways, ramps, floors and passageways clean, in good repair, and free from trip hazards and obstructions (e.g. electrical leads/cables crossing walkways)?				
• For every staircase (...) a substantial handrail shall be provided.	g) Are oil and grease spills cleaned immediately?				
	h) Are floors kept dry?				
	i) Is matting or grating used where walking surfaces may be slippery?				
	j) Are all the stairway, ramp, floor and passageway lights functioning and in good repair?				
	k) Are all the stairway/ramps equipped with a sturdy hand rail?				
	l) Are the stairs/ramps firm and well maintained (not broken)?				
PROVISIONS STATED IN OSHA 2007	**2. VENTILATION AND LIGHTING**	**YES**	**NO**	**N/A**	**COMMENT**
Ventilation (49 (1)): • An occupier shall ensure that effective and suitable provision is made for securing and maintaining the circulation of fresh air in each workroom.	a) Is there sufficient fresh air in the work area? (I.e. no problems or complaints about stuffiness, odours or lack of fresh air?)				
	b) Is the work area at a comfortable temperature? (I.e. no problems or complaints about being too cold, hot or fluctuating?)				
	c) Are employees free from dry or irritated eyes?				
Lighting (50 (1)):	d) Is adequate natural lighting available?				
• An occupier shall ensure that effective	e) Is there sufficient lighting for performance of tasks?				

provision is made for securing and maintaining sufficient and suitable lighting, in every part of his workplace in which persons are working or passing.	f) Are passage ways well illuminated?				
	g) Are work surfaces free from lighting causing reflections or shadows over the task?				
	h) Are employees free from tired or sore eyes?				
PROVISIONS STATED IN OSHA 2007	**3. CLEANLINESS**	**YES**	**NO**	**N/A**	**COMMENT**
Cleanliness (47 (1a,b)): • Accumulations of dirt and refuse shall be removed daily by a suitable method from the floors and benches of workrooms, and from the staircases and passages. • The floor of every workroom shall be cleaned at least once in every week by washing or, if it is effective and suitable, by sweeping or by any other method. ***Drainage of Floors (51):*** • Effective means shall be provided and maintained for draining of floors liable to be wet.	a) Is the general work area cleaned regularly (floors, benches, tables)? How often and by whom?				
	b) Are the floors dried (not kept wet) after being cleaned?				
	c) Are workstations neat and tidy?				
	d) Are workstations free from dust and dirt?				
	e) Are there an adequate number of rubbish bins available in the work area?				
	f) Are the rubbish bins located in suitable points?				
	g) Are the rubbish bins emptied regularly? How often and by whom?				
PROVISIONS STATED IN OSHA 2007	**4. WELFARE FACILITIES**	**YES**	**NO**	**N/A**	**COMMENT**
Sanitary Conveniences (52 (1)): • Sufficient and suitable sanitary conveniences for the persons employed in the workplace shall be provided, maintained, and kept clean. ***Washing Facilities (92 (1)):*** • Every occupier shall provide and maintain for the use of persons employed, adequate and suitable facilities for washing, which shall be conveniently accessible and shall be kept in a clean and orderly condition. ***Accommodation for Clothing (93):*** • Every occupier shall provide and maintain for the use of persons	a) Are there suitable sanitary facilities (toilets) located in a convenient location to the work area?				
	b) Are there suitable washing facilities (showers) available for employees?				
	c) Is potable water for hand/eye washing available in the work area?				
	d) Is there a suitable and safe storage facility for employees' personal clothing to be kept while on duty?				
	e) Is there a lunchroom available for employees to use?				
	f) Is there an adequate supply of drinking water in the work area?				

employed, adequate and suitable accommodation for clothing not worn during working hours. ***Supply of Drinking Water (91 (1)):*** • Every occupier shall provide and maintain an adequate supply of wholesome drinking water at suitable points conveniently accessible to all persons employed. ***Facilities for Sitting (94):*** • Every occupier shall provide and maintain, for the use of a person employed whose work is done standing, suitable facilities for sitting, sufficient to enable the person employed to take advantage of any opportunities for resting which may occur in the course of his employment. ***Ergonomics at the workplace (76 (2)):*** • Every employer shall take necessary steps to ensure that workstations, equipment and work tasks are adapted to fit the employee and the employee's ability including protection against mental strain. ***First Aid (95):*** • Every occupier shall provide and maintain, so as to be readily accessible, a first-aid box or cupboard of the prescribed standard.					
	g) Is the drinking water located in a convenient area?				
	h) Are workstations and equipment set up to reduce awkward postures?				
	i) Are standing workstations suitable for a range of users with different heights?				
	j) Is there provision for sitting in the work area?				
	k) Is there a first aider available in the work area? If so, whom?				
	l) Are employees aware who the first aider on duty is?				
	m) Is there a list of first aiders displayed?				
	n) Are First-Aid kits clearly labelled?				
	o) Are First-Aid kits easily accessible?				
	p) When First-Aid equipment is used, is it recorded? By whom?				
	q) Are the First-Aid kits appropriately equipped and replenished? How often and by whom?				
PROVISIONS STATED IN OSHA 2007	**5. MECHANICAL/ELECTRICAL**	**YES**	**NO**	**N/A**	**COMMENT**
Machinery Safety (55,58 (1)): • All plant, machinery and equipment shall only be used for work which they are designed for and be operated by a competent person.	a) Are all machinery/electrical appliances in the work area cleaned regularly?				
	b) Are all electrical appliances in the work area inspected regularly? How often and by whom?				
	c) Are any dangerous parts of machinery adequately				

• Every dangerous part of any machinery shall be securely fenced.	guarded?				
	d) Are operators trained adequately in the use of the electrical appliances?				
	e) Are plugs, sockets or switches well maintained (not broken)?				
	f) Are wires/cables well maintained (not frayed or damaged)?				
	g) Are cables/wires kept in a neat and organized manner?				
	h) Are cables/wires kept away from damp areas?				
PROVISIONS STATED IN OSHA 2007	**6. FIRE SAFETY**	**YES**	**NO**	**N/A**	**COMMENT**
Safe Means of Access and Safe Place of Employment (77 (9)): • While any person is within a workplace (...) any doors which afford a means of exit for persons employed (...) shall not be locked or fastened in such manner that they cannot be easily and immediately opened from the inside. ***Safety Provisions in case of Fire (81 (1a,2,3))***: • In every workplace or workroom there shall be provided and maintained, and conspicuously displayed and free from any obstruction so as to be readily accessible, means for extinguishing fire. • Every workplace shall be provided with adequate means of escape, in case of fire, for the persons employed therein, having regard to the circumstances of each case. • All means of escape (...) shall be properly maintained and kept free from obstruction.	a) Are the fire exit doors self closing/latching and functioning correctly? Who checks the functioning and how often?				
	b) Are the fire exit corridors and doors clearly marked and kept clear at all times?				
	c) Are emergency fire safety procedures written and clearly posted in the work area?				
	d) Are employees aware of fire fighting/evacuation procedures?				
	e) Is emergency lighting working properly and checked regularly? How often and by whom?				
	f) Are fire alarm systems regularly tested? How often and by whom?				
	g) Is there a safe means of access and exit from all work areas?				
	h) Are smoke detection systems regularly inspected? How often and by whom?				
	i) Are fire extinguishers and other fire fighting equipment regularly inspected? How often and by whom?				
	j) Are fire extinguishers and other fire fighting equipment clearly marked and located in a suitable place?				
PROVISIONS STATED IN OSHA 2007	**7. HAZARDOUS SUBSTANCES**	**YES**	**NO**	**N/A**	**COMMENT**
Material Safety Data Sheets (MSDS) (84	a) Do all chemicals/hazardous substances contain legible				

(3)): • Every employer shall ensure the availability at the workplace of MSDS for all chemicals and other hazardous substances in use at the premises of the employer, containing detailed essential information regarding the identity, suppliers' classification of hazards, safety precautions and emergency procedures.	warning signs?				
	b) Are all users adequately trained in the use of the chemical/hazardous substance?				
	c) Are all chemical/hazardous substances stored in their appropriate containers?				
	d) Do all containers containing the chemical/hazardous substance have an appropriate and legible supplier or workplace label?				
	e) Are all MSDS readily available to employees for all chemical/hazardous substances?				
PROVISIONS STATED IN OSHA 2007	**8. PERSONAL PROTECTIVE EQUIPMENT (PPE)**	**YES**	**NO**	**N/A**	**COMMENT**
Protective Clothing and Appliances (101 (1)): • Every employer shall provide and maintain (...) for the use of employees (...)employed in any process involving exposure to wet or to any injurious or offensive substance, adequate, effective and suitable protective clothing and appliances, including, where necessary, suitable gloves, footwear, goggles and head coverings.	a) Is adequate protection worn or used where a person may be exposed to a hazard that may injure the skin; face; eyes or body?				
	b) Is adequate protection worn or used where a person may be exposed to a hazard that may affect their respiratory system?				
	c) Is appropriate footwear worn where there is a risk of foot injury?				

APPENDIX 2: **KITCHEN OBSERVATION CHECKLIST**

	KITCHEN OHS:				
PROVISIONS STATED IN OSHA 2007	**9. REFRIGERATION AND STORAGE**	**YES**	**NO**	**N/A**	**COMMENT**
Refrigeration Plant (71 (1a,b,3)): • Every refrigeration plant capable of being entered by an employee shall have all control valves situated outside the cold storage room; and have all doors of cold storage room capable of being opened easily and quickly from the inside and outside. • The occupier (...) shall cause an approved person to examine, test and	a) Are control valves situated outside cold storage rooms?				
	b) Can the doors of cold storage rooms be easily opened from the inside and outside?				
	c) Are entries into the cold storage rooms controlled? By whom?				
	d) Are the doors of cold storage rooms lockable?				
	e) Are the floors of cold storage rooms non-slippery?				
	f) Are items in the cold storage rooms stored in a neat and organized manner?				
	g) Is the storage of raw meat separated from other foods?				

certify at least once in every period of twelve months the entire (refrigeration) plant together with all its components and auxiliary parts. ***Storage (74 (1a))***: • All goods, articles and substances stored in a workplace shall be stored or stacked in such a manner as will ensure their stability and prevent any fall or collapse of the stack.	h) Are cooked and raw foods stored in different areas?				
	i) Are food items in cold storage rooms and other refrigerators properly covered and dated?				
	j) Are food items in general storage properly covered and dated?				
	k) Are stored food items regularly checked for "best by" or "use by" dates? How often and by whom?				
	l) Are chemicals stored away from food?				
	m) Are storage areas in a clean condition?				
	10. HYGIENE	**YES**	**NO**	**N/A**	**COMMENT**
	a) Are employees trained in personal hygiene? How often and by whom?				
	b) Are employees trained in food hygiene practices? How often and by whom?				
	c) Are employees subjected to health screening-inclusive of blood testing? How often and by whom?				
	d) Are employees wearing appropriate gloves (particularly in hand-to-plate service operations)?				
	e) Is the kitchen and storage area pest proofed?				
	f) Is the overhead area, including pipes and ducts, maintained free of grease and dirt?				
	g) Is there a program in place to clean the entire food preparation area on a regular basis? How often and by whom?				
	11. OTHERS	**YES**	**NO**	**N/A**	**COMMENT**
	a) Are employees trained for work involving hot oils and steam cooking?				
	b) Are all gas cylinders secured?				
	c) Are sharp tools stored safely?				
	d) Is there a sharps container for broken glass?				
	e) Is access to the kitchen controlled?				
	f) Is the cleaning store readily accessible and fully stocked (e.g. mop, broom, dust pan, "wet floor" signs etc.)				

APPENDIX 3: **FOOD AND BEVERAGE SERVICE OBSERVATION CHECKLIST**

	FOOD AND BEVERAGE (F&B) SERVICE AREA OHS:				
PROVISIONS STATED IN OSHA 2007	**12. BEVERAGE (BAR) AREA**	**YES**	**NO**	**N/A**	**COMMENT**
Storage (74 (1a)): • All goods, articles and substances stored in a workplace shall be stored or stacked in such a manner as will ensure their stability and prevent any fall or collapse of the stack.	a) Are alcoholic beverage servers and other servers trained in responsible alcohol service or equivalent programs? How often and by whom?				
	b) Is signage required by the liquor licensing body clearly displayed (e.g. sale of alcohol/cigarettes to minors)				
	c) Are highly pressurized containers secured (e.g. beer kegs)?				
	d) Are employees trained in the safe use of these containers?				
	e) Are employees trained in the safe use of coffee machines?				
	f) Is access to alcohol storage/refrigerators controlled? By whom?				
	g) Are alcohol storage/refrigerators lockable?				
	h) Are anti-slip mats available to employees behind the bar area?				
	i) Are bottle crates stacked in a stable manner?				
	13. DINING AREA	**YES**	**NO**	**N/A**	**COMMENT**
	a) Are smoking regulations being observed in the dining area?				
	b) Have cash handling procedures been communicated to the relevant employees?				
	c) Are all electrical leads, kettle cords, hot surfaces etc. away from pedestrian paths and out of reach of children?				
	d) Is all dining room furniture stable and regularly inspected (tables, chairs, high-chairs)?				
	e) Are employees aware of the proper handling of buffet chafing dishes including lighting them?				
	14. OTHERS	**YES**	**NO**	**N/A**	**COMMENT**
	a) Are employees trained in personal hygiene? How often and by whom?				
	b) Are employees trained in food hygiene practices? How often and by whom?				
	c) Are employees subjected to health screening-inclusive of blood testing? How often and by whom?				
	d) Are employees trained in safe manual handling practices? (e.g. for carrying trays, lifting heavy objects etc.) How often and by whom?				

	e) Is the F&B service area pest proofed?				
	f) Is there a program in place to clean the entire food service area on a regular basis? How often and by whom?				
	g) Are sharp tools stored safely?				
	h) Is there a sharps container for broken glass?				
	i) Is the cleaning store readily accessible and fully stocked (e.g. mop, broom, dust pan, "wet floor" signs etc.)				

APPENDIX 4: **HOUSEKEEPING OBSERVATION CHECKLIST**

	HOUSEKEEPING OHS:				
PROVISIONS STATED IN OSHA 2007	**15. LAUNDRY AREA**	**YES**	**NO**	**N/A**	**COMMENT**
Storage (74 (1a)): • All goods, articles and substances stored in a workplace shall be stored or stacked in such a manner as will ensure their stability and prevent any fall or collapse of the stack.	a) Is lint cleaned from behind the dryers, all pipes, ducts and overhead fixtures on a regular basis? How often and by whom?				
	b) Is a soiled linen holding room provided with adequate forced air exhaust ducted to the exterior?				
	c) Are strict clothing and linen handling procedures in place and followed by laundry personnel to avoid contamination?				
	d) Are rubber gloves and protective covering worn when handling and loading soiled linen?				
	e) Is clean linen transported in covered containers and stored in covered areas?				
	f) When stored, is clean linen stacked in a neat, organized and stable manner?				
	g) Is dirty linen separated from clean ones at all times?				
	h) Is soiled linen kept in a covered barrel at all times?				
	i) Are linen barrels lined with plastic bags which cover the inside surface at all times?				
	j) Are linen folding surfaces cleaned with a detergent germicide solution? How often?				
	k) Are all laundry appliances (washers/dryers, carts) cleaned daily with detergent germicide solutions?				
	16. CLEANING OPERATIONS AND OTHERS	**YES**	**NO**	**N/A**	**COMMENT**
	a) Are all housekeeping keys signed in/out by supervisors and				

	stored in a secure place?				
	b) Are lost and found items logged in daily and properly secured?				
	c) Are employees trained on safe lifting techniques? How often and by whom?				
	d) For room cleaning operations, are all mops, buckets and other cleaning equipment placed where no one can fall over them?				
	e) Are employees trained on the hazards of all cleaning solutions or chemicals? How often and by whom?				
	f) Are rubber gloves worn when using strong cleaning solutions?				
	g) Are employees trained on safe handling procedures for potential biologically contaminated objects (e.g. used condoms, sanitary pads etc.)?				
	h) Is all linen, rugs and spreads rolled up before putting them in soiled laundry bundles?				
	i) Are employees instructed not to run their hands along or inside objects unless they have checked first for razor blades, needles, broken glass etc.?				
	j) Are public toilets isolated for all wet cleaning operations?				

APPENDIX 5: **HEALTH CLUB OBSERVATION CHECKLIST**

	HEALTH CLUB OHS:				
	17. SWIMMING POOL	**YES**	**NO**	**N/A**	**COMMENT**
	a) Is there a pool barrier erected that restricts access to the pool?				
	b) Are pool drain covers in place, secure and in good condition?				
	c) Are the drain covers flat surfaced?				
	d) Is the pool pump room kept clean and neat?				
	e) Are swimming pool rules posted?				
	f) Are there life safety devices in place, highly visible, easily accessible and in good repair?				
	g) Is the pool supervised by trained life guards?				
	h) Is there a clear separation for shallow/deep areas?				
	i) Are depths marked in feet and metres?				

	j) Are pool chemical quality assurance checks made? How often and by whom?				
	k) Is the pool temperature tested? How often and by whom?				
	l) Are inspections of pool steps, ladders and railings performed? How often and by whom?				
	m) Is all food and drink services to poolside areas done so in break proof (non glass) receptacles?				
	18. FITNESS CENTRE	**YES**	**NO**	**N/A**	**COMMENT**
	a) Are periodic inspections of fitness centre equipment undertaken? How often and by whom?				
	b) Are rules posted for fitness centre equipment use?				
	c) Are instructions posted for the use of specific equipment?				
	d) Do they contain medical advisories?				
	e) Are minimum age restrictions posted?				
	f) Is the fitness area and guests using equipment supervised at all times?				
	g) Are the steam and sauna (spa) equipped with emergency shut off switch?				
	h) Is the spa equipped with a timer (15mins maximum), and temperature controls?				
	i) Is the floor of the spa textured in order to prevent slips?				
	j) Is the spa clean and neat?				
	k) Is the spa regularly inspected? How often and by whom?				
	l) Are rules posted for the use of the spa?				
	m) Is a maximum time limit for use established and posted?				
	19. OTHERS	**YES**	**NO**	**N/A**	**COMMENT**
	a) Are chemicals appropriately and safely stored and is appropriate PPE provided (e.g. safety goggles)?				
	b) Is an emergency phone in place, clearly marked, and in working order?				

APPENDIX 6: **FRONT OFFICE OBSERVATION CHECKLIST**

	FRONT OFFICE OHS:				
	20. RECEPTION	**YES**	**NO**	**N/A**	**COMMENT**
	a) Have cash handling procedures been communicated to the relevant employees?				
	b) Are duress alarms fitted at the Reception (particularly at cash handling points)?				
	c) In case of a security threat, are employees trained on the emergency procedure to follow (e.g. for armed hold up, bomb threat etc.)?				
	d) Are Reception employees careful to not say guest names or guest room numbers out loud?				
	e) Are telephone operators trained in guest room privacy issues?				
	f) For Visual Display Units, is there adjustability of the screen height?				
	g) Are the keys on the keyboard comfortable to press (not too hard or too light)?				
PROVISIONS STATED IN OSHA 2007	**21. CONCIERGE**	**YES**	**NO**	**N/A**	**COMMENT**
Storage (74 (1a)): • All goods, articles and substances stored in a workplace shall be stored or stacked in such a manner as will ensure their stability and prevent any fall or collapse of the stack.	a) Are lobby doors being kept free of obstructions, such as trolleys and luggage?				
	b) Is there a policy in place related to unattended or abandoned luggage?				
	c) Is there a secure storage area for left luggage?				
	d) Is there a receipt system for the storage of luggage?				
	e) Is the luggage stored in an organized and stable manner?				
	f) Are security checks on stored luggage undertaken (e.g. explosives trace tests)?				
	g) Are employees trained on safe lifting techniques? How often and by whom?				

APPENDIX 7: **OHS EMPLOYEE SURVEY (QUESTIONNAIRE)**

Dear Participant, you have been randomly selected to partake in this survey on Occupational Health and Safety (OHS). Thank you for taking the time to fill out this questionnaire. Please note this survey is for academic purposes and all participants will remain anonymous. Kindly answer all questions.

1. Please circle the department you work in (Please circle one only):

Kitchen Food & Beverage Service Housekeeping Health Club Front Office

PART 1: HAZARDS

Please CIRCLE (O) the frequency of the hazards that occur in your specific department.
(**N**=Never; **R**=Rarely; **O**=Occasionally; **F**=Frequently; **VF**=Very Frequently. Where **N** *means* no occurrences of the hazard stated and **VF** *means* the hazard stated occurs almost all of the time).

2. PHYSICAL HAZARDS:

a.	There is loud noise in my work area	**N**	**R**	**O**	**F**	**VF**
b.	There are extreme temperatures in my work area (hot/cold)	**N**	**R**	**O**	**F**	**VF**
c.	My job requires me to use ladders	**N**	**R**	**O**	**F**	**VF**
d.	There are slippery surfaces in my work area (e.g. smooth; wet)	**N**	**R**	**O**	**F**	**VF**
e.	There are steep ramps/steps in my work area	**N**	**R**	**O**	**F**	**VF**
f.	Floor surface is worn out in my work area (e.g. carpeting; tiles)	**N**	**R**	**O**	**F**	**VF**
g.	My work area is untidy and cluttered	**N**	**R**	**O**	**F**	**VF**

3. CHEMICAL HAZARDS:

a.	My job requires me to use cleaning agents	**N**	**R**	**O**	**F**	**VF**
b.	My job requires me to use chemicals/solvents	**N**	**R**	**O**	**F**	**VF**
c.	My job requires me to use pesticides	**N**	**R**	**O**	**F**	**VF**
d.	My job exposes me to fumes (e.g. smoke; gaseous fumes; tobacco smoke)	**N**	**R**	**O**	**F**	**VF**

4. BIOLOGICAL HAZARDS:

a.	My job exposes me to bodily fluids	**N**	**R**	**O**	**F**	**VF**
b.	My job exposes me to food or water borne pathogens	**N**	**R**	**O**	**F**	**VF**
c.	My work area is dirty	**N**	**R**	**O**	**F**	**VF**
d.	There is mould in my work area	**N**	**R**	**O**	**F**	**VF**
e.	There are pests in my work area (e.g. insects; rodents)	**N**	**R**	**O**	**F**	**VF**

5. MECHANICAL/ELECTRICAL HAZARDS:

a.	Loose power points/switches in my work area	**N**	**R**	**O**	**F**	**VF**
b.	Cluttered cords/wires in my work area	**N**	**R**	**O**	**F**	**VF**
c.	Cords/wires are exposed to wet areas	**N**	**R**	**O**	**F**	**VF**
d.	Machinery/Equipment in poor condition	**N**	**R**	**O**	**F**	**VF**
e.	No guardrails around dangerous machinery (e.g. machinery with blades)	**N**	**R**	**O**	**F**	**VF**

6. ERGONOMIC HAZARDS:

a.	I handle large/awkward/heavy objects in my job	**N**	**R**	**O**	**F**	**VF**
b.	Lack of lighting in my work area	**N**	**R**	**O**	**F**	**VF**
c.	Lack of space in my work area	**N**	**R**	**O**	**F**	**VF**
d.	Lack of fresh air in my work area	**N**	**R**	**O**	**F**	**VF**
e.	My job requires me to be on my feet (no sitting)	**N**	**R**	**O**	**F**	**VF**

7. PSYCHOSOCIAL HAZARDS:

a.	My job tasks are unfulfilling (boring)	**N**	**R**	**O**	**F**	**VF**
b.	Unclear requirements of my job tasks	**N**	**R**	**O**	**F**	**VF**
c.	I have no control over how to perform my duties	**N**	**R**	**O**	**F**	**VF**
d.	I am given excessive workloads	**N**	**R**	**O**	**F**	**VF**
e.	No information/training provided to perform my job well	**N**	**R**	**O**	**F**	**VF**
f.	No feedback on my job performance	**N**	**R**	**O**	**F**	**VF**
g.	Lack of acknowledgement or recognition from superiors	**N**	**R**	**O**	**F**	**VF**
h.	Lack of support from superiors	**N**	**R**	**O**	**F**	**VF**
i.	Lack of guidance from superiors	**N**	**R**	**O**	**F**	**VF**
j.	I do not participate in decision making	**N**	**R**	**O**	**F**	**VF**
k.	I am not given the opportunity to express my views or opinions	**N**	**R**	**O**	**F**	**VF**
l.	I have job insecurity (I can easily be transferred or fired)	**N**	**R**	**O**	**F**	**VF**
m.	I am not given enough time to complete my job task	**N**	**R**	**O**	**F**	**VF**
n.	I work overtime	**N**	**R**	**O**	**F**	**VF**
o.	I work unsocial hours	**N**	**R**	**O**	**F**	**VF**
p.	I have no rest breaks during my shift	**N**	**R**	**O**	**F**	**VF**
q.	I have no control over my days off/leave time	**N**	**R**	**O**	**F**	**VF**
r.	My job exposes me to criminals	**N**	**R**	**O**	**F**	**VF**
s.	I experience conflict with my superiors	**N**	**R**	**O**	**F**	**VF**
t.	I experience conflict with my co-workers	**N**	**R**	**O**	**F**	**VF**
u.	I experience conflict with clients	**N**	**R**	**O**	**F**	**VF**

v.	I experience sexual harassment at work	**N**	**R**	**O**	**F**	**VF**
w.	I experience verbal bullying at work	**N**	**R**	**O**	**F**	**VF**
x.	I experience physical bullying at work	**N**	**R**	**O**	**F**	**VF**
y.	I experience racial discrimination at work	**N**	**R**	**O**	**F**	**VF**
z.	I experience health discrimination at work (e.g. HIV status; disabilities)	**N**	**R**	**O**	**F**	**VF**

PART 2: RISKS

Please CIRCLE (O) the frequency of the risks that occur in your specific department.
(**N**=Never; **R**=Rarely; **O**=Occasionally; **F**=Frequently; **VF**=Very Frequently. Where **N** *means* no occurrences of the risk stated and **VF** *means* the risk stated occurs almost all of the time).

8. PHYSICAL WELLBEING:

a. Mild:

i.	Mild burns	**N**	**R**	**O**	**F**	**VF**
ii.	Mild cuts	**N**	**R**	**O**	**F**	**VF**
iii.	Bruises	**N**	**R**	**O**	**F**	**VF**
iv.	Muscular strains/sprains	**N**	**R**	**O**	**F**	**VF**
v.	Dizziness	**N**	**R**	**O**	**F**	**VF**
vi.	Slips/trips	**N**	**R**	**O**	**F**	**VF**

b. Moderate:

i.	Difficulty hearing	**N**	**R**	**O**	**F**	**VF**
ii.	Fractured bones	**N**	**R**	**O**	**F**	**VF**
iii.	Fainting	**N**	**R**	**O**	**F**	**VF**
iv.	Breathing problems	**N**	**R**	**O**	**F**	**VF**
v.	Skin dermatitis	**N**	**R**	**O**	**F**	**VF**
vi.	Infections	**N**	**R**	**O**	**F**	**VF**
vii.	Neck/back injury	**N**	**R**	**O**	**F**	**VF**
viii.	Falls	**N**	**R**	**O**	**F**	**VF**

c. Major:

i.	Major burns	**N**	**R**	**O**	**F**	**VF**
ii.	Major lacerations	**N**	**R**	**O**	**F**	**VF**
iii.	Major falls	**N**	**R**	**O**	**F**	**VF**
iv.	Muscular/skeletal disorders	**N**	**R**	**O**	**F**	**VF**
v.	Electric shock	**N**	**R**	**O**	**F**	**VF**
vi.	Broken bones	**N**	**R**	**O**	**F**	**VF**
vii.	Amputated limbs	**N**	**R**	**O**	**F**	**VF**
viii.	Death	**N**	**R**	**O**	**F**	**VF**

9. MENTAL WELLBEING:

a. Mild:

i.	Headaches	**N**	**R**	**O**	**F**	**VF**
ii.	Indigestion	**N**	**R**	**O**	**F**	**VF**
iii.	Restless sleep	**N**	**R**	**O**	**F**	**VF**
iv.	I drink alcohol	**N**	**R**	**O**	**F**	**VF**
v.	I smoke cigarettes	**N**	**R**	**O**	**F**	**VF**
vi.	I rely on caffeine (e.g. tea; coffee; energy drinks)	**N**	**R**	**O**	**F**	**VF**

b. Moderate:

i.	I am not able to meet my personal needs	**N**	**R**	**O**	**F**	**VF**
ii.	I am not able to meet my family and social obligations	**N**	**R**	**O**	**F**	**VF**
iii.	I rely on medication (e.g. painkillers; antacids; anti anxiety pills)	**N**	**R**	**O**	**F**	**VF**
iv.	Fatigue	**N**	**R**	**O**	**F**	**VF**
v.	I lack confidence	**N**	**R**	**O**	**F**	**VF**
vi.	I feel emotionless in my job (I don't care)	**N**	**R**	**O**	**F**	**VF**
vii.	I feel disoriented (unable to concentrate)	**N**	**R**	**O**	**F**	**VF**
viii.	I feel angry	**N**	**R**	**O**	**F**	**VF**
ix.	I over eat	**N**	**R**	**O**	**F**	**VF**
x.	I under eat	**N**	**R**	**O**	**F**	**VF**

c. Major:

i.	I use recreational drugs (e.g. marijuana; *khat*; cocaine)	**N**	**R**	**O**	**F**	**VF**
ii.	I have high blood pressure	**N**	**R**	**O**	**F**	**VF**
iii.	I have insomnia	**N**	**R**	**O**	**F**	**VF**
iv.	I have violent tendencies	**N**	**R**	**O**	**F**	**VF**
v.	I feel depressed	**N**	**R**	**O**	**F**	**VF**
vi.	I have suicidal thoughts	**N**	**R**	**O**	**F**	**VF**

PART 3: OCCUPATIONAL SAFETY & HEALTH MANAGEMENT SYSTEM (OSHMS)

10. In your department, have you encountered any accidents/incidences in relation to the hazards previously stated? If so, please use the list provided in Part 1: Hazards to state which one.

_____

11. Please use the list of Risks provided in Part 2: Risks to state what risk occurred in relation to the above accident/incidence.

_____

12. Briefly describe how the accident/incidence occurred.

_____
_____
_____
_____
_____
_____

13. How was the accident/incidence managed? (**please tick one**):

a. The employee returned to his current job in full health

b. The employee returned to work but was given a different job role

c. The employee did not return to work

d. Other (Please Specify):

_____

14. In case of a fire in the hotel, are you aware of the emergency procedure to follow?

☐ YES ☐ NO

15. In case of a security threat to the hotel (e.g. bomb threat) are you aware of the emergency procedure to follow?

☐ YES ☐ NO

16. In case a co-worker suffers an injury/illness while working, are you aware of the emergency procedure to follow?

☐ YES ☐ NO

17. In the list below of Risk Controls, please tick as many as appropriate that you prefer to be implemented in the hotel.

- ☐ Health and Safety Trainings
- ☐ Conflict Resolution Trainings
- ☐ Bullying/Harassment Trainings
- ☐ Stress Management Trainings
- ☐ Emergency Procedure Trainings
- ☐ Slip resistant flooring
- ☐ Improved ventilation in your work area
- ☐ Noise buffers on noisy equipment
- ☐ Preventive maintenance on machinery/equipment
- ☐ Increased cleaning schedules for work areas
- ☐ More flexibility over choice of shift schedules/time off
- ☐ Emergency/Safety Procedures to be posted in each work area
- ☐ Sanitizers available in work areas
- ☐ Safety signs
- ☐ Protective clothing (e.g. gloves; footwear; goggles)
- ☐ First Aid Equipment

-----End-----

APPENDIX 8: **KEY INFORMANT INTERVIEW QUESTIONS on the HOTEL'S OSHMS:**

I. SAFETY AND HEALTH POLICY STATEMENT

Section 7 of OSHA (2007) requires the Occupier to prepare and regularly revise a written statement of the organizations safety and health policy; including the arrangements in force for carrying out that policy; and to bring the statement and any revision of it to the notice of all employees.

1. **Does the hotel have a written policy statement reflecting the organization's commitment to safety and health/risk control?** *(ask for copy)*
2. **Is the policy readily available to employees? Is it included in manuals, employee handbook, notice boards etc.?**
3. **Is the Safety and Health Policy regularly reviewed to ensure it is working?**
4. **How often is the Safety and Health Policy reviewed?**
5. **Who conducts the review of the Policy?**
6. **How is the review conducted? (E.g. does it involve reviewing accident/incident data and details; alarm activation reports; insurance premiums; risk assessment reports etc.?)**
7. **Are reviews of the Policy brought to the attention of employees? (if yes) How (e.g. through seminars, notice boards etc.)?**

II. SAFETY AND HEALTH COMMITTEE

Section 9 of OSHA (2007) and The Factories and Other Places of Work (Safety and Health Committees) Rules (2004) require Occupiers to establish a Safety and Health Committee where there are 20 or more persons employed at a work place.

8. **Is there a Safety and Health Committee established for the hotel?**
9. **(if yes) Are there representatives (managerial and non-managerial employees) from different departments assigned to the Safety and Health Committee? What are the details of the Committee Members (Names and Job titles; the Chairman of the Committee, Secretary to the Committee and the Safety Representatives)?**

Section 6 of The Factories and Other Places of Work (Safety and Health Committees) Rules (2004) lists the functions and duties of the Safety and Health Committee; such as, conducting safety and health inspections every 3 months; inspecting, investigating, making recommendations, and compiling statistics of any accidents or incidents that take place; and conducting workers' education programmes on safety, health and welfare at the workplace.

10. **Do the Committee members understand and confidently perform their roles and duties as Safety and Health Representatives? What are some of their duties?**

Section 7 of The Factories and Other Places of Work (Safety and Health Committees) Rules (2004) requires the Safety and Health Committee to have their meetings at least 4 times a year, and to save minutes of these meetings.

11. **How often a year does the Safety and Health Committee hold their meetings?**

12. **Are copies of the minutes of these meetings available to the other employees?** *(ask for copies of the minutes of the last two meetings)*

13. **Are records (such as all health and safety trainings, inspection reports, audit reports, safe work procedures) and statistics (number and nature of incidents, injuries, first-aid, medical care etc.) maintained and reviewed?**

14. **Who has the responsibility of maintaining and reviewing these records and statistics?**

III. RISK ASSESSMENTS

Section 6 of OSHA (2007) requires the Occupier to carry out appropriate risk assessments of the workplace, and on the basis of those results, adopt preventative and protective measures to ensure the safety and health of persons employed.

15. **Does the hotel carry out occupational health and safety risk assessments?**

16. **How often are these risk assessments conducted?**

17. **Who conducts the risk assessments (are they conducted by internal officers or is it out-sourced)?**

18. **Are recommendations made in the assessments successfully implemented at the hotel to ensure employee health and safety? Any examples of successful preventative and protective measures taken at the hotel?**

IV. SAFETY AND HEALTH AUDITS

Section 11 of OSHA (2007) requires a Safety and Health Audit to be carried out at the workplace at least once a year by a professional safety and health advisor (e.g. an occupational safety and health officer from the Director of Occupational Safety and Health Services (DOSHS)).

19. **Has an Occupational Health and Safety Officer from the DOSHS ever conducted a safety and health audit at the hotel? (If yes) How often has this audit been conducted?**

20. **Are the audit reports available to employees?**

21. **What other duties has the DOSHS Occupational Health and Safety Officer performed at the hotel?**

V. EMERGENCY PLANNING AND PREPAREDNESS

22. **Is there a written Emergency Plan that includes procedures for e.g. bomb or terrorist threat; death/suicide; elevator failure; medical emergencies; power failure; or robbery?**

23. **Are the plans/procedures easily accessible or noticeable to employees?**

24. **Who is responsible for maintaining or updating the plan?**

25. **Are there adequately and appropriately trained first aid personnel amongst all Front of House and Back of House employees?**

26. **Are fire systems (e.g. extinguishers, hoses, alarms etc.) tested and inspected regularly? By whom?**

27. **Are fire drills conducted on a regular basis? How often?**

VI. ACCIDENT/INCIDENT MANAGEMENT

28. **Does the organization have a formal system for the reporting, recording and investigation of incidents, injuries and illnesses?**

29. **Who is responsible for maintaining these reports and records?**

30. **Are these reports regularly reviewed to identify e.g. trends of injuries/illnesses? (if yes) who reviews them?**

31. **Does the organization have an injury management or rehabilitation policy/program for employees who suffer work related injury or illnesses?**

32. **Finally, in your opinion, is Occupational Health and Safety a vital component in a city hotel work setting?**

---- End ----

APPENDIX 9: **KEY INFORMANT INTERVIEW QUESTIONS (GUIDE):**

(HOTEL NURSE)

In your experience, what type of injuries and illnesses are the employees in the following departments likely to face? And in your opinion, what type of measures can be taken to help prevent these types of injuries or illnesses from occurring?

1. **Kitchen Department:**
   a. Injuries:

   b. Illnesses:

   c. Precautionary measures:

2. **Food and Beverage Service Department:**
   a. Injuries:

   b. Illnesses:

   c. Precautionary measures:

3. **Housekeeping Department:**
   a. Injuries:

   b. Illnesses:

   c. Precautionary measures:

4. **Health Club:**
   a. Injuries:

   b. Illnesses:

   c. Precautionary measures:

5. **Front Office:**
   a. Injuries:

   b. Illnesses:

   c. Precautionary measures:

---- End ----

APPENDIX 10: **Accident/Incidences Descriptions**

The following table describes briefly some of the major incidences that have occurred from 2011-2015 at the Sarova Stanley Hotel:

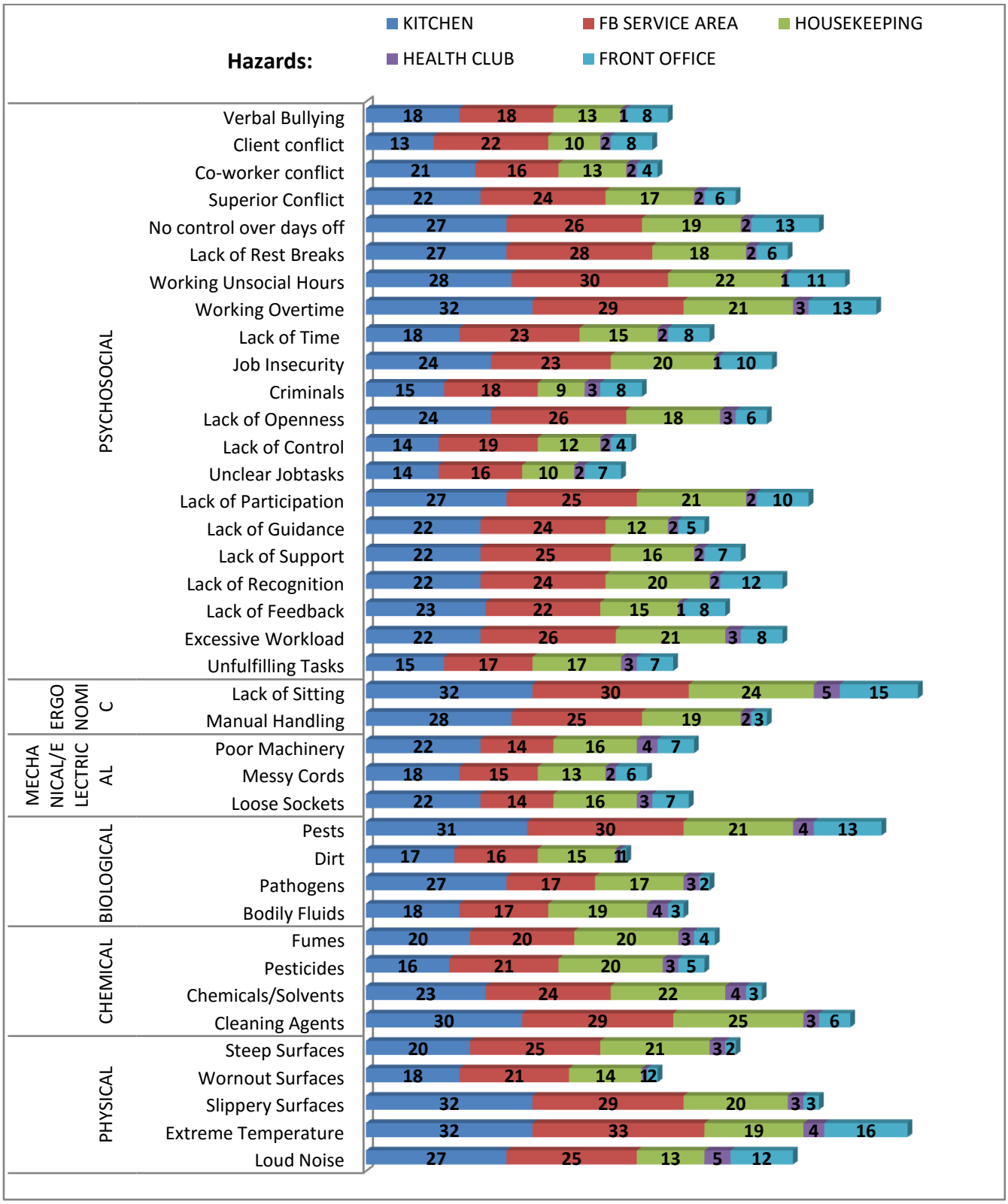
YEAR, TYPE AND AREA OF INCIDENT	DESCRIPTION OF INCIDENT	HOW INCIDENT WAS MANAGED
2011; Fingers Amputation; Laundry Area (Housekeeping)	A laundry attendant accidentally put his hand right into the hot calendar ironer machine while using it, causing his hand to get severely burnt and his fingers amputated.	Employee spent more than a week in hospital and underwent several treatments. Apart from medical bills being catered for, the hotel's insurance as well paid compensation to him. He eventually returned to work and was given a different job role (still in housekeeping but more administration work).
2012; Threatening text messages; Thorn Tree Restaurant	Two Thorn Tree Restaurant supervisors were receiving life threatening SMS's from anonymous numbers but messages were signed off as 'From Thorn Tree guys'.	Hotel security eventually tracked down the sender of the messages who was a waitress in the restaurant. She confessed and was eventually fired from the hotel.
2013; Dislocated Knee; Banqueting Store Room	A maintenance trainee was attempting to fix an ice maker machine when he slipped on the wet floor and dislocated his knee.	First aid was administered on the trainee and he was taken to hospital and medical bills catered for by hotel. It was concluded that he should have been wearing proper non-slip safety boots and the floor was wet (there was no caution sign put out).
2013; Death; Health Club	Guest collapsed unconscious while climbing stairs from the changing rooms back up to the Health Club reception.	Hotel doctor was called in and he pronounced the guest had passed away. Matter was escalated to the police and the British High Commission (guest was a British citizen). Coroner reports concluded he died from a heart attack. It was found he was using the fitness and steam/sauna rooms and should not have been.
2013; Slip/Fall; Staff Entrance	A Steward slipped and fell on the wet floor at the loading zone of the staff entrance (as it was just cleaned). He fell over the bollard parking post which hit him in the abdomen.	He was immediately administered first aid and was taken to the hospital. Medical bills catered for by hotel insurance. No major injuries were reported and the steward eventually returned to work.
2014; Road Accident; Main Roads	A hotel driver was returning to the hotel when a bus drove across the pavement and hit the hotel car head on. Driver was trapped within the car and hacksaw and other	Hotel security rushed to the scene and driver was rescued and taken with an ambulance to the hospital. Driver spent night in hospital, he was in shock but no major physical

	equipment had to be used to remove him from the wreckage.	injuries were noted. Approximately 3-4 days sick off given. Medical bills catered for by the hotel insurance.
2014; Major Laceration; Thorn Tree Restaurant	When a steward was cleaning the sugarcane juicing machine after breakfast service his right hand fingers got stuck in the grinder. Maintenance team had to open the machine to free his fingers.	It was found that it was an act of negligence as the machine was still running while the steward was trying to clean it-it was not his first time cleaning the machine. He was administered first aid by the clinical officer and rushed to hospital. His fingers were crushed and flesh had been stripped off. Fingers fixed by doctor. Staff eventually returned to his job in full health after approximately a week in hospital. Treatment costs taken care of by the hotel insurance and WIBA.
2014; Slip/Fall; First Floor Staircase	An Exchange Bar supervisor missed a step when walking down to the lobby & slipped down the staircase. He felt pain and swelling of his ankle and was given first aid and rushed to hospital. The doctor reported ligament injury but no fracture/dislocation of his foot. Staff eventually returned to his job in full health.	Housekeeping informed to check on any possible spillage on the staircase that might have caused the slip but nothing was found. Medical bills taken care of by hotel insurance. Maintenance team asked to consider putting 'mind the stairs' sign on staircase. At the time of research no sign was put as yet.

Source: Field Data (2015)

APPENDIX 11: **Common Hazards amongst the Front of House Departments**

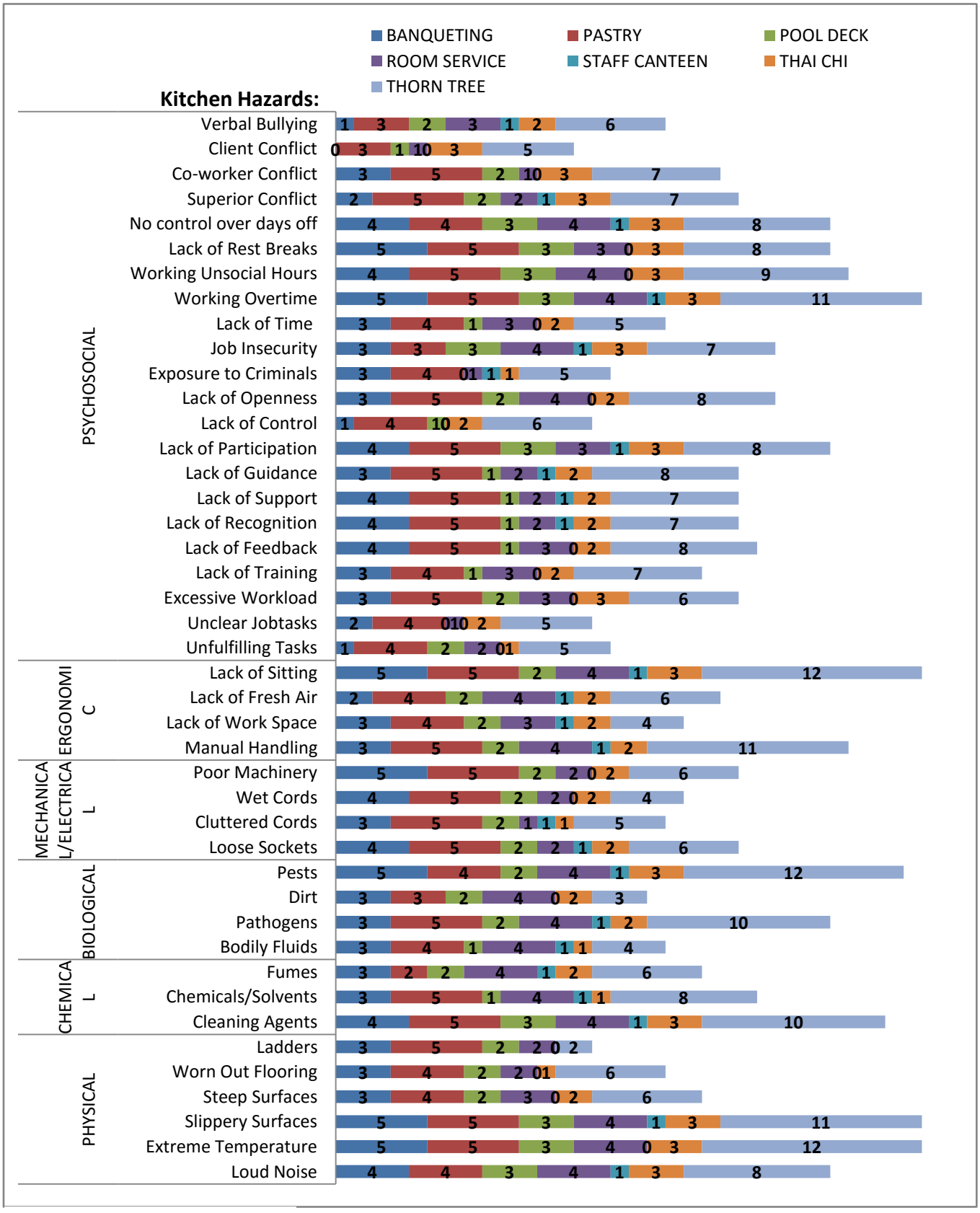
The following bar chart shows the occurrences of common hazards amongst the 5 Front of House Departments according to the employee survey. The figures represent the total number of participants per department that responded the stated hazard occurs.



Source: Field Data (2015)

APPENDIX 12: **Kitchen Hazards**

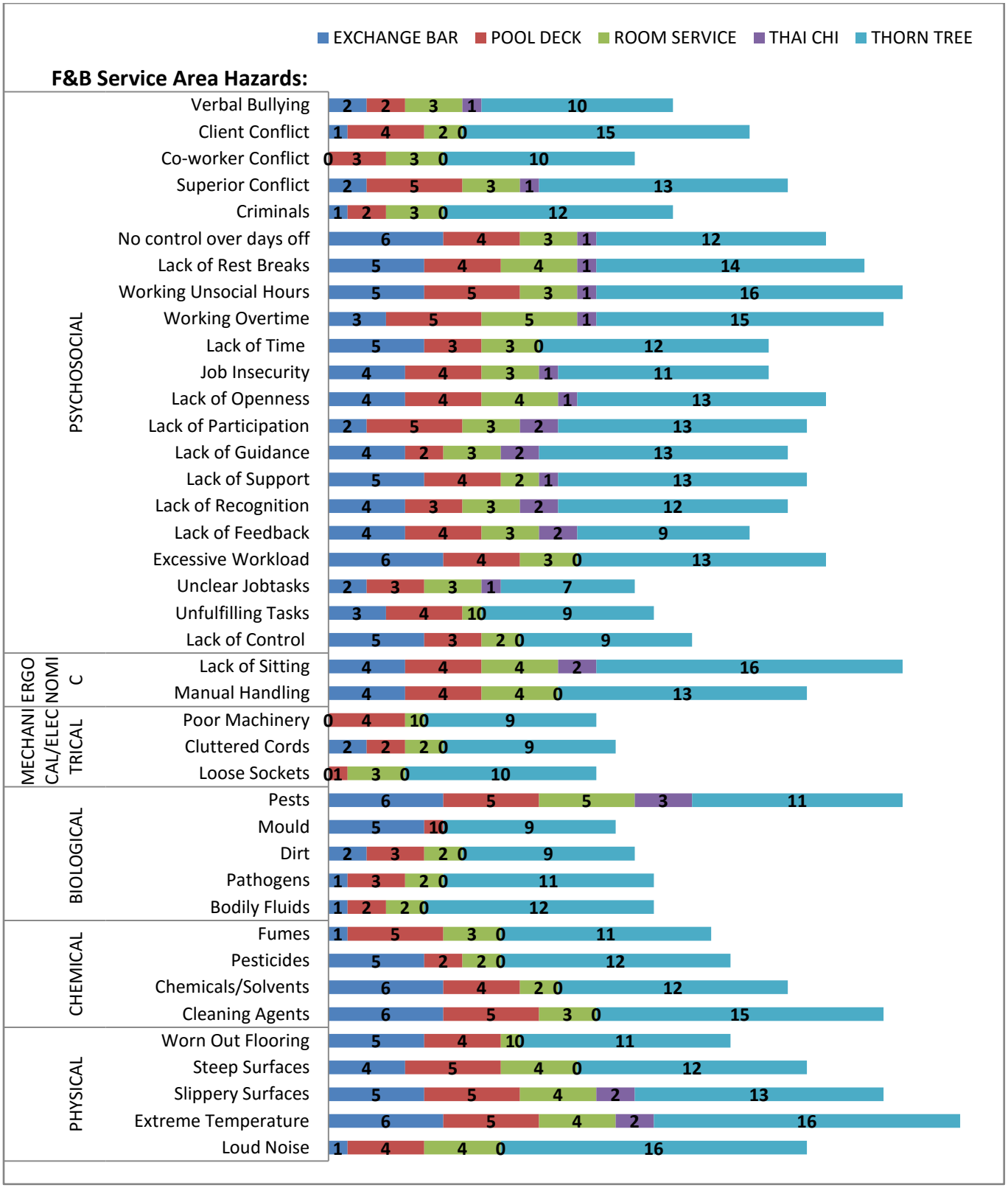
The following bar chart breaks down the occurrences of hazards in the Kitchen Department as per the employee survey. The figures represent the total number of participants that work in the various kitchen areas that responded the stated hazard occurs.



Source: Field Data (2015)

APPENDIX 13: **Food & Beverage Service Hazards**

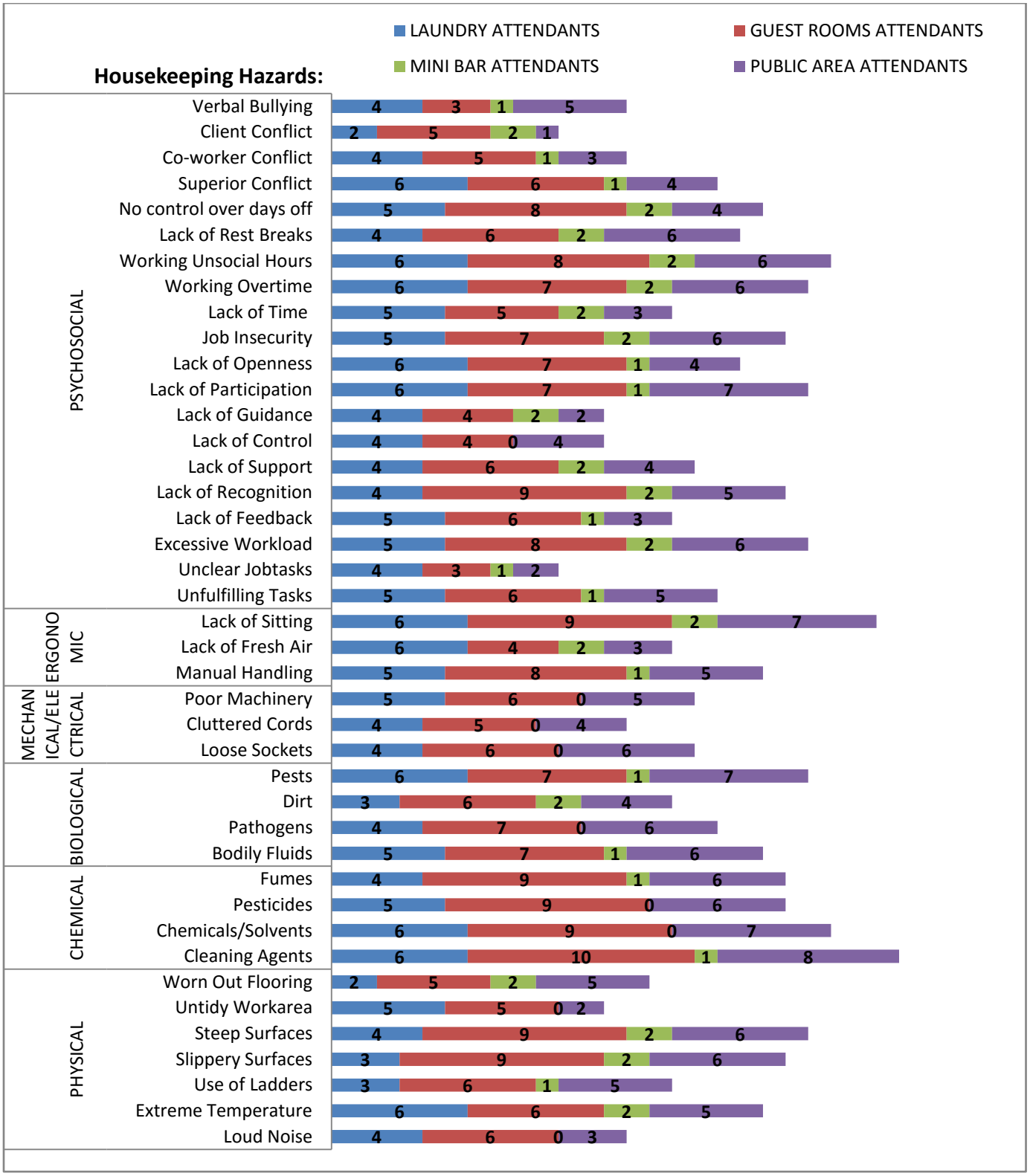
The following bar chart breaks down the occurrences of hazards in the F&B Service Department as per the employee survey. The figures represent the total number of participants that work in the various F&B service areas that responded the stated hazard occurs.



Source: Field Data (2015)

APPENDIX 14: **Housekeeping Hazards**

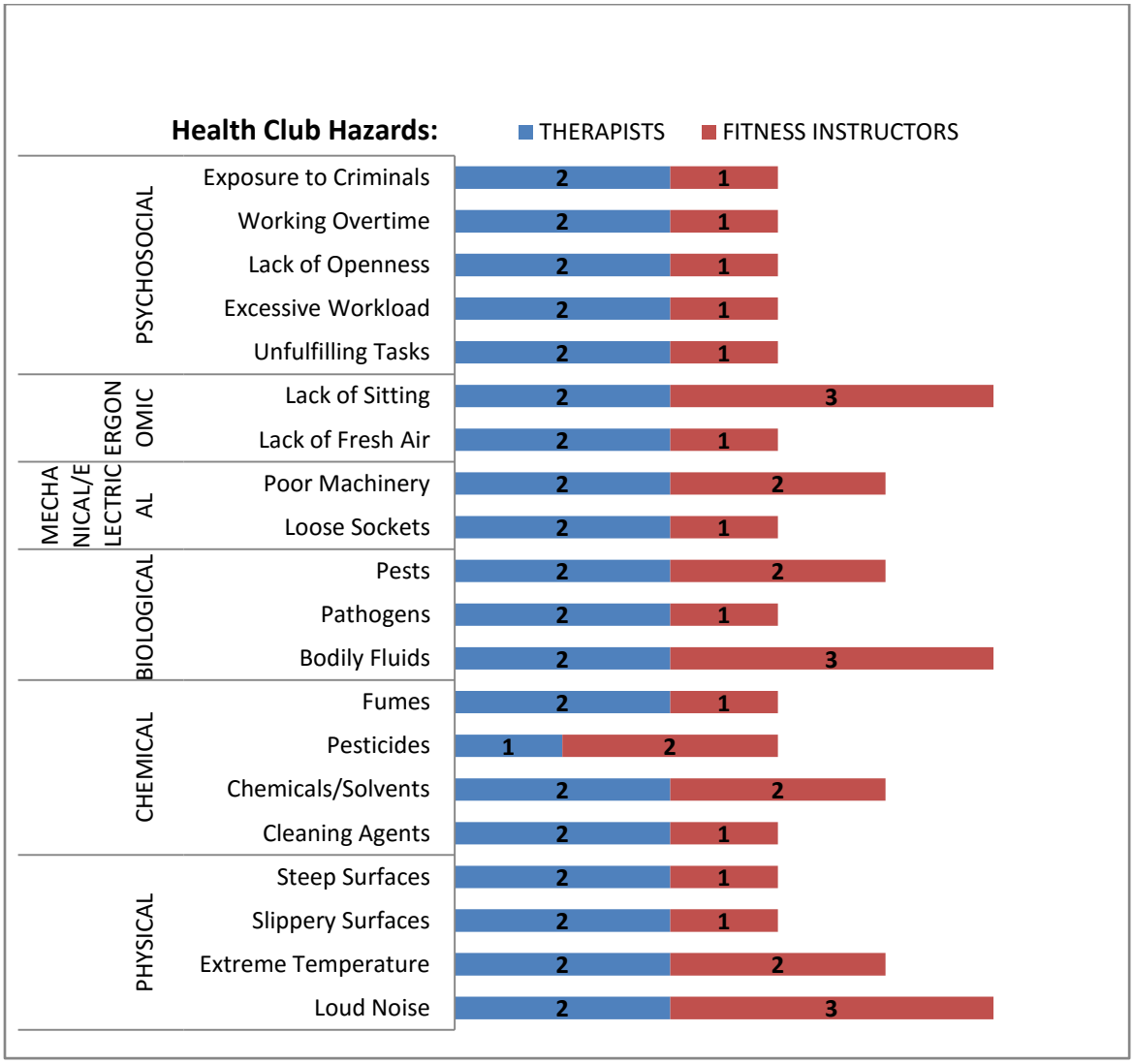
The following bar chart breaks down the occurrences of hazards in the Housekeeping Department as per the employee survey. The figures represent the total number of participants that work in the various Housekeeping areas that responded the stated hazard occurs.



Source: Field Data (2015)

APPENDIX 15: **Health Club Hazards**

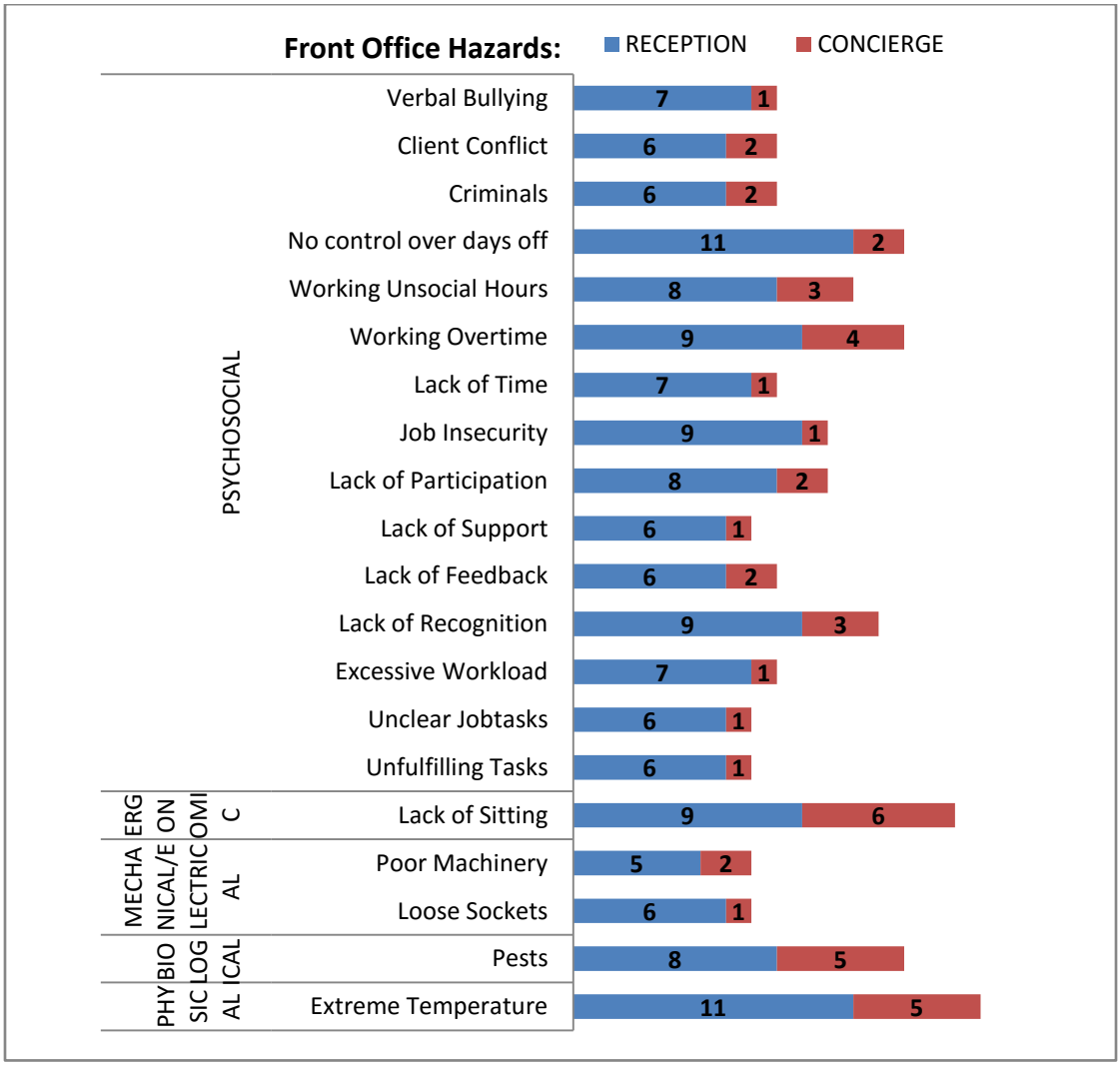
The following bar chart breaks down the occurrences of hazards in the Health Club Department as per the employee survey. The figures represent the total number of participants that work in the two Health Club areas that responded the stated hazard occurs.



Source: Field Data (2015)

APPENDIX 16: **Front Office Hazards**

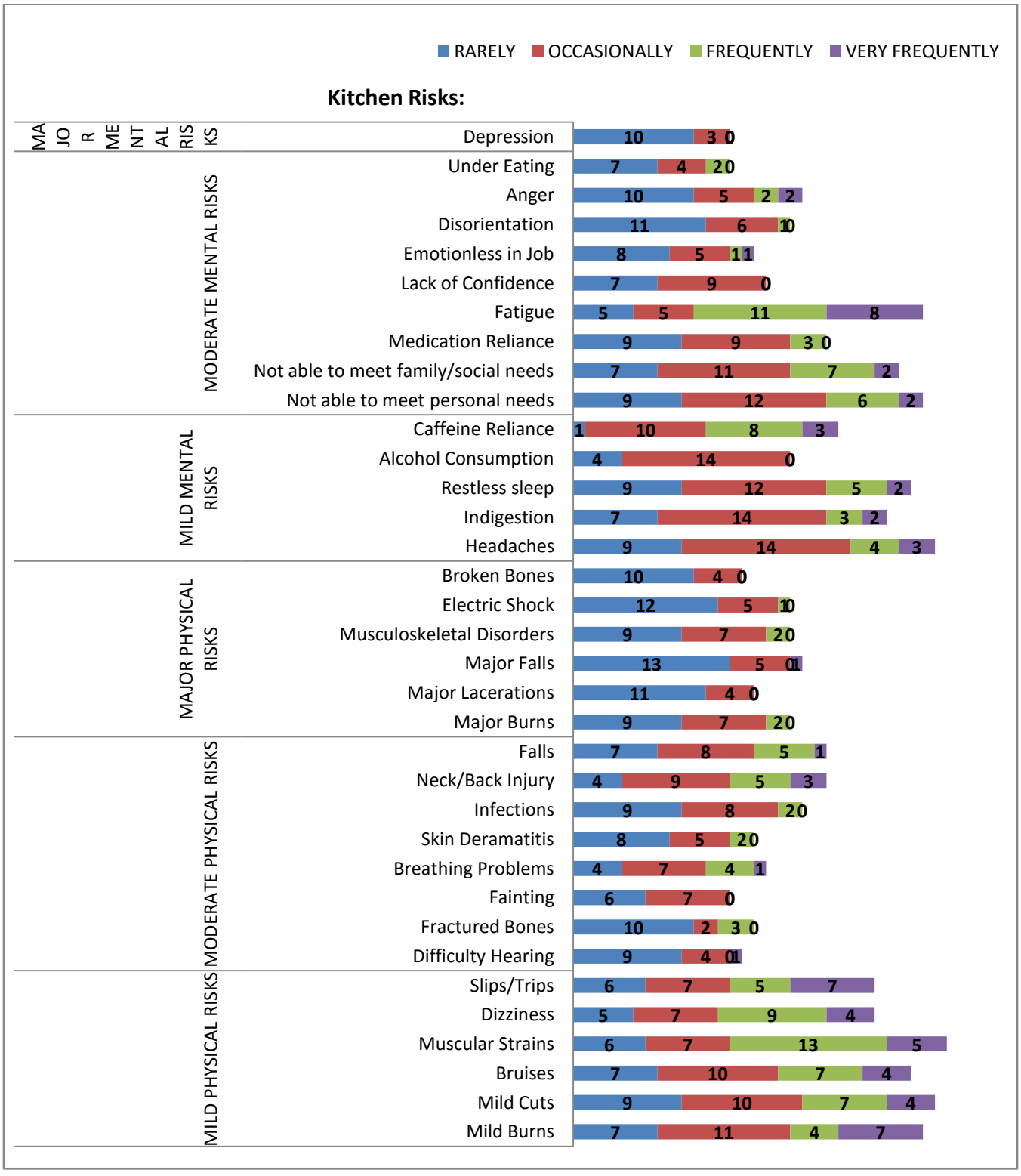
The following bar chart breaks down the occurrences of hazards in the Front Office Department as per the employee survey. The figures represent the total number of participants that work in the two Front Office areas that responded the stated hazard occurs.



Source: Field Data (2015)

APPENDIX 17: **Kitchen Risks**

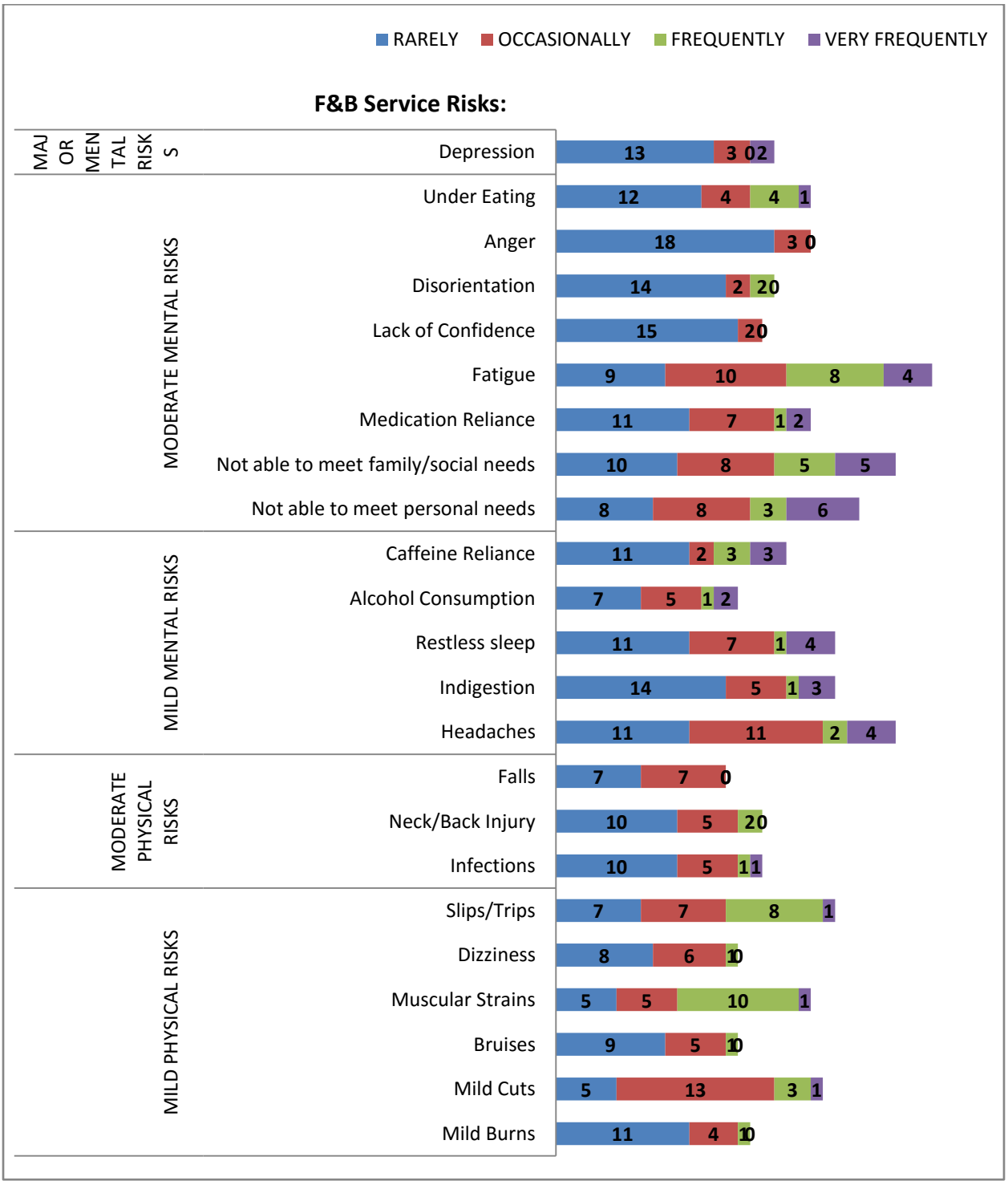
The following bar chart shows the occurrences/likelihood of risks in the Kitchen department according to the questionnaire responses of the 33 randomly sampled kitchen employees; e.g. for 'Depression', 10 participants responded 'Rarely' and 3 participants responded 'Occasionally'.



Source: Field Data (2015)

APPENDIX 18: **Food & Beverage Service Risks**

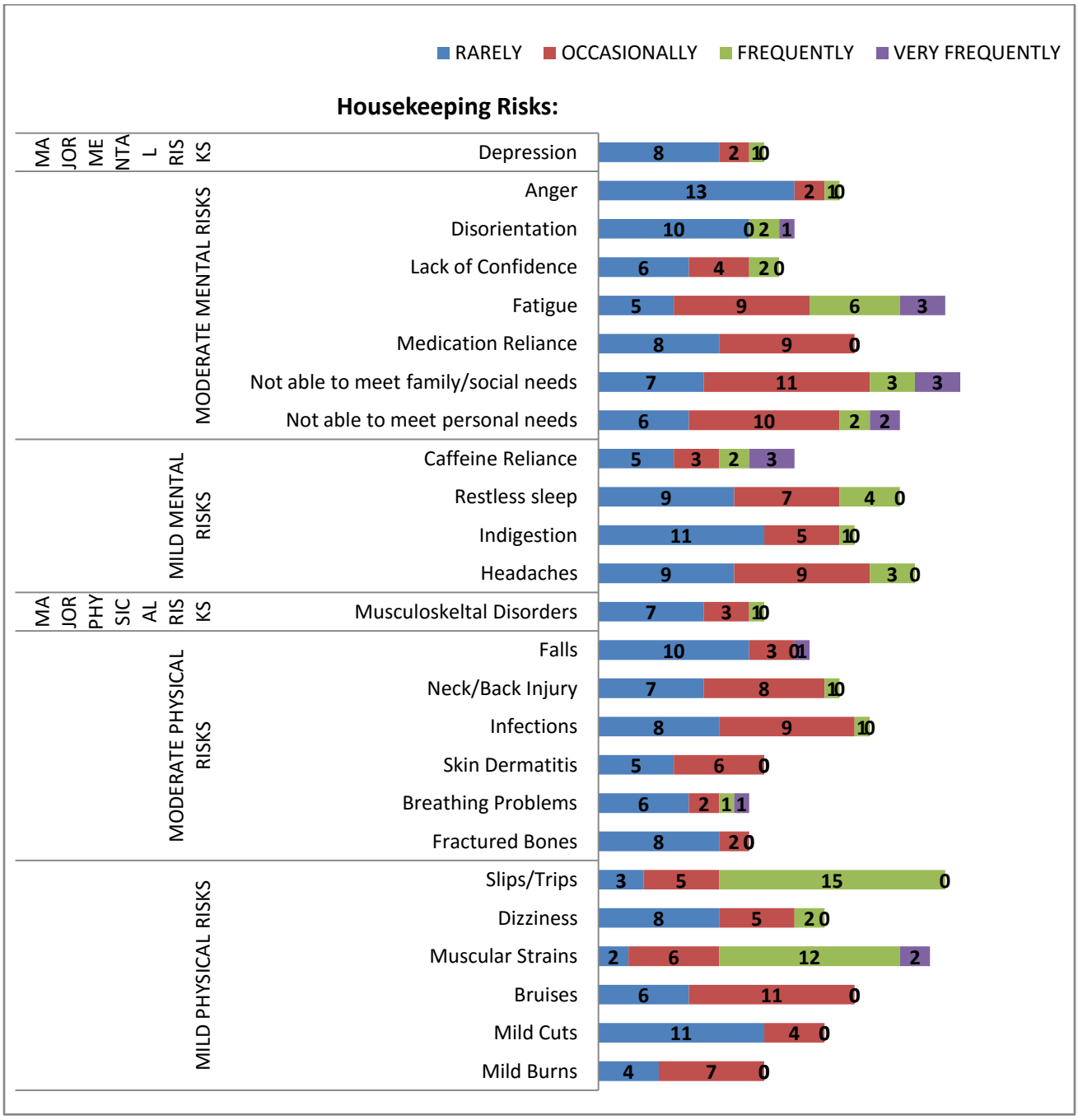
The following bar chart shows the occurrences/likelihood of risks in the Food & Beverage Service department according to the questionnaire responses of the 36 randomly sampled F&B service employees; e.g. for 'Depression', 13 participants responded 'Rarely', 3 participants responded 'Occasionally', and 2 participants responded 'Very Frequently'.



Source: Field Data (2015)

APPENDIX 19: **Housekeeping Risks**

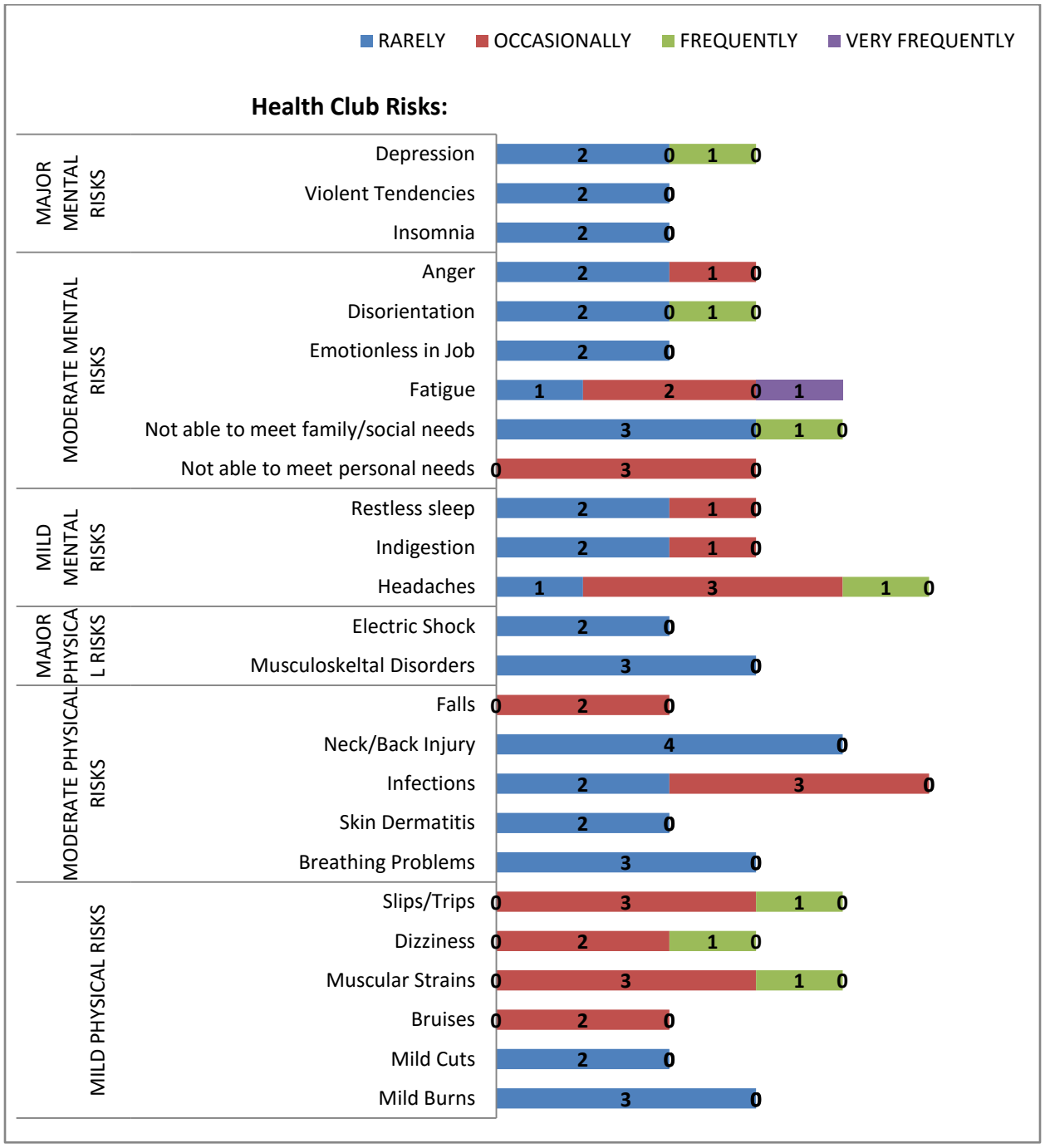
The following bar chart shows the occurrences/likelihood of risks in the Housekeeping department according to the questionnaire responses of the 26 randomly sampled housekeeping employees; e.g. for 'Depression', 8 participants responded 'Rarely', 2 participants responded 'Occasionally', and 1 participant responded 'Frequently'.



Source: Field Data (2015)

APPENDIX 20: **Health Club Risks**

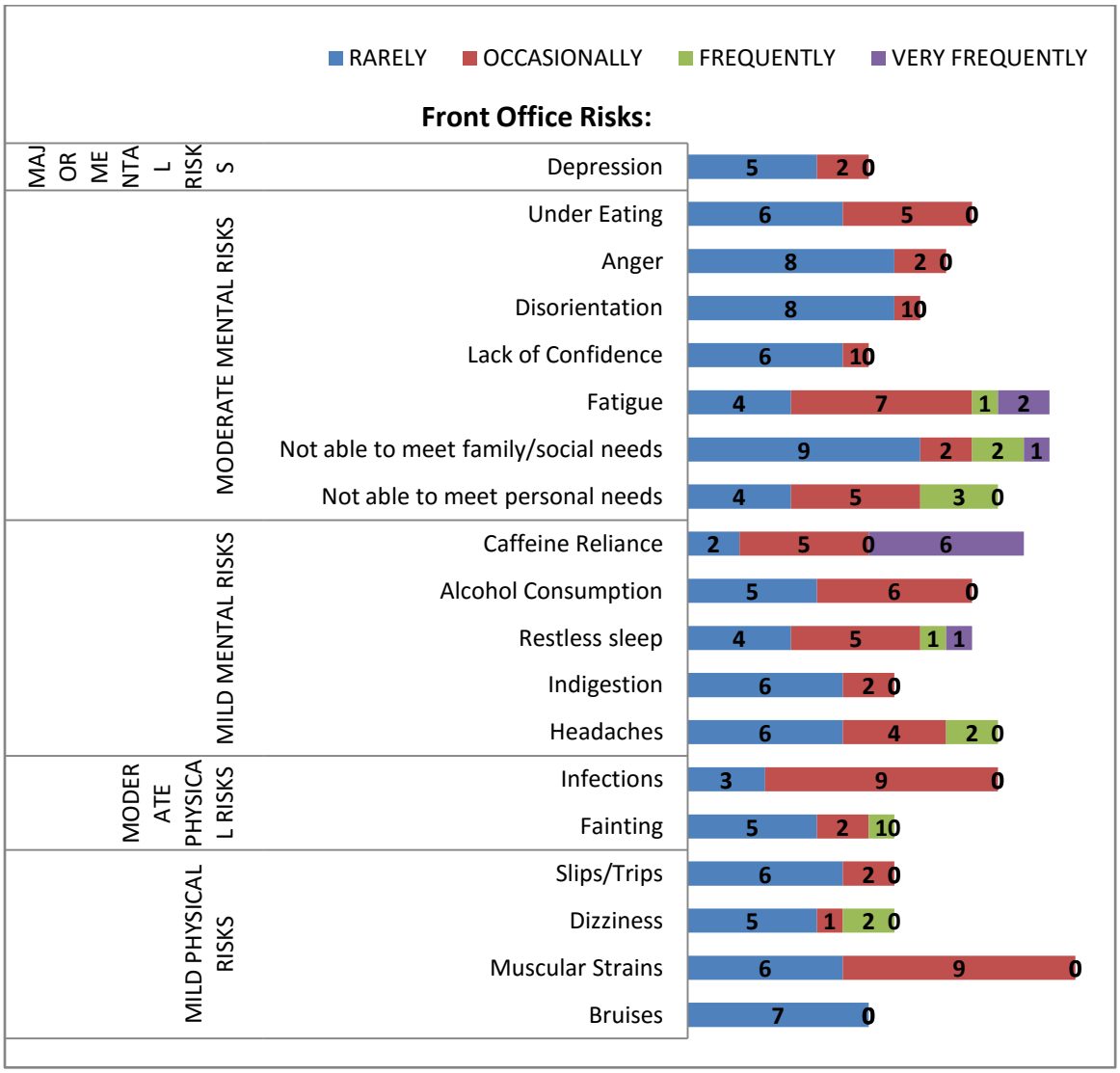
The following bar chart shows the occurrences/likelihood of risks in the Health Club according to the questionnaire responses of the 5 randomly sampled health club employees; e.g. for 'Depression', 2 participants responded 'Rarely', and 1 participant responded 'Frequently'.



Source: Field Data (2015)

APPENDIX 21: **Front Office Risks**

The following bar chart shows the occurrences/likelihood of risks in the Front Office department according to the questionnaire responses of the 18 randomly sampled front office employees; e.g. for 'Depression', 5 participants responded 'Rarely', and 2 participants responded 'Occasionally'.



Source: Field Data (2015)