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Understanding of Occupational Health and Safety Risks and Participatory Practices in Small Businesses

Qualitative Case Studies of Three Small Cafe and Restaurant Businesses

A thesis presented in partial fulfilment of the requirements for the degree of

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Abstract

Small businesses are generally characterised as having highly hazardous working environments and significant exposure to occupational health and safety (OHS) risks. Regulation, irrespective of the size and nature, requires all businesses to take reasonable measures to minimise hazards and hazardous exposures. Limited resource availability and limited market share, in particular, differentiate SBs from large ones in relation to OHS practices such as the identification of OHS hazards, reduction of hazardous exposures and minimisation of risks. Further the owner-managed nature of the operation, manifesting informal human resource management practices and employment relations, makes them unique and different from large businesses in relation to OHS practices. Nevertheless, the informal social relation and the local work environment context where the employer works alongside employees facing the same hazards is considered to provide a unique opportunity to owner/managers and employees to establish a similar/common understanding of OHS risks, and thus a better opportunity for hazards and risk control in SBs.

The understanding of OHS hazards and risks in the local work environment context is called the local theory (of work environment). The local theory is deemed indispensable for participatory practice (participation by both owner/manager and employees) in the identification and control of OHS hazards and risks. However, an understanding of OHS risks and participation in the identification and control of OHS hazards and risks in the local work environment in SBs has been little studied. Importantly, there has not been any precedence in the use of the local theory of work environment (LTWE) to explore an understanding of OHS risks and participation in the identification and (local understanding) control of OHS hazards and risks in SBs. Therefore, the objective of this study was to explore the owner/managers' and employees' understanding of OHS risks and their participation in the identification and control of hazards and risks using the four elements of the LTWE: experience, causal relations, legitimisation and action.

Qualitative case studies of three SBs, employing between six to 19 employees, was undertaken to examine local understanding of OHS risks and participation in identification and control of OHS hazards and risks. This involved ethnographic field observations and semi-structured interviews with the employer and employees in three independently owned restaurants and cafes from the Manawatu region of the Central

North Island, New Zealand. Data obtained from interview responses and field observations were analysed thematically. The four elements of the LTWE as the units of analysis, in combination with the techniques of network diagram, were used to examine understanding of OHS risks in the local work environment. The technique of typology development was used to understand participation in the identification and control of OHS hazards and risks.

The study showed that the employers' and employees' understanding of OHS risks was experiential such that primarily the directly experienced obvious, physical and immediate effect hazards, events and consequences were understood as OHS risks. Experience of hazards that can be associated or not with immediate effects was related to the construction of similar or different understandings of OHS risks between the owner/manager and employees. The element of legitimisation – the ability to bring up issues and the accepted reasons allowing them to bring up hazards and risks for discussion and broader attention in the local work environment – was pivotal to the development of similar or different understandings of OHS risks in the local work environment. The understanding of OHS risks by the owner/manager and employees depicted the local theory, which consequently determined participation by the owner/manager and employees in the identification and control of hazards and risks and the approaches considered appropriate for hazards identification and control.

Understanding of OHS risks, the construction of a local theory and participation in the identification and control of OHS risks were different from one case to the other as were their characteristic contexts. Open participation, lead-through participation and closed participation were the three different typologies of participation that were observed predominantly in each of the three business cases, respectively. An important finding of the study was that the different typologies of participation influenced legitimisation of OHS hazards and risks differently, which was observed to determine the way hazards and risks were dealt with. Open participation was observed to legitimise most OHS issues unselectively and take the approach of elimination to control hazards and risks, as opposed to a closed participation, which allowed selective legitimisation of OHS issues tending largely to be an approach of minimisation to control hazards and risks.

The findings suggest that the management of hazards in SBs is informal and reactive in nature and that by expanding and extending the sphere of legitimisation, through a more structured approach to hazard identification and recognition, it is possible to establish a more predictive (proactive) hazard management strategy. This, in turn, could lead to a more open participatory work environment, where more appropriate (and potentially more effective approaches) to the control of hazards and risk would be employed.

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Table of Contents

Abstract ..... *i*

Acknowledgements ..... *iv*

Table of Contents ..... *v*

List of Tables ..... *ix*

List of Figures ..... *x*

List of Observation Notes ..... *xi*

Chapter 1 Introduction *1*

1.1 **The context and relevance of the present study** **1**

1.1.1 Small businesses context 1

1.1.2 Legal requirements for managing workplace hazards and risks 5

1.1.3 Participatory practices 5

1.1.4 Understanding of OHS risks 6

1.1.5 Local theory of work environment 9

1.2 Structure of the thesis **11**

Chapter 2 Literature Review *13*

2.1 Review of literature **13**

2.1.1 Participation, participatory practice and its impacts 13

2.1.2 Context of management of SBs and control of OHS risks 19

2.1.3 Understanding of OHS risks, risk control and participation in SBs 22

Chapter 3 Methods *28*

3.1 Timeframe of the study **28**

3.2 Study objectives **28**

3.3 Study design and approach **29**

3.4 Study strategies **31**

3.5 Methodological approach **34**

3.5.1 Screening of participating cases 36

3.5.2 Data collection 39
3.5.3 Data analysis 46

3.6 Summary **50**

Chapter 4 Case Study 1 – A Cafe ***52***

4.1 Case description **52**

4.1.1 The food products 52
4.1.2 Organisation structure 53
4.1.3 Tasks and roles in a day's work 54
4.1.4 The working environment 57

4.2 Employers'/employees' understanding of OHS risks **62**

4.2.1 Element of experience and element of causal relations 66
4.2.2 Element of action 67
4.2.3 Element of legitimisation 68
4.2.4 Common understanding of OHS risks and development of LTWE 70

4.3 Employer/employee participation in OHS risk prevention **72**

4.4 Conclusion **77**

Chapter 5 Case Study 2 – A Cafe and Restaurant ***80***

5.1 Case description **80**

5.1.1 The food products 80
5.1.2 Organisation structure 81
5.1.3 Tasks and roles in a day's work 82
5.1.4 The working environment 84

5.2 Employers'/employees' understanding of OHS risks **90**

5.2.1 Element of experience and element of causal relations 94
5.2.2 Element of action 96
5.2.3 Element of legitimisation 98
5.2.4 Common understanding of OHS risks and development of LTWE 101

5.3 Employer/employees participation in OHS risk prevention **103**

5.4 Conclusion **113**

Chapter 6 Case Study 3 – A Restaurant and Bar ***115***

6.1 Case description 115

6.1.1 The food products 116

6.1.2 Organisation structure 116

6.1.3 Tasks and roles in a day's work 117

6.1.4 The working environment 122

6.2 Employers'/employees' understanding of OHS risks 129

6.2.1 Element of experience and element of causal relation 133

6.2.2 Element of action 135

6.2.3 Element of legitimisation 137

6.2.4 Common understanding of OHS risks and development of LTWE 139

6.3 Employers'/employees' participation on OHS risks prevention 141

6.4 Conclusion 149

Chapter 7 Cross-Case Findings and Discussion 151

7.1 Business contexts of the three cases 151

7.2 Employer/employee understanding of OHS risks 153

7.2.1 Understanding of OHS risks 153

7.2.2 Understanding of OHS risks and a local theory 157

7.2.3 Understanding of OHS risks and control of hazards and risks 168

7.3 Employer/employee participation in control of OHS hazards and risks .. 173

7.4 Implications of the findings to OHS practice 182

Chapter 8 Conclusions 186

8.1 Limitations of the study 188

8.2 Future research 190

Appendices 192

Appendix 1: Information sheet for owner/manager 193

Appendix 2: Screening Questionnaire for Low Risk Notification 196

Appendix 3: Low Risk Notification for Research Involving Human participants 200

Appendix 4: Information sheet for employees 204

Appendix 5: Areas of enquiry and general probes for semi-structured interviews 207

Appendix 6: Participant Consent Form for owner/managers 208

Appendix 7: Participant Consent Form for Employees 209

Appendix 8: Interview guide – Areas of enquiry for semi-structured interview 210

Appendix 9: Network diagram for the four elements of LTWE – Case 1 211

A. Initial coding - Employer 211

B. Developing categories - Employer 212

C. Initial coding - Employees 213

D. Developing categories - Employees 214

Appendix 10: Network diagram for the four elements of LTWE – Case 2 215

A. Initial coding – Owner/manager 215

B. Developing categories – Owner/manager 216

C. Initial coding - Employees 217

D. Developing categories – Employees 218

Appendix 11: Network diagram for the four elements of LTWE – Case 3 219

A. Initial coding – Owner/managers 219

B. Developing categories – owner/managers 220

C. Initial coding - employees 221

D. Developing categories - employees 222

References 223

List of Tables

Table 3-1: ANZSIC classification for restaurant and cafes industry sector 37

Table 4-1: Summary of the characteristics – Case 1..... 56

Table 4-2: Recounted OHS problems grouped into categories..... 63

Table 4-3: Themes for the four elements of LTWE common to employer and employees 70

Table 4-4: Open participation – characteristics and drive..... 76

Table 5-1: Summary of the characteristics – Case 2..... 84

Table 5-2: OHS concerns in the workplace..... 90

Table 5-3: Theme for the four elements of LTWE for owner/managers and employees .102

Table 5-4: Lead-through participation – characteristics and drivers.....111

Table 6-1: Summary of the characteristics – Case 3.....122

Table 6-2: Categorised representation of reported OHS risks experienced in the workplace 129

Table 6-3: Theme for the four elements of LTWE common to owner/managers and employees 140

Table 6-4: Closed participation – characteristics and drive.....147

Table 7-1: Business context across three cases 152

Table 7-2: OHS issues mentioned as OHS risks by owner/manager and employee groups – common across the cases 154

Table 7-3: OHS issues mentioned as OHS risks – different across the cases.....154

Table 7-4: Common themes for the elements of LTWE and the construction of a local theory.....157

Table 7-5: Different themes for the elements of LTWE and the construction of a local theory.....160

Table 7-6: Understanding of stress as OHS risk across the three cases.....162

Table 7-7: Hierarchy of hazard control 170

Table 7-8: Elements of LTWE and typologies of participation – cross-case comparison ..174

Table 7-9: Participation typologies in relation to identification and control of OHS hazards and risks 177

Table 7-10: Summary of findings related to the objectives of the study 182

List of Figures

Figure 3-1: Applying network diagram to LTWE framework 49

Figure 3-2: Methodological framework relating data collection, analysis techniques and study objectives 51

Figure 4-1: Business Case 1 – schematic diagram of physical layout of the operation (not to scale) 58

Figure 4-2: Development of categories of responses and emergent themes for employer – Case 1 64

Figure 4-3: Development of categories of responses and emergent themes for employees – Case 1 65

Figure 4-4: Indigenous concepts of participation and participation typologies 75

Figure 5-1: Organisational structure – Case 2 81

Figure 5-2: Business Case 2 – schematic diagram of physical layout of the operation (not to scale) 86

Figure 5-3: Development of categories of responses and emergent themes for employer – Case 2 92

Figure 5-4: Development of categories of responses and emergent themes for employees – Case 2 93

Figure 5-5: Indigenous concepts of participation and participation typologies 110

Figure 6-1: Organisational structure – Case 3 117

Figure 6-2: Business Case 3 – schematic diagram of physical layout of the operation (not to scale) 124

Figure 6-3: Categories of responses and developing emergent themes for employer – Case 3 131

Figure 6-4: Categories of responses and development of emergent themes for employees – Case 3 132

Figure 6-5: Indigenous concepts of participation and participation typologies 146

Figure 7-1: Illustrating the key role of element of legitimisation on identification and control of risks 164

Figure 7-2: Effectual relation between participation, legitimisation and hazard control action 178

Figure 7-3: Participation continuum 180

List of Observation Notes

Box 4-1: Observation notes, 3 March 2010 53

Box 4-2: Observation notes, 3 March 2010 54

Box 4-3: Observation notes, 2 March 2010 55

Box 4-4: Observation notes, 19 March 2010 73

Box 4-5: Observation notes, 16 March 2010 74

Box 4-6: Observation notes, 10 March 2010 76

Box 5-1: Observation notes, 10 May 2010 83

Box 5-2: Observation notes, 3 May 2010 104

Box 5-3: Observation notes, 4 May 2010 105

Box 5-4: Observation notes, 11 May 2010 107

Box 5-5: Observation notes, 18 May 2010 108

Box 6-1: Observation notes, 15 July 2010 117

Box 6-2: Observation notes, 6 July 2010 118

Box 6-3: Observation notes, 9 July 2010 148

Chapter 1 Introduction

Risks exist in all work environments. The identification, assessment and control of these risks are key strategies in occupational health and safety (OHS) practice. How employees and, importantly, employers, recognise and understand these risks influences how effectively they are controlled or managed.

A variety of approaches and strategies for managing hazards and risks have been developed over decades (Quinlan, Bohle, & Lamm, 2010). The fundamental foci of these approaches have been the identification of hazards, assessment of risks, and control of these hazards and risks in workplaces as a general strategy. Participatory approaches, involving employers and employees as a key element of a number of these strategies, have been found to have positive outcomes in relation to the reduction of injuries and ill health and improved work environments (Champoux & Brun, 2003; Elfering, Dubi, & Semmer, 2009; Geldart, Smith, Shannon, & Lohfeld, 2010; Mylett & Markey, 2007). Some other studies (Holmes, Triggs, Gifford, & Dawkins, 1997) have suggested different risk prevention strategies depending on whether there exists conflicting or consensual (different or common) understanding of OHS risks between the employer and employees.

However, in order to explore our understanding of risks and participatory approaches in the management of hazards and risks in workplaces, we need to describe the context of the New Zealand business environment, and in particular the small business (SB) context of which over 95% of all enterprises are classified.

1.1 The context and relevance of the present study

1.1.1 Small businesses context

Small and medium-sized enterprises (SMEs) of up to 20 employees are an important part of the New Zealand economy. According to the latest data from Statistics New Zealand, they account for 97.2% (455,907) of all enterprises, 30.2% (581,540) of all employees and an estimated 27.8% of New Zealand's gross domestic product (GDP). Although large enterprises generate the majority of our jobs, innovation and exports, smaller businesses make a significant contribution (Statistics New Zealand, 2011a).

Enterprise size

There exists no universally accepted definition of SBs. Although the concept of 'owner-managed' seems to form the core basis of defining SBs (Bolton, 1971), the level of turnover is also sometimes used alternatively (Massey, 2005b). However, as both these bases pose the challenge of being recognised as an internationally acceptable definition of SBs, the number of people employed within a firm, usually termed as the total number of full-time equivalent staff (FTEs), has been taken as the basis of defining SBs in most of the countries studied (Legg et al., 2009; Massey, 2005b). For example, in Australia any business employing five to 20 FTEs is defined as a SB (Australian Bureau of Statistics, 2001). Whereas in New Zealand the Ministry of Economic Development (MED) in its first annual report, *SMEs in New Zealand: Structures and Dynamics* (Massey, 2011; Ministry of Economic Development, 2007), defined a firm employing fewer than five employees as a small enterprise, those employing six to 19 employees as a medium enterprise, and less than 20 employees collectively as an SME. Since then the Employee Count (EC), the head count of salary and wage earners, seems to be the official basis for determining the size of a business and defining them as small, medium or large businesses (Legg, et al., 2009). Alternatively, FTE has also been in use in New Zealand to define businesses. On that basis firms employing fewer than five FTEs have been defined as micro-enterprises, those with between six to 49 FTEs as small firms, those with 49-99 FTEs as medium firms, and any firm employing more than 100 FTEs as large firms (Cameron & Massey, 1999; Massey, 2011). FTE takes into account the paid employees as well as the working proprietors (even though they are not in the payroll) as the basis for determining the size of a business. Despite these differences in the terms used to define the number of people employed, there seems to be a consensus that defining SBs on the basis of size provides the best representation of the operational differences, namely, the formality and degree of owner-management of the businesses among different sizes. The literature indicates that a 20 EC is the cut-off point where the informal and owner-managed operation of the business starts to grow in size beyond the 'span of control' of the owner-manager. This necessitates added management levels (Massey, 2005b; Wilkinson, 1999), including management of OHS (Baldock, James, Smallbone, & Vickers, 2006; Okun, Lentz, Schulte, & Stayner, 2001; Vickers, Baldock, Smallbone, James, & Ekanem, 2003). On the basis of the literature

evidence and the definition used in statistics and research, I have focused the present study on firms employing six to 19 employees (EC) as SBs.

In addition, there are a number of contextual factors different to those of large businesses in general that make the study of SBs unique and distinctive. SB operations are generally considered to have an informal, non-strategic and short-term operation (Mayhew, 1997) as opposed to the formal, strategic and long-term undertaking of a large business (Coviello, Brodie, & Munro, 2000). SBs, as such, have been traditionally assumed to be the premature stage of a large firm that either grew into a large business or inevitably faced becoming an economic casualty and dying out (Massey, 2009). Works such the *Bolton Report* (Great Britain Committee of Inquiry on Small Firms, 1971) in the early 1970s, and that of Storey (Storey, 1994) in the 1990s, identified particular characteristics of SBs that pioneered the establishment of them as unique and distinct entities and made it important to understand them in this way and not as immature large business.

Independent owner-managed operation

An SB is usually independently managed by the owner. Such independent owner-management is generally reflected in important decisions, in relation to the operation of the business, being made by the owner personally independent of any internal assistance (Eakin, 1992; Hasle, 2000). Such independent owner-management also means that the owner-manager undertakes multiple roles fulfilling responsibilities such as accounting, human resource management, procurement and customer relations without much specialist external advice even on crucial functional areas such as these (Cameron & Massey, 1999; Lamm, 1997, 2002; Lewis, Ashby, Coetzer, Harris, & Massey, 2005; Mayhew, 1997).

Resource constraints

SBs tend to have limited resources, both in terms of finances right from set-up to survival and growth (Cameron & Massey, 1999; Haugh & McKee, 2004; Lewis, et al., 2005), as well as in respect of the knowledge and expertise of the staff (R. Hill & Steward, 2000; Institute of Employment Studies, 2005; Wilkinson, 1999).

Limited market share

SBs usually have a small market share in terms of products and customers as well as cooperation and competition with other firms (Massey, 2002). The limited market share, cooperation and competition make it inconsequential for SBs, as opposed to large ones, to adopt formalised practices (Vickers, James, Smallbone, & Baldock, 2005).

Other characteristics

In addition to these particular characteristics, there are other noted characteristics that influence OHS practice in SBs, such that they primarily pose as barriers to the way hazards and risks are identified and controlled. These characteristics include: support from their family and friends during business start-up and expansion; the close personal and informal relationship that usually exists between family, friends, employees and the owner-manager (Mayhew, 2002); the high rate of death of SBs in combination with perceived economic disincentive for implementation of OHS practices (Lamm, 2002; Massey, 2003); and the prevalence of seasonal workers in SBs (Legg, et al., 2009; Quinlan, Claire, & Bohle, 2001).

In contrast, the prevalence of family involvement may institute a high level of trust, and a strong sense of responsibility and loyalty between the employer and employees, making implementation of good OHS practice more prevalent. The employer and employees working alongside each other under the same conditions of work and facing similar hazards make it more likely that the employer and employee groups come to a similar understanding of work environment problems and their causes. Such understanding is assumed to facilitate the two parties to put collective efforts, and thus participation in the identification and control of hazards and risks and prevention of exposure to OHS risks therefore results in reduced ill health.

Interestingly, in a typical SB, employees work selflessly in the best interests of the employer alongside the employer as in "a big happy family" (Eakin & MacEachen, 1998). Smooth running of the business to maintain adequate turnover, which guarantees job security for the employees and business security for the employer, is apparently their common interest that in general culminates in corresponding participation by the two parties in daily activities.

Finally, the legislative requirements for the control and management of hazards and risks in the workplace are universal features that apply to all enterprises, irrespective of size, in most industrialised countries.

1.1.2 Legal requirements for managing workplace hazards and risks

Defining hazards and risks through legislation has been a major influence on the way employers and employees recognise and understand hazards and risks. This is evident in the legislative outlines established in many of the developing countries in the early 1970s and 1980s (Frick & Wren, 2000). These regulatory definitions and prescriptions establish a common basis for risk understanding, but promote a 'one size fits all' strategy (Holmes, et al., 1997) towards the identification and control of OHS risks in the work environment. One of the major issues of a general strategy for the identification and control of hazards and risks is its inability to address the differences in the nature and extent of them being present in the work environment of diverse industry sectors (O'Hara, Dickety, & Weyman, 2005; Quinlan, et al., 2001; Walters & Lamm, 2003). The other deficiency of such a strategy is its failure, particularly in SBs, to address the precarious nature of OHS outcomes such as fatalistic resignation to accident and injuries as an inherent part of the job (Lingard & Holmes, 2001), and the tendency to avoid responsibility towards the work environment (Hasle, Limborg, Kallehave, Klitgaard, & Andersen, 2012), or to discount or normalise hazards and risks at work (Lamm, 2002; Mayhew, 2002; Quinlan, et al., 2001). Given the shortcomings of the regulatory prescriptions in adequately addressing health and safety issues, most of the industrialised countries have introduced, in recent times, major reforms to their health and safety regulation and framework (Frick & Wren, 2000; Gunningham, 1999; Lamm, 1994). Many of these reforms have their bases in the report by Lord Robens (1972) and have strongly promoted and encouraged employee participation in identifying and managing hazards and risk.

1.1.3 Participatory practices

Participatory practice (also termed participatory approach, method or technique) has been defined as variedly as it has been applied. Participation in the planning of interventions by the stakeholders – individual or group – that is impacted by or impacts upon such action (Hickey & Kothari, 2009) is a generic definition of participatory practice. Applied to ergonomics it is defined as "the involvement of people in planning

and controlling significant amount of their own work activities, with sufficient knowledge and power to influence both processes and outcomes in order to achieve desirable goals" (Wilson & Haines, 1997, pp. 492-493). In business organisations in general, participatory practice has been used interchangeably with employee participation (Black & Gregersen, 1997). Participatory practice in business organisations is widely applied to areas such as design and decision making e.g. new product design, work station design and participative decision making.

Since employee participation became institutionalised in business discourse, it has been discussed and debated, and its impacts on organisational performance widely studied. An important conclusion drawn from these discussions and studies is that employee participation in organisations takes diverse forms with varying degrees of influence that define the different levels of participation with subsequently diverse outcomes (Cabrera, Ortega, & Cabrera, 2002; Cotton, Vollrath, Froggatt, Lengnick-Hall, & Jennings, 1988; Dachler & Wilpert, 1978; Gill & Krieger, 1999; Seibold & Shea, 2001).

Participatory practices in OHS risk prevention can be traced back to as early as the turn of the 20th century. Originating in the form of cooperation between the employer and employees in the minimisation of accidents, participatory practice in OHS risk prevention began with large business organisations voluntarily applying Taylor's management principles to accident prevention (Frick & Wren, 2000). The legislative reforms of the 1960s-1970s and onwards, in many developed countries, placed strong emphasis on employee participation in the communication and control of OHS hazards.

1.1.4 Understanding of OHS risks

Understanding of OHS risks has also been affected by these regulatory reforms. The reforms were primarily driven by the influence of the UK Lord Robens report (1972) which moved the management of health and safety at work from a regulatory prescriptive approach to the identification and control of specific hazards and risks (Lamm, 1994) to a self-regulation philosophy (Frick, Jensen, Quinlan, & Wilthagen, 2000). Most of these self-regulation reforms require the employer to manage hazards and risks to employees by establishing a process and system of hazard identification and control that allows reasonable opportunities for employee participation in the process (Lamm, 1994; Shearn, 2004; Walters & Frick, 2000).

Despite the reforms and all the good intentions of improving the conditions of health and safety in workplaces, regulatory approaches have been criticised for their limited effectiveness in achieving their intended purpose. For example, data on work-related fatality rates for New Zealand, Australia, Canada, Norway and the UK (the countries where a self-regulation approach to health and safety is evident), show that New Zealand has one of the highest rates of work-related fatalities (Jager, 2012). Although there is a lack of clear statistics on work-related injuries across the different business sizes in this country (Jager, 2012; Legg, et al., 2009), indications are that the SB sector (despite providing a high percentage of the total employment) bears a large percentage of the economic burden because of poor OHS performance (Adams et al., 2002; Jager, 2012; Pezzullo & Crook, 2006; Statistics New Zealand, 2011b). This highlights the unique contextual factors and situations of SBs.

Concepts of risk

A variety of perspectives of risk, other than legislative, also exist (Jensen, 2002; Rayner, 1992; Renn, 1992). Among the psychological, economic (risk-benefit comparison), technical (probabilistic risk analysis), cultural and social perspectives about risks, social construction of risks (Eakin, 1992; Heimer, 1988; Holmes, 1999; Holmes & Gifford, 1997; Rayner, 1992) – an approach to the identification and control of hazards and risks based on local understanding and priorities – arguably provides the most direct and elegant explanation for the cause-effect relations in a work environment context (Jensen, 2002; Karageorgiou, Jensen, Walters, & Withagen, 2000).

Social construction of risk defines risks on the basis of social judgement so that the interpretation of risks is linked with the social interest and values of social groups i.e. the owner/manager and employees in the local work environment (Renn, 1992). Interpretation of risks and risk prevention – the significance of OHS problems, the causes behind them, and the consequences and measures to control the problems – are driven by the knowledge, experience and resource capabilities of social groups (O'Hara, et al., 2005; Walls, Pidgeon, Weyman, & Horlick-Jones, 2004). Employers and employees understand the same risk as carrying different levels of riskiness based on what each group perceives as the causes and consequences of the risks (Holmes, et al., 1997). In addition, the enquiry of understanding of OHS risks by social groups needs to be embarked upon judiciously across different sizes and sectors of businesses for the

primary reason of contextual differences. Evidently, the general business context of large businesses in understanding of OHS risks and the subsequent identification and control of hazards and risks is not applicable to SBs (Laird, Olsen, Harris, Legg, & Perry, 2009; Legg, et al., 2009).

The literature focused on SBs largely explains the understanding of the causal relations of OHS risks and subsequent control of OHS hazards either from the employers' perspective (Champoux & Brun, 2003; Eakin, 1992; Hasle, Kines, & Andersen, 2009; Hasle, et al., 2012) or that of employees (Eakin & MacEachen, 1998; MacEachen et al., 2010). A recent study conducted on attribution of causes of accidents and their prevention which involved owners of SBs (employing between one and 19 employees) showed that the owners attributed the causes behind accidents primarily to unforeseeable circumstances and secondarily to worker fault (Hasle, et al., 2009). The study points to a defensive stance taken by the owner/manager to avoid responsibility and blame as a possible explanation for such attribution. Similar were the findings of a study by Champoux and Brun (2003) where the SB owners largely reported employees as the main cause of accidents in the workplace. Another study involving owners of SBs, which examined the owners' understanding of the work environment (OHS), revealed that they largely discounted risks and devolved the responsibility of controlling OHS hazards to the employees (Hasle, et al., 2012). Likewise, in a study involving owners from SBs in Canada, Eakin (1992) reported that most of the owners understood OHS activities to be associated with the personal behaviour of the employees and that they took a 'leave it up to the workers' stance in terms of the identification and control of risks. These studies made an important suggestion: that both attribution of the causes behind OHS risks to employees and employers' exhibition of a defensive stance towards control of risks are unhelpful in the identification and control of OHS risks.

Just as SB owners have been found to attribute the cause and control of OHS risks to employees, there is evidence too that employees exhibit a similarly negative perception of the employer/owner. For example, a study on the health-related experiences of employees in Canada that involved employees from SBs (Eakin & MacEachen, 1998) found that they largely perceived employers' negligence and lack of action as the cause behind OHS problems in the work environment. The study also found that the employees tended to either trivialise or normalise OHS problems as part of the job and

take a more accommodative stance. The study (Eakin & MacEachen, 1998) suggested that the 'problematised' or 'normalised' construction of health-related OHS problems was based on their perception of a 'strained' or a 'positive' employment relationship at work, possibly reflecting the perceived social exchange relationship (Blau, 1964; Ekeh, 1974; Parzefall & Salin, 2010; Zafirovski, 2003). Few other studies have attempted to reciprocally ascertain the owner/manager and employee understanding and perception of OHS risks in SBs. Notably, a study by Gardener et al. (1999) and those by Holmes and Gifford (1997), Holmes, Triggs, Gifford and Dawkins (1997), and Holmes, Gifford and Triggs (1998) revealed that owners perceived employees failing to follow safe work practices as the major cause behind accidents. On the other hand, employees considered the tools and equipment in addition to failure on the employer's part to take responsibility for risk control as the cause behind accidents and OHS risks.

The differences or similarities in interpretation of the degree of risk between the social groups give rise to conflicts/disagreements or consensus/agreement as to an understanding of OHS hazards and associated risks. In terms of control, employees possess relevant experience and knowledge of hazards and their causes whereas employers possess the resource capacities to take the necessary control actions (Malchaire, 2006). The differences and similarities in understanding of hazards and risks between the social groups in conjunction with their knowledge and capacities impart another general context to how hazards and risks are identified and controlled. Holmes, Gifford and Triggs (1998) in their study in the small paint industry sector found that perception and understanding of risks and their control were mediated by social context of work. They have appropriately suggested that in the local work environment, the practice of management of OHS (identification and control of OHS hazards and risks) should take account of the risk perception and social understanding of risks for both the employer and employees (Holmes & Gifford, 1997; Holmes, et al., 1998). The conceptual framework of a local theory of work environment (LTWE) appears to be the most appropriate model for examining the interaction between social understanding of risks and the practice of identification and control of hazards and risks in enterprises.

1.1.5 Local theory of work environment

Understanding of OHS risks by the social groups in a specific work environment has been articulated as the LTWE (Jensen, 2002). The concept of a local theory was

developed by Sørenson and Sætnan (1983), which Jensen (2002) extended as the LTWE to OHS hazards and risks in the local work environment. The LTWE conceptualises that the understanding of OHS risks in the local work environment is based on the understanding of the different attributes of OHS risks. These attributes are described as: what the social groups experience and consider as problems or concerns that pose health and safety risks; their understanding of the causes behind the problem; whether they are acceptable to be brought up for wider attention and the acceptable reasons for doing so; and what is considered as the course of action. The understanding of these different attributes of OHS risks has been postulated as the four intrinsic and intertwined elements of LTWE: experience, causal relations, legitimisation and action. Their understanding has been related to the understanding of OHS risks by social groups which provides the fundamental basis for the way hazards and risks are identified and controlled (Lingard & Holmes, 2001). Jensen (2002) suggested that the LTWE is a precondition for participatory collective action on work environment problems.

The social construction of OHS risks asserts that the understanding and meaning of risks are different from one social group to the other based on their experience, knowledge, values and interests (Renn, 1992). The difficulty in directly relating productivity with efforts in the management of OHS hazards and risks (Lamm, Massey, & Perry, 2007) makes it difficult to ascertain a common interest between employers and employees in relation to the identification and control of hazards and risks. Given the unique context of the informal social relationship between owner/manager and employees prevalent in SBs, clarification of the employer and employee understanding of OHS risks, particularly in SBs, is proposed as fundamental to understanding their efforts and strategies in the identification and control of OHS hazards and risks (Granzow & Theberge, 2009). However, the employer and employee understanding of OHS risks in the context of the local work environment has been little studied. Additionally, the way a common or a different understanding of OHS risks (local understanding) is related to participation in the identification and control of OHS risks, in particular in SBs given the backdrop of social construction of OHS risks and the lack of productivity connection is little understood. Therefore, this thesis, using the theoretical framework of LTWE, qualitatively explored: (a) the (local) understanding of OHS risks by the owner/manager and employees; (b) the implication of a common or

different understanding of OHS risks for the identification of hazards and control of risks; and (c) the owner/managers' and employees' participation in the identification and control of OHS hazards and risks given their local understanding of these.

1.2 Structure of the thesis

This thesis is presented in the structure outlined below.

Chapter 1 establishes the context and relevance of the present study.

Chapter 2 presents the review of relevant literature establishing the rationale for the present study. The literature review is a critical review of the available literature on the understanding of OHS risks and participatory practices in the identification and control of these risks. The literature review focused on identifying the gaps in established knowledge in relation to: (i) understanding of OHS risks in a local work environment context; and (ii) participatory practices in the identification and control of risks in SBs in relation to a local understanding of risks. This was established by focusing the literature review on: (i) participation, participatory practice and its impacts; (ii) the context of management of SBs and control of OHS risks; and (iii) understanding of OHS risks, risk control and participation in SBs.

Chapter 3 outlines the stages and timeframe of the overall study, the specific objectives, study design and the methodological approach adopted for this research. The chapter describes the methods adopted in the present study for data collection and analysis to achieve the objectives of the study. The chapter initially discusses the study design and strategy, which establishes the rationale for taking a qualitative case study approach. The chapter then describes the methodological framework and establishes the rationale for adoption of two data collection techniques (semi-structured interview and ethnographic field observation), as well as two techniques adopted for thematic analysis of data responses (network diagram and developing typologies).

Chapters 4 to 6 present the findings of the study as three separate case studies. These studies initially provide a description of the three cases in relation to their organisational structure, working environment and management of hazards and risks in the work environment. The case studies present the findings of the thematic analysis for understanding of OHS risks by the owner/manager and employees and the typologies of participation by the two groups in the identification and control of hazards and risks.

Chapter 7 is a further critical analysis of the results of the study, which compares and contrasts the findings across the three case studies. The chapter discusses the results, with the evidence established in the available literature. The chapter also discusses the implications of the findings in relation to OHS management in SBs and possible areas of future research.

Chapter 8 concludes the study by highlighting its implications in relation to the communication and control of OHS hazards in SBs, and identifies some directions for possible future studies in the area.

A series of Appendices are included to substantiate the process of data collection and analysis. These include the information sheets and consent forms, the network diagrams developed during for initial coding, and the development of categories for thematic analysis.

Chapter 2 Literature Review

This chapter details the process of literature citation and the actual review of relevant citations. In doing so, the chapter initially provides an account of the literature citation undertaken. This is followed by the actual review and critique of retrieved literature pertinent to the area of enquiry. The review of the literature is divided into three relevant areas in order to allow systematic development of a rationale for the study.

2.1 Review of literature

The main purpose of the literature review was to identify the areas of strong literature evidence and the areas of weak literature evidence in relation to the main focus of the study – understanding of OHS risks and participatory practices with SBs in focus. The literature review revealed a strong presence of evidence on the positive impacts of participation and participatory practice, especially in large businesses. It also uncovered the existence of an ever-widening body of knowledge on the context of management of SBs and where management of OHS fits within these contexts. The literature review also unravelled the existence of a body of knowledge on the understanding of OHS risks in SBs from the employers' or employees' perspective as two distinct social groups. However, a small body of knowledge was evidenced to exist on the local understanding and participation in the identification and control of hazards and risks in SBs. The literature review intended to critically justify the chosen topic of study and contextualise the research objectives.

2.1.1 Participation, participatory practice and its impacts

2.1.1.1 *Definition, concept and context*

Participatory practice is broadly defined as participation by stakeholders in decisions and action on issues affecting them. Product development (Spinuzzi, 2005), product design (Demirbilek & Demirkan, 2004) and work station design (Launis, Vuori, & Lehtela, 1996; Pehkonena et al., 2008) are a few of the areas where participatory approach (participation by stakeholders) to design decisions is widely applied. Such participatory practices are evidenced to have positive results on user performance, productivity and decision processes (Zwick, 2004) as well as improved user comfort (Elfering, et al., 2009). As applied to business organisations, participatory practice is defined as employee participation in decision making on work activities and other aspects of organisational functioning traditionally considered the prerogatives of hierarchical superiors (Sagie &

Koslowsky, 2000). Participatory practice in OHS, particularly ergonomics, has positive impacts on controlling the risk of injuries with reduced rates and consequences for ill health (Carrivick, Lee, Yau, & Stevenson, 2005; Kuorinka & Patry, 1995; Rivilis et al., 2008), primarily in large businesses.

Participatory practice (also termed participatory approach, method or technique) has been defined as variedly as it has been applied. Participation in planning of interventions by the stakeholders – individual or group – that is impacted by or impacts upon such action (Hickey & Kothari, 2009) is a generic definition of participatory practice. Wilson and Haines (1997, pp. 492-493) have defined participatory practice as "the involvement of people in planning and controlling a significant amount of their own work activities, with sufficient knowledge and power to influence both processes and outcomes in order to achieve desirable goals". In business organisations in general, participatory practice has been used interchangeably with employee participation. The lexicological meaning of participation is "to take part in an activity" ("Cambridge Advanced Learners Dictionary," 2008). Extending the meaning of participation to the workplace, employee participation has been defined as a process which allows employees to exert some influence over their work and the conditions under which they work through efforts and interactions beyond those normally associated with work activities (Heller, Pusic, Strauss, & Wilpert, 1998; Stohl & Cheney, 2001).

Participatory practice as an approach was originally conceived by the Colonial Office in the UK through community development projects, aimed at producing stable rural communities by urging participation by the general public in the planning of projects intended to counteract the negative effects of the process of urbanisation and socio-political change (Hickey & Kothari, 2009). As one of the influences of the colonial era, the origin of participatory practice can be traced back to the early 1940s. Over the years the approach has been developed as a key element in the planning and implementation of projects in development discourse and has expanded to areas such as political systems, economic systems, social justice, governance, education systems, natural resource management and sustainable development (Hickey & Kothari, 2009).

Participatory practice in business organisations is widely applied to areas such as design and decision making e.g. new product design, work station design and participative decision making. Participatory practice as a method and approach in business

organisations is used synonymously and interchangeably with employee participation (Black & Gregersen, 1997). Employee participation, as a process, originated in the early 19th century with the establishment of worker cooperatives in England (Deutsch, 2005). The Human Relations Movement of the 1920s rekindled interest in putting employee participation into practice, while the legislative provisions initiated during the 1970s in many countries established the institutional base for it. The legislative initiatives of the 1970s drew immense research interest in the impact of employee participation on worker motivation, productivity, work performance and product quality. Since then employee participation as a form of participatory practice has been applied to a wide range of organisational functioning, including the identification and control of OHS risks.

Participatory practices in OHS risk prevention can be traced back to as early as the turn of the 20th century. Originating in the form of cooperation between employer and employees in the minimisation of accidents, participatory practice in OHS risk prevention began with large business organisations voluntarily applying Taylor's management principles to accident prevention (Frick & Wren, 2000). Notable among such applications are the Safety Movement and H.W. Heinrich's Loss Control approach. Reducing compensation costs associated with accidents was a major motivator for participatory approaches to accident prevention rather than the protection of workers' lives and health. Nevertheless, these movements pioneered participatory practice in OHS risk prevention. The legislative initiatives of the 1960s-1970s and onwards, in many developed countries, placed strong emphasis on employee participation in the communication and control of OHS hazards. Some of the factors driving these legislative initiatives were the increasingly diverse nature of hazards and exposure to them in the work environment as the result of rapid advancements in the technologies used, increased use of chemicals, the diverse nature of chemicals used, as well as the prevailing socio-political contexts. Employee participation is notably an inherent element of many of these legislative initiatives. For example, the Health and Safety at Work etc Act ("Health and Safety at Work etc. Act," 1974) of the UK specifies, as the general duty of the employer to their employee, the appointment of safety representatives for employees and consultation with such representatives in order to develop and maintain measures to ensure the health and safety of employees at work ("Health and Safety at Work etc. Act," 1974). Similarly, the Danish Work Environment

Act of 1975, consolidated in September 2010 (Danish Working Environment Authority, 2010), stipulates that health and safety work at the enterprise level should be carried out through cooperation between employer and employees. The Act further specifies whether such cooperation should occur at the individual level through personal consultation or at the enterprise level through a health and safety organisation based on the number of employees employed. Likewise, the 2002 amendment to the New Zealand Health and Safety in Employment Act, 1992 ("Health and Safety in Employment Act 1992 Amendment Act ", 2002) clearly spells out the requirement to provide reasonable opportunity to the employees for participation in on-going processes of health and safety improvement in addition to the employer's duty to ensure the safety and health of the employees at work ("Health and Safety in Employment Act, No 96," 1992).

Since employee participation became institutionalised in the business discourse, it has been discussed and debated, and its impacts on organisational performance widely studied. An important conclusion drawn from these discussions and studies is that employee participation in organisations takes diverse forms with varying degrees of influence that define the different levels of participation with subsequently diverse outcomes (Cabrera, et al., 2002; Cotton, et al., 1988; Dachler & Wilpert, 1978; Gill & Krieger, 1999; Seibold & Shea, 2001). In addition to the forms and content of participation, as illustrated in Black and Gregersen (1997) the suggested decision process is the other critical dimension along which employee participation varies. Black and Gregersen considered employee participation to generally occur and vary across five elements of decision process: i. Identifying (problems and issues); ii. Generating (alternative solutions to the problems); iii. Selecting (specific solutions); iv. Planning (implementation of the selected solution); and v. Evaluating (the results of implementation).

2.1.1.2 *Impacts and outcomes*

Just as there are diverse forms, different content and several decision dimensions, so too are there varied outcomes of participatory practice. Based on the findings of a study on participatory practice on work station design, carried out in three large assembly plants manufacturing three different products (industrial furniture, consumer electronics and

large electromechanical products), Launis, Vuori and Lahtela (1996) concluded that participatory design in the workplace has an important impact on motivating people to learn the use of the designed workplace and at the same time actually make the best use of it. Similarly, an experimental study conducted on participatory product design involving the designing of screwdrivers that workers used in their daily work indicated better user performance in terms of increased comfort in their usage and reduced blister conditions, consequently leading to increased productivity (Vink & Eijk, 2007).

A participatory decision making (employee participation in decision making) process significantly contributes to improvement in employee motivation, job performance and firm performance (Bakan, Suseno, Pinnington, & Money, 2004). It is a key factor in employees' acceptance of any organisational change (Gilberg, 1988; Maree, 2000) and is associated with more positive work behaviours measured as level of pride in work, job satisfaction, creativity, peer training, cooperation, effort and commitment (Black & Gregersen, 1997; Hodson, 2002). In contrast, lack of participation in decision making by employees is associated with perceived low level of job security, less employee willingness to use initiative in work and activities, and lowered solidarity in the workplace (Hodson, 2002). Zwick (2004) found that reduced hierarchies and direct involvement of shop floor workers in decision making through teams and workgroups, as a form of employee participation, increased firm performance in terms of increased productivity. The EPOC (Employee Direct Participation in Organizational Change) Project's examination of direct participation (individual/group consultation/delegation) in European countries showed such participation to have a strong impact on economic performance. In particular, the more the employees were consulted and informed, the more positive were the economic effects. As a result the workplaces with participative cultures significantly outperformed, in economic terms, those with no participative cultures (EPOC, 1997).

2.1.1.3 *Participatory practices and OHS risk control*

Participatory practice as a generic approach in the OHS discipline has been applied, studied and demonstrated to display positive results in terms of prevention of injuries, reduced compensation claims and sickness absences. An overview of participatory strategies in four case studies conducted in Canada found the participatory approach to be a more effective means of preventing occupational diseases and, more generally,

promoting occupational health, rather than eliminating only specific risk factors (Kuorinka & Patry, 1995; Pehkonena, et al., 2008; Rivilis, et al., 2008). Similarly, a study that evaluated the participatory ergonomics intervention process, which allowed workers in 59 municipality kitchens in Finland to generate solutions to optimise the musculoskeletal load in their work, found that such an approach was perceived to improve musculoskeletal health in terms of OHS outcomes (Pehkonena, et al., 2008). The study also identified support from the management as an important factor facilitating implementation of the participatory process. A systematic review of health outcomes of participatory ergonomics found partial to moderate evidence that participatory ergonomics intervention had a positive impact on musculoskeletal symptoms, reducing injuries and lost days from work or sickness absences (Rivilis, et al., 2008). A study that applied the participatory approach to product development in an automotive plant concluded that such an approach facilitated better communication among different groups in the process, thus increasing cooperation and potentially improving productivity and ergonomics (Sundin, Christmansson, & Larsson, 2004). Some other studies (Geldart, et al., 2010; Wokutch & VanSandt, 2000) found higher levels of management-employee cooperation through worker participation, and the management involvement in OHS initiatives led to establishment of safer workplaces with lowered lost-time injury frequency rates and reduced workplace injuries. A study on OHS management practice in enterprises in Canada found that the firms which entrusted employees to identify hazards in the workplace and were more open to sharing opinions on control measures were positively related to taking a participatory approach to actual control of hazard and risks in the work environment (Champoux & Brun, 2003). Such an inclination to adopting the participatory approach was found to lead to identification of organisational and job-related factors as the cause behind injuries, as opposed to blaming individual employees as the cause. However, these findings were related to those firms employing between 26 and 50 employees. The existing literature such as these abundantly evidence the positive impacts of participatory practice in the workplace, but mainly in the areas of ergonomics (Granzow & Theberge, 2009; Kuorinka & Patry, 1995; Pehkonena, et al., 2008; Rivilis, et al., 2008), the ergonomic design of workplace and workstations (Geldart, et al., 2010; Markey & Patmore, 2011; Shearn, 2004; Wokutch & VanSandt, 2000) and predominantly in large businesses. Participatory practices in SBs remain little studied and in particular there is a

dearth of knowledge on this in the identification and control of OHS hazards and risks in SBs.

2.1.2 Context of management of SBs and control of OHS risks

Research and studies on SBs have substantially evidenced that they have their own complex contexts of entrepreneurship, human resource management practices and training and employee relations. Situated within this complexity is the OHS practice of the identification and control of OHS hazards and risks. This section of the thesis deals with where OHS practice fits within the complex contexts of various management practices in SBs.

2.1.2.1 Entrepreneurship and OHS practices

The available literature evidences the existence of a large body of knowledge on entrepreneurship in SBs. Such a knowledge base pertains largely to the intentions and motivations for starting up a business and profiling of the owner-manager based on these factors (Akehurst, Simarro, & Mas-Tur, 2012; Bridge, O'Neill, & Cromie, 2003; Deakins & Freel, 2003; Lewis, 2008; McMohan, 2001; Storey, 1994; Tregar, 2005). Even though there is an ever-growing knowledge base and research evidence on SB entrepreneurship, their economic contribution and the challenges faced by them (Akehurst, et al., 2012; Brush & Cooper, 2012; Davis & Shaver, 2012; Lockyer & George, 2012), the literature largely shows an almost complete absence of evidence on the way the entrepreneurs in SBs manage OHS hazards and risks. In addition, given the situation that the owner-manager is the key person in making decisions in SBs and his/her values determine the approaches taken to managing OHS hazards and risks in the work environment (Hasle & Limborg, 2006; Vickers, et al., 2003; Vickers, et al., 2005), there is an urgent need to reconsider ways of exploring the identification and control of OHS risks and hazards in SBs to raise the profile of OHS so as to improve the well-being of people in the local work environment. As rightly said by Dawson and Zanko (2009), "… many mainstream companies, managers are not managing OHS effectively. This neglect is reflected in the mainstream management and human resource management research literatures, where a longitudinal review of key journals showed an almost complete absence of scholars considering OHS management in organizations ..". Thus there is a need to raise the profile of OHS and to consider new and innovative ways of developing OHS to improve the well-being of people at work" (pp. 7).

2.1.2.2 Human resource management and OHS practice

The effect and interaction of external factors (such as industry, sector, the market structure and human resource supply) and internal factors (such as size, management style and ownership) make human resource management in SBs complex and emergent (Harney & Dundon, 2006). The level of external uncertainties (Casson, 2003; Storey, 1994) and the interaction and interrelationships between the business and family-friends (Goffee, 1996) make an SB a complex entity. Harney and Dundon (2006) suggested that as survival is the most pressing issue for SBs, the owner-managers usually work intuitively and apply informal measures such as 'keeping busy all the time' as an indicator of human resource management performance. As such, the human resource management practice is based on the need of the time driven by experience-based knowledge of the owner-manager (Lewis & Coetzer, 2009), resource availability and the owner-manager's interest (Cassell, Nadin, Gray, & Clegg, 2002; Saru, 2009). Within such human resource practices, SBs seem to take an ad hoc approach, i.e. informal, implicit and reactive approach, to the identification and control of OHS hazards and risks (Vickers, et al., 2003). Family-friends seem to be the main source of support and advice on managing hazards and risks in the work environment (Down, 2006; Lamm, 2002; Marlow & Patton, 2002) on top of managing various functions of the business (Cameron & Massey, 1999; Lamm, 2002; Lewis, et al., 2005).

The informal and needs-based human resource practice extends well into training, education and learning of the employees, which is primarily driven by the knowledge of 'what works best' on the part of the owner-manager (Lewis & Coetzer, 2009). Training and learning at work have been positively related to performance of the business in general (Cassell, et al., 2002; Saru, 2009). Similar was the finding of a study by Corneliusson (2005) in relation to the identification and control of hazards and risks. In her case study of a biotech firm, she found that because of the high level of education, training and professionalism, the employees had a better understanding of hazards and risks which they exhibited through high standards of safe practices, despite not being aware of the detailed policies on OHS and the lack of a formal OHS system in place.

2.1.2.3 Employee relations and OHS practices

For many of the SB owner-managers, the autonomy and desire to provide a good service are the dominant drivers for setting up a business and not profit maximisation (Beaver, 2003a, 2003b). In that respect, the employee relation is an important aspect of

the daily business routines of the owner-manager. The management of an SB usually follows informal, verbal and short lines of communication and a simple structure (Eakin, Lamm, & Limborg, 2000; Larsson, 2003; Mayhew, 2002; Walters & Lamm, 2003). As such, the owner-manager and employees in an SB have personal contact on a daily basis such that the interaction and interrelationships between the owner-manager and employees are personal, informal (Marlow & Patton, 2002; Tsai, Sengupta, & Edwards, 2007) as well as a mix of dissent and accommodation, conflict and cooperation (Edwards, Ram, Sengupta, & Tsai, 2006; Lamm, 2002). The employment relations practice in SBs could take a superior form because of the lower level of conflict, less bureaucracy, flexible work environment and simpler communication processes. Or it could take a poorer form because of the possibility of obscured conflict, lack of formality in recruitment, training and division of labour and poor working conditions (Massey, 2004; Wilkinson, 1999). Because of such mixed interactions and interrelationships, the owner-manager strives to establish a good relationship with the employees in the work environment (Edwards, et al., 2006; Tsai, et al., 2007). Reciprocally, the employees by exhibiting increased participation in the daily business activities, appreciate the close relationships and accept the values and decisions of the owner-manager including approaches taken to health and safety management (Hasle & Limborg, 2006; Vickers, et al., 2003).

2.1.2.4 Regulatory compliance and OHS practices

In relation to regulatory compliance, accountants are found to be the widely recognised professional resource for information and advice including OHS compliance (Cameron & Kirkley, 2011; Lamm, 1997, 2002). With the high level of trust and reliance on internal staff members or close associates for compliance advice, regulatory agencies are shunned in gaining access to SBs and as a result they are generally overlooked by such agencies (Lamm, 1997, 2002). Such situations potentially lead to SBs' lack of trust in the regulatory agencies, undermining compliance and monitoring of activities in the identification and control of hazards and risks (Eakin, et al., 2000; Laird, et al., 2009; Legg, et al., 2009). For example in New Zealand, the Health and Safety in Employment Act, 1992 was introduced with the broad aims of preventing injuries at work as well as promoting the management of hazards and risks in workplace. The Act sets out general duties for both the employers and employees in relation to managing hazards and risks in the workplace. OHS responsibility and accountability, such as establishing and

maintaining a system to deal with hazards and risks, sit largely with the employer and to a lesser degree the employee. However, SB employers have mostly exhibited indifference to OHS regulatory inspectorates and perceived such regulatory compliance to be inappropriate and an added burden for them (Lamm, 1999). Factors such as unskilled/semi-skilled casual employment (Lamm, 2002), owner/managers' incompetence to put in place OHS procedures (Walters & Lamm, 2003) and them being unaware of the regulatory provisions (Lamm & Tiplpes, 2011) add to regulatory non-compliance and deteriorating OHS conditions in an SB work environment. The other factor significantly closely associated with compliance and regulation in relation to OHS in SBs is the cultural and social norms of the owner/manager in individual SBs (Massey & Ingley, 2007).

In the backdrop to the characteristics of SBs – the contexts of entrepreneurship, human resource management, employee relations, and compliance and regulation of OHS in SBs – there exists very little knowledge of the understanding of OHS risks and participation by the employer and employee on the identification and control of hazards and risk in the work environment.

2.1.3 Understanding of OHS risks, risk control and participation in SBs

Simply defined, OHS risk is the possible injuries or bodily harms arising from an undesirable event associated with hazard present at a work environment (Quinlan, 2010). But OHS hazards and risk is a topic that is examined from a broad number of disciplinary perspectives. Prominent among these perspectives are occupational medicine, hygiene, engineering, ergonomics, work psychology, employment relations, law and economics (Quinlan, et al., 2010). For example, occupational medicine relates workplace hazards with the direct and indirect impact on bodily functions and contributes towards protecting employee health from specific hazards. On the other hand, the occupational hygiene perspective relates OHS hazards to managing occupational health through the identification, evaluation and control of hazards namely, physical, chemical and biological hazards (Quinlan, et al., 2010). The engineering perspective examines risks as the probability of injuries and endeavours to minimise such risks by minimising the exposure to hazards through engineering means. The work psychology perspective, on the other hand, relates injuries and ill health to individual behaviour rather than the conditions of work and exposure to hazards,

focusing on psychological discipline and individual behaviour as preventive and control measures (Quinlan, et al., 2010).

The different perspectives of examining hazards and risks potential means resorting to different conceptions and approaches to the identification and control of hazards and risks by the social groups at various level of their influence. On the basis of risk conception and control approaches, OHS risks can be described along three broad and prominent perspectives that yield different definitions of these risks and correspondingly varied concepts/approaches to risk control. These are: i. Technical approach; ii. Psychological approach; and iii. Social approach (Quinlan, et al., 2010; Renn, 1992). The technical approach to OHS risks defines risks as the physical harms, such as injuries or ill-health, arising from undesirable events. Such an approach to risk tries to establish a relationship between the potential risk agent and the risk of physical harm by quantifying risks through scientific (e.g. statistical extrapolation of data on physical harms, accidents and injuries), technical (e.g. predicting failure probability of technological systems through probabilities risk assessment) or medical (e.g. toxicological or epidemiological methods of quantifying the possibility of undesirable events and exploring causal relationships) knowledge (Renn, 1992). In terms of control, the technical approach describes risks control as a three stage process (Holmes, et al., 1998; Quinlan, et al., 2010). The first stage of risk control is identification of the physical, chemical, biological or ergonomic hazards associated with the risks from all possible sources. Second, identification of hazards follows assessment or evaluation of the level of risk associated with these hazards. Assessment in the technical risk approach involves quantifying the level of risks as a product of probability of occurrence of an undesirable event and the severity of the consequence of such an event. Finally, with successful identification of hazards and assessment of associated risks, control strategies are devised to bring the level of risks down to an acceptable level. The risk control strategies include elimination, substitution, isolation and minimisation and constitute the hierarchy of preference in order of effectiveness, with elimination (through technological and engineering techniques) as the most preferred strategy and minimisation (through the use of personal protective equipment or administratively) as the least preferred (Alli, 2001; AS/NZS, 2001; Lingard & Holmes, 2001).

The second approach to risk conception and control is the psychological approach, or the behavioural perspective, of defining risks based on individual perception and the subjective judgement of perceived nature and magnitude of risks (Holmes, et al., 1998; Renn, 1992). Risk perception, or the behavioural perspective of risk, is influenced by a number of variables that explain the apparent differences in risk judgement and control of risk (Renn, 1992). These variables are divided into three categories – risk characteristics, risk knowledge and risk potential. Risk characteristics are the perceived properties of risk source, perception of possible consequences, confidence in one's ability to control risk (control over probability or magnitude), perception of risk sharing and potential to blame a person or institution. Risk knowledge is the knowledge and beliefs about the nature, consequence and the justifiable cause of risk. Risk potential pertains to the perceived seriousness in terms of probability and consequences. Risk control, whether or not risks are controllable or controlled through human intervention, from the psychological perspective are mainly determined by risk characteristics and risk potential. For example, an individual or a group of individuals are likely to pursue control of risk catastrophically harming a large number of people at one time even if it is perceived of low probability as opposed to not pursuing to control a risk harming one person at a time over a long period of time. This is despite having perceived the risk as of high probability.

The third perspective of risk conception, the social perspective, defines risk as the outcome of how social groups perceive potential hazards, injuries and harms within the social context of their occurrence. Institutional and organisational dimensions, such as who can take a decision or who has the authority to allocate resources, constitute the social contexts. In that respect the social institution and organisations have primary influence on the production, perception and control of risks (Holmes, et al., 1998). The social contexts of equalities and inequalities (or similarities and differences) raise similarities and differences in what are understood by different social groups as risks as well as the meaning of risks to them. Importantly, these similarities and differences are reflected in risk control such that some risks are considered important/beneficial to control while others are not and are left uncontrolled.

The three perspectives on risk conception are closely related to the concept of understanding of risks as suggested by Jensen (2002). Jensen (2002, p. 211) who states

that risk understanding can be explained at three levels: expert-based understanding; legal understanding; and local understanding. The expert-based understanding of risk is the quantitative product of the probability of occurrence of an undesirable event and the consequences of such an event (Jensen, 2002; Renn, 1992) and is closely associated with the technical perspective on risk conception. The legal understanding of risk is the product of political processes of compromise and consensus among various stakeholders and arrival at a definition and characterisation of risks and risk control. Such compromise and consensus is based on the existing knowledge of risk characteristics and risk potential and thus is closely associated with the psychological perspective of risk conception. The local understanding of risks relates to the establishment of a shared/common definition of risks between social groups, the employer and employees, within their work environment context. In the context of a local work environment, understanding of OHS risks as gained by the employer and employees, the two social groups, is key to approaches and strategies for the identification and control of hazards and risks (Hasle, et al., 2012; Holmes, et al., 1997).

A systematic review of the qualitative literature on findings about the employer and employee understanding and processes on OHS reported that both groups largely showed workplace health risks as an individually navigated phenomenon. This meant that the employees showed a strong belief that the control of workplace health risks was their responsibility and the employers did not feel any responsibility towards the identification and control of hazards and risks (MacEachen, et al., 2010). The few studies that explored the meaning of risks for employers and employees in relation to their control found that the parties generally considered OHS hazards as either not really dangerous or as an acceptable part of their work or that the hazards were not preventable (Holmes, et al., 1998; Holmes, Lingard, Yesilyurt, & Munk, 1999).

The differences in understanding and perception of OHS risks not only add to the conflicts between employer and employees about whose interests health and safety action best serve (Walters & Frick, 2000), but importantly hinder prevention of workplace injuries and accidents (Holmes, et al., 1998; Holmes, et al., 1997). Furthermore, the understanding that hazards are either just normal occurrences in the workplace or that they are not preventable are counterproductive to their realistic identification and control (Hasle, et al., 2009). The literature suggests that a number of

factors add to the grimmer situation of OHS performance in SBs. Most of all, SBs lack the necessary financial resources and time to seek the advice, information, tools and techniques necessary to meet regulatory compliance requirements (Champoux & Brun, 2003; Fabiano, Curro, & Pastorino, 2004; Hasle & Jensen, 2006; Hasle & Limborg, 2006; Walters, 2004).

In addition, the perceived economic disincentive of OHS compliance (Legg, et al., 2009), trivialisation of commonly occurring risks (Hasle, et al., 2012; Mayhew, 2002), and incapacity to hire specific personnel for OHS surveillance resulting in the need for the employer-manager to take multiple roles and carry out various tasks as needed (Hasle & Limborg, 2006; Okun, et al., 2001) seem to undermine the activities for the identification and control of hazards and risks and participation (Gardner, et al., 1999; Hasle & Limborg, 2006; Mayhew, 2002; Walters & Lamm, 2003). However, the context of the employer-owners in SBs acting as accountant, quality controller, human resource manager and health and safety advisor (Hasle, et al., 2009; Legg, et al., 2009) makes them very adept in undertaking multiple roles (Cameron & Massey, 1999; Lamm, 2002). Similarly, employees in the absence of precise role specification undertake a variety of tasks, fulfilling a number of roles, and through hands-on participation align themselves with the ideals of the employer-owner in seeking organisational goals (Legg, et al., 2009). The characteristic way the employer-owner and employees are engaged in the day-to-day operation provides a basis for participatory practice in SBs. In particular, the employer and employees work alongside each other, making it inevitable for them to face diversely similar hazards under similar conditions of work (Champoux & Brun, 2003). Similar experience of the work environment for employer and employees creates a unique situation and is a key condition for similar understanding of OHS risks and consequent participation in their identification and control. However, given the context and characteristics of the management of SBs, the existing literature evidences the presence of a very small body of knowledge on the understanding of OHS risks between employers and employees in the local work environment in SBs and how such understanding is related to participation in the identification and control of OHS hazards and risks.

The present study, therefore, aimed to examine the understanding of OHS risks by employer and employees in the SB work environment and the implications of such

(local) understanding of OHS risks on participation in the identification and control of hazards and risks by these groups.

Chapter 3 Methods

This chapter outlines different stages and the timeframe of the overall study, the specific objectives of the study and its methodological approach, including the methods of data collection and analytical technique adopted to achieve these research objectives.

3.1 Timeframe of the study

The study was conducted over a period of four-and-a-half years since the initial conception until final submission of the thesis, from 2 February 2008 until 15 August 2012. Accomplishment of the entire study transpired in four subsequent stages: i. Initial conception and development of study proposal; ii. Data collection field work; iii. Data processing and analysis; and iv. Thesis write-up and submission. The initial conception and proposal writing was completed in March 2009 with confirmation of registration. This followed data collection field work which included screening and selection of businesses and accomplishment of pilot study to test interview techniques and subsequent full data collection. Data collection field work was accomplished by the end of July 2010. Data processing and analysis was accomplished during the period from August 2010 until April 2011. Data processing involved transcribing interview responses and importing them into computer software for analysis. Starting from May of 2011, writing up of thesis was completed in mid-August 2012 and thus submitted for examination.

3.2 Study objectives

The study explores understanding of OHS risks by the owner/manager and employees with the overall aim of establishing empirical knowledge about the way such understanding of OHS risks shapes their participation in the identification and control of OHS hazards and risks. In broad terms, this study aimed to qualitatively explore the understanding of OHS risks by employer and employees in the local work environment context and explain participation in the identification and control of hazards and risks based on the local understanding of these risks. Overall the study had the following specific objectives:

First, to determine the understanding of OHS risks by employer and employees;

Second, to identify whether employers and employees have a common or a different understanding of OHS risks utilising the four elements of the LTWE (Jensen, 2002) framework;

Third, to establish the explanations for the similarities and differences in the understanding of OHS risks between employer and employee groups through the LTWE (Jensen, 2002) framework;

Fourth, to examine the usefulness of the LTWE (Jensen, 2002) framework in relation to the approaches taken towards the identification and control of hazards and risks in SBs;

Fifth, to characterise owner/manager and employee participation in the identification and control of OHS hazards and risks in light of the both groups' understanding (i.e. local understanding) of these risks;

Finally, to determine the influence of participatory characteristics on the identification and control of OHS hazards and risks.

Accomplishment of these objectives would significantly contribute to a general understanding of why some risks and associated hazards in small workplaces are controlled while some others remain uncontrolled. In addition, it may provide some useful insight into the appropriateness of the LTWE framework in the SB context in relation to the control of OHS hazards and risks.

3.3 Study design and approach

The study took an inductive qualitative approach (Gibson & Brown, 2009; Patton, 2002; Saunders, Lewis, & Thornhill, 2007) using the LTWE as the analytical framework and adopted the epistemological stance of constructivism (Patton, 2002; Saunders, et al., 2007).

Understanding of OHS risk is socially constructed. What one person perceives as an OHS risk in the workplace may not be perceived equally as a risk by another person or vice versa. Similarly, what one social group (e.g. employees) considers a definite OHS risk may not be considered as much a risk by the other social group (e.g. owner/managers). Risk may mean not only different things to different groups, but even the same hazard may be understood differently and may be perceived by different groups as carrying different levels of risk (Renn, 1992). Therefore, constructivism (Burr,

2003; Flick, 2004) is a strongly advocated qualitative research paradigm in relation to SBs simply because: "It is an approach which embraces the notion of multiple realities and accepts that each individual constructs their own reality as they interpret and perceive their world. To represent this world, therefore, means that the researcher must represent or reconstruct the world as seen by others" (J. Hill & McGowan, 1999). The other issue that needs to be considered while researching SBs is the epistemological stance. This stance is the process of going into the social world of the subjects, understanding this world from their perspective, and interpreting the meaning from their standpoint (Saunders, et al., 2007). Given the dynamic, unstructured, chaotic characteristics of SBs and the influence of individual personality and behaviour of owner-managers in decision making (J. Hill & McGowan, 1999), including decisions related to the identification and control of OHS hazards and risks, Hill and McGowan (1999) rightly advocate for the epistemological stance that necessitates researcher immersion into the SB and that dictates minimisation of the distance between the researcher and subject. The adoption of the constructivism paradigm and the aforementioned epistemological stance is proven appropriate for the reason that they are rooted in the acceptance of multiple realities and complex situations (Lewis & Massey, 2007) which, in particular, allows comprehension of a social construction of an understanding of OHS risks from the perspective of the social groups grounded in their experience in the local work environment. In addition, the study envisages using the LTWE (Jensen, 2002) as an analytical tool to examine local understanding of OHS risks by social groups. There exists little prior knowledge about such an application. The constructivist paradigm with the adoption of a qualitative approach allows enhanced an understanding of OHS risks by the social groups and their participation in the identification and control of OHS hazards and risks in their work environment. Such an interpretation and explanation would subsequently establish empirical knowledge and understanding of the usefulness of LTWE.

Drawing from the qualitative paradigm and epistemological stance of researching SBs, a number of methods and approaches have been suggested and advocated (Curran & Blackburn, 2001; J. Hill & McGowan, 1999). Case studies (Chetty, 1996; Romano, 1989; Yin, 2009), ethnographic research (Holliday, 1995; Miles & Huberman, 1994; Patton, 2002) and grounded theory (Douglas, 2003a, 2003b; Strauss & Corbin, 1990) are the main widely suggested qualitative research methods and approaches for SBs. Because of

their highly individualised nature of operation with a unique local work environment context, SBs are likely to induce considerable variation in the nature and content of data responses in relation to the understanding of OHS risks and their identification and control. A research approach based on qualitative methods is "data driven" (Patton, 2002, p. 58), which permits a concrete outcome of the study to be derived by allowing the comprehension of the possible variations in the data sets. As stated by Patton (2002), "Qualitative inquiry is particularly oriented towards exploration, discovery and inductive logic. Inductive analysis begins with specific observations and builds towards general patterns (pp. 55-56)", which draws data from multiple sources – detailed observations, quotations, documents and interviews (J. Hill & McGowan, 1999; Lewis & Massey, 2007; Romano, 1989; Yin, 2009). The present study adopts a qualitative multiple case study as the study approach.

3.4 Study strategies

SBs are uniquely different from one enterprise to another in terms of organisation and structure in general as well as management and control of OHS hazards and risks in particular. The difference among SBs in relation to the identification and control of OHS hazards and risks is brought about by the fact that the values and opinions of the owner-manager as the key person is largely the approach taken to the management of hazards and risks (Eakin, et al., 2000; Hasle, 2000; Mayhew, 1997). Given the multiple realities and unique characteristics, SB research strategies must take an open-ended approach if such research is to develop into a deeper understanding of these multiple issues (Romano, 1989). Adoption of a case study approach allows the investigation of contemporary phenomenon within the present circumstances and real life context (Chetty, 1996; Travers, 2001; Yin, 2009). The rationale for the adoption of a qualitative case study approach in the present study is established by the following reasons. First, there is a lack of pre-existing knowledge on the use of the LTWE framework in deriving the understanding of OHS risks by employer and employees in the local work environment context. Lack of such previous knowledge makes it difficult to adopt a quantitative approach in the study, as it is difficult to develop categories of questions on which such an approach is based. The absence of prior knowledge on the use and usefulness of LTWE makes it appropriate to take an inductive case study approach to the study. Although factors like the firm size and training have been shown to be

correlated with reduced injuries as a measure of better OHS performance (Champoux & Brun, 2003; Corneliusson, 2005), the causality remains little known.

The case study approach generates a wealth of information and unique perspectives on the world. Based on the interpretation of this information this approach contributes greatly to context-dependent meaningful learning (Flyvbjerg, 2001, 2006; Travers, 2001). The opportunities grounded in the contexts of the source of data and information form an important basis for acquiring newer knowledge encasing heterogeneity of the issues and procedures and their relationships in the context in which they are applied (Romano, 1989).

It is therefore argued that the case study approach to the present study will provide an opportunity to explore and better understand the causality of understanding of OHS risks and the relationship of understanding of these risks with participation in the identification and control of risks. The adoption of a multi case study approach allows the possibility to study patterns common to cases and avoid chance associations (Eisenhardt, 1991). In that respect, the multi case study approach offers wider and deeper insight into the issues, procedures and their relationships under study. As observed by Miles and Huberman (1994, p. 151), "By comparing cited cases one can establish the range of generality of a finding or explanation and at the same time pin down the conditions under which that finding will occur … There is much potential for both greater explanatory power and greater generalisability than a single case study can deliver". Importantly, the multi case study approach follows the replication logic of multiple experiment design such that the evidence from a multi case study is more compelling and the overall research is regarded as more robust (Yin, 2009). It is therefore argued that the multi case study approach adopted in the present study allows a greater opportunity to explain how OHS risks and hazards are understood by social groups. In addition, such an approach allows the possibility of explaining participation in the identification and control of hazards and risk as well as why some hazards and risks are identified and controlled while some are not.

The present study was based on three case studies of restaurants and cafes in operation in the central region of the North Island, New Zealand. While adopting a multi case case study approach there is always the danger of getting overloaded with data and the level of analysis to be executed. Therefore the numbers of case studies to be

encompassed in the study need to be decided skilfully such that consistency can be obtained over the processes and procedures and also that the case study analysis allows an in-depth analysis of the variables that are important to the area of enquiry (Romano, 1989). It is therefore argued that the decision to encompass three case studies allowed the possibility of maintaining the balance between getting the desired level of consistency in terms of data collection and analysis procedure. But importantly, theoretical saturation (George & Bennett, 2005) in terms of applying LTWE to the three possible scenarios of SB nature, informal, transitional and formal operation, potentially allows achieving the depth and breadth of analysis on the subject of interest.

The restaurant and cafe industry sector was selected for this examination for a number of reasons. First, restaurants and cafes are known as a sector predominantly with SBs, which have unique contexts in relation to OHS risks. Restaurants and cafes combine elements of simultaneous production/transformation, service and consumption in their operations, with customers as active participants in the process. Meeting the needs of customers, who are integrally involved in the production/transformation process, requires a combination of a wide range of activities with a high degree of coordination (Mullins, 1993). Such requirements often involve performing tasks under time pressure and at the same time demand long and 'unsocial' hours of work.

A second reason for choosing the restaurant and cafe industry was that it is a sector which is characterised by individual owner/manager operated SBs, which may have a short lifespan, and commonly have a high level of temporary and part-time employment (Ryan, 1996). Such characteristics create specific problems for the control of OHS hazards. The combination of these factors generates a unique context that contributes to an increased diversity of occupational hazards in addition to the more traditional physical and chemical hazards in the work environment. Slips, trips and falls (Verma et al., 2010), burns and heat stress (Young & Corsun, 2010), manual tasks, machinery and equipment, and chemicals are some of the important OHS problems outlined in most of the hazard identification procedures (Worksafe-Australia, 2010). Research studies reported physical, chemical and psychosocial exposure as the main hazards in the restaurant and cafe work environment (Jayaraman, Dropkin, Siby, Alston, & Markowitz, 2011; Suzman, Sobocinnski, Himel, & Yurt, 2001).

Most research in relation to employer and employee understanding of OHS risks in the local work environment context has been undertaken in sectors other than restaurants and cafes and has primarily explained the causes behind OHS risks as perceived by the employer and employees (Holmes & Gifford, 1997; Holmes, et al., 1998; Holmes, et al., 1997; Lingard & Holmes, 2001). Those studies involving restaurants and cafes have largely focused on employment relationship (Ryan, 1996) or food safety (Taylor, 2008; Taylor, Assan, Green, MCann, & Rodriguez, 2008) issues and very few sought to explore the identification and control of OHS hazards and risks in this sector. Most of the available literatures related to small restaurants and cafes pertain to documentation of practical processes and procedures on the identification of OHS hazards and risks in the work environment (Worksafe-Australia, 2010). Although a few of the research studies mention hazards and health outcomes (e.g. (Jayaraman, et al., 2011), and injuries (e.g. (Young & Corsun, 2010) in the restaurant and cafe sector), studies exploring employer and employee understanding of OHS risk in the local context of small restaurants and cafes and explaining the participatory approach to the identification and control of OHS risks in light of such an understanding are largely not evident.

3.5 Methodological approach

The methodological approach described in this section of the thesis pertains to screening of the SB cases participating in the study, the techniques of data collection and analysis.

The participating cases were positively selected (Patton, 2002; Saunders, et al., 2007) from those falling within the set criteria. As a selection criterion, the participating business cases were independently owned SBs employing between six to 19 employees and had been in operation for more than a year. Independent ownership, as a selection criterion, allowed de-selection of franchises and chain restaurants and cafes despite these falling within the definition of SBs. Unlike independently owned SBs, franchise and chain restaurants and cafes were assumed to have formal OHS practices in place governed by their respective parent organisations. This was assumed to be a key difference between them and the general population of SBs, and thus explained their de-selection for the present study. The length of time in operation, set at a minimum of one year as a selection criterion, was considered as allowing selection of SBs with stable employment relations and operational practices including OHS. Finally, as the focus of

the present study was on SBs, an EC of six to 19 was used as the defining criterion for selection of businesses for inclusion in the study, and this has indeed been the widely used classification of SBs in research (Massey, 2004, 2005b).

The study was designed to combine the techniques of semi-structured interviews (SSI) (J. Hill & McGowan, 1999; Kvale, 1996) with participant-as-observer ethnographic field observations (Patton, 2002; Yin, 2009) for data collection and thematic analysis (Braun & Clarke, 2006; Miles & Huberman, 1994; Patton, 2002) for data analysis. A semi-structured interview technique allows plentiful opportunities for open-ended responses as well as in-depth enquiry through follow-up questions making investigation into the area of study easy, free flowing and warranted (Kvale, 1996). As put forward by Patton, such "open ended responses permit one to understand the world as seen by the respondent" (Patton, 2002, p. 24), which fitted well with the constructionist philosophical stance taken by the study. This, in congruence with the objectives of the study, enabled empirical understanding of the development of a local understanding of OHS risks and participatory practice in the identification and control of risks. In addition, the close congruence between the philosophical stances the study adopted with a semi-structured interview technique for data collection enabled the study to uncover the points of view of the respondents without any imposition of the researcher viewpoint through pre-determined categories of questionnaires or questions.

Participant-as-observer ethnographic observation meant that my identity and purpose as the researcher were fully revealed to the employer and employees before commencing field observation (Patton, 2002; Saunders, et al., 2007; Yin, 2009). Revelation of identity was considered to have a number of methodological advantages. First, the identity of the researcher had to be revealed to the employer to obtain their initial consent to participate in the study and to access the workplace for observation and the employees for interviews. In that respect, revealing my identity to the employees before commencing field observation was considered a fair approach in terms of delivering equal information to employer and employees. Revelation of identity at the beginning was appropriate to dispel any possible sense of deception, as it otherwise would have had to be revealed later during interviews. Second, identity revelation was envisaged to foster positive acceptance of the presence of the researcher (Patton, 2002) and promote uniformly neutral treatment by all in the work environment setting (they would more

likely see me as 'one of them'), which otherwise would have been difficult to achieve in a short period of time. Finally, revelation of identity was assumed to institute a neutral researcher presence in the field observation situation and minimise biased responses (Saunders, et al., 2007).

The combination of these two techniques had two advantages. First, it allowed the possibility of gathering in-depth and detailed data complementing interview responses (J. Hill & McGowan, 1999; Perren & Ram, 2004), enabling me to understand the point of view of the subjects in their setting and therefore to achieve the study objectives optimally (J. Hill, Nancarrow, & Wright, 2002; Patton, 2002; Romano, 1989; Saunders, et al., 2007). Second, the field observation data allowed for the possibility of validation of data responses obtained from semi-structured interviews (J. Hill & McGowan, 1999; Patton, 2002; Saunders, et al., 2007) which, as noted by Patton (1990), "would have limitation to how much can be learned from what people say to understand the complexities of many situations" (p. 25). In addition, the observer-as-participant ethnographic observation provides the opportunity for the observer and participants to establish a common field of knowledge about the work environment and the hazards and risks and thus overcome discrepancies in the data (Romano, 1989). Observer-as-participant ethnographic field observation is therefore argued to provide the opportunity to obtain first-hand knowledge and data rich with information on owner/manager and employee participation in the identification and control of OHS risks which otherwise would have been difficult to acquire only through interview responses (Tedlock, 1991).

3.5.1 Screening of participating cases

The Australia and New Zealand Standard Industrial Classification (ANZSIC) system was used to make selection of the participating cases in the study. This system classifies restaurant and cafe businesses (ANZSIC H451100) as one of the three sub-groups under ANZSIC H451. Table 3-1 illustrates the ANZSIC classification of restaurant and cafe.

Table 3-1: ANZSIC classification for restaurant and cafes industry sector

Classification code	*Group and sub-groups of industries*	
H	Accommodation and Food Services	
	H44	Accommodation
	H45	Food and Beverage Services
		H451 Cafes, Restaurants and Takeaway Food Services
		H451100 Cafes and Restaurants
		H451200 Takeaway Food Services
		H451300 Catering Services
		H452 Pubs, Taverns and Bars
		H453 Clubs (Hospitality)

A web search through the *Yellow Pages* (Yellow Pages Group, 2008) resulted in a listing of 194 businesses in the Manawatu district in the North Island of New Zealand which belonged to the three sub-groups collectively under the classification group ANZSIC H451. An initial screening was performed which excluded those firms belonging to the other two sub-groups of industries, Takeaway Food Services and Catering Services, as potential participants in the study. Further screening based on the number of employees excluded those businesses employing fewer than five employees from participation in the study. Exclusion/inclusion of participating businesses based on the number of employees was based on the web results for the ECs, which not all the businesses had disclosed. Despite having approached Statistics New Zealand (SNZ) and the Hospitality Association of New Zealand (HANZ) to assist with providing demographic information on the small restaurants and cafes in operation in the Manawatu district, which would have enabled rigorous screening, compliance with the provisions of the Privacy Act, (1993) made it impossible for them to release such information. This subsequently hindered screening of potential participant businesses on the basis of EC. With the screening that was able to be done, 166 businesses were left identified as possible participants for the present study.

Further screening was carried out to exclude businesses catering for ethnic food. There were mainly two reasons for exclusion of ethnic restaurants from the present study. First is that the social groups, employer and employees, engaged in ethnic businesses are most likely to be from the same ethnic and cultural background (Massey, 2005a). This is envisaged to have a significant cultural influence on entrepreneurial behaviour with regard to organisational issues (Basu & Altinay, 2002), e.g. team-based working (So, West, & Dawson, 2011), as well as on understanding of OHS risks and participation in

the identification and control of these risks (Gephart, Steier, & Lawrence, 1990; Lamm, 2002; Legg, et al., 2009; Pidgeon, 1997; Richter, 2003). As cultural influence is not the focus of the present study, ethnic restaurant and cafe businesses were excluded from participation in order to mitigate such influences. Second, with ethnic businesses, one of the important cultural attributes of the employer and employees is having English as their second language (Basu & Altinay, 2002; Lamm, 2002; Massey, 2005b). Being myself a speaker of English as a second language, I considered that this could potentially create significant communication barriers between me as researcher and the study subjects, possibly resulting in inadequate data responses to answer the research questions persuasively. Exclusion of ethnic restaurants was confirmed through telephone conversation. After these exclusions, 141 businesses remained as potential participants for the study.

Cases participating in the study were selected randomly from the list of restaurants and cafes that were retained after de-selection and exclusion of the other restaurant and cafe businesses that did not meet the inclusion criteria. Telephone contact was made with as many businesses as possible. Most of the businesses contacted were not willing to be part of the study and the most common response from them was "we are very busy" and/or "we do not have time". Some of the businesses did not want to say no instantly to my request to conduct the study in their organisation. Those businesses suggested leaving my name and contact phone number so that they would be able to contact me later to agree or disagree to participate in the study. None of these businesses contacted me later and I assumed it was another way of saying no to their involvement in the study. Some businesses responded positively to the possibility of conducting the study but informed it needed to be discussed with and agreed by the owner. I obtained the contact details including the suitable time to contact. With only a few businesses could I talk directly to the owner in my first contact. I also made follow-up contact with the other businesses where I had the contact details for the owner. During these first contacts with the owner I briefly explained about the purpose of my study. I also gathered very general information around the number of employees and the number of years in operation. As the focus of the study was the SBs employing six to 19 employees that had been in operation for more than a year, I positively selected those businesses in operation for more than this time. From the remaining businesses, to allow consistency over the processes and procedures as well as in-depth analysis of the important

variables, (Romano, 1989) they were divided into three groups – those employing six to nine, 10-14 and 15-19 employees. The division was based on the notion that an SB tends to transit from its informal nature of operation to a more formal nature as the number of grows, with six to nine being a size exhibiting informal nature of operation, 15-19 exhibiting a more formal nature and 10-14 being the transitional size (Cameron & Massey, 1999). During the second round of contact the first business from each of these three groups that agreed to take part in the study was positively selected for inclusion in the study. The deliberate selection of SBs from these three groups was considered to present different and quite distinct OHS issues. Primarily the growth in the number of employees in small restaurant and cafe business is closely associated with transition of operation from 'cafe' to 'cafe and restaurant' to 'restaurant and bar'. In other words, a small restaurant and cafe business with six to nine employees largely operates as a cafe; the one with nine to 14 operates as cafe and restaurant; and others with 15-19 largely operate as restaurant and bar. As such, the OHS issues in a cafe are considered to be distinct and different from those in a cafe and restaurant to those of a restaurant and bar. No further enquiries were made with the rest of the businesses retained in the list after the deliberate selection of these three cases.

Prior to commencing any work in relation to data collection, both ethnographic field observation and interviews, an application was made to the Massey University Human Ethics Committee (MUHEC) to ensure that the study fell within the scope of the code of the Human Ethics Committee. This was important to make sure that the research involving human participants was conducted ethically and responsibly in compliance with the Massey University Code of Ethical Conduct. Subsequent ethical approval from MUHEC for the study was obtained on 24 July 2009.

3.5.2 Data collection

Following on the owner/manager's initial consent to participate in the study, a visit to the business was organised. The purpose of this visit was to physically introduce myself, as the researcher, to the owner/manager and if possible to the employees, and familiarise myself with the work and work environment of the business case. The other purpose was to explain to the owner/manager and employees in detail the objectives of the study, the method of data collection the study intended to adopt, and the intended involvement of the researcher in the daily activities of the business in relation to data

collection. An information sheet (Appendix 1) was used to ensure informed consent from the owner/manager allowing conducting the study in his/her firm as one of the business cases. A schedule for field work and data collection was presented to the owner/manager during this face-to-face visit to make sure that the time and hours of work planned for the field work, in particular participant-as-observer ethnographic observation, was compatible with the staff roster and service hours. A suitable time and hours for ethnographic field observation was confirmed through a second round of telephone conversations.

3.5.2.1 Ethnographic field observations

I, as the primary student researcher, carried out ethnographic field observation (Luders, 2004) by becoming fully involved in the daily work activities in the three business cases. The first day at each of the three cases was expended on by: introducing myself to the employees, the supervisor and managers; explaining the purpose of my involvement in the daily activities of the business; the intended plan of interviewing the staff members; and knowing the work environment more closely. Ethnographic field observations in the first business case commenced from 1 March until 26 March 2010 for a period of four weeks. Start/finish hours and the work area for field observation were different for each week. In the first week field observation was commenced in the front of house area with the field work starting at 8:30 am and finishing at 12:30 pm. In the second week, the field observation was carried out working in the cooking area starting at 10:30 am. In the third week the field work started at 9:00 am finishing at 1:00 pm and the observation was carried working in dish area. In the fourth week the field work was commenced in the baking and front desk with work commencing from 11:30 am until 3:30 pm.

In the second business case, ethnographic field observation commenced from 3 May until 28 May 2010 for a period of four weeks. In the first week, the ethnographic field observation was carried out in preparation area starting from 10:30 am until 2:30 pm. In the second week, field observation started from 9:00 am until 1:00 pm working mainly in the baking area. In the third week field observation was accomplished from 11:30 am until 3:30 pm working in the dish area and the dashboard. In the fourth week, the field observation was carried out from 9:30 am until 1:30 pm working in the frying area.

The field observation in the third business was carried out for a period from 21 June 2010 until 23 July 2010 for a period of five weeks. In the first week, the field observation was carried out from 1:00 pm until 5:00 pm working in the front of house area. In the second week the observation was commenced from 9:00 am until 1:00 pm working in the dry storage area. In the third week, the observation was accomplished from 9:00 am until 1:00 pm working in the dish area. In the fourth week the observation was accomplished from 9:00 am to 1:00 pm spending most of the time on the preparation work. The final week was spent making observation working in the dashboard area and front of house between 1:00 pm and 5:00 pm.

The field work observations were focused on six observational areas of enquiry and are outlined below where OBN stands for observation notes (1-6).

OBN-1 Physical situation – working conditions, documents, procedures, equipment

OBN-2 Incidents occurring during observation period

OBN-3 Workplace interactions

OBN-4 Decision attitudes – who is expected to do what, what people do/decide on their own, what people need to ask etc

OBN-5 Responsibilities – job responsibilities, health and safety responsibilities e.g. who does or does not do something?

OBN-6 Employer/employee engagement in dealing with hazards and risks.

Field work experience indicated that four to five weeks of observation allowed sufficient time to obtain saturation in terms of new data generation as well as verification (Patton, 2002). Scheduling of field work observation at different times of the day over the weeks allowed the opportunity to capture the possible variations likely to occur around observational areas of enquiry at different times of the day (Liamputtong & Ezzy, 2005). The field observations were handwritten in the form of field notes each day. A journal was maintained for this purpose. Field notes were made away from the business premises and done on the day of observation (by the end of the same day). Any observation of particular interest, e.g. conversations that had taken place between employer and employees or among employees related to health and safety or any new happening related to the main areas of enquiry that were different to previous observations, were noted as soon as possible (sometimes even during observation). On

such occasions notes were made as discretely as possible, usually when everyone had gone out for a rest break or when I intentionally excused myself to go for a rest away from the workplace and away from the sight of the people who were the subject of field observation.

The date and the work area where observations were made were strictly noted as part of the field observation documentation to facilitate data management and citation during analysis. The field notes for each day's observation were recorded in two parts. The first part was the textual record of the actual observation of what happened and what took place in the workplace setting. The second part was the researcher's own reflections on what had been observed. These included: the researcher's own concerns and feelings about the setting; reflections on the possible reasons as to the way things were or the way things happened; a critique of the researcher's own role in the setting; reminders about what needed to be examined, observed or particularly looked for; or anything that could have been of interest for further exploration during subsequent observations and interview data collection, specifically the validity of my own interpretation of observation (Kvale, 1996; Liamputtong & Ezzy, 2005; Patton, 2002; Saunders, et al., 2007). The issue of observers' interpretation was accounted for in the field notes as observers' reflection which was validated through informal talk and discussion with the subjects during subsequent observation (Luders, 2004).

3.5.2.2 Interview data collection

Data collection interviews were accomplished in two stages – pilot interviews and main data interviews. There were specific purposes behind commencing pilot interviews (Saunders, et al., 2007). First, it was to trial the interview questions to assess whether these were easily understood and the respondents could answer them without difficulty. The second purpose was to evaluate whether the technique of structured interview guided by pre-formulated questions or a semi-structured interview led by an interview guide would be appropriate to obtain adequate data responses to achieve the research objectives outlined. In addition, the pilot was envisaged to allow the researcher an opportunity to gain hands-on experience in using the two interview techniques and learn the skills of generating follow-up questions, particularly in a semi-structured interview setting. As part of ensuring that the research was conducted in a responsible and ethical manner, the Screening Questionnaire (Appendix 2) was completed followed by

submission of Low Risk Notification (Appendix 3) to the Ethics Administrator, Massey University prior to commencing the pilot interviews. This was to determine the risk of the study causing physical or psychological harm to participants and whether the nature of the harm was minimal and no more than was normally encountered in daily life. The degree of risk identified by the Screening Questionnaire was then used to determine the appropriate approval procedure (outlined in by Massey University Human Ethics Committee, Appendix 2).

Pilot data collection involved two restaurants and cafes identified through word of mouth. Nevertheless, the possibility of gaining access to both the owner as well as a number of employees was an important consideration in selecting participating SBs for the pilot study. As part of the pilot study the two interview techniques were trialled with both owner/manager and employees. An informed consent for participation in the interview was obtained from each respondent prior to commencement of the actual interview. This involved handing in the information sheet (Appendix 4), explaining the purpose of the study, and signing a consent form. Structured interviews were guided by pre-formulated interview questions. Two separate sets of interview questions were developed, one for owner/managers and the other employees, although the questions were very similar in nature. Semi-structured interviews did not have any pre-determined set of questions, but four main areas of enquiry, which were: work environment in general; work environment hazards and risks; practice of the identification and control of these hazards and risks; and involvement from the owner/manager and employees in these practices.

The pilot interviews that trialled the two interview techniques revealed a number of issues. First, that the structured interview proved difficult to be manage. This was mainly because the interview responses never occurred in the sequence of the pre-determined set of questions so that a subsequent question would be a follow-up question to the response for the previous one. It therefore required a lot of jumping up and down the list to locate appropriate follow-up questions. This not only wasted a lot of time searching for the right question to be asked as follow-up, but importantly diminished the vibe as well as the focus on the interview. On the contrary, the semi-structured interviews were free flowing such that the follow-up questions could be generated instantaneously and asked based on the responses from the respondents. It

also allowed for a profuse focus on the interview itself that was necessary to generate follow-up questions instantaneously and maintain the interview vibe. The pilot interviews also revealed that the owner/manager and employees understood issues of hygiene and food safety as issues of OHS as well. Therefore, obtaining data rich with information that might not fit with the LTWE framework was anticipated.

Drawing from the experience of pilot interviews, a semi-structured interview was adopted as the appropriate interview technique for the present study as it allowed plenty of opportunities to obtain data response rich in relevant information (Kvale, 1996; Saunders, et al., 2007) to fully achieve the objectives of the study. Importantly, the experience with pilot interviews helped to identify the need for an outline of general probes within each of these main areas of enquiry. As a result a consolidated semi-structured interviews guide that included general probes (Appendix 5) was developed to guide the semi-structured interviews.

3.5.2.2.1 Semi-structured interviews (SSI)

Prior to commencing semi-structured interviews, a verbal request was made with the employer/owner, managers and each employee in all the three business cases. The employer/owner in each case consented to participate in the interview, whereas in the case of employees only those who agreed to the verbal request to participate were invited for the actual interview. The main reasons for the employees' reluctance to agree for an interview were: not being able to avail themselves for the interview at times other than during work hours; some being students who worked part-time and therefore were not able to spare the time for an interview; and some of them who were new to the job in the restaurant and cafe sector considered themselves naive about the area of OHS and therefore withdrew themselves from the interview.

Altogether 20 employees from the three businesses took part in a face-to-face semi-structured interview, of which: three were from the first SB that employed eight employees; 10 from the second SB employing 13 employees; and seven from the third SB which had 19 employees. Owner/managers from all the three SBs took part in the interview. In addition, the only manager from the second SB and two managers from the third SB agreed to an interview. Prior to commencing any interview, a written informed consent was obtained from each interviewee. As with the pilot interviews this involved: explaining the purpose of the study through the information sheet (Appendix

4); handing them a copy of it; and afterwards having the interviewee sign and date consent form (Appendix 6 and Appendix 7). An important element of the consent form for the owner/manager was their consent to allow their employees to be interviewed in relation to OHS practice in the work environment. Each employee was informed of the written consent from their respective employers for the interview to make sure the employees felt free to disclose information and not have a fear of any punitive response from the owner/manager. The information sheet was the other mechanism used to ensure that the employees felt free to disclose information and thus minimise potential omission of information. The information sheet explained adherence to complete anonymity such that participating businesses and the interviewees are protected from disclosure, thus maintaining the confidentiality of information provided. The information sheet also informed both the employer and employees of the area of enquiry of the study with examples of possible interview questions. The informed consent was expected to enhance free disclosure of issues minimising potential omissions.

The interviews with the owner-owner/manager took place at the beginning of the field work whereas those with the employees largely took place towards the end. Foreseeing very less possibility for a follow-up interview with the owner-owner/managers, such an arrangement allowed the possibility of clarifying interview responses or making additional informal enquiry on the subject during field work observation. Similarly, the field work observation provided ample opportunity to talk to employees informally on the area of enquiry. Such opportunity not only allowed the possibility of identifying issues for deeper probe during the actual interview, but importantly permitted time to talk over issues informally off the record which otherwise would have potentially been omitted for reasons such as being recorded, fear of disclosure and punitive fear.

The pilot interviews made the categorical interview questions redundant. Therefore instead of making use of the definite interview questions, the main areas of enquiry were identified as the focus of semi-structured interviews. The specific probing questions around these areas of enquiry were generated there and then during the interview such that these questions varied from interviewee to interviewee and the questions investigating different areas of enquiry did not follow any particular order or pattern. The main areas of enquiry for the semi-structured interview and the general probe

questions were as outlined below, where SSI-1 to SSI-4 refer to question sets within the interview schedule.

SSI-1 The work environment and work environment conditions: e.g. what is working well? What is good about the working environment? What is not working well or not right in the work environment?

SSI-2 Hazards and risks in the workplace: e.g. what concerns you in the work environment? What are the OHS hazards and risks that are of concern?

SSI-3 Hazards and risks identification and control practice: e.g. why are they a concern? What are the causes behind these hazards and risks? How do people come to know about the presence of these hazards and the risks they pose? What is done to control them? What do you think can be done?

SSI-4 Employers' and employees' involvement in control of hazards and prevention of risks and the ways in which hazards and risks are dealt with e.g. has any incident and accident occurred in the workplace? What is done to rectify the cause? What is done to prevent recurrence?

In each instance of the semi-structured interview, the interviewee was asked to identify a place and location of their choice where they felt comfortable to have the interview conducted. Based on the choice of the interviewees, both the owner/manager and employees, the interviews were conducted within the premises of the business at one of the far corners in the dining area. The length of interviews varied from interviewee to interviewee ranging from the shortest of 12 minutes to the longest of 70 minutes. The length of interviews varied based on the knowledge of the interviewees in the area of enquiry as well as the length of their experience in the work environment. All the interview responses with permission from each of the interviewees were digitally recorded. The recorded responses were transcribed verbatim using an Olympus DSS Transcription Module. Interview transcription used business case numbers and interviewee number as an identifier of different respondents. Any names used as part of the interview response were changed to fictitious names during transcription.

3.5.3 Data analysis

Raw data available for analysis in the present study consisted of interview responses from employer/owners, managers and employees as well as field observation notes. For the purpose of analysis, interview responses from the employer/owners and managers

were treated as one set of data responses while those from employees formed the other set in each case. The data sets, both sets of interview responses and the field observation notes, were analysed thematically (Gibson & Brown, 2009). Thematic analysis was accomplished using network diagrams (Arvanitoyannis & Varzakas, 2007; Ishikawa, 1985) and the development of typologies (Patton, 2002) as the two specific techniques of formulating themes. Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data. This is accomplished in six stages: familiarisation with data, generating initial codes, reorganising initial codes, categorising, identifying potential themes and developing themes (Braun & Clarke, 2006). Thematic analysis was the main method on which the analytical process was based. However, a network diagram was used as the technique for accomplishing thematic analysis to develop themes for the elements of LTWE and comprehend a local understanding of OHS risks. Developing typologies, a technique of thematic analysis (Patton, 2002), was used to generate themes for participatory practices. The two techniques corresponded to the qualitative research design and approach and most closely enabled achieving the objectives of the study (Hammersley & Atkinson, 1995; Patton, 2002). These are described in detail in the following sections.

3.5.3.1 Thematic analysis using framework of LTWE

Thematic analysis technique using the framework of LTWE started with familiarisation with the data collected (Braun & Clarke, 2006). The first stage of the familiarisation process consisted of reading and re-reading interview transcripts and observation notes. This was followed by identifying, separating out and noting down from the bulk data the threads of interview responses and textual notes that provided a close description of the four elements of LTWE: the OHS problems experienced in the work environment; associated causes behind the problems; remedial measures; and the reasons for accepting them as problems. Summarised below are the descriptions of threads of responses and notes that were sought in the data that portrayed the four elements of LTWE.

The OHS problems such as reference to hazards confronted in the workplace, description of injuries and incidents encountered or experienced in the workplace (e.g. cuts, burns, slips and falls) constituted the element of experience.

The element of causal relations (causes behind the problems) encompassed factors mentioned as the sources of the hazards or description of causes behind injuries, incidents and health and safety problems.

The element of action (remedial action) pertained to: the descriptions of measures in place or the way things are done to control OHS hazards and sources of hazards; and a description of the measures in place to minimise injuries and remedy the causes behind them.

The element of legitimisation (reasons for bringing to attention OHS problems in the wider work environment) related to the reasons discerned valid to bring OHS hazards, sources of hazards, injuries or the causes behind them to wider attention in the work environment.

The threads of responses and textual notes from ethnographic field observation generated the initial codes (Miles & Huberman, 1994) for each of the four elements of LTWE. These initial codes were entered in NVivo software (Gibbs, 2002; QSR International, 2010) for record and further analysis. NVivo allows for sequential processing and analysis of qualitative data through the stages of initial data entry, categorisation and the development of themes. To keep analysis of data simple and elegant, the textual responses noted as initial codes were entered separately for owner/managers and employees under each business case in NVivo software. In doing this, initially two Tree Nodes (Gibbs, 2002) were created for each of the participating SBs and named as Employer and Employees. Under each of these Tree Nodes four sub-folders corresponding to the four elements of LTWE were created. The responses from the employer and employees describing each of the four elements of LTWE were then coded under the corresponding Tree Nodes.

Using the initial codes for each element of LTWE, a network diagram was developed which depicted the cause and effect relationship between the four elements of LTWE. For this an OHS problem that was described the most by both owner/managers and employees was taken. The initial codes relating to the identified problem, but describing the elements of causal relations, were put in a diagram connected by arrows to the OHS problem identified as shown in Figure 3-1.

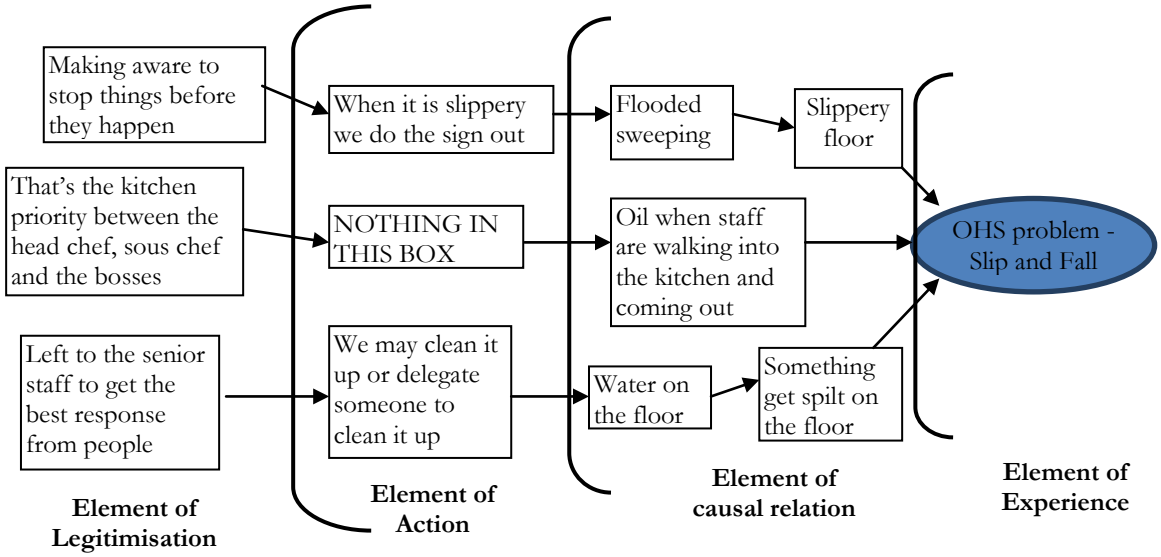

Figure 3-1: Applying network diagram to LTWE framework

Working backwards, the initial codes describing the elements of action were connected to the elements of causal relations depicting the actions taken to control or prevent the causes of the problem. The network diagram was completed by connecting the initial codes describing the elements of legitimisation indicating what might have influenced them to take the actions. A separate network diagram for owner/managers and employees was developed for the same problem identified. Once the initial notes pertaining to the *elements* were built into the diagram, these were scrutinised for common threads. The common threads of responses were grouped together to develop into categories. The categories of responses summarising common characteristics were then grouped together to develop themes.

3.5.3.2 Developing typologies of participation

Typologies, as explained Patton (2002), are classification systems made up of categories which are built on ideal types of illustrative end points that divide some aspects of the world into parts along a continuum. Constructing typologies involves creating classification types to elucidate the research findings by making explicit the patterns and themes that appear to exist but remain unperceived by the people studied (Patton, 2002). Developing typologies as an analytical technique was used in the present study to characterise participation in the identification and control of OHS hazards and minimisation of risks. The characteristic typologies of participation were then analytically correlated with understanding of OHS risks and used to explain why some

OHS hazards were controlled and the associated risks minimised while others remained uncontrolled.

The process of developing typologies was accomplished in three steps: i. Identifying indigenous concepts; ii. Illuminating indigenous typologies; and iii. Constructing typologies (Patton, 2002). Similar to the method of thematic analysis, identifying indigenous concepts as the first step of the process of developing typologies involved reading and re-reading through the data, and separating and recording key terms, words, language or expressions used that defined participation and indicated the practices unique or special to the people in the settings. This step also involved separating out the practices, ways of doing things and interactions that were observed to be particular or unique in relation to participation in identifying and controlling OHS risks. This process of identifying indigenous concepts through the terms, languages and practices of the informants themselves is also referred to as *in vivo coding* (Braun & Clarke, 2006; Patton, 2002). Identifying indigenous concepts led to the creation of distinguishable labels for concepts or practice. The second step in the technique involved illuminating indigenous typologies. This involved revealing attributions and characteristics that distinguished the one indigenous concept of participation from the other and grouping together these distinguishing characteristics categories or labels. This was similar to the step of categorising and identifying potential themes in the thematic analysis method. The final step in the process was constructing typologies. This involved identifying the linkage and close fit among the categories of participation characteristics and identifying themes emergent from these linkages. The emergent themes thus identified characterised distinguishable participation practices or concepts in the three business settings and were formulated together to generate participation typologies.

3.6 Summary

The methodological framework, Figure 3-2, illustrates the close fit of the data collection and analysis techniques in answering the stipulated research questions and achieving the outlined objectives of the study.

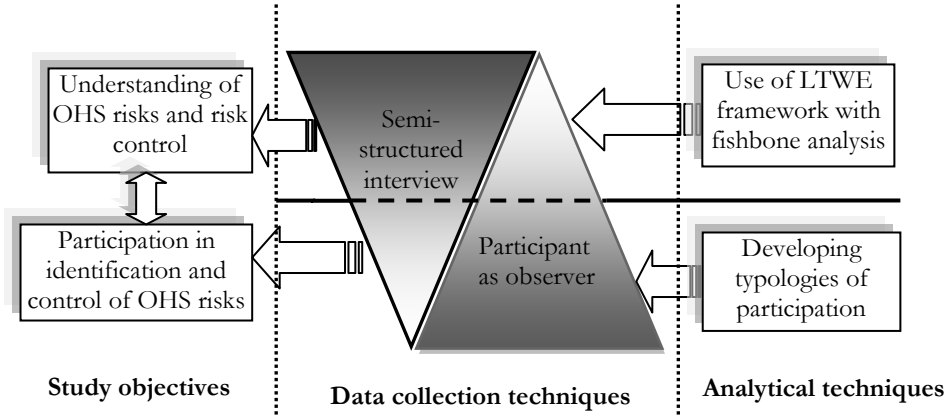

Figure 3-2: Methodological framework relating data collection, analysis techniques and study objectives

The figure diagrammatically illustrates that the data from semi-structured interviews was largely subjected to analysis using the network diagram combined with the LTWE framework to achieve the objectives of understanding OHS risks. The data obtained from participant-as-observer field observation was used to develop typologies to explain participation in the identification and control of OHS risks.

In summary, this chapter establishes the rationale for using a qualitative approach in the present study. It has outlined the techniques of data collection and analysis adopted and detailed the characteristics of the methodologies utilised. The study used the LTWE as the theoretical/analytical framework within the SB context. It adopted thematic analysis as the core analytical approach through: (a) a combination of the LTWE framework with a network diagram technique to construct a local understanding of OHS risks; and (b) the development of typologies to understand participatory practices in identification and control of OHS risks. The analytical approach and techniques were applied individually to three case studies.

Chapter 4 Case Study 1 – A Cafe

This chapter provides details of the first SB case study and: describes the relevant characteristics of the business including details of the product range; gives an outline of the organisational structure; provides an account of a day's work by describing the tasks and roles; and outlines a description of the working environment and OHS management. The chapter then presents results of the analysis of employer and employee understanding of OHS risks using: the four elements of the LTWE framework; local understanding and common understanding of OHS risks between employer and employees as depicted by the elements of LTWE; and findings on employer/employee participation in the communication and control of OHS hazards and risks. Finally, a brief conclusion on the case is provided.

4.1 Case description

The business was an independently owned restaurant and cafe that had been in operation for more than seven years. During this time there had been a change in the ownership of the business, with the last two years of operation under the present ownership. The business operation was run by eight employees, six of whom were under permanent contract while two staff were employed on a temporary/casual basis. Regardless of the type of employment, the employer in close consultation with the employees decided the number of work hours available to each employee over a week's period and intended to distribute the available hours equitably among the employees.

The operation ran seven days a week with the services open for customers from 9:30 am until 3:00 pm. For employees, the work hours ran from 8:30 am until 4:00 pm. In addition, occasionally the cafe opened in the evening to host pre-booked functions.

The business, in terms of physical location, was situated in the middle of a municipal park. The typical customers were people visiting the park for leisure.

4.1.1 The food products

The restaurant offered breakfast, combined breakfast-lunch and lunch. A combination of bread toast, poached eggs, mushrooms, hash browns and gourmet bacon were the main food items offered for breakfast. Pita, chicken liver pate, fries, wedges and nachos accompanied by side dishes were offered for a combined breakfast and lunch. Soup of

the day, battered fish and chips, pasta, steak and chicken curry were offered for lunch. In addition, a range of wines and beers were available.

4.1.2 Organisation structure

The organisation had a flat business structure, such that it lacked strictly distinguishable supervisory levels. Even though the owner as the main person in the business oversees the overall business, no-one was a designated supervisor and no-one was a subordinate. As such no-one held a designation of head chef, baker or kitchen hand. The small numbers of employees worked as a single team undertaking many and any tasks. The employer (including the employer's parents) readily took up tasks in the kitchen and in front of house in order to assist the team in accomplishing daily routines. The owner/manager, being an accountant by profession, had with little previous experience in cafe operation. This may be a reason for him promoting and relying a lot on team work. Absence of individually designated roles in performing daily tasks is illustrated by the following observation notes (Box 4-1).

Box 4-1: Observation notes, 3 March 2010

It was my second day at the restaurant today. Even these two days were enough for me to realise how the power structure and the work attitudes are completely different to what I anticipated. Everyone seemed relaxed and calm in doing what needed to be done. In one instance I saw Marie preparing dough for muffins. As the cafe started to get a little busier, as soon as she had prepared the dough and placed it into the oven, I saw her out in the front clearing tables and bringing dirty dishes to the dish washing area. Similarly, when Ruth finished working on the dough she was preparing for bacon and egg pie, she went out the front to serve coffee to the customers. Sally and Sue were attending to the orders coming through. Ben (the father) began to wash dishes that had piled up in the wash basin. Everyone in the kitchen is a chef, a baker and a kitchen hand.

The kitchen has four staff members all possessing the skill to perform any tasks required in the kitchen including cooking. Multi-tasking seems to be the normal way of working. Even those in the front of house perform these tasks when necessary.

The duty manager was the only nominated designation in the organisation. Communication was the primary purpose behind designating a duty manager and was

mainly intended to indicate to the customers who to approach in case they had any issues with the food or the service provided. However, the communication among the staff and between the employer and employees was open, direct and face-to-face without any protocol to follow or formality to fulfil. The only visible formal communication was a written down checklist for opening up, closing down and daily cleaning routine of the restaurant which was signed by one of the staff at closing down time each day. As such, the employer and employees defined themselves as a small team with each individual as a member of the team committed and focused on accomplishing their part of the job well i.e. to 'keep the cogs turning'. The observation notes in Box 4-2 illustrate the informal nature of staff interaction and task accomplishment in this business case.

Box 4-2: Observation notes, 3 March 2010

Four staff in total run the front of house. One of them is acknowledged as the duty manager. The duty manager, in addition to the daily routine in the front of house, is to ensure that the customers are happy with the food and service provided and attend to any grumbles in that respect. The two of the front of house staff who have been working there since the beginning take the role of duty manager alternatively each day. As additional support to the staff roster, the parents of the owner engage in both kitchen and front of house work as needed during busy hours. The owner oversees the overall operation of the business as well as supporting employees with various tasks in the kitchen and in the front of house. If there are things that needed to be communicated to the employer, when he is not around everyone talks to one of the staff in the kitchen who is considered experienced and judicious by the employees. However, among the employees themselves the communication is open and direct.

4.1.3 Tasks and roles in a day's work

Physical separation of the cafe into kitchen, front of house and dining made employees more responsible to one area than the other which depended on where they started their work at the beginning of the day. However, in the absence of apparently specific job descriptions or designated work areas, the area of responsibility and work changed over time during the day depending on service pressure. This meant that anyone could be working in the front of house, the kitchen or in dining area. However, the certification requirement from the council demanded food-handling certificates for those handling

food, especially milk products, which to some extent limited handling of milk products to a few employees only. Nevertheless, generally, employees from the kitchen went out in the front serving the customers, clearing tables and taking orders, and front of house employees came into the kitchen to heat up the panini iron, warm up the salmon stack, or do the dishes depending upon whichever area got busier or congested over time. Employees generally took on work spontaneously on their own initiative and at their own discretion whichever area they might be working in. For example, in the kitchen, baking, cooking and dish washing were the three major tasks to be performed. These tasks were open to anyone to assist with. As described by an employee, "tasks are picked from each other" spontaneously. No-one had to tell anybody what to do or how to do it, it was just done. The spontaneity at work was apparent from the way the orders coming through were handled, where the one receiving the orders told the kitchen staff what the order was and the other staff indicated which of them would prepare components of the order. The following observation notes (Box 4-3) illustrate the discretionary way of performing daily tasks.

Box 4-3: Observation notes, 2 March 2010

My first day of observation. Marie was working on the dough for pies; Ruth was doing the dishes; Sue was grating vegetables for mixed vegetable pan cakes. Sandy arrived in the kitchen. She started working on potato fillets. I asked her if I could help her with chopping vegetables. She was happy with that and I started chopping vegetables for the potato fillets.

Sandy and Sue were working at the work bench on the cooking side in the kitchen. I took the vegetables and the chopping board to the other work bench opposite the cooking side. It was about 11:00 am by then and the orders for lunch started to come through. As Sue and Sandy were working on the cooking side they attended to the orders coming through. When an order comes through, the one picking up the order would call out what the order was and the item she was going to work on. If she was not able to work on the order she would simply call out the items required. In such instances another person doing the dishes or the vegetables (considered less urgent tasks) would respond to the calls and indicate what she or he would work on.

Task accomplishment, as evidenced from the observations above where everyone responds to the call from the other person, was driven by the eagerness to work in a team and contribute as much as possible to accomplishing the required tasks. Open and continuous interaction among employees and between the employer and employees encouraged team effort in the workplace. Announcing the items in an order when it came through for everyone to respond to, detailing the conversation after a phone call has been received, cautioning each other if anything seemed out of place or posed as a hazard, or gathering over tea or coffee at the end of the day, were a few examples of the constant spontaneous interactions. The presence of the employer added dynamism to task accomplishment mainly because it allowed the employer and employees to share opinions first-hand and make decisions as a team instantaneously.

Accomplishment of tasks with no specific boundary typically characterised this work organisation. The absence of a distinctly specified boundary of work organisation extended to decision issues such that any and every concern in the work environment could be brought up by anyone for discussion and decision. Crossing over of work between kitchen and front of house, irrespective of where a staff started his/her day's work, also illustrated such a lack of boundaries in this work organisation.

A description of the business that shows its general operation, structure and individual owner/manager characteristics is summarised in Table 4-1.

Table 4-1: Summary of the characteristics – Case 1

Characteristics	*Description*
Number of employees	Eight
Years in operation	Two years
Ownership	Independent individual ownership.
Owners' involvement	General overseeing as owner.
Characteristics of owner/manager	Accountant by profession; no previous experience on operation of cafe and restaurant; no formal training in occupational health and safety; learning about hazard and risks management through experience.
Daily management of operation	Chef and duty manager.
Task definition	No defined task – multi-tasking.
Structure	Team bonded flat structure with owner as one of the members of the team and overlapping roles among employees.
Documentation	Written checklist for opening up and closing down; checklist for daily itinerary – such as cleaning benches, scrubbing floors. A book for keeping record of bookings and orders for functions and special events.
Communication	Open, free and informal communication and sharing of information in the form of suggestions, opinions, ideas or notification. Abundant consultation, with employees by owner and employees openly share opinions and ideas with the employer.

The characteristics of the business in relation to work environment, work organisation and the way OHS hazards and risks were managed are described in the subsequent sections.

4.1.4 The working environment

4.1.4.1 Physical layout

The layout of the cafe was physically divided into three areas – kitchen, the front of house and the dining area. The kitchen was quite small and was tightly set up to maximise the available space for the movement of people and materials. The kitchen accommodated four work spaces where tasks were carried out which included areas for food preparation work, cooking, baking and dish washing. Dish washing occupied one of the corners in the kitchen which was set up with a dish washer, a wash basin and a bench space for dirty dishes. Adjacent to the dish washer was the work bench where most of the food preparation work was undertaken. The oven and deep fryer were installed opposite the dish washer. At one end of the kitchen was a door, which was used as a back entrance and at the other end was the chiller, which stored all the perishable food items. In the middle of the room in between the dish wash area and oven area was another work bench. This was used by chefs to perform smaller chopping and slicing work, as well as to place ready to serve plates for wait staff for easy access. A trolley table located at the corner adjacent to the chiller was used as a work bench for baking. This usually had a panini iron on it.

In the front of house, the usual work stations were the till where orders were received and payments made, the coffee and milkshake machine, the cabinet area, which contained in-house baking and ice-cream, and the dining area. The cabinet holding in-house baked food items separated the dining area from the general front of house work area. The location of kitchen, front of house and dining in the cafe and the various work spaces are diagrammatically presented in Figure 4-1.

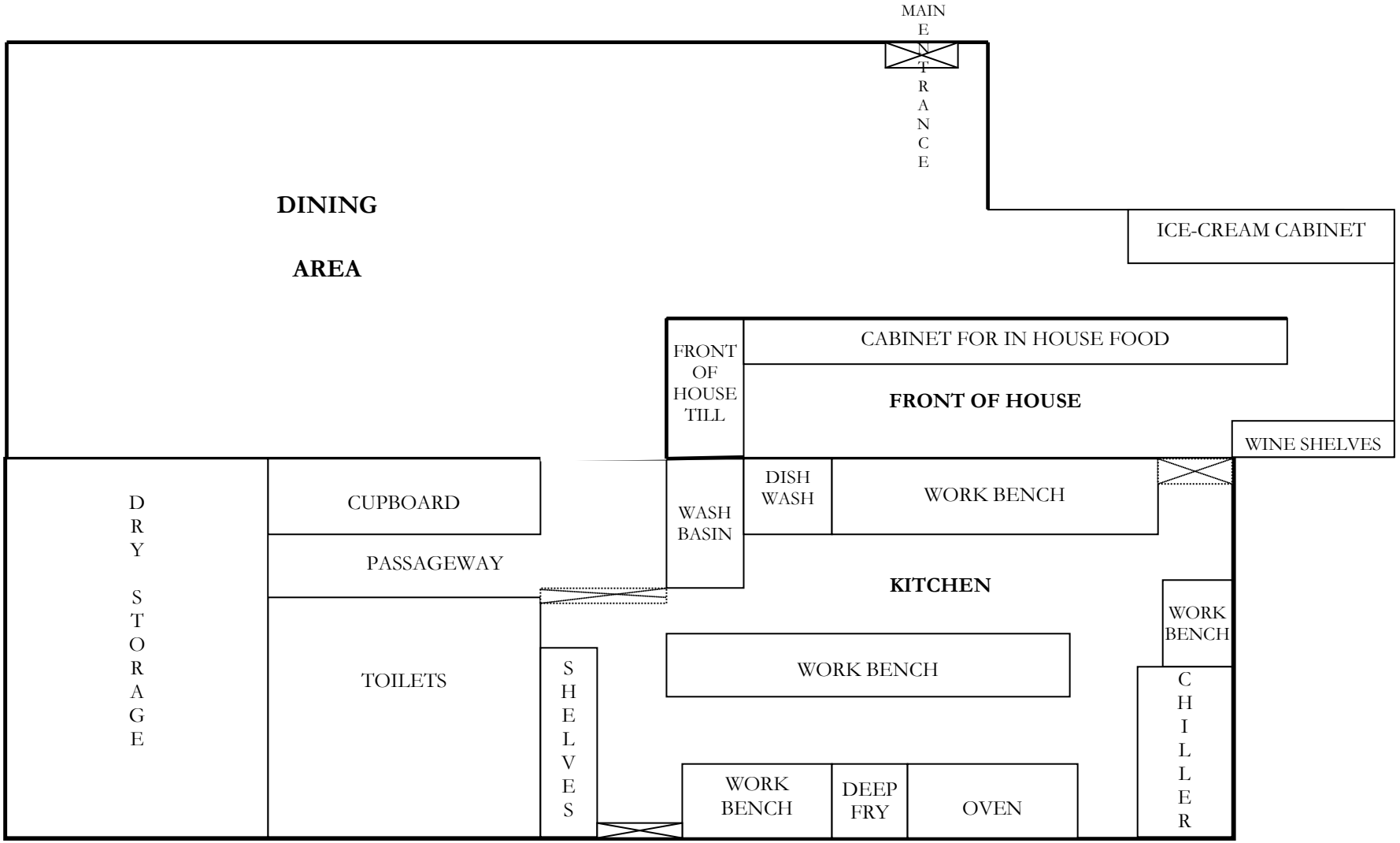

Figure 4-1: Business Case 1 – schematic diagram of physical layout of the operation (not to scale)

4.1.4.2 Work organisation (how things are done)

A typical day in the front of house began with starting up the electrical appliances e.g. coffee machine and milkshake machine. This was followed by filling and decorating the cabinet with ready to serve food items. Setting up the shelves, till and racks was usually the discretion of the duty manager and this was done in a way he/she felt was both safe and convenient. Setting up of the dining area also formed part of the start-up work in the front of house. This included vacuuming the dining area and setting up tables and chairs. Setting up of the front of house was closely linked with the flow of work and the ability of the staff to deliver prompt services. Ensuring orders coming through to the kitchen were unambiguous, and making themselves available for kitchen work if the kitchen needed an extra pair of hands to attend to the orders promptly, formed the other important task of front of house staff.

A day's work in the kitchen typically began with starting up of the appliances – oven, stove, panini iron and dish washer. This was followed by preparation work which involved: getting vegetables and meats chopped; pre-cooking meat and vegetables that normally took longer to be cooked; boiling and containing pasta and spaghetti; preparation of the food of the day; stacking together the ingredients for salmon stacks; moulding mashed potato cakes; applying butter spread over bread; and preparing ingredients for regular main food items in the menu. Preparation work in the kitchen generally lasted up to two hours. It also involved preparing ready to serve food items such as muffins, pies and salmon stacks. Both employer and employees perceived the ready to serve food prepared in-house as specialities of the business and took immense pride in them. As explained by an employee:

"… *everything we sell from the cabinet pretty much is made on-site and you know she has a lot of pride in it. You can say, 'well, we have made that here and that's unique to us'. ... If you look at mac n cheese, lamb fry and all that, now that's special to us and we take a lot of pride and boast 'look, we made this, try it'. And it gives you a sense of belonging, I suppose* …" (Employee 3)

Orders for lunch started to come through usually around 11:00 am. Customers arriving before then largely picked items from the shelves or usually ordered breakfast and coffee which limited the orders coming through to the kitchen. As the orders for lunch started to come through, the kitchen started to get busier. A mini-printer located near

the oven area printed out orders coming through from the main till. The person working with the ovens generally picked up the order slip coming through.

The employer normally joined the staff around 11:30 am when the service started to get busier. The owner was obviously in charge of the overall business and played a key role in making sure it was running smoothly. The owner did this by: being around to listen to the employees; making sure they were informed of any changes; consulting the employees to provide an opportunity for them to discuss things; and fostering team spirit by involving himself as a member of the team. Upon arrival at the cafe, the owner involved himself in the daily routine by taking orders, serving customers, clearing tables and doing dishes, particularly during the busy times. The daily routines of dish washing, cooking and serving the customers were also taken up by the parents of the owner when they were around in addition to the task of purchase of material supplies. The employer's involvement in the daily task and routine work, as explained by an employee, was seen as a leadership skill that bound the employer and employees as one happy family.

In addition to the daily routine of serving the customers, responding to telephone calls formed an important part of the job in general for everyone. When there was a call, anyone who happened to pass by the telephone or was working in the proximity picked up the handset and answered it. Regardless of who answered, whether the employer or an employee, the person answering told everyone what the call was about and who the person making the call was. Anything requiring immediate decisions in relation to the subject of the call was discussed momentarily as a team. Decisions were usually made as a team in both the presence and the absence of the employer. Such decisions included new reservations and orders, changes in booked functions, cancellation of bookings, changes in ordered deliveries, changes in work routines, work processes or work set-up. All of the information related to orders and functions were noted down in the function register kept near the telephone for everyone to access and share. This register worked as the information centre and was an important means of internal communication.

The busy hour lasted until about 2:00 pm and thereafter the work routine started to ease off. The work shift ended with clearing away dishes, sweeping and mopping the floors, cleaning work benches, putting away kitchen wares, and storing cabinet foods and surplus food materials in the chiller. Signing off the close-down checklist was another

important task staff in the kitchen executed daily. Each day, this task was assigned to a different person who was expected to go through a checklist to ensure proper closing down at the end of the day. A day ended with everybody (employer and employees) gathering around a table and talking informally about a variety of matters (including the way the day went, pre-booked orders or reservations for the following day) over a tea or coffee.

4.1.4.3 OHS hazard management

Prominent hazards and OHS risks were brought to everyone's attention immediately and informally when a situation occurred. In that respect there was no formal hazard management procedure in place. But hazard management was generally based on the assumption that everyone was responsive to the identification and control of hazards and risks as an obligation to ensure each other's safety in the workplace. Control of OHS hazards and safety at work was perceived as everyone's responsibility. This notion of universal responsibility to identification and control of OHS hazards was exhibited by the employer and employees by being thoughtful of each other's safety at all times and keeping a lookout for obvious hazards in the workplace. Workplace social norms, such as courtesy and mutual obligation, appeared to constitute the core element of such universal responsibility in order to prevent or limit the risk of injury to others. For example, when the person working on the oven brought a hot pan straight from the oven and delivered it to the person doing the dishes, she told the person doing the dishes that it was either hot or very hot. On one occasion table forks and knives cleared away from the tables were placed in the container upside down with the sharp ends pointing upwards. The employer, having noticed them, immediately placed them the other way up and cautioned the person doing the dishes: "Be aware! These are hazards".

Employer and employees, based on their experience, identified a range of hazards and associated risks. Main hazards identified were the appliances (such as oven, deep fryer, overhead gas toaster, panini iron, milk-shake maker) and other aspects of the physical set-up of the workplace (windows, steps and the floor) as OHS hazards in the workplace. As these appliances remained on and open at all times, there had been occasional experience of burns and bruises as a result of contact with these, which had been identified as associated OHS risks. The other OHS risks identified by the employer and employees were a number of accidents that had some severe consequences and

were associated largely with the physical set-up of the workplace. For example, the employer had his arm broken by a window that broke off its hinge and fell down, the parent of the employer fell down the slippery steps and broke his back, and one of the employees slipped on a wet (mopped) floor and hit his head against the wall. Precautionary signs such as "Be careful! Wet floor" were generally put up after the floor was mopped. A sign hanging on the dish washer that said "Do not put pans through the dish wash" observably formed a part of the approach to the identification and control of hazards and risks. Similarly, getting cleared away immediately the oil and water spills around the kitchen area and the dish wash area or any food scraps and water on the floor in the restaurant by whoever noticed it first irrespective of how it happened, or placing the dirty cutting knives separate from the other dirty dishes in the dish washing area, were some other obvious examples of the ways hazards and risks were identified and controlled in this business case. As illustrated, the hazards management practice was basically informal in nature.

4.2 Employers'/employees' understanding of OHS risks

This section presents the findings on employers' and employees' understanding of OHS risks, the similarities and differences in relation to the development of LTWE i.e. local understanding of OHS risks, and participation in the identification and control of OHS hazards and risks.

The employer and three out of a total of seven employees took part in an interview. During each interview, the employer and employees described a number of OHS issues as OHS risks. The OHS risks mentioned by the employer and employees can be divided into three categories: the actual hazards faced in the workplace; undesirable events of injuries and incidents; and the consequences anticipated from such events. These are presented in Table 4-2.

Table 4-2: Recounted OHS problems grouped into categories

	Employer	*Employee*
Hazards	Knives	Knives (1)
		Slippery floor (1)
		Spills (2)
		Panini iron (2)
	Hot jugs	Hot pans (2)
		Milkshake machine (1)
Undesirable events	Slips and falls	Slips and falls (3)
	Grab hot pans	Grab hot pans (2)
Consequences	Burns	Burns (3)
	Cuts	Cuts (3)
		Minor cuts (3)
	Broken arm	Broken arms (3)
	Broken back	

The numbers in parentheses in Table 4-2 indicate the number of employees that mentioned the corresponding issues as OHS risks. The employer and all of the three employee respondents reported 'slips and falls' as one of the major concerns in relation to OHS risk experienced in the workplace which has also been identified in the existing literature as the persistent OHS problem in the restaurant and cafe sector (Courtney et al., 2010; Verma, et al., 2010). Therefore, 'slips and falls' as an illustrative example of OHS problems is examined to explain the understanding of OHS risks by the employer and employees in relation to the four elements of LTWE.

The data responses and textual notes describing the four elements of LTWE pertaining to 'slips and falls' were entered into a network diagram, separate for the owner/manager end employees, respectively, as illustrated in Appendix 9 A and C. The initial coding for each element in the diagrams typifying unique characteristics are grouped together, which is shown as encompassed within a shaded box. The next step of the analysis, developing categories, is shown separately for the employer/owner and employees in Appendix 9 B and D, respectively. This step involved forming categories for each group of coded responses. The final step of developing themes based on the categories formulated is shown in Figures 4-2 and 4-3. This involved constructing themes that are characterised altogether by the initial coding and categories formulated. The emergent themes in Figures 4-2 and 4-3 are shown in bold letters encompassed side by side the categories characterising the emergent themes.

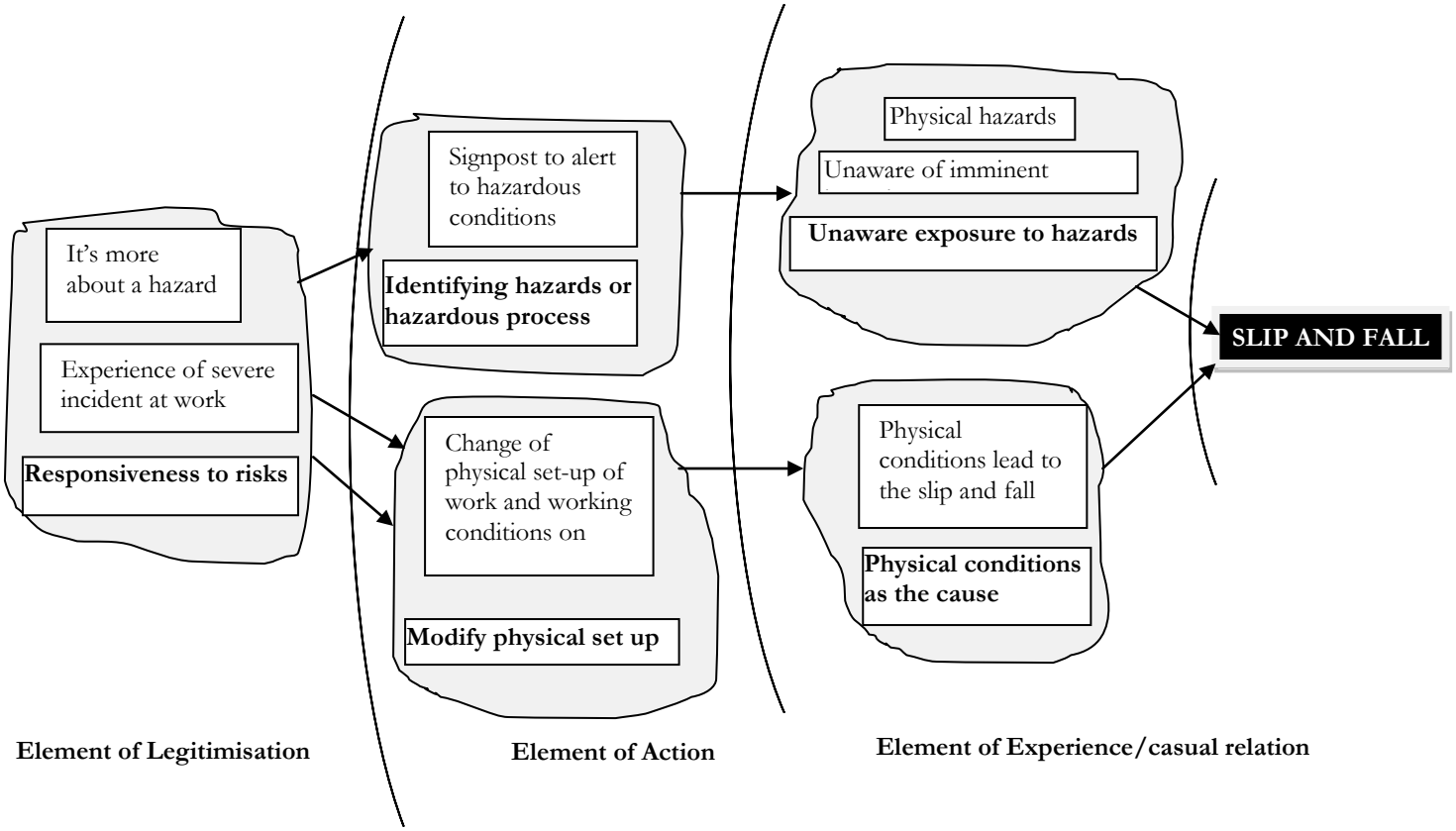

Figure 4-2: Development of categories of responses and emergent themes for employer – Case 1

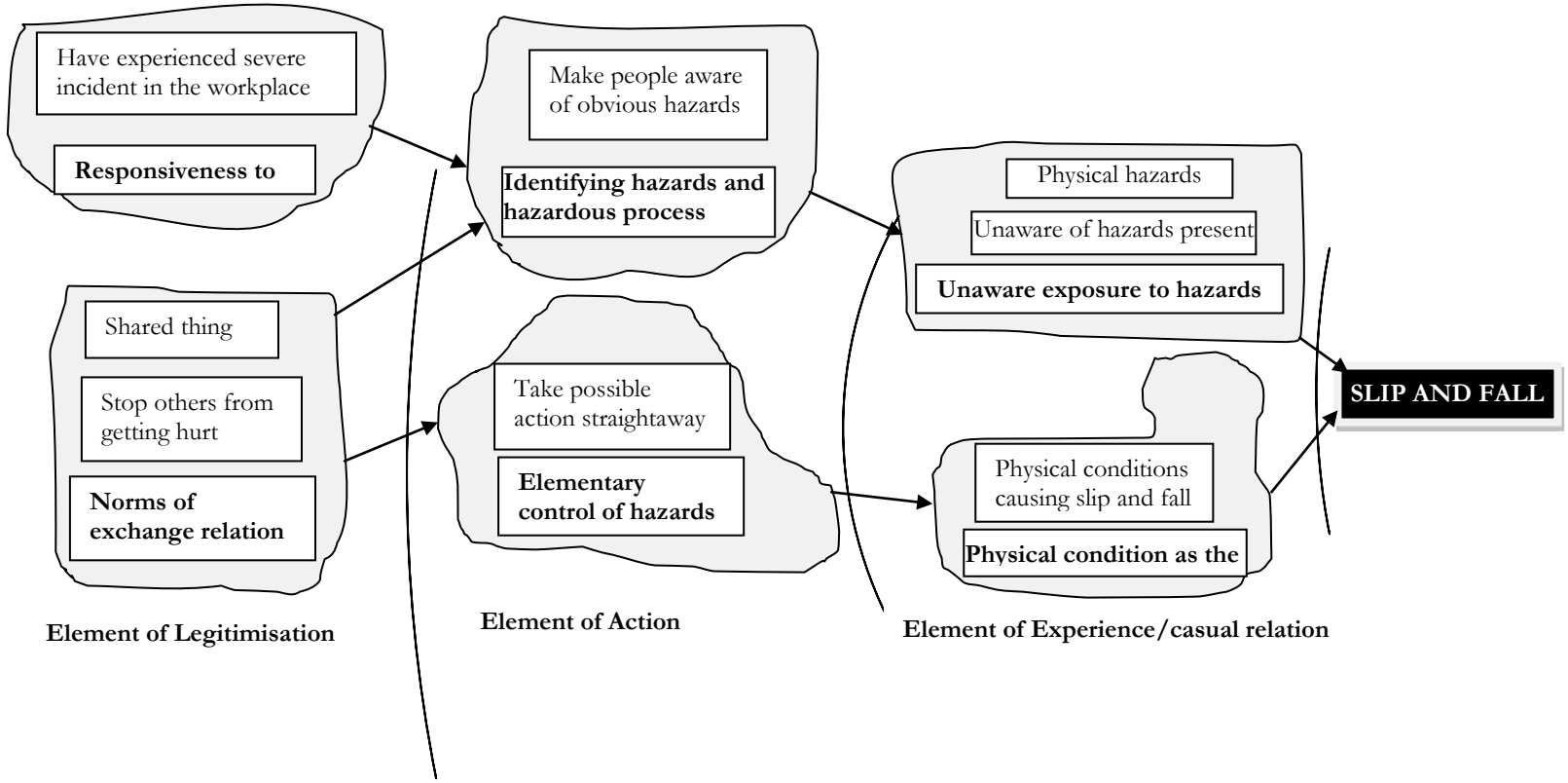

Figure 4-3: Development of categories of responses and emergent themes for employees – Case 1

4.2.1 Element of experience and element of causal relations

4.2.1.1 Employers' and employees' understanding of element of experience

The employers' description of slips and falls as one of the main OHS problems experienced in the workplace is illustrated by the following comment from the employer:

"*... The other one is these steps are very slippery ... That's a big thing …".*

Employees were found to be equally concerned with slips and falls experienced in the workplace. The main reason for such a concern was that the employees had either experienced a slip and fall leading to immediate effect risks, i.e. injuries to themselves, or had witnessed such events at work. The following comments from the employees illustrate the concerns employees had:

"*.... one of our chefs who used to work here slipped over and hit his head on the side of a wall …*" (Employee 3)

"*.... like the steps .... those steps. I mean, Brian's fallen down from those steps ...*" (Employee 2)

Thus, slips and falls emerged as one of the OHS problems experienced in the workplace, and the employer and employees identified a number of causal factors (relations) leading to slips and falls in the workplace.

4.2.1.2 Employers' understanding of element of causal relations

The employer identified two main causes behind slips and falls. First, he considered physical conditions in the workplace, such as the steps becoming slippery due to rain or the floor becoming slippery after being mopped, as the cause behind the slip and fall. Second, the employer understood the reasons such as the employees being busy with work leading them to forget to keep alert of hazardous physical conditions or not anticipating the eminence of exposure to slips and falls. As described by the employer:

" *… when busy mopping people just get so occupied with the work that they forget the floor could be slippery and forget to let others know that the floor has just been mopped ..."*

Thus, **unaware exposure to hazards** and **physical conditions as the cause** emerged as the theme for the element of causal relation.

4.2.1.3 Employees' understanding of element of causal relations

Employees recounted two conditions as the main cause leading to occurrence of slips and falls as undesirable events in the workplace. First, the physical conditions of the workplace, such as the wet floor after it had been mopped or the spills on the floor, under which the work was to be performed. Second, the situation where the employees, because of their busy work schedule, were unable to attend to such conditions or alert each other and anticipate the hazardous exposure arising from such conditions as the cause. As commented by an employee:

"… after the toilet had been mopped he (chef) went in and didn't know the floor was wet and just slipped over ..." (Employee 3)

*"... if someone smashed a glass of water all over the floor, you know either you clean it up straight away or make people aware …" (*Employee 3)

Therefore, two themes emerged for the element of casual relation for OHS risks. These are: i. **Physical condition as the cause;** and ii. **Unaware exposure to hazards**.

4.2.2 Element of action

4.2.2.1 Employer's understanding of element of action

Corresponding to the perceived causal relations, the measures the employer described as taken to control and minimise exposure to slips and falls in the work environment can be largely explained as two types. First, the employer considered the practice of identifying hazards to employees and alerting them of associated risks verbally at the time of occurrence of such exposure or through the use of display signs and notices as an important control mechanism. Second, the employer described the modification of the physical set-up of the work place as another mechanism for control and minimisation of slips and falls as an obvious hazard and risk in the work environment. Putting up netting on the steps, installing a railing on the side of the steps and renovation of the kitchen floor are a few examples of the measures the employer described as taken to control and minimise slips and falls. As explained by the employer:

"… Little things like what we do now is when busy mopping we put up special signs saying 'careful slippery when wet' you know that sort of thing …" (Employer)

"… *We have done the big things, we done a big spin already. The kitchen, chiller, bathrooms … There are always things that you can improve all the time … we have put netting and a rail on the steps there …" (Employer)*

Therefore, two themes emerged for the element of action for the employer: i. **Identifying hazards and hazardous processes;** and ii. **Physical modification of the workplace**.

4.2.2.2 Employees' understanding of element of action

In relation to employees, their understanding of OHS hazards in the workplace was reflected in their responsiveness towards the control of hazards and prevention of risks to the best of their ability. For example, even the small actions such as cleaning up the floor as soon as there was a spill of water or food scraps on the floor, or keeping each other informed of such situations in case such immediate actions were not possible, described the measures in practice for the control of hazards and risks in the work environment. The following response from an employee is illustrative of such effort put forth by employees towards the control of hazards and risk in the workplace:

"… *you just have to be very aware of your surroundings all the time and if you see something there that could quite possibly be a hazard that they might not pick up on you've got to either deal with it, isolate it or make it known. Like if someone smashed water or glass all over the floor you know either you clean it straight away or if you can't get there block if off, make people aware* …" (Employee 3)

Corresponding to their understanding of the causes behind the perceived OHS problems, employees were responsive in controlling such hazards and hazardous exposures. For example, employees controlled hazards first through actions such as clearing away spills or blocking off a floor area that was slippery. Second, they tended to identify hazards and possible risks and alert other staff to these potential risks. Therefore, two themes emerged for the element of action for employees. These were: i. **Identifying hazards and hazardous process;** and ii. **Elementary control of hazards**.

4.2.3 Element of legitimisation

4.2.3.1 Employer's understanding of element of legitimisation

The employer was found to be concerned about the hazards present in the workplace, and that even a little thing such as slippery steps can put the whole workplace at risk in terms of hazardous exposures. As described by the employer:

"… *the steps there become slippery … They are very slippery when it rains which is a hazard that puts us in a big disadvantage in terms of risk of slips and falls in the whole building* ..." (Employer)

The employer was found to be aware of the presence of obvious hazards in the work environment. The employer was found to understand that failing to deal with hazards effectively bore the risk of incidents and accidents and the associated consequences of injury and harm. Such an understanding was found to be one of the reasons for constantly bringing these issues to everyone's attention. Further, the employer's comprehension that bringing up such hazards for wider attention in the work environment context leading to relevant control of hazards and risks was another important reason for raising OHS problems. As mentioned by the employer:

"… *small dangers are real dangers … it's more about hazards … they all are aware of these things … everything is being shared …*" (Employer)

Therefore, **responsiveness to risks** emerged as the theme for the element of legitimisation i.e. reasons established as acceptable for bringing up OHS problems for the employer.

4.2.3.2 Employees' understanding of element of legitimisation

Employees considered that informing each other of hazards and associated risks present in the workplace formed a part of the work environment obligation. A sense of courtesy developed out of the close working relationship established between each other is seen as the main driver behind their obligation. The employees believed that the environment of working alongside each other in a team induced a feeling of mutual obligation involving a sense of responsibility for communication of potential hazards. This is established as the general work environment norm. The following response from an employee exemplifies such norms in the work environment:

"… *most of the time it's about looking after other people as much as looking after myself I suppose …*" (Employee 1)

Usually anyone who sees something as an OHS problem or a hazard in the work environment brings such issues to everyone's attention. Such communication and identification happens in a very informal way and at very informal level. Identification of OHS problems and hazards is perceived as 'shared things' in the work environment.

Sharing with each other the potential hazards is driven by the general understanding that the occurrence of undesirable events and injuries in the workplace is preventable. Therefore, two themes emerged for the element of legitimisation for employees. These were: i. **Responsiveness to risks;** and ii. **Norms of exchange relations**.

The themes that resulted for the four elements of LTWE in relation to the employer are schematically presented in Figure 4-2 and those apparent for employees in Figure 4-3.

4.2.4 Common understanding of OHS risks and development of LTWE

With slips and falls as an illustrative example, common understanding of OHS risks between employer and employees and development of LTWE was sought by looking at the common themes for the four elements of LTWE. The common themes that emerged for the four elements of LTWE for employer and employees are summarised in Table 4-3.

Table 4-3: Themes for the four elements of LTWE common to employer and employees

Elements of LTWE	*Element of experience*	*Element of causal relation*	*Element of action*	*Element of legitimisation*
Employer	Slips and falls	Unaware exposure to hazards	Identifying hazards and hazardous process	Responsiveness to risks
		Physical condition as the cause		
Employees	Slips and falls	Unaware exposure to hazards	Identifying hazards and hazardous processes	Responsiveness to risks
		Physical condition as the cause		

'Slips and falls' emerged as a common experience of OHS problem in the work environment (element of experience) faced by both employer and employees. 'Unaware exposure to hazards' and 'physical conditions' were commonly perceived as the cause**,** suggesting employer and employees had a similar understanding of the element of causal relation. For example, both the employer and employees identified the floor becoming slippery after it had been mopped in combination with not being aware of such hazardous situations were identified as the cause behind slips and falls. Identifying hazards and hazardous processes emerged as the theme common for employer and employees in terms of action on control of OHS hazards (element of action). Being responsive to risks, making each other aware and alert to hazards without putting blame on anyone, but as a way of controlling hazards and responding to risks, emerged as the

theme common to employer and employees for the element of legitimisation. The employer having experienced the situation of an undesirable event himself, and the employees having observed and acquainted such events, has made both the parties come to a realisation that undesirable events, in the words of the employer, were "more about hazards" and a common understanding that an obvious implication in relation to initiating the control was "sharing with each other" these apparent hazards. The mutual sharing of OHS problems and their causes enhanced legitimisation of these problems, which furthered opinions and partaking in the identification and control of hazards and risks. .

4.2.4.1 Development of LTWE

The themes that emerged for the employers' and employees' groups for the four elements of LTWE, with slips and falls as the element of experience, indicated the local theory the two groups established in the work environment. As Table 4-3 shows, for slips and falls as the OHS problem in the work environment, both the employers' and employees' groups understood that "**unaware exposure to hazards**" was the cause and "**identifying hazards and hazardous processes**" was conceived as the control action in common. Identifying hazards and hazardous processes relates to actions such as making others aware of the obvious hazards e.g. a wet floor. Importantly, such actions were instigated by the employer and employees being responsive to risk. Responsiveness to risk as an element of legitimisation, common to both the employer and employees, is recognising that OHS problems and risks in the workplace are more about hazards and hazardous conditions themselves and not the behaviour or fault of the employees and therefore bringing up such conditions to wider attention is necessary. The common themes that emerged for the two social groups indicated a similar understanding of the elements of LTWE and the development of a common LTWE.

Referring to Table 4-3, the development of a local theory around physical conditions as the element of casual relation can be seen as being different for employers and employees. The difference, as can be seen from the tables, arises from the differences in the themes that emerged for the element of action and the element of legitimisation. The employer envisaged modifying the physical conditions at work, e.g. netting on the steps, as the element of action towards controlling OHS problems (causally linked to physical conditions). On the other hand employees considered taking simple and basic

measures, such as clearing away spills immediately or picking up food scraps from the floor straightaway, as appropriate action as a way of controlling hazards. For the employer, being cognisant to deal with risks and exhibiting an attitude of being responsive to hazards and risks was an important reason prompting them to bring up OHS problems for wider attention. Whereas for employees, the norms such as looking after each other and the workplace courtesy, were the main reasons for bringing up OHS problems in the wider work environment and to each other's attention. These results show that despite the emergence of slips and falls as the theme common for the element of experience, and physical conditions as the cause for the element of causal relation for both employers and employees, different themes for the element of action and element of legitimisation apparently indicate the development of a different LTWE between these two groups.

4.3 Employer/employee participation in OHS risk prevention

In relation to participation in the identification and control of OHS hazards and risks, the employees without any restrictions had the possibility to give opinions on any work environment issues and to take part in the decision process. Employees' participation in the identification and control of hazards and risks emerged emphatically as part of their mutual obligation in the work environment. The following response from an employee illustrates their participation in the identification and control of hazards and risks:

"*... we all put in input as to what we think and then at the end of the day it's Goran who has the final say. But we all sort of throw it in (ideas and opinions). Robin does actually change things usually. But we still have the say and we would say yes or no. It usually goes round; everybody is asked if there is anything they wanted to talk about. He will have his say, Ruth will have her say, and Sue would if she wanted to bring up anything. Yes, everybody can say anything they want to bring up; grunts or good things or whatever suggestions on what we can do. Yeah he is very open and I feel I can talk of anything any time* ..." (Employee 1)

Similarly, their participation in the decision process was instigated by the possibility of making work-related decisions independently as part of their routine task without being prompted, coerced or interfered with by the employer. Employees showed they had sufficient autonomy to make changes to the work environment, daily tasks and food selection (cabinet food items) at their own discretion. The decision autonomy at work

and making changes in the workplace is illustrated by the following responses from employees in business Case 1:

" … *they are not necessarily the ones who have to work here all the time. They will be off doing other things whereas we're the ones working here all the time. That's our work environment and we want to set up to how we work. But the changes that have happened in the front are really good. It's working really well at the moment. There are a few bits that were not working so well. But we've just changed them and adopted them to find a system that works. For example, something may change without us being informed but we always get a chance to give feedback, to give our opinion later on …"* (Employee 3)

The following field observation notes illustrate employees' participation in the decision process and typify spontaneous and unprompted participation without the employer's prompting.

Box 4-4: Observation notes, 19 March 2010

I came in the restaurant around 11:30 am. I noticed that the day was a bit quiet and the work seemed to be moving at a much slower pace. As I entered the restaurant Maggie commented "we are all struggling to find work today". After some time I noticed Sue, Caitlin and Ruth sitting around a table discussing something, while Maggie attended to the orders coming through. After the three of them finished the discussion they all came in and informed Maggie about the decision. I heard that the discussion was over a change in the menu and the three of them had decided on a reshuffle of the menu. While informing Maggie about the decision they also tried to provide their logic for the change. Everyone seemed to agree on the envisaged change.

Goran (the owner) came in around 12:00 noon. As usual he greeted everyone and started off with serving the customers. After a while as there were no more orders coming through Sue, Caitlin, Ruth, Maggie and Ben gathered in a circle in the kitchen and started to talk to Goran about the decisions made in the morning, and the reasons behind them. Goran seemed to be happy about the decisions and agreed by saying "give it a go".

On the employers' side, the participation is characterised by them getting involved in the daily activities of the business through constant sharing of ideas and opinions,

consulting the employees on workplace matters and openly sharing information with employees. In addition, when the employer engages in daily tasks such as clearing tables or doing dishes as does any other staff member, the employees appreciated and perceived this as generous support which also characterises open participation. The following responses from the employees illustrate such characteristics:

" … *they walk in and when there is coffee on the table they will take them … bosses are then prepared to do whatever you do. So yeah, I think it's supportive … for us all to get on together, all to work together and not, you know, falling apart … get to the common grounds … getting the food in the cabinet, serving the customers, getting food out the customers want* …" (Employee 1)

"*... consult us with things, just always there ... if you would make a mistake then he doesn't just come and tell you off. He understands because he is probably part of it ... always being here, showing us, working with us, understanding ...*" (Employee 2)

Such participation characterised by the employer's involvement in consulting and sharing information with employees is further illustrated by the field observation notes presented below.

Box 4-5: Observation notes, 16 March 2010

While I was preparing salmon stack, the phone rang. Maggie picked up the phone. She called Goran to the phone. As soon as Goran hung up the phone he turned to Maggie (she was the only one in the kitchen at that time) and asked her if there was a way to stop people cancelling the booking at the last moment when everything is already prepared for the event. Maggie replied by suggesting that one thing they could do is to make people pay a certain amount of booking fee, which would be non-refundable in case of cancellation of the bookings. Goran agreed that that was a good and practical idea.

The employer in a way is observed to keep the employees up to date on what is going on in the restaurant at all times. It could be: keeping up to date with the bookings made or cancelled; a more formal type of meeting planned; special functions and events planned in the location; and the planning needing to be ready for such events. (Observation notes, 16/03/2010)

The responses from the employers and employees were coded in NVivo, which provided the initial description of the characteristics of participation in relation to the identification and control of OHS hazards and risks. These were then segregated into thematic categories, which led to identifying illuminating typologies and eventually to the construction of participation typologies. This process of segregating the responses into thematic categories and construction of participation typologies is illustrated diagrammatically in Figure 4-4, where noted within the plain oval shapes are the indigenous concepts of participation. The grouping together of these indigenous concepts led to creating distinguished characteristic labels (categories) illustrated within the shaded oval shapes, and the linkages between the identified characteristic labels led to the generation of participation typologies (participation themes) illustrated within the shaded octagonal shapes.

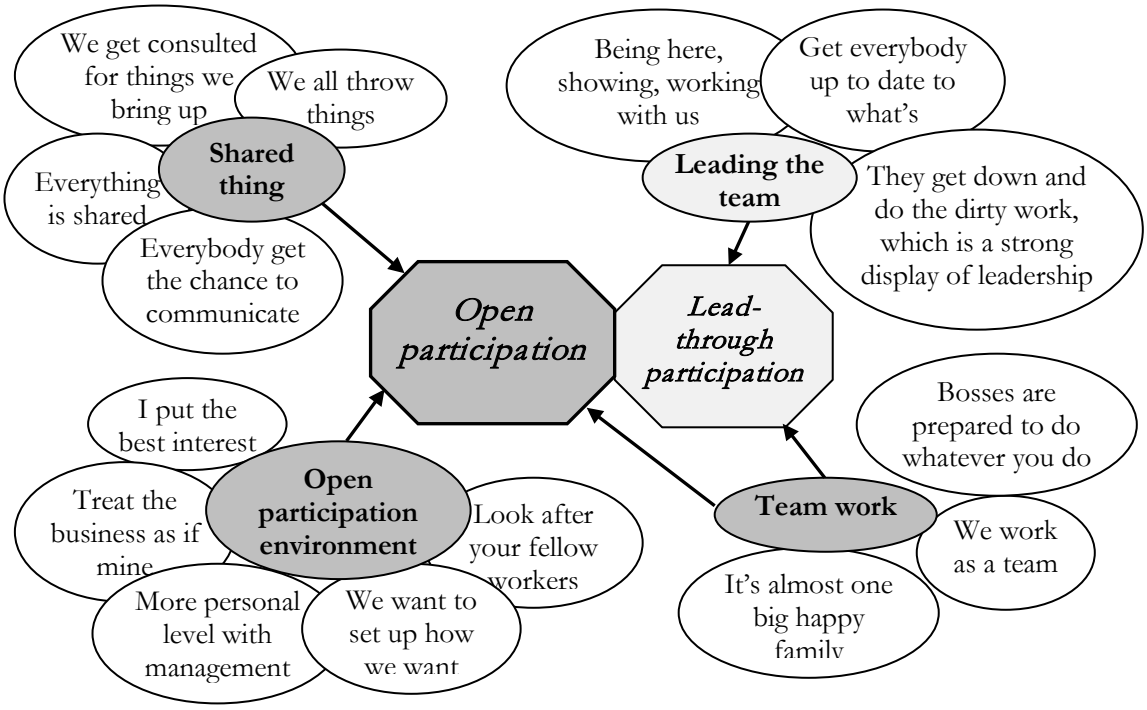

Figure 4-4: Indigenous concepts of participation and participation typologies

Open participation emerged as the predominant typology for employer/employee participation in the identification and control of OHS hazards and risks in the business Case 1. Informal participation in the identification of hazards and risks that broadly included any issues on working conditions and work environment characterised the typology of open participation. The ability of the employees to change or discard a

decision on work and work environment conditions also described open participation typologies. A less predominant typology of participation (illustrated through lighter shades of the octagonal shape representing participation typologies in Figure 4-4) is **lead-through participation**, which is indicative of the employee's expectation of the owner/manager to work with them – not to command and control but as a mentor and team leader.

The characteristics and drivers of open participation that resulted as the predominant typology of participation for Case 1 from data analysis are summarised in Table 4-4.

Table 4-4: Open participation – characteristics and drive

	Characteristics	*Drive*
Employer	Being around to show and guide Seeking ideas and opinions Consulting and sharing information	Keep everything up and running
Employees	Get consulted and give opinions unrestrictedly Autonomy to make changes Unprompted participation in decision process	Being on an equal level with the employer

Open participation, as the predominant typology of participation, is found to have some important and obvious implications for the identification and control of hazards and risks in the working environment. First, open participation allowed employers and employees equally to bring up wide-ranging issues of OHS problems in the work environment with no restraints. Such a possibility established wider acceptance of the OHS issues as legitimate work environment problems that required attention and action for control. Second, closely connected to legitimate acceptance of OHS problems was the approach taken by both the employer and employees not to trivialise or ignore such problems, but rather act more readily to control them. Keeping observant of the possible hazards and risks in the work environment and putting instantaneous efforts for their identification and control, as exemplified by the field observation notes presented below, illustrate non-trivialisation of OHS problems in the work environment.

Box 4-6: Observation notes, 10 March 2010

It has been a week since I started my field observation in this cafe. I have learnt a few recipes already and as it seems the staff are slowly gaining confidence in me being able work on a few of these items independently. It may be the reflection of such confidence

that today as soon as I entered the kitchen, Sasha asked me if I could make salmon stack today as well. I told her that it would not be a problem. She told me, "If you are not sure of anything please just ask any of us". I could see Maggie working on dough and Ruth on muffin bakes. I started slicing tomatoes for the stack. As I had sliced a few tomatoes Sasha approached me and told me that the way I was doing the tomatoes was not safe. She showed me that the flat side of the tomato should rest on the board so that it is stable while slicing. She explained, "If it is rested on the round side then it becomes unstable and there is a chance that you will get your finger chopped off". She then told me that the same thing applies when cutting pumpkins as well. Once I finished with the salmon stack I went to help with dish washing. Every time someone was coming with a hot pan or a hot pot, they would tell me "a hot pan" or "a very hot pan – be careful". On occasions when the pan seemed to be really very hot then the person would simply grab the water jet from me, spray cold water over the pan and leave it in the basin.

As the service was really busy today, Goran was fully occupied with clearing tables and bringing dirty dishes to the wash basin. I have observed, as a norm, the person bringing dirty dishes would usually sort out the cutlery and place the knives, forks and spoons in different containers that contained soap and water. While Goran was sorting the cutlery, he noticed that the forks and knives were placed in the container with their sharp ends pointing upwards. Goran pointed to the wrongly placed cutlery immediately and told me aloud, "Be careful, those are hazards. They should not have been placed in the container that way; we need to talk to everyone".

The unrestrained spontaneity in bringing up OHS problems for wider attention, the constant identification of hazards and risks in the work environment, and the sharing of ideas and opinions were found to have key role in legitimate acceptance of OHS problems. Such legitimate acceptance largely influenced what was considered appropriate in relation to the control of OHS hazards and risks and stopped trivialisation of OHS problems.

4.4 Conclusion

The emergent themes for the four elements of LTWE indicated the understanding of OHS risks by the employer and employees and consequently the LTWE the two parties established. Same themes that came up for the four elements of LTWE for the two

social groups indicated establishment of similar local theory and the development of a common understanding of OHS risks. Slips and falls as an illustrative example of element of experience showed that the employer and employees in common perceived "unaware exposure to hazards" as the element of causal relation, identifying hazards and hazardous process as the element of action, and responsiveness to risks as the element of legitimisation. This indicated the establishment of a similar local theory and a common understanding of OHS risks. In contrary, despite having identified physical conditions in common by the employer and employees as the element of causal relation for slips and falls (element of experience), different themes emerged for the two groups for the element of action and element of legitimisation. These results indicated that for the same OHS problem, depending on the number of different themes for the four elements of LTWE, a social group established one or more different local theories. Consequently, the two social groups established local theories that were different between them.

The development of a number of local theories that were same or different were indicative of a number of different approaches deemed appropriate for the identification and control of OHS risks and hazards by the two social groups. Different local theories established by the employer and employees also reflects the differences in the way risks are accepted as a legitimate work environment problem and what was envisaged as appropriate control mechanisms.

Open participation characterised by informality, openness, mutual seeking/sharing of opinions and ideas and unprompted participation by employees in decision making emerged as the typology of employer/employee participation in the identification and control of OHS hazards in this SB case. Mutually shared opinions and decisions determined open participation, which influenced legitimisation of OHS problems and the development of LTWE. The influence of open participation on legitimisation is reflected in the employer and employees being responsive to risks. Similarly, legitimisation equally influenced open participation. The employer seeing himself in a supporting role to "keep everything running", rather than as an authoritative owner, and employees belonging to a team with common goals exemplify the influence of legitimisation on open participation. Thus, open participation had an important influence on legitimisation of OHS risks, associated hazards and the sources of hazards,

which subsequently influenced development of LTWE and the approaches to the identification and control of hazards and risks.

Chapter 5 Case Study 2 – A Cafe and Restaurant

This chapter provides a detailed account of employers' and employees' understanding of OHS risks and participation in controlling OHS risk in the second business case involved in the present study. The chapter does this by first providing a general description of the case and a description of the work environment. This is then followed by findings on employers' and employees' understanding of OHS risks utilising the four elements of LTWE. The chapter then reports the findings on employers' and employees' participation in OHS risk communication and control. Final conclusions bring the chapter to a close.

5.1 Case description

The business was an independently owned enterprise that had been in operation for more than a year. The business was run under single independent ownership. It employed 13 employees in total, of which five were in permanent employment and eight were temporary. Functionally six of the employees ran the kitchen operation; six were engaged in the front of house while one oversaw the general administration.

The restaurant ran seven days a week and opened for the customers just after 9:30 am until 10:00 pm at night every day. However, the kitchen operated in two shifts – the first covering from 9:00 am to 3:00 pm and the second from 6:00 pm to 10:00 pm, with a break in between the two shifts. The front of house ran continuously from 9:00 am until 10:00 pm, with a number of employees covering four hourly shifts at different hours of the day.

The business was located in the middle of the town in the Central Business District (CBD), which catered a complete range of food services from breakfast, lunch to dinner largely targeted at corporate customers.

5.1.1 The food products

The business served a variety of pastas, cakes and vegetable salads combined with toast and sandwiches for breakfast. The menus for lunch and dinner comprised of roasted beef, chicken or lamb and pan-seared salmon or ostrich served with seasonal vegetable sides. It offered chocolate mousse cake, ice-cream, blackberry tart and chocolate liqueur

truffle for desserts. Tea, coffee, soft drinks, fruit juices and various blends of beer and wine were the usual beverages offered. The front of house of the restaurant remained open even when the kitchen remained on standby during the time between the morning and evening shifts where mainly beverages and shelved products such as muffins, pies and cakes were served.

5.1.2 Organisation structure

The business had a hierarchical structure with two obvious supervisory levels set out to manage the operation. The owner supervised the overall operation of the business and was also designated as the executive chef. This comes out logically as the owner is trained as chef and has more than 20 years of experience in commercial kitchens. Below him were the duty managers and head chef supervising staff and reporting to the executive chef as their supervisor. The staff included the wait staff in the front of house and the dish hand, kitchen hand, baker and chefs in the kitchen.

The organisational structure is presented diagrammatically in Figure 5-1.

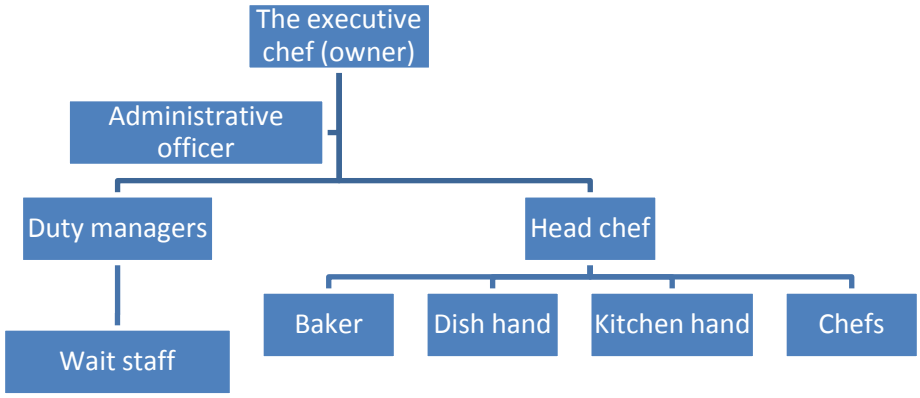

Figure 5-1: Organisational structure – Case 2

As the executive chef, the owner/manager formed a part of the staff roster for kitchen work as well as supervising the daily running of the kitchen. In the absence of the executive chef, the head chef supervised the kitchen operation. The head chef and the duty manager generally formed the channel of communication between the owner and employees. They also formed this channel between the kitchen and the front of house. Instructions on work and work organisation were the usual context of communication from the supervisory level down to employees. Suggestions and opinions when sought were usually communicated from employees upward towards the supervisors. In

addition, any specific information such as the special dish of the day, materials that were out of stock, or any work that was pending which needed someone to attend to were communicated by writing on the kitchen wall.

5.1.3 Tasks and roles in a day's work

A clearly defined organisation structure meant clearly defined job responsibility and well-outlined work organisation. This meant that the employees, in general, had a responsibility assigned either to the kitchen or the front of house. The job descriptions outlined the work they were expected to perform. They also had more or less a designated work space to accomplish their job. The defined job description did not exist formally in writing, but rather as an informal-verbal description from the supervisors, which the employer described as "a flying thing". A few examples of such job descriptions were:

- duty managers sending orders through to the kitchen
- executive chef/head chef attending to the orders in the kitchen
- wait staff attending to the assigned table in the front of house
- kitchen hand assigned to assist chefs with preparation of side dishes and decorating plates during busy services
- dish hand being responsible for cleaning all the kitchen utensils, storing them away appropriately and keeping the kitchen floor dry, and free of spills and food scraps.

Informal job descriptions guided the work each person did. Thus, devolving tasks such as preparing side dishes, salads and decorating plates in the kitchen by the executive chef or the head chef to the subordinates during busy service was well accepted despite them having their own described jobs. In the front of house such task devolvement did not usually happen. Handling of milk products in the front of house was the responsibility of particular persons as the council required them to obtain a food-handling certificate as part of its hygiene certification. Similarly, as part of the training to get into the profession of chef, all the chefs had taken a hygiene course as well as health and safety courses during their training. In that respect, ascertaining the quality of food served was clearly regarded as the responsibility of the chefs. This pertained to checking the stock rotation of stored preparations, ensuring the correct type and proportion of

ingredients in pre-cooked items and that food items were not over or under-cooked. This pertained to checking stock rotation, the proportionate combination of ingredients and the proper cooking of food items.

Box 5-1: Observation notes, 10 May 2010

I started my field work from 9:00 am today. As I entered the kitchen I could see a big heap of dirty dishes in the basin and on the bench by its side. That must have been from the busy service the previous night. I could see Jane and Mike starting up the kitchen. As I got into the working apron Mike showed me the preparation list where he had marked some of the work with my initials. I started to work on chopping capsicum and onions. Rob (the executive chef) joined the others in the kitchen as I was about to start the task assigned to me. Mike showed him the preparation list with my initials. Once I finished these I started to work on the potato cakes.

The service started to get busy quite early on today. By 9:30 am I could see both Mike and Rob fully occupied with cooking and frying. Around 9:30 the kitchen hand joined in.

Around 10:15 am the service got really busy with orders coming in for breakfast and combined breakfast and lunch. Initially when the orders were light the chefs managed to get the plate ready themselves. But as the orders started to get piled up the chefs focused on cooking and preparing the main meals only and called in the kitchen hand to work on the salads and side dishes. With further orders coming through, the baker joined in to assist with side dishes, salads and decorations. It was quite interesting to see how the kitchen hand and the baker engaged themselves in attending to the orders during busy hours and disengaged during slack periods. Once the busy lunch hour was over, and the chefs managed to attend to the orders coming through, the kitchen hand and baker were back at their own work stations focused on their respective routine jobs.

In relation to OHS hazards, any hazard that posed a health and safety risk in the workplace was brought to attention, as a workplace norm, to the other person exposed to such hazards and risks. For example, the chefs always told the dish hand if a pan or a tray they had brought to the wash basin was hot, or when the dish hand had to walk

past the hot side or work behind a chef, he/she always let the chef know that he/she was around by saying "behind".

The characteristics of the business case are summarised in Table 5-1.

Table 5-1: Summary of the characteristics – Case 2

Characteristics	*Description*
Number of employees	Thirteen
Year in operation	One-and-a-half years
Ownership	Independent individual ownership.
Owner's involvement	General overseeing of the business as well as in staff roster as executive chef.
Characteristics of the owner/manager	Both the owner and the head chef are trained chefs, knowledgeable about the identification and control of hazards and risks. This has come about initially as part of their training, but largely from the number of years of experience in the area.
Daily management of operation	Head chef and duty manager
Task definition	Defined tasks with multi-tasking to some extent
Structure	Multi-layered – owner (executive chef) at the top, head chef (the manager) in the middle, and employees (chefs, wait staff and kitchen hand) at the bottom.
Documentation	Checklist for opening up and closing down; checklist for daily cleaning schedule; checklist for daily preparation of food materials.
Communication	Informal top down communication in the form of instructions and bottom up communication as suggestions and opinions (when sought by supervisors).

5.1.4 The working environment

5.1.4.1 Physical layout

The physical set-up of the restaurant had two main areas – the kitchen and front of house. The front of house largely comprised of the dining area with order till and liquor rack near the entrance to the kitchen. The dining area occupied spaces both on the ground floor and the first floor.

The main kitchen was spacious considering the amount of movement of people it allowed while at work. The kitchen was divided into a 'hot' work area ('hot side') and a 'cold' work area ('cold side'). The hot side was the main cooking area, which had the oven, stoves and deep fryer. The cold side comprised other work areas that included dish wash, dry storage, cold storage, baking and general work spaces in the kitchen. A long work bench divided the kitchen into hot and cold sides. Cooking, baking and dish wash areas were the ones that had a lot of movement of people and materials, whereas

dry storage and cold storage had relatively less movement and occupied separate areas remote from the general work spaces.

Staff had designated work spaces corresponding to their work tasks. Dish washing and baking occupied the corners of the kitchen adjacent to the front of house area. These activities could be performed uninterrupted by movement of people and material in the kitchen. The hot side of the kitchen was the designated work area for the chef. Chefs were responsible for the hot side of kitchen work. The other persons apart from the chefs to access the hot area were the dish hand, who put away clean dishes on shelves, and the baker who used the oven for baking.

The front of house occupied a small area adjacent to the kitchen. The front of house had a coffee machine, a water boiler and a till for accepting orders and payments. The front of house led into the kitchen through an open passageway, which allowed free movement of people and material between the two areas. The cold storage and dry storage were at the far end of the kitchen opposite the front of house area. The front of house staff needed to access the cold storage regularly. The set-up of a work bench in the middle of the kitchen seemed such that it allowed safe access to the storage. Both as a rule and in general practice the passage on the hot side was never used as an access way. The physical set-up of the business is shown schematically in Figure 5-2.

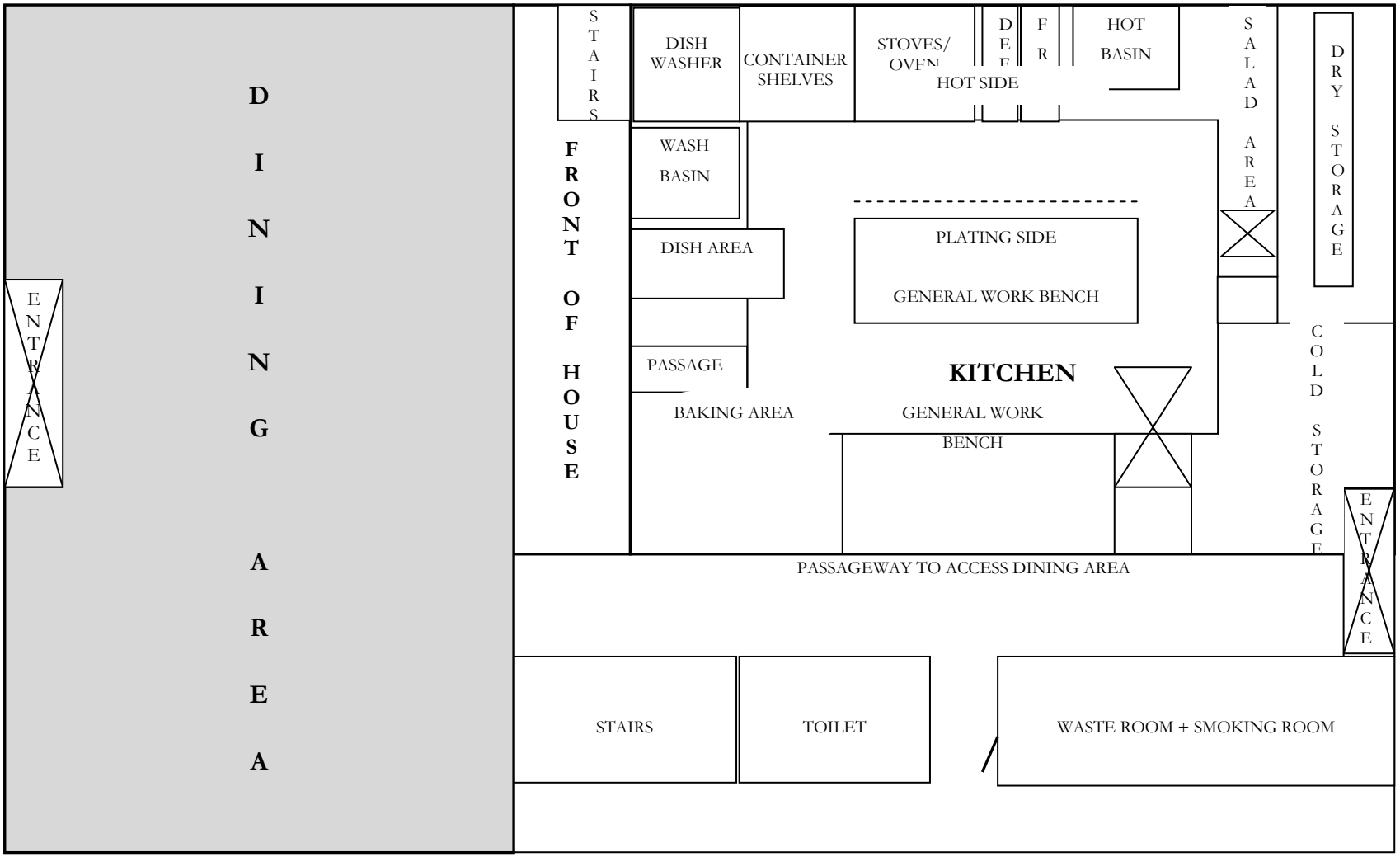

Figure 5-2: Business Case 2 – schematic diagram of physical layout of the operation (not to scale)

5.1.4.2 Work organisation (how things are done)

A typical day in the kitchen began with starting up kitchen appliances – the oven, deep fry, overhead gas toaster and panini iron. This was followed by preparation work. Cooking and baking involved their own distinct preparation work. For cooking, this meant preparing the necessary ingredients for the main course e.g. rice, rice cakes, lamb chops; preparing vegetables for salads; grilling of mushrooms, tomatoes and meat items; and the preparation of dips and dressings such as mayonnaise and sauces. The baking side entailed preparing mixes for cakes, muffins and desserts. The baker was responsible for preparing cakes and desserts, which she was encouraged to decide at her own discretion.

Start-up preparation on the 'cooking side' was handled by a chef whereas the 'baking side' was organised by the baker. On the cooking side the chef usually dealt with the 'hot side' of preparation, whereas the 'cold side', such as chopping/peeling of vegetables, containing grilled materials etc was delegated to dish hands. The person starting up the cooking side was joined by another chef later in the morning before lunch orders started to come through. On the cooking side, either the head chef or the executive chef was present alongside the other chef.

The early orders coming through were for breakfast and once the orders for lunch started the services started to get busier. The head chef usually attended to the orders coming through on the dockets. Once an order came through the head chef indicated to the other chef the items being ordered and those he would work on. The other chef prepared the remainder of the ordered items. When the service got very busy and the chefs had to be very focused on cooking, they would call in the dish hands to help with side dishes and salads. In such instances of task delegation the chef-in-charge would be constantly asking the dish hand or the kitchen hand for the next item or ingredient he wanted to put together to complete the order. Everyone else was focused on preparing a delegated item while at the same time listening for a call out by the chef-in-charge for his/her item. When an order was ready to be served the front of house staff were let know by chiming a bell.

In the front of house a typical day started with setting up the tables, checking for replenishment of shelved food products and starting up the coffee machine and hot

water boiler. The till is set up and order docket is readied. Usually two persons started up the front of house, one of whom was the duty manager.

Managing the daily work activities in the front of house was the prerogative of the duty managers who supervised the wait staff. The duty managers were generally responsible for taking orders, sending orders through to the kitchen, assigning tables for wait staff, and starting up and closing down the front of house. Each wait person in the front of house was assigned particular tables to attend to and were therefore in charge of: serving and attending to the tables they were assigned to; clearing away dirty dishes; cleaning the tables; and clearing the floor of any spills and food scraps.

5.1.4.3 OHS hazard management

Employer and employees, in general, seemed to consider wet slippery floors as a major health and safety concern in the working environment, both in the kitchen and front of house. As part of their code of conduct and a safety measure against slips and falls the employees were required to put on flat shoes at work. A sign saying 'wet floor' is put up primarily as a safety measure against customers slipping and falling in this area. The stairs that led to the dining area on the first floor were another safety concern, particularly when staff were carrying plates and glasses up and down them. As a safety measure to minimise the risks of tripping and falling on the stairs, employees were instructed not to use the stairs designated for customer use.

In the kitchen particularly, knives, hot pans, hot trays directly from the oven, oil and water spills on the floor were considered obvious health and safety hazards. At dish washing, hot pans, sharp knives, broken glass and water spills were the obvious hazards potentially causing burns, cuts, slips and falls. Always placing the hot pans from the oven into the right-hand basin in the dish wash area, sorting out table knives and forks into a container with soapy water, and placing kitchen knives separate from other dirty dishes were the main OHS management practices observable in place. In the cooking area, hot pans and hot oil were of main concern as hazards as there had been past experience of burns from these. The employer and employees considered water and oil spillage and food scraps on the kitchen floor as health and safety hazard in general. However, there was no particular practice and procedure in place that was observable for clearing away spills and scraps on the floor and managing associated risks. Usually the spills and scraps on the floor were cleaned away by whoever had time to do it and

the practice was more to keep it clean and less as part of hazard management practice. The field observations revealed that bare floors without mats not only accentuated the risks of slipping and falling, but also increased the possibilities of sore legs and fatigue having to stand for prolonged period on the hard floor surface. Work stress due to high service demand during lunch hours with large numbers of orders coming through was an additional observable health and safety hazard in general.

The executive chef and head chef were responsible for making sure that the place was running smoothly. These involved: placing orders for delivery of materials or making purchases; allocating hours of work equitably among staff members; as well as imparting knowledge on the safe working procedure to employees by explaining about the task, system and equipment. The chefs generally acquired knowledge of health and safety during their formal chef training which they happen to share either casually at work on a one-to-one basis or through occasional informal meetings with staff members performing the task or using the system and equipment. In that respect, the employer and the manager seemed to be always attentive to the work employees were doing and the way it was done, which they termed as "keeping an eye" on the workplace safety practice. The owner/manager translated this into them being perceptive of obvious hazards and taking the responsibility to make the employees aware of the hazards in the work environment. The owner/manager presented themselves as mentors demonstrating safer ways of accomplishing work to the employees and taking time to do so. In the event of an incident or accident or any other problems considered serious, the executive chef usually convened a staff meeting.

Depending upon how serious the problem was assessed to be, the executive chef or the head chef either made everyone aware of the potential concern, tried to fix the problem immediately, or sought the employees' opinions on ways to control it. For example, on one occasion there was a pool of water on the floor that had not dried completely from having been cleaned up the previous night. The baker who saw it notified the situation to the head chef who then alerted everyone coming into the kitchen about the slipperiness of the floor and advised all to be careful around that area. On another occasion, while I was chopping tomatoes, the executive chef noticed that the way I was executing the task was unsafe. He immediately approached me and explained that resting a tomato on its flat surface on the chopping board was a much safer way of

carrying out the work. Despite plenty of these occasions where health and safety concerns were brought to everyone's attention, the work under time pressure during busy hours and the fatigue and stress experience thereof or sore legs due to having to stand long on hard floors were not raised, discussed or mentioned as a concern among employees or between the employee and the employer. The hazard management practice can be summarised as being basically informal and at the discretion of the owner/manager.

5.2 Employers'/employees' understanding of OHS risks

The owner/manager and employees identified either undesirable events or associated hazards, or the consequences of such events, as OHS risks experienced in the workplace. The OHS risks as reported by the owner/manager and employees have therefore been grouped as hazards, undesirable events and consequences and presented in Table 5-2. The numbers in brackets against the issues listed in Table 5-2 indicate the number of respondents that identified it as an OHS concern from a total of nine employees and two owner/managers (the owner and a manager) as respondents.

Table 5-2: OHS concerns in the workplace

	Owner/manager	*Employee*
Hazards	Hot pans (1) Hot jugs (1) Knives (1)	Sharp knives (6) Hot pans (4) Hot plates (2) Hot fryer (1) Hot oil (1) Slippery floor (1) Water and oil spills (2)
Undesirable events	Slips and falls (2) Improper knife handling (1)	Slips and falls (1) Grab hot tray (1)
Consequences	Burns (2) Cuts (2)	Burns (7) Cuts (6) Stress (1)

The owner/manager and the majority of the employee respondents (seven out of nine) widely reported burns as a concern. Therefore, 'burns' was being stated as the major OHS concern in the work environment and taken as an illustrative example of an OHS problem for examination of understanding of OHS risks by the employer and employees using the LTWE framework.

The responses and textual notes pertaining to the four elements of LTWE were transformed into a network diagram, separate for the owner/manager and employees, as presented in Appendix 10 A and C, respectively.

Initial coding demonstrating similar characteristics were grouped together and developed into categories for each element of LTWE for both the owner/manager and employees groups, respectively. Formulation into different categories involved grouping together the coding that described similar characteristics of each element of LTWE. These are shown separately for the owner/manager and employees in Appendix 10 B and D, respectively. Encompassed within the same shaded box are the similar categories of initial coding. Categories describing similar characteristics of the element of LTWE led to the development of the emergent themes. The development of emergent themes for the elements of LTWE for the owner/manager and employees are diagrammatically presented in Figure 5-3 and Figure 5-4, respectively. The emergent themes are shown in bold letters within a box in Figures 5-3 and 5-4.

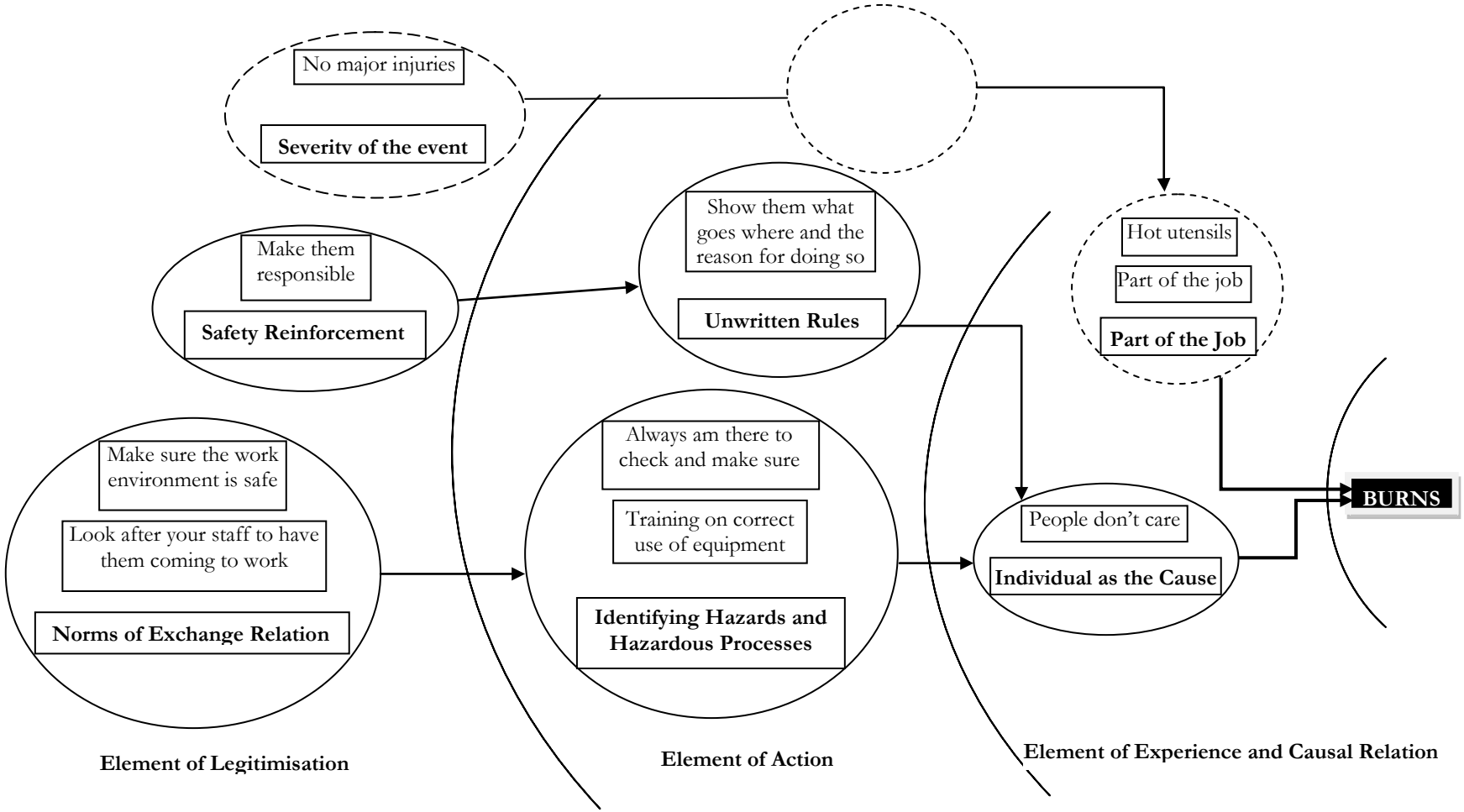

Figure 5-3: Development of categories of responses and emergent themes for employer – Case 2

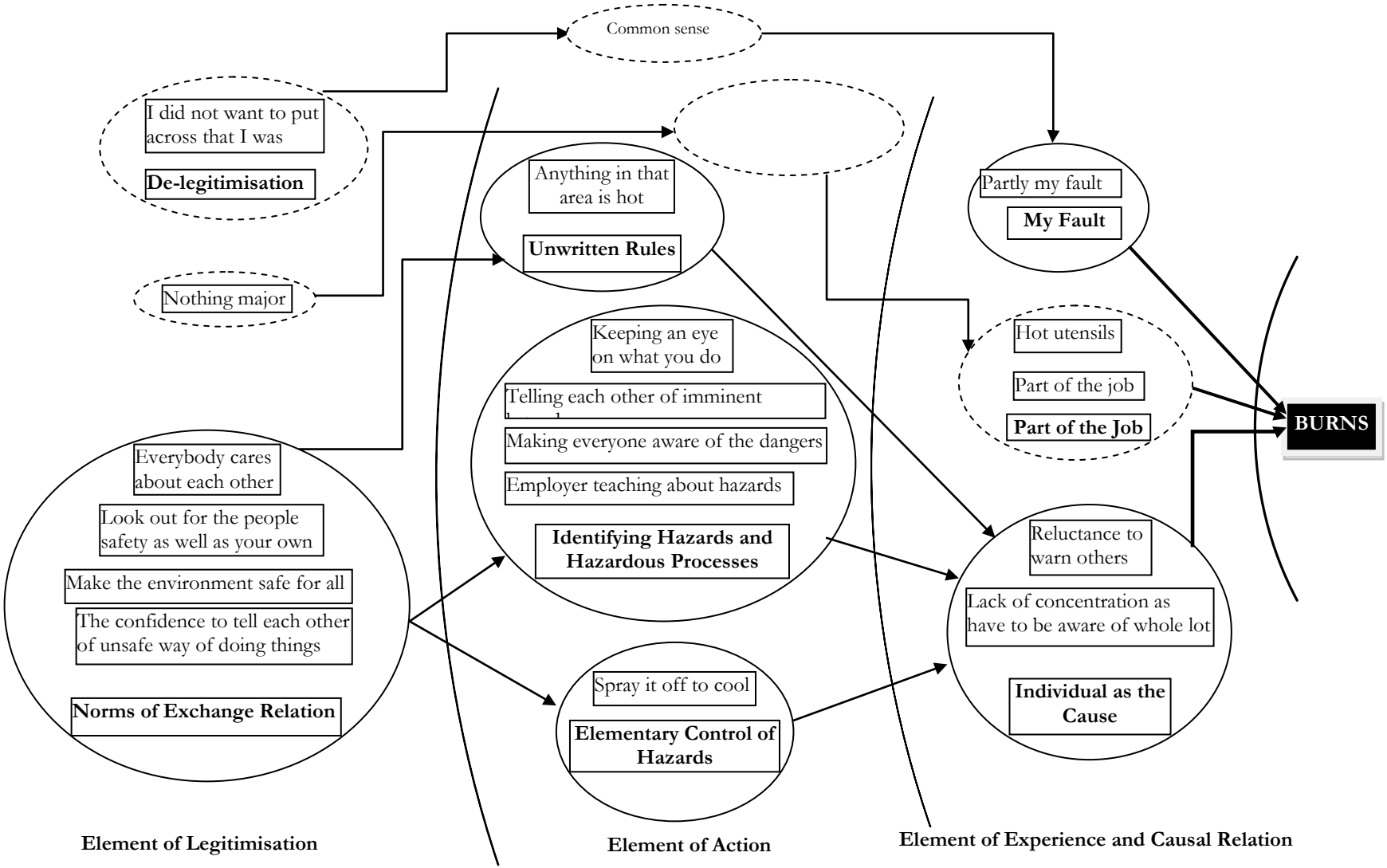

Figure 5-4: Development of categories of responses and emergent themes for employees – Case 2

5.2.1 Element of experience and element of causal relations

5.2.1.1 Employers' and employees' understanding of element of experience

The owner/manager identified burns as one of the widely experienced problems in the workplace. The following comments by them illustrate their understanding. For example:

"*… I was doing training with the staff with coffee … one of them was holding the jug in her hand and trying to steam the milk, and by the time it got hot the hand started burning …*"

Similar was the response from the manager:

" *.... there is a lot of hot stuff but they don't tend to burn themselves too often. But like I said, I mean, if you work with fire eventually you're going to get burnt, so you know it is a hazard …*"

Employees in general also conceded that burns were undesirable events in the workplace, which they associated with hot equipment and utensils. Such a notion of burns as an OHS problem encountered in the workplace is illustrated by the following comments from the employees:

"*We get a lot of burns ... there is a lot of hot things ... hot pots ... hot pans ...*" (Employee 8)

"*… chefs often get burns on their arms or hands from the pans because they're doing gas …*" (Employee 6)

Thus, burns are identified as one of the widely experienced OHS problems by both the owner/manager and employees. With burns as an element of experience, both groups identified a number of causes as the element of causal relation behind the problem. These will be described in detail in the following sections.

5.2.1.2 Employers' understanding of element of causal relations

For the owner/manager the causes of burns, as an illustrative example, were primarily related to employees not thinking or not being careful in what they were doing. There were instances where such events were considered part of the job, but even then, the individual's level of awareness (or lack of awareness) of the work situation and surrounding was considered as the primary cause of the event. The following comments from the employer and the manager illustrate these causal attributions:

" *... I think people just being silly and not thinking and that's the biggest thing I think that people just don't use their brains you know and a lot of them just don't care and that's where I think people who do get injured a lot of the time just don't really care ...*" (Employer)

" *... Burns, burns are just the part of the job ... the hot stuff, they are aware that that's hot, you know it is a hazard but I don't think it's a hazard that's avoidable completely, but lot of it depends on them using common sense ..."* (Manager)

"**Individual as the cause**" emerged as the theme for understanding of the element of causal relation behind OHS problems for the owner/manager.

5.2.1.3 Employees' understanding of element of causal relations

Employees largely identified the casual relation behind the OHS problems in the work environment to the individual employees. For example, the individual employees not using common sense or failing to think before doing anything (such as the reluctance to warn each other of obvious hazards or easily losing concentration at work) were identified as the general causes behind undesirable events. The following responses from the employees illustrate this attribution of causal relation:

" *... when you're walking behind the cooks by the stoves you could have said 'behind' because once or twice previously we had someone hit when they were swapping around with the pans to put it on the plates and someone was behind them with the chef not knowing it and you are always going to get hit. We had people burnt but like that ... But that's all part of learning and it's not on purpose to have accidents but it is things that could be brought up here or produced by bit reluctance to say 'behind' or 'around here' ...*" (Employee 2)

"*… when you're busy and you're so busy that you've got to think about 10 to 20 things at once while you're doing it and doing the job ... but not only that, just your brain is going so fast and you forget that you've put something down and it's still hot. So, you grab it without even thinking. And you know you burn … So, I think lack of concentration and the vision is really a major factor …*" (Employee 8)

In addition, employees most of the time attributed the causes behind the occurrence of such events to themselves and blame themselves, particularly if they believed they were in the wrong. For example as one employee commented:

" *... there were some gourmet potatoes in the oven and they needed them out. He (chef) couldn't get them out. So, I grabbed them and because everything was kind of bit chaotic, there was not really any bench*

space or anything to put it on. So I ended up holding it and burning my hand ... Yeah, that was partly my fault, because I didn't use a tea towel ..." (Employee 7)

Two themes emerged as the cause behind OHS problems. These were: i. **Individual as the cause**; and ii. **My fault**.

5.2.2 Element of action

5.2.2.1 Employers' understanding of element of action

In line with the perceived causes behind OHS problems, the owner/manager identified unwritten rules as one of the actions for prevention of OHS risks. For example, there are a number of 'unwritten' or 'understood' rules in place which the owner/manager understands as the measures in place to control possible risks of injuries and accidents. As explained by the owner/manager:

" *... everything that goes into the right sink is always hot ... always grab a fry pan with a cloth, it is generally hot ...*" (Manager)

" *... there is no real safety guidelines in place as set out on paper but just telling them this is what you have to do; this is how you do it; don't do this way; the reason why is because this will happen .... I show them this is where this is kept; the reason for this is that, the reasons for that is that ...*" (Employer)

In addition, the owner/manager reinforces the unwritten rules among the employees by reminding them of work practices (unwritten rules) in order to make individual employees responsible for their actions.

Thus, "**unwritten rules**" emerged as a theme for the element of action for employer.

Similarly, the owner/manager seems to ensure the safety of employees by constantly teaching and training them in the proper way of carrying out work e.g. making coffee or slicing onions and identifying hazards and hazardous acts constitute an integral element of such activities. They consider such activities as their obligation which is described as the norm of exchange relations that exists between the employer and employees in the work environment. As reported by the employer:

" *... just training how to use it ... and making sure they know how to use the machine properly ... I'm always there and I always say I don't want to it done this way, I want it done that way ... you have to*

make sure that everybody is safe in their work environment ... if not there is no point in why they should come back to work tomorrow …"

"**Identifying hazards and hazardous processes**" emerged as the second theme for the element of action for owner/manager.

Development of categories of responses and themes from data responses are presented schematically in Figure 5-3.

5.2.2.2 Employees' understanding of element of action

Keeping an eye on each other's work and making each other aware of any obvious hazards were identified as the important factors of preventive action the employees consider as being in place to minimise occurrence of injuries. This corresponded with employees' general perception of individuals as the cause behind injuries and incidents such as burns, slips and falls as OHS problems in the work environment:

"... we say when we've got something or we're walking behind someone we always say 'behind'. And that's a safety thing ... its making everyone aware of the dangers that are in our workplace in our industry ... when someone's mopped the floor, or there has been a spillage, it's just the courtesy. Say if I've spilt oil along the floor, I want everyone to know in the kitchen or anyone. I would let them know "Hey, I have spilt some oil, it's a bit slippery down there. Please just watch ..." (Employee 8)

The other preventive measure the employees considered being in place to control OHS hazards and risks was by placing potential sources of hazards, e.g. hot pans, sharp knives and cutlery, in certain areas. As explained by an employee, such action was understood by everyone as the general rule in the workplace that enabled each other to identify potential hazards and control the risks of injuries:

" *... when the chefs are cooking and they have got hot pans they would put that in a certain area. So, the dish hand knows they are hot. So, if they are going to put them into the sink they will tell the dish hand that's a hot pan be careful, same with the plates. You know when we heat plates up and put it onto another plate we always tell the dish hand 'that's hot, don't touch it' ..."* (Employee 1)

In addition, employees tended to adopt simple and basic measures such as spraying a hot pan with cold water when delivered to the dish hand or placing sharp knives and cutlery in a separate container and not in the wash basin to minimise the risks of injuries and incidents. Verbal assertions that make the concerned person aware of any obvious

hazards and identify them also formed an important element of such actions. The following responses exemplify such remedial actions:

" *... they would bring it over and put in the sink and tell me it's a hot pan or A HOT PAN (the employee says it putting a lot of stress to exemplify when the pan is very hot) and spray it off to cool down .... generally when you are over cooking you always use a tea towel, unless you're absolutely certain that it's not hot. But yeah sometimes you don't know. Most of the time it's like you just tell each other* ..." (Employee 7)

"**Unwritten rules**", "**identifying hazards and hazardous processes**" and "**elementary control of hazards**" emerged as the themes for element of action.

5.2.3 Element of legitimisation

5.2.3.1 Employers' understanding of element of legitimisation

In congruence with the perception that individual employees themselves are the causes behind OHS concerns, the owner/manager tended to bring up hazards and hazardous work practices for the wider attention of the employees. The general hazards (such as those associated with the hot water boiler and the coffee machine in the front of house and hot pans, hot trays and spills on the floor as hazards in the kitchen) which the employees encounter all the time are brought up and identified informally. The specific health and safety issues (such as those extending to compliance standard and inspection e.g. fire drills and delegation of tasks during fire emergencies) are brought up and discussed formally through general staff meetings. The important reasons for the employer/manager to bring up OHS problems and identify hazards in the wider work environment include not only making the employees more responsible for the control of hazards but also fulfilling the employer's obligation to provide a safe working environment (impelled by the social exchange relation at the workplace and regulatory demands) as well as prevention of risks. As mentioned by both the employer and the manager:

"*.... we have jugs which we heat the milk up with steam ... one of them had a jug in her hand and was trying to steam the milk and by the time it gets hot the hand starts burning ... we have got a hot water machine where you put the glass and then you press it and hot water comes out. They are holding the glass and trying to push the water down and by the time that comes out it will splash over and all over the hand ..."* (Employer)

" *... there is a lot of hot stuff goes into the sinks and they are aware that that's hot and they don't tend to burn themselves too often ... grab a fry pan with a cloth, it is generally hot. Just telling them I guess and trying drumming it in ...*" (Manager)

Similarly, the owner/manager brought hazards to everyone's general attention to correct any observable hazardous practices and make sure that the employees were working towards making the workplace safer for each other. A comment from the employer illustrates this point:

" *... as you are going along you see things and you say to them you do it this way .., What I do have is I do what you call a assessment on my staff every six months and there is a list of different things that you have to do making sure that they know that they are looking after (other) staff properly, looking after products properly and go through the list ...*"

The owner from this SB case expressed the belief that legislation largely favours employees such that a failure to ensure a safe work environment to the employees possibly results in legal prosecution. This makes it necessary for the owner/manager to identify OHS hazards and control risks to ensure a safe work environment. In addition, the realisation that the employees were the ones working hard to get the customers and get the business running engendered in the employer a feeling of obligation to provide a safer work environment and thus encourage wider identification of OHS hazards for relevant control. For example, the employer commented:

"*... I think it's more that there is so much legislation there for the employee against the employer. So you have to make sure that everything you do is good because if it is not then you can easily just get sued or sort of taken to court for whatever negligence you have ... you have to make sure that everybody is safe in their work environment. Because if they are not I mean no reason why they would want to work for you ... You know if the floor is over-slippery, if the electrics are damaged or something like that and the ovens aren't working and trying to light them all the time with flames and something like that and you know people aren't going to be at work because they say 'why should we work in this environment?' ... You have to look after your staff. Your staffs are the things that make you money. You know they are the guys who are going to work for you. They are the ones who are going to bring in the customers ...*" (Employer)

"**Reinforcement of safety**" and "**norms of exchange relations**" emerged as the two themes for the element of legitimisation from the employer's/manager's perspective. Interestingly, they considered injuries such as burns and cuts that did not require medical attention or led to absence from work as minor injuries and not really OHS risks. The minor injuries were perceived as "**just part of the job**" and such perceptions emerged as an important reason for not bringing to attention OHS hazards occasionally. This therefore de-legitimised the identification and control of OHS risks in the work environment.

5.2.3.2 Employees' understanding of element of legitimisation

It is a commonly accepted supposition among employees in this business case that while at work one has to be aware of a lot of things. Also accepted is the conjecture that people having to attend to a wide range of tasks at once increase their propensity to lose concentration and forget about obvious hazards present. The employees were aware that they were exposed to the hazards and associated risks primarily because of the business at work and therefore brought such hazards into each other's attention. This is seen to form the basic conviction for raising OHS concerns to wider attention. The following comments from employees illustrate these convictions:

" *... looking after each other. There might be someone doing something that might not be safe. For example, I always tell them to keep off that knife, try this way so you don't hurt yourself ...*"
(Employee 3)

"*... as a chef myself I tend to look out more for others than myself. Because I know that they're carrying around sharp knives, even though I know how to carry them, it's a hazard for other people ... if no-one has told you won't know and you probably fall over and hurt yourself. But if I said 'hey, I've mopped up the chiller floor. Probably it is going to be bit slippery till it dries. Even just that I think would contribute a lot to the safety of everyone. I mean no-one wants to be hurt and no-one wants to hurt anybody else ...*" (Employee 8)

Thus, "**norms of exchange relations**" emerged as the theme for the element of legitimisation of OHS problems from the employees' perspective.

Not all the hazards are brought up for identification and control in the work environment. Primarily the OHS problems the employees considered minor in relation to the seriousness of other incidents emerged as an important reason for not bringing

up OHS hazards for wider attention. Similarly the employees' perception (regarding the causes behind incidents) of the individual as the cause was another reason for not bringing up OHS hazards. The following comments illustrate such a perception:

" *... no-one here had really cut himself majorly to incur like stitches or anything like that or, you know, I think we all had the nips in our fingers and basically yes, we just look at cleaning it, you know, putting plaster on it, covering your hand with a glove and finishing doing whatever .... we haven't had any major incident where someone's had to have ACC or time off work for cutting through themselves or burning themselves* ..." (Employee 1)

" *... chefs often get burns on their arms or hands from the pans because they're doing gas. But they also use tea towels. But nothing serious, nothing that requires immediate medical attention* ..." (Employee 6)

"Minor injuries" (perception regarding seriousness of injuries) and "my fault" (perception regarding the causes behind injuries) emerged as reasons for de-legitimisation of OHS hazards and risks for their identification and control.

5.2.4 Common understanding of OHS risks and development of LTWE

The employer and employees both perceived burns as an OHS problem widely experienced at work and either attributed the cause to individuals or thought of it as simply part of the job. These emerged as the two themes for the element of causal relation common for the employer and employees. 'Individual as the cause' was related to either individuals lacking concentration or not caring about the safety of others. In that respect, constantly identifying hazards and hazardous processes to each other, and having in place unwritten but understood rules, emerged as the common theme for the employer and employees for the element of action. The obligation to ensure the safety of each other in the workplace (out of normal expectations from each other as part of the social relation) defines the norms of exchange expectation towards the identification of hazards and control of risks among employees. By the same token the obligation on the employer to provide a safe work environment for the employees emerged as the theme common to employer and employees for the element of legitimisation.

Table 5-3 summarises the themes that emerged for the four elements of LTWE for the owner/manager and employees in SB Case 2. The colour shadings show themes that were the same for the owner/manager and employees for the elements of LTWE.

Table 5-3: Theme for the four elements of LTWE for owner/managers and employees

Elements of LTWE	*Element of experience*	*Element of causal relation*	*Element of action*	*Element of legitimisation*
Employer	Burns	Part of the job		Severity of the event
		Individual as the cause	Unwritten rules	Safety reinforcement
			Identifying hazards and hazardous process	Norms of exchange relation
Employees	Burns	My fault	Using common sense	
		Part of the job		Severity of event
		Individual as the cause	Unwritten rules	Norms of exchange relations
			Identifying hazards and hazardous processes	

The result showed instances of consistent emergent themes for the four elements of LTWE for the owner/manager and employee groups, indicating the development of a local theory on relevant identification of hazards and control of risks for the two groups. The result also showed instances where the themes for the elements of LTWE for the two groups were inconsistent, indicating occasions where hazards and risks were not identified and controlled relevantly. Common themes between the owner/manager and employees for the four elements of LTWE that resulted from network diagram indicated the development of a common understanding (or local understanding) of OHS risks.

5.2.4.1 Development of LTWE

Development of the LTWE is discernible from the themes emergent for the four elements of LTWE for the employer and employees in this case study. Based on the themes in this case, two parallel local theories pertaining to the identification of hazards and control of risks were found to be developed. The first local theory centred primarily on the individual perceived as the cause behind risks of injuries in conjunction with norms of exchange relations as the main reason for legitimisation of associated hazards. As such, the remedial actions seem to be around identifying hazards and hazardous processes. This related to the development of local theory for the relevant identification of hazards and control of risks even though largely administratively.

The other local theory was developed around the perception of the hazards and consequences as 'part of the job' and emerged as the theme common for element of causal relation between employer and employees. Usually injuries and incidents that do not result in absence from work or require medical attention were regarded as minor

and therefore considered part of the job. Injuries such as burns and cuts being considered 'nothing major' and 'just a part of the job' was an important factor for de-legitimisation of OHS problems. De-legitimisation is being translated into ignoring, concealing or leading to 'unwitting' exposures to the OHS problems resulting in being unaware of hazards and risks and thus lack of identification and control. The LTWE thus developed lacks the element of action.

From these results on the development of a local theory, a number of inferences can be drawn. First, both the owner/manager and employees group understood 'burn' as one of the obvious OHS risks in the work environment. Second, with burn as an example of the element of experience, a number of themes emerged common between the two groups for the other three elements of LTWE as summarised in Table 5-3. Third, development of a local theory can be assumed to be based around the element of causal relation. On this assumption, the two groups were shown to have developed two local theories that were common between the groups. One local theory was based on 'individual as the cause' while the other on 'part of the job' as the element of causal relation. Fourth, a theme for the element of action and element of legitimisation emerged consistently and in common for the two groups was the local theory based on 'individual as the cause' whereas it was not the case for the local theory based on 'part of the job' as the element of causal relation. Finally, the local theory developed common and consistent themes for the four elements of LTWE indicated development of common understanding towards relevant identification of hazards and control of risks. Whereas inconsistent emergent themes for the elements of LTWE indicated local theories not directed at relevant identification of control of hazards and risks.

5.3 Employer/employees participation in OHS risk prevention

The employer was in the workplace all the time as one of the staff members in the daily roster. As a consequence they were always approachable. The employer as the executive chef had his own ideas about what he wanted doing and made rulings on the way they needed to be done. The employees perceived the employer as a mentor who was always available to talk to, who would come to employees to ask the reason for doing things in a certain way, or were constantly involved in explaining the reason for doing things differently. The comments from the employer, one of the employees and the field observation notes detailed below exemplify the characteristics of the employers'

participation in the daily activities in the restaurant:

" ... Rob (the owner/manager) is always there, always approachable. So, if you have any problems, if you would like he comes down and speaks around. He does lots of these. He does have a lot to do with the business as well. So, he is always around ... he is here a lot ... So you do always have him there if you have to talk to and if you've any problems you can talk to them (employer or the manager) about it. Also they do ask for staff input on the way the business is run. So, it's nice to have your boss there who appreciates the staff and lets them have a say in the way it's run as well ..." (Employee 6)

"*... even in the kitchen I have a head chef who works for me and I am the executive chef and I always be there and I always say I don't want to it done this way, I want it done that way … When things get out of hand I will just say 'that's just enough, hold a minute, stop right now, we can't do this anymore'* ..." (Employer)

Box 5-2: Observation notes, 3 May 2010

Adam took me to a work station and asked me to contain a can of tomato sauce into a plastic container, date it and label it with my initials. Adam told me what to do and how to do things while Rob (owner) was away. Adam asked me if I could cut red onions. I told him I could. While I was cutting red onions Rob walked into the kitchen and asked me if everything was alright. After some time Rob came in with his working apron on. He started working alongside Adam, attending to the orders coming through and preparing food. From that point on Rob showed me what to do and how to do it. He showed me the way preparations contained in the plastic container were stacked in the cold storage; he explained to me the reason for having the containers initialled and dated; he explained me that the first thing for the person starting in the kitchen is to tidy up the kitchen with the deliveries received and free up all the working spaces. He then took me to the dry storage and showed where different items were stored. He explained that there are specific places on the shelves for each item and showed me the markings with name of each item. He then led me to the waste room where waste bins are kept. He showed me the first aid kit and designated place for keeping it, showed me the toilet, took me upstairs which he explained is being used to host functions. On the way downstairs he showed me the other staircase and explained that this one was strictly being used by the staff while the other stairs were being restricted to the use of the customers only. Rob explained that allocation of separate staircases was the result of a number of incidents of staff bumping into customers with food trays ...

As such there was a substantial free and open flow of communication from the executive chef and head chef to staff i.e. the baker, duty manager, cook, wait staff and kitchen hands. Communication played an important role in establishing a common goal and was instrumental in leading the team to accomplish the common goal in a safe environment. The following observation notes illustrate the open type of communication that takes place between the owner/manager and employees.

Box 5-3: Observation notes, 4 May 2010

… I observed very direct and open communication occurring among the staff. Rob would generally be asking the employees how things were with them. On one occasion I heard them talk about the Rugby World Cup, whereas on the other occasions it was about wedding anniversaries, number of years in marriage, and golf. However, it would usually be the executive chef or the head chef initiating the dialogue and the other staff members would follow through participating in the conversation giving their own opinions. I also observed whenever there is a phone call the staff responding to the call would usually ask Rob and if necessary he would direct it either to the head chef or the duty manager or answer himself. The kitchen wall is used as an important means of communication. Usually the things needing a purchase order to be placed are written on the wall which the executive chef or the head chef attends to. The wall is also used to write down the speciality food of the day – soup of the day, food of the day, dessert of the day, which the front of the house have to be very aware of, for which the wall works well to communicate these openly and clearly.

In relation to hazards and risks in the work environment, primarily the employer is the one involved in identification if hazards and risks through teaching and training the employees the proper way of doing things in relation to controlling OHS hazards and preventing occurrence of undesirable events. The following comments from the employer and an employee exemplify such involvement of the employer:

"... *if Rob (the owner) sees anything he will tell them. I mean any of us would say if there was something that looked incredibly dangerous, generally* ..." (Employee 9)

"*.... There is no real safety guidelines in place as set out in paper but just telling them this is what you have to do, this is how you do it. don't do this way, the reason why is because this will happen ...*" (Employer)

Frequent communication from the owner/manager and participation in identification of hazards has played an important role in controlling hazards and risks in the working environment. The employer's participation in hazard identification and risk control is driven by two factors. First, their knowledge of legislative requirements of the employer to make sure the workplace is safe for the employees. Second, the felt responsibility to ensure a safe working environment towards the employees in exchange for the services they provide to the business, but also to ensure smooth running of the place to guard against losing the employees and the customers and potentially unaffordable costs associated with this equally drives the employer's participation in the identification and control of OHS hazards and risks. The following response from the employer illustrates these drives for participation:

" ... I think it's more that there is so much legislation there for the employee against the employer. So you have to make sure that everything you do is good because if it is not then you can easily just get sued or sort of taken to court for whatever negligence you have ... My responsibility is day-to-day running of the business. Making sure that everything is running smoothly ... You have to look after your staff. Your staff are the things that make you money. You know they are the guys who are going to work for you. They are the ones who are going to bring in the customers. If you don't look after them you know they are going to think 'oh these guys really don't care, and you know it's just like a tug of war ..." (Employer)

The other equally important aspect of participation in identification hazards and control of risks is employee participation. Employee participation, in general, was characteristically informal meaning that formally written processes and procedures were almost non-existent. The employer's expectation for employees to approach him if they wanted to make changes in the workplace, employees being asked for their opinions on such changes, or 'things being normally aired' were the important characteristics encompassing employee participation. The following comments from the employer and one of the employees and field observation notes exemplify the informal nature of employee participation:

"*... checking and making sure that they are doing things the way that I wanted and not the way they wanted done or they feel it should be done. If they think that it should be done that way then they should come and see me and say to me, 'Oh I think it should be done this way' ... Sometimes they come to me and say, 'What do think about this? or What do you think about that?' And I will say ok, we'll we sit down and talk about it and think about it ...*" (Employer)

" *... we can always put in our opinion. But at the end of the day he's going to make the big decisions ... if we are managing that night we sort of say how we would want to run it and what would make it easier on our spot to make it benefit the customers and things like that, we can always put in our opinion. He takes our opinion on board because obviously we are the ones who going to doing this. So, it does matter. But I think we get things being normally aired and I think our say is counted ...*" (Employee 4)

Box 5-4: Observation notes, 11 May 2010

Arrived at the restaurant at 9:15 am and headed into the kitchen. I saw Rob (the owner) working in the front of house. I greeted him and headed into the kitchen. Josh, the head chef, was in the kitchen. The preparation list had my initials against the preparatory work to be done. So, I started my work with packing bread. Then I did chopping tomatoes, slicing onions and cutting cheese ... Josh was in charge of the kitchen today. He asked Jane which cake she was preparing for today. He would also call Garth to fetch items in the cold storage for him from time to time ... Since I started my work here, I observed today as the busiest day. It was due to the Massey University graduation ceremony ... During busy hours chefs concentrate on the main menu. The chefs delegate preparation of side dishes to the cook, kitchen hand and the baker. One of the chefs would call aloud what are the items to be prepared, tell the other chef what he would be working on and ask either the cook or the kitchen hand to work on side dishes. The chef would always be calling out to the others what he needs next in terms of completing the ordered plate. Everyone else seems to be working in pace with the chef so that each one finishes preparing his part of the items in perfect harmony with the other such that the plate can be served hot and fresh.

In relation to hazard identification and risk control in the working environment, the informal nature of employee participation is illustrated by occasional notifications of hazards and/or frequently reminding each other of the associated risks while at work.

The following comment made by an employee and the field observation note typify an informal characteristic of employee participation in OHS risk control:

"*.... if there is an accident or something we are all notified of it ... Most of it (notifying of hazards) at the moment is through the meetings ... and just word of mouth. So when we talk Ruth would usually tell one of the kitchen staff, they will come and tell us. And they will tell one of the front of the house and say pass it on ... most of it is through the word of mouth. So it's occasional ... the best thing we could do is just remind each other that the fry area is hot and you should always use a tea towel or something to actually pick up anything in that area ... use a cloth when you grab something around those areas. And just keep an eye on each other ...*" (Employee 2)

Box 5-5: Observation notes, 18 May 2010

As I entered the restaurant, I saw Jane pouring detergent water on the floor around the oven area and sweeping. After she finished sweeping and mopping, the floor was still wet. She turned to me and said, 'It will take a while to dry up. So, be careful, it might be slippery'. Just then Kate came to fetch some tea towels from that corner of the kitchen. As Kate was climbing up and down the shelves on which she stepped to get the tea towels from a higher rack (as they were not placed too high on the shelves she might have thought a ladder was not necessary), Jane was constantly keeping her eye on Kate and cautioned her to be careful as she reached for the towels and climbed down the shelves.

The other important characteristic of employee participation was the factors driving it. Employee participation, in general and in relation to identification and control of OHS risks, is driven by factors such as the opportunity to grow, their attitude of working together to make things happen and the employer's attitude of making things run smoothly. The employees regard the employer as a well-learned chef with more than 20 years of experience in the restaurant business and saw a plenty of learning opportunities with him. These opportunities pertained from product knowledge to health and safety confidence in terms of identifying hazards and risks to each other. The following responses from the employees illustrate employee participation driven by the opportunities to learn:

"*.... it's sort of new things we do have available to learn. But it's more the fact that he would get someone in to train us. For example with the wine tasting he would have someone come in obviously for*

fair rating. Wine tasting gets to go through all our wines and he'll explain what the plans are and things like. So, front of house knowledge is something we get to learn a lot especially with our new menus and the bar. When he'll go through our new menu, he'll put out a few dishes so we get product knowledge there. Same with coffees. We'll get him get someone to train us on that. So, yeah I think we get to learn a lot with his input ..." (Employee 4)

"*... it improves health safety confidence. The confidence to tell each other, that 'ok you are doing this way. If you do it this way either you are going to get cut or if you do it this way is that really the easiest way to do it or the best way to do it?' So, making the environment safer for you and other person ...*" (Employee 2)

The other important driver for employee participation in hazard identification and risks control is the attitude of the employees to work together and make things happen. The following examples of statements made by the manager and one of the employees illustrate such an attitude:

" *... We're a small team and we've got to work together to be able to make it happen. A lot of people don't understand that cooking's demanding ...*" (Employee 3)

"*.... every now and then if he is messy and things like that. So, I guess there is an influence there. But, in general, I think everybody is different, everybody has different standards and morals. But at the end of the day I think everybody here is on the same sort of par ...*" (Manager)

The final factor driving employee participation in the work environment is the employer's attitude of ensuring that the daily operation is running smoothly. The employer had the attitude of supporting the employees in terms of ensuring that they performed their job safely by using relevant identification and control of hazards. The following comments made by the employees exemplify employee participation in the identification and control of hazards driven by the supportive attitude taken by the employer:

" *... sometimes when I am doing desserts, I kind of do them and he is watching me like he wants me to get it right because he is there but also I want to do it. As far as I know because I know he might not want it that way. So, he can correct me on it ... it's not that I will be good because he is there and be lazy because he is not there or because I am wanting just to please him. But because with everybody just how they (executive chef and head chef) help out and make everything go smoothly ...*" (Employee 7)

"*... all of us are really keen as chefs so that helps as well. So really keen to get the job done and make sure we perform at our best ...*" (Employee 8)

The responses from the owner/manager and employees describing and typifying the characteristics of participation in the identification and control of OHS hazards and risks were initially coded in NVivo. These initial coding formed the indigenous concepts of participation. The indigenous concepts were segregated into distinguished attribution and characteristic or label of participation, also known as categorisation, thus illuminating indigenous typologies. The final step involved establishing the linkages and close fit between the characteristic labels and identifying the distinguishable participation practice or typologies. The process of identifying indigenous concepts, illuminating indigenous participation characteristics and construction of participation typologies is illustrated diagrammatically in Figure 5-5.

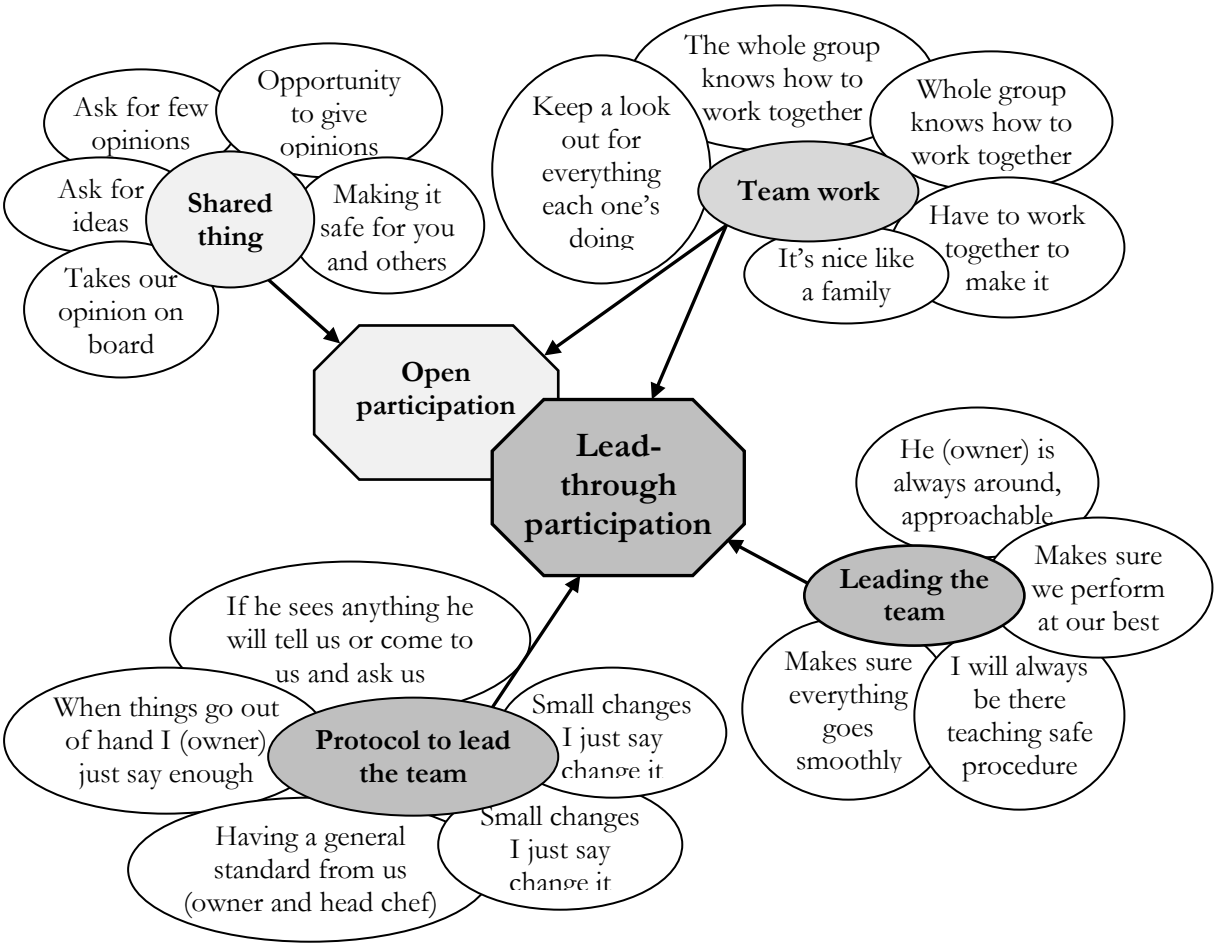

Figure 5-5: Indigenous concepts of participation and participation typologies

Contained in the plain oval shapes, in Figure 5-5, are the indigenous concepts of participation that are grouped together to create distinguished characteristic labels (categories). The grouped distinguished characteristic labels are linked with each other to create participation typologies (participation themes), illustrated within the shaded octagonal shapes.

Lead-through participation emerged as the predominant typology (signified by darker shades in Figure 5-5) of employer/employee participation in business Case 2. The lead-through participation is characterised by informal, open and free communication flowing primarily downwards from the executive chef and head chef to the employees in the form of instructions, guidance and teaching. In such participation, employees are normally asked their opinions without a guarantee that these will be taken on. The employer (or representative) is always available to inform, decide and lead to make sure everyone is on the same level in relation to the service quality and standard of task accomplishment. The practice of working together as a team where the employees seem to be concerned about each other's safety and the owner indicated to strive to provide a safe working environment demonstrated the presence of **open participation** as the other typology of participation, to a lesser extent (suggested through the lighter shades of the shapes illustrating participation typologies in Figure 5-5). The characteristics and the drivers for employer/employee participation in lead-through typology are summarised in Table 5-4.

Table 5-4: Lead-through participation – characteristics and drivers

	Characteristics	*Drive*
Employer	Always around Inform and lead Downward informal communication	Regulatory compliance requirement Cannot afford to lose the employees
Employees	Opportunity to give opinions Look out for each other Notification of hazards	Opportunity to grow Attitude of working together Employer attitude of making things run smoothly

Lead-through participation, as a predominant typology of participation as found in this business case, has important implications in relation to the identification and control of OHS problems in the workplace. It was found that such participation has a key influence on the identification of hazards and control of risks, but is limited to only those problems which are considered legitimate to be brought up for wider attention. The owner/managers as the persons leading the operation and business were perceived as the ones endorsing legitimacy of OHS problems and wider acceptance in the work

environment. Depending on their legitimisation/acceptance some OHS problems were appropriately identified and controlled while others were not. Specifically, those problems which were accepted as having serious consequences (such as those on service delivery or regulatory compliance) were identified and controlled, whereas those which were accepted as part of the job or as arising out of the employee's fault (not using common sense) were not. The comments from the owner/manager or the employees illustrate this dichotomised identification/control of OHS problems. For example:

"*... you could get a knife cut or something but it's, I mean, you are not going to play rugby without grazing your knee on the grass ... it's the same sort of thing. You can have little accidents but general health and safety. I think we're pretty good ... we've had no major injuries that somebody slipped on the floor and been in or gone to hospital or anything like that ... we do work pretty well safety wise ... it's kind of having general standards from* Rob *and I. Both of us don't like it messy. I am quite often tidying the freezer or tidying the dry shelves. Just tidying things up and tidying shelves ... we generally don't like it dirty ... we do have messy services, it does get messy ... it is very difficult to do a busy service without being messy with, you know, food scraps going here and there. But it gets cleaned up properly afterwards ... Just* Rob *and I just don't really like it messy ... what a lot of it comes down to is that you wanted to have it to a certain standard of cleanliness, hygiene and safety ... there's probably been mornings where you've heard Jane talk about the floors being all covered with food scraps and oil spills and water spills from the kitchen hands ... and it's to try and avoid all of that ... they drop something on the floor they'll pick it up ... no running in the kitchen ... grab a fry pan with a tea towel. So, I would have it at a standard, say, every day ...*" (Manager)

Such dichotomised identification of hazards and control of risks is reinforced by the response from an employee detailed below:

"... I did not really (tell) that night because I really didn't want to put that across that I was weak or that I was complaining about it or I wanted to get out of the job or anything .... But it wasn't really a very big deal ... sometimes you cut your hands on knives slightly. But I have never had any major cuts either ... sometimes when you're really busy you put quite a lot in there and kind of chuck it in there and trip a glass or something. I've cut myself couple of times doing that ... That's a personal thing really; it's not a really general thing for everyone ..." (Employee 7)

Therefore, lead-through participation implies trivialisation of some OHS problems and thus lack of appropriate identification and control of OHS hazards and risks based on their legitimisation and acceptance by the owner/manager. By contrast, those OHS

problems which are perceived and accepted as OHS hazards and risks in the work environment are identified and controlled.

5.4 Conclusion

In considering burns as an element of experience in the workplace, it was found that the employer associated the cause either with the individual employee or else as part of the job. Thus, these emerged as the themes for the element of causal relation for burns as OHS problems as noted by employer. In terms of the themes that emerged for the element of action, the employer perceived unwritten rules and identifying hazards and hazardous processes as the measures in place to remedy the problem. Norms of exchange relation was the theme for element of legitimisation. Interestingly, perceived seriousness of the consequence of an incident or event was found to be another element determining whether an OHS risk was brought up and accepted as needing action. Thus, severity of consequences was also a theme for element of legitimisation, although primarily in the sense of de-legitimising OHS problems by trivialising their consequences.

Burns were found to be a frequently encountered OHS problem in the workplace and thus served as good example for the element of experience. 'Individual as the cause' of burn injuries and burns as 'part of the job' or as 'my fault' were found to be the themes for the element of causal relation. The employees identified unwritten rules, seeing hazards and hazardous processes and elementary control of hazards as the remedial measures in place to control the occurrence of such events. These were the themes that emerged for the element of action for employees. 'Norms of exchange relation' were revealed as the theme for the element of legitimisation for employees. Similar to the findings for the employer, severity of consequence was a theme that significantly influenced de-legitimisation of OHS risks by ignoring, concealing, trivialising or submitting to OHS problems and not bringing them to wider attention.

The themes that were common between employer and employees in terms of the four elements of LTWE seemingly indicate the development of a common understanding of OHS risks. However, emergent common themes for the elements of LTWE individually do not necessarily translate into identification and control of OHS risks. This requires a fully developed LTWE where employer and employees have the same emergent themes across the four elements of LTWE, and thus a common understanding of the four

elements, so it is likely to lead to remedial measures directed at controlling OHS problems.

Lead-through participation emerged as the typology of employer/employee participation in the identification and control of OHS hazards in this case. Informal, open communication dictated from the top (executive chefs and head chefs) down to the employees in the form of instructions, teaching/training and precautionary affirmations or seeking opinions characterise lead-through participation. Despite the different drivers behind employer and employee participation, lead-through participation has an important role to play in developing a common understanding of OHS risks and the development of LTWE. Lead-through participation plays an important role in the development of LTWE determining employer and employees' priorities in relation to identification of OHS problems, their control and risk prevention. The participation typology and its influence on development of a local theory are thus reflected in relevant identification of OHS hazards and control of risks or lack of them.

Chapter 6 Case Study 3 – A Restaurant and Bar

This chapter provides a detailed account of the third small restaurant and cafe business involved in the study. The chapter first provides an overview of its organisational characteristics (the products, organisational structure) and the task and roles in relation to accomplishment of the daily work. This is followed by a description of the work environment explaining organisation of work and hazards management processes in place. This is then followed by a detailed presentation of the results and findings corresponding to the aims of the study – understanding of OHS risks by the owner/manager and employees, the development of local theory between the owner/manager and employees, and participation in OHS identification and control of hazards and risks.

6.1 Case description

The business was an independent operation under the ownership of three shareholding partners that had been in operation for more than three years. The business employed 19 staff, of which six were permanent and 13 temporary. All the employees, whether permanent or temporary, worked part-time. As explained by the employer, seasonal unpredictability of customer turnover, weekly variation in the numbers of bookings and reservations (and thus variation in the number of hours required) made it difficult for the management to offer full-time work hours to employees.

The operation ran in shifts that were different between the kitchen and the front of house. In the kitchen, the first shift started at 9:00 am and finished at 3:00 pm. The second shift operated from 5:00 pm till 10:30 pm. Staff in the kitchen got a break in between the two shifts. In the front of house staff did shifts of four to eight hours duration with the service remaining open to customers from 9:30 am until 10:00 pm.

The business was located in an affluent residential area of the town. The employer and employees identify the operation as a restaurant and bar targeting the local residents as potential customers and catering to their dietary needs. For example, many of the menu items offered were gluten free and there were also the dietary requirements of the elderly residents in the locality.

6.1.1 The food products

The business catered food products for breakfast, combined breakfast and lunch, and dinner. The food products offered as main course included a combination of paninis, toast, pancakes, pumpkin/courgette/aubergine lasagne and pasta served with chicken, lamb or salmon. All main courses were served along with green salads. Optionally, customers could choose chicken/bacon and seafood salad alongside 'the curry of the day' instead of green salad as well as pudding and ice-cream for dessert. The main products offered for breakfast and lunch to cater for gluten free requirements were chicken and bacon salad, grilled rib-eye steak and scrambled egg.

6.1.2 Organisation structure

The organisation of operations was hierarchical in structure consisting of a number of specified, distinct supervisory levels. At the top of the hierarchy was the shareholding owner/manager who was in charge of the general operation and overall management of the business. The shareholding owner/manager has more than 10 years of experience in running a restaurant and bar even, although he was not trained as a chef. Subordinate to the owner/manager were the head chef and front of house managers who were responsible for supervising the daily running of the kitchen and the front of house including the bar, respectively. Working directly under the head chef in the kitchen was the sous chef, who supervised the other chefs, apprentice chef and the kitchen hands in the absence of the head chef. All the chefs have undertaken formal training course for being a chef. Similarly, in the front of house, under the managers were the duty managers who supervised the wait staff. The front of house managers were formally trained in their respective professions. At the bottom of the hierarchy were the chefs, apprentice chef, kitchen hand and wait staff who literally were the shop floor workers. Figure 6-1 schematically depicts the hierarchical structure of the organisation.

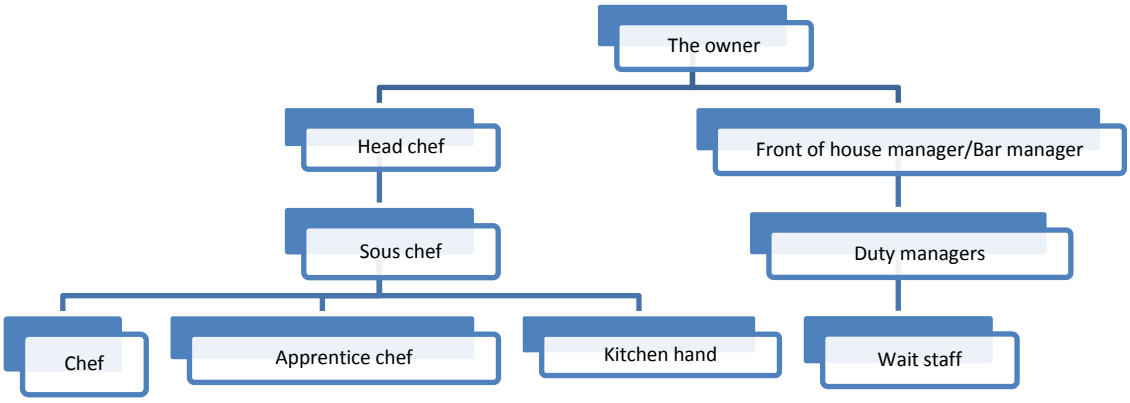

Figure 6-1: Organisational structure – Case 3

6.1.3 Tasks and roles in a day's work

The business as a whole was run as a combined operation of kitchen and front of house service functioning as two separate departments. Indeed, the kitchen having its own manager to organise the daily routines, and the front of house having its own to organise daily services, made the distinction between the two departments even more obvious. Although the two areas of services ran separately, their routines were coordinated and ran complementary to each other.

In the kitchen, accomplishment of daily work activities revolved around well-defined job descriptions. For example, normally: the head chef and sous chef confined themselves to attending to orders coming through from the front of house and cooking main dishes; the other chefs worked on side dishes; the apprentice chef worked on salads and dressings; and the dish hand cleaned dishes and kept the kitchen area clear of spill and food scraps. There was no crossing over of the boundaries, mainly as defined by the job descriptions, unless commanded by the head chef. These job descriptions established the protocols for individual task execution. Actions performed and opinions expressed within the terms of one's protocol were conceded as acceptable to all the staff members in the work environment, whereas those perceived to fall outside protocol were not. A field observation presented in Box 6-1 illustrates this point.

Box 6-1: Observation notes, 15 July 2010

I have been doing the morning shifts this week. I arrived at the restaurant at 9:00 am, which is the time the operation is started. As I have been working in the kitchen the whole week, I headed straight to the kitchen. One of the chefs was already starting up

the oven, stoves, the fries and setting up her work bench for the day. As I greeted her, she asked me to do the risotto cakes. I took the corner next to the freezer in the kitchen to work on these. After finishing the cakes I tidied up the cold storage outside, which the head chef had asked me to do the previous day. Then I went inside and checked on the list of preparation work. A few items had my initial on them showing the work that was assigned to me. I worked on slicing camembert cheese. As I came to the end bit of the cheese the knife I was using somehow slipped and cut one of my fingers. I put a strip tape on the cut and continued with the work.

It was about 10:00 am. The sous chef arrived about that time. The dish hand came about five minutes later. As he came in he turned to the chefs and said, "*Sorry, I am late*". The sous chef told him, "*This is the second time you are late this week*", with a warning tone in her voice. The dish hand did not reply but started with his usual work, the dishes.

Once I finished with other tasks that had my initial on the list, the chef asked me to peel potatoes. The dish hand heard that and told me, "*You may not have to do that. I did a bucket of potatoes yesterday*". Hearing what the dish hand said just then, the chef looked at the dish hand disconcertedly with a sort of expression like, "*Who are you to dismiss what I ask?"* They told the dish hand, "*Oh, have you? But we have used all that*". So, I started off peeling the potatoes.

Taking an action or giving an opinion in contradiction to the established protocol or overriding such protocols was regarded as not acceptable and generally discounted. Similarly, those actions and opinions which were considered not to fall within one's protocol were either not put across or dismissed by those in possession of the authority to do so. For example, although the leaky oil container placed near the swing door between the kitchen and front of house exposed everyone passing through the door to the risk of slipping and falling, it was not brought to wider attention by either the front of house staff or the kitchen staff. The observation notes in Box 6-2 illustrate how well established was the system of protocol in the daily task execution in the work environment in this business case.

Box 6-2: Observation notes, 6 July 2010

Over the two weeks I have been working here two things have intrigued me. First is that there is a big oil container located by the side of the swinging door between the kitchen

and front of house. And second is that the materials ordered are delivered to the laundry room and abandoned on the floor with no-one concerned; instead, they carry out their own work as if the materials were not there. Moreover, it is not the oil container or the deliveries that have attracted my attention but the underestimation of safety risk they pose that has added to my bafflement. I am baffled due to the fact that no-one (as far as I am aware), neither from the kitchen nor from the front of house, has attempted to do anything about it, nor have I heard anyone mention it. For example, with the big oil container, oil leaks from it all the time and flows over a small plastic container placed underneath to contain the leakage onto the floor making it slippery and hazardous. The location of the container and the leakage is such that the number of people moving past the area and the frequency of their movement through simply aggravates the slipperiness and makes it even more of a OHS hazard. However, eventually I learnt that action or inaction in such matters is not based on the seriousness or triviality of risk exposure but more on the established protocol around whose area of command it is.

Similar was the style of work organisation in the front of house. The duty managers assigned the wait staff the tables they were expected to attend to and the customers to be served. According to the protocol for the duty managers, they received orders, sent them through to the kitchen as appropriate, communicated with the chefs in relation to orders sent through if necessary, and handled the till. The front of house managers were the ones to whom any problems, such as disputes among employees or any incidences of staff dissatisfaction, were reported and possibly resolved. Where anything other than the orders needed to be communicated between the staff in the kitchen and the front of house, dialogue between the front of house manager and the head chef was the usual protocol, leading to them divulging necessary information to respective subordinates and staff. Reshuffling of staff between kitchen and front of house, or distribution of orders over a period of time to manageably serve the customers, were examples of such dialogue. As a protocol, coordinating the efforts put forth by kitchen and front of house staff to serve the customers was the prerogative of the respective managers.

With a clear differentiation of the operations between the front of house and kitchen, the two areas had different activities to start a day. In the front of house operation, a typical day started with setting up the tables, turning on electrical appliances such as the milkshake machine and coffee machine, topping up the refrigerator with cold drinks and

milk products, and getting the till and docket ready to take orders. Usually two persons started up the front of house, one of these being the duty manager. The duty manager was usually in charge of the till where orders were placed and payments made.

The front of house manager, in conjunction with the owner, played a key role in ensuring smooth running of services in the front of house and the bar. This involved being attentive to the issues raised by the employees and either attempting to resolve them or passing them on to the owner to be dealt with. The manager, as recounted, constituted the first point of contact for employees to raise issues concerning themselves at work. For example, as stated by the manager:

"… *if one of the girls have got a general complaint I honestly take them. I sit down with them and hear them out. And depending on the complaint I may talk to the bosses. It depends on what it is. But basically if these girls have something that worries them or anything like that, they know who to go to … if it is not a big thing they will come up to me and say 'hey, look' because I am the second in charge. You know, I am the second in charge of the restaurant and Kev's the second in charge of the kitchen. It depends on the level of the complaint. If it's a very very serious problem I let them (the owners) know so that we can get it solved before them. So that they know we are here to listen to what they're saying …*"

Under the supervision of the manager were the duty managers, whose primary role was to ensure flawless services to the customers mainly with regard to fulfilling the dietary requirements of the customers. Accordingly, the duty manager had an important role to communicate and clarify orders and any specific dietary requirements of the customer with the head chef and chefs in the kitchen. Under the direct supervision of the duty managers were the wait staff who actually dealt with the customers on the shop floor.

The head chef had the primary role of ensuring efficient running of the kitchen, which included ensuring prompt attendance to the orders coming through and delegating tasks to chefs, the apprentice chef and kitchen hands. Ensuring efficient running of the kitchen also entailed placing purchase orders for materials. The head chef was further responsible for ensuring minimisation of injuries and incidents in the kitchen. The chefs generally undertake training on health and safety during their formal chef course. Such training imparts them knowledge about the identification and control of hazards and risks, enabling them to take initiative to some extent of hazard management in the work environment. As explained by the head chef himself, the major role undertaken in this

regard was in establishing rules on safe work practices for employees to follow in the kitchen. The following response from the head chef illustrated the role of protocol in the kitchen.

"*… it's much to the senior staff to do that (make others aware to respond to hazards). If something is spilt on the ground 'hey, do this, grab something and you just knock that off for me please?'. You don't risk. You just make them aware of that to respond as soon and sooner the better ... You just keep an eye on things and make sure that they don't get out of control. So you are like a control point.…"* (Manager 1/Head Chef)

The sous chef, in the absence of the head chef, executed the role carried out by the head chef.

The chef, apprentice chef and the kitchen hand all had designated roles to play in the kitchen. The chefs and the apprentice chef undertook cooking tasks delegated by the head chef. The apprentice chef, being a trainee rather than a fully trained chef, had the role of helping the chef and performing tasks under the constant guidance of the chef or head chef, and as such rarely worked independently. The key tasks of the kitchen hand were cleaning away dirty dishes, keeping the kitchen clean and clearing spills and food scraps on the floor.

The owner as the overall manager of the operation had the major role to ensure smooth and efficient running of daily services. This included allocating work hours among the employees, developing the staff roster, resolving staff disputes or taking disciplinary action if necessary, addressing customer complaints, and attending to extra dietary requirements of customers.

Table 6-1 summarises the organisational characteristics. The subsequent sections provide descriptions of the business case in relation to the work environment and OHS hazard management.

Table 6-1: Summary of the characteristics – Case 3

Characteristics	*Description*
Number of employees	Eighteen
Year in operation	Three years
Ownership	Three shareholding ownership.
Owners' involvement	General overseeing and overall front of house management.
Characteristics of owner/manager	The shareholding owner and the managers have a great amount of business experience. As such, they are very influential in the identification and control of hazards and risks and are generally expected to provide guidance and instructions.
Daily management of operation	Head chef and front of house manager/bar manager.
Task definition	Specifically defined tasks.
Structure	Multi-layered – owners at top; manager (head chef and front of house managers) in the middle; sous chef and duty managers at supervisory level; chefs, kitchen hands, apprentice chef, wait staff at the bottom.
Documentation	Checklist for opening up and closing down; checklist for daily cleaning schedule; checklist for monthly cleaning schedule; checklist for required daily preparations.
Communication	Informal communication in the workplace mainly manifested as instructions from the supervisors to subordinates. The communication is largely governed by their respective work protocols and therefore limits the flow of information and sharing of opinions.

6.1.4 The working environment

6.1.4.1 The physical layout

Physically the set-up of the restaurant comprised mainly the kitchen area and front of house area that included the dining lounge and the bar. The main kitchen was relatively spacious in terms of having distinct work areas for dish washing, cooking, dry storage and preparation work. A work bench along the middle of the kitchen separated the 'cooking side' from the other work areas. The cooking side was the work area designated exclusively for the chefs and was installed with two sets of ovens and stove tops, a fry panel and two sets of deep fry pans. Located on one side of the cooking area was an entrance leading into the front of house, while the other side led into the laundry room exiting to the outside. The kitchen area leading to the laundry was set up with dry storage for shelving non-perishable food materials, whereas the chiller was stored with perishable food preparations. The laundry room was used as a bay for delivery of goods ordered and storage for non-food items. Bulk vegetables were stored in a cold storage located outside as a stand-alone container.

The physical set-up of front of the house can be described in terms of four work areas: the coffee/milkshake-making area, the till, the bar and the dining area. The till, coffee/milkshake-making area and the bar extended along the inner wall in front of house, which were located on either side of a swing door that provided access to the kitchen area from the front of house. Display cabinets containing baked items and shelves for glasses partitioned the front of house work stations from dining areas.

Figure 6-2 shows schematically the physical layout of different work areas. The dining area was relatively spacious and contained formal dining set-up furnished with dining tables and chairs, as well as a casual dining area furnished with lounge suites and low tables.

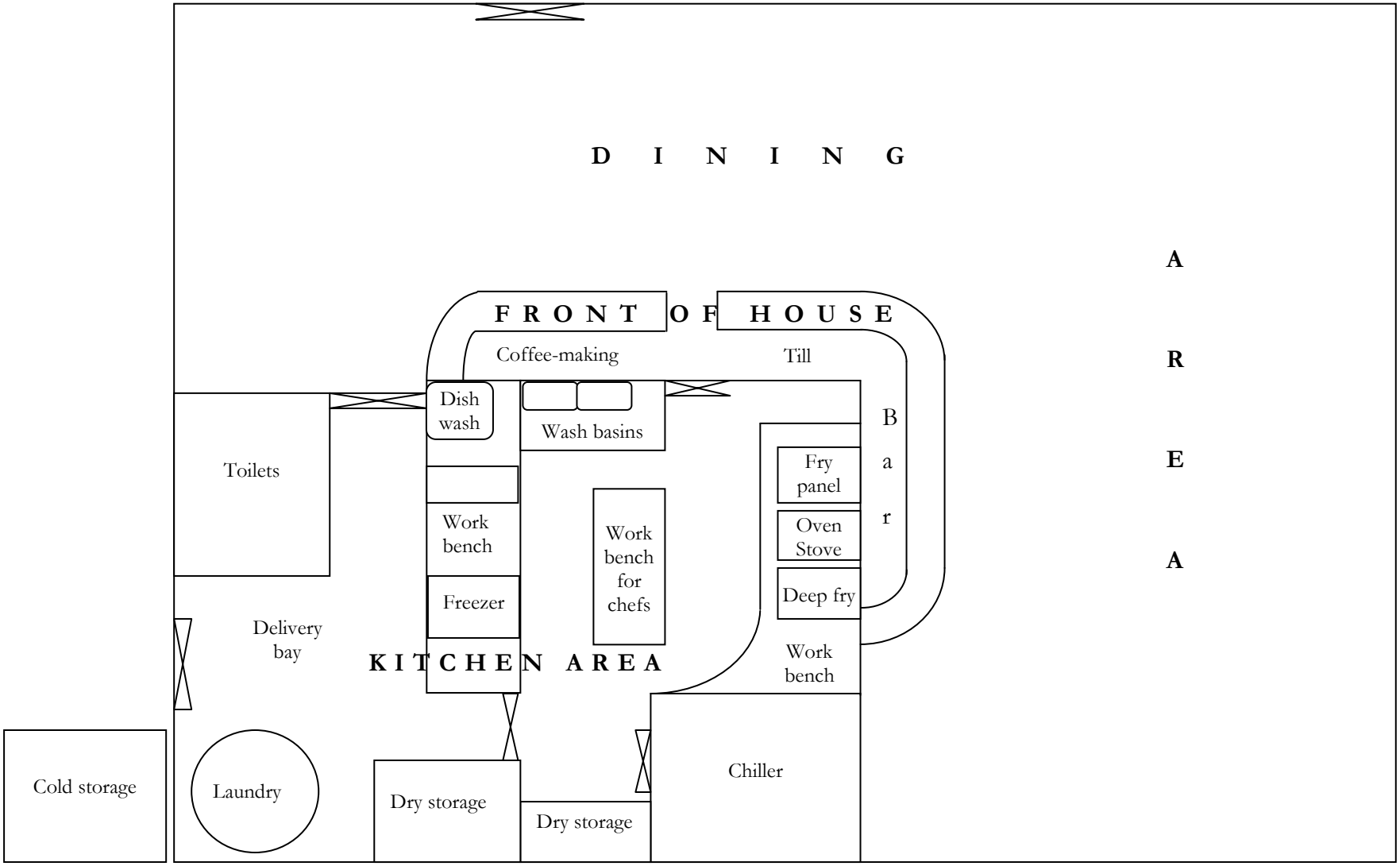

Figure 6-2: Business Case 3 – schematic diagram of physical layout of the operation (not to scale)

6.1.4.2 Work organisation (how things are done)

Services usually started around 9:30 am with the arrival of early customers. The early orders were for coffee and light breakfast such as toast and scrambled egg, which made the services relatively undemanding. As lunch hour approached the service started to gain routine momentum. This involved the tasks of: putting orders through to the kitchen; attending to ready to serve food on the sounding of the bell from the kitchen; serving the customers; clearing away dishes from the tables; cleaning the tables and setting up for next occupancy. Although the tasks performed in the front of house were routine, the naturally established and understood goal of delivering fast service to the customers made task performance demanding. The field observation revealed that the demanding nature of customer service added to fatigue and stress as OHS hazards.

In the kitchen, a typical day started with starting up the appliances – the oven, deep fry, overhead gas toaster and panini iron. This was followed by food preparation work that included: dicing onions and capsicums; peeling potatoes and carrots; chopping and grilling mushrooms and tomatoes; and moulding rice cakes and potato cakes. A checklist encapsulated the preparation work necessary for a particular day. The chef and the apprentice chef were responsible for ensuring that the food materials and ingredients necessary for the day's service were fully prepared and ready to be used.

Two chefs were responsible for starting up the kitchen, one of them being either the head chef or the sous chef. The dish hand and apprentice chef joined in around 10:00 am, about the time orders for breakfast/lunch start to come through. Depending upon the work load the chefs handed over some of the preparation works to the dish hand. As a routine, preparation work was performed before orders started to come through and thus seemed relatively undemanding. Cuts from sharp knives, fatigue and sore legs due to work carried out while standing, and back pain from work involving frequent lifting, are particular instances of hazardous exposure encountered during preparation work. Work becoming demanding with the service getting busier worsens such exposures.

The kitchen work starts to get busier and the cooking work more strenuous once orders for breakfast/lunch start to come through. The order dockets are generally attended to either by the head chef or the sous chef. Whoever attends to the orders, the items on

the docket are said aloud so that the other chef knows what items have been ordered. The head chef or the sous chef works on preparing the main item while the other chef works on the side dish and the apprentice chef on salads and dressings as per the usual working protocol. For example, if the order was for a set lunch then the person in charge of the kitchen (either the head chef or the sous chef) worked on the main item – grilled rib-eye steak, chicken pasta or savoury pancakes – while the other chef prepared the extra items ordered (e.g. fish and chips, breakfast items, courgette and aubergine lasagne etc). The apprentice chef usually handled salads and dressings – beef and prawn salad, chicken and bacon salad, curry of the day – and items requiring less intense cooking. At times when the service got very busy the chefs directed the dish hand to provide additional support with making side dishes, salads or other preparations that had run out. Saying aloud the items on the order docket and commanding subordinates in attending to orders were perceptibly the main occasions of communication occurring in the kitchen. Otherwise, there was not much interaction happening among the employees in the kitchen. Normally, as the working protocol, the chefs were focused on preparation of the main food item, thus taking control of cooking side, while the apprentice chef worked on the side dishes and the dish hand on cleaning away dirty dishes.

The orders coming through to the kitchen usually attenuated after around 2:00 pm, and thereafter the pace of work began to slacken. During this time the kitchen work for the day's shift is wrapped up. This involved sweeping and mopping the floors, cleaning and shelving away dishes, and storing away raw food preparations not consumed. This was followed by preparing raw food materials for items in the dinner menu. Periods of diminishing orders are observed occasionally even during lunch hours. Such instances offer brief respite to the staff from demands of providing customer service. The head chef or the sous chef would usually lead the staff members for breaks during such periods.

The evening shift started around 6:00 pm and lasted until around 10:00 pm. The evening shift, serving dinner, was observably less demanding compared to serving lunch. This allowed the staff members to execute their tasks at a more relaxed pace, potentially allowing them to take measures to reduce exposure to workplace hazards and

thus contributing to reductions in health and safety risks through injuries, cuts, burns, slips and falls.

6.1.4.3 OHS hazard management

The main hazards that the employees were exposed to in the front of house were slippery floor, sharp fragments form broken glasses and long, busy services which were associated with the risk of slipping and falling, cuts and fatigue/stress. Slippery floors were caused by water spills, food scraps and mopping and they were a hazard to employees as much as to the customers. Employees, as part of the condition of work, were required to wear flat shoes. The owner explained that wearing flat shoes was found to be an effective measure in controlling slips and falls in the workplace.

"*... No, not the staff, we've never had (slippery floors as an issue) because we wear flat shoes. We don't really wear shoes with steel toe or things like that. So, part of the requirements for the girls is to wear flat shoes. So, you're not allowed to work in shoes with heels. Yeah, so, we don't have any of that problems (slipping and falling) ...*" (Employer/Owner)

Putting up signs saying 'wet floor' was the other general approach put into practice to manage exposure to slippery floors as an OHS hazard. Again, as explained by one of the managers, managing hazards in the workplace was the prerogative of the management and therefore it formed part of their protocol. For example:

"*... it's probably more up to the senior staff to sort that out ... just having rules in place. And just involve them really in the day-to-day (task). If something gets spilt on the ground then you may, you clean it up or we delegate someone to clean it up. So, you've just got to be aware of it as a senior staff member and not let things or what they do get out of control ...*" (Manager 1)

Kitchen knives, hot pans from the oven and water spills on the floor were general health and safety hazards in the workplace. Observably the chefs were constantly exposed to hot ovens and stove tops, hot oil, hot pans and hot pots as obvious hazards while performing their tasks. Sharp knives were major work related hazards faced by the apprentice chef as the main task she performed was food preparation, which involved a lot of knife handling. The dish hand was recurrently exposed to the dangers of hot pans and sharp knives. Slippery floors and working long periods while standing were the general work hazards that the owner/manager and employees were equally exposed to.

Slippery floors were as much an OHS hazard in the kitchen as they were in the front of house. Unlike in the front of house, where the manager took charge of controlling exposure to slippery floors as a prominent hazard, in the kitchen the dish hand was assigned the task of keeping the floor free of spills, scraps and minimising the risk of slips and falls. As explained by the dish hand:

"… *with that oil that's next to the push door, I reckon there could be something done about that because when the oil does leak it gets really slippery unless someone fixes it. And I am usually the one who fixes it … I usually mop up the oil with a towel. And then I usually sprinkle salt over it so that it absorbs the thing. And then I let it settle for about five minutes and then mop it up again with a towel – and then it seems to be pretty much dry and non-slippery …*"

With the oil spill as an example, other than the effort made by the dish hand, no-one was bothered by the problem or concerned enough to take action to minimise exposure to the oily, slippery floor as a hazard. Again, as reported by the manager, the responsibility of "keeping an eye on things to make sure they don't get out of control" was perceived to reside with him and therefore it was a matter that was overlooked by others.

In general, stowing knives safely and drying the wet floor around the dish wash area were the two important measures for control of hazard exposure that fall within the protocol of the dish hand. Similarly, drying the floor around the cooking area was within the protocol of the chefs. Further, the cooking area was strictly considered a workplace for chefs only, with no-one else allowed access to that area except the dish hand for occasional shelving of pans and trays. This was established as a mechanism to minimise occurrence of undesirable events and an unwritten/understood rule against hazardous exposure. Dish hand saying "behind' while around the coking area or the chefs saying "hot pan" or "very hot pan" when delivering fry pans straight from the ovens to the dish hands were a few other examples of practices established as unwritten/understood rules aimed at minimising exposure to hazards in the workplace in this business case. Placing the hot pans into the right-hand basin in the dish wash area was another observable hazard management practice in place.

Interestingly, there were instances where hazards and hazardous exposures remained unattended. Notably, the laundry room was an obvious example of such instances. The

laundry room was the area where delivered materials were received. This was also the passageway to get access to the common room and cold store outside. However, it usually got piled up with materials delivered obstructing access to the cold store, the common room, or even movement of people and materials and without anyone getting concerned to clear them away. Similar was the condition of the cold store where the floor got spills every now and then with no-one bothering to clear and dry them away, or oil got spilt on the floor near the entrance between the kitchen and front of house without anyone being concerned. It was observed that mitigation of these hazards in the workplace fell within no-one's task accomplishment protocol.

In addition, the field observation revealed that the demanding nature of customer service added to fatigue and stress as OHS hazards. Moreover, with the service becoming busier, individual task performance became much more demanding which increased the exposure to hazards and consequently the risk of occurrence of undesirable events – injuries, cuts, burns, slips and falls. However, stress associated with busy services was neither considered an OHS hazard in itself nor brought up as a cause behind undesirable events. Despite the chefs having acquired formal knowledge on occupational health and safety through formal courses during their professional training, the hazard management practice in place in this business case basically remained informal and was largely governed by the work protocol of the individual employees, manager and employer.

6.2 Employers'/employees' understanding of OHS risks

Owner/managers and employees reported a number of OHS problems as OHS risks experienced in the workplace. Many of the OHS problems described as OHS risks were physical hazards present in the workplace, while some were undesirable events and others the consequences experienced. Reported OHS risks have been categorised into hazards, undesirable events and consequences and presented in Table 6-2. The numbers within brackets, in Table 6-2, indicate the number of respondents that reported experiencing a particular OHS problem in the workplace.

Table 6-2: Categorised representation of reported OHS risks experienced in the workplace

	Owner/managers	*Employee*
Hazards	Slippery floor (3) Knives (3) Fire (2)	Slippery floor (5) Hot pans (4) Oil next to the door (3)

	Heat (2) Chip in the glass (1) Oil (1) Water on the floor (1)	Knife handling (3) Sharp knives (3) Oil from deep fry (2) Swinging door (2) Oven (1)
Undesirable events	Slips and falls (3)	Slips and falls (6)
	Pan catching fire (1) Knocking into each other (1)	 Tripping over people (1) Two fires in small period of time
Consequences	Cuts (3)	Cuts (3)
	Burns (2) Ended up bleeding (1) Small cuts (1) Little knick on the hand (1) Stress (1)	Burns (5) Cut finger off (2) Little cuts (3) No major burns (3) Stress (1)

From Table 6-2, it can be seen that the employer along with two managers and six employees (out of seven employee respondents) reported slips and falls as OHS risks experienced in the workplace. As most of the respondents mentioned slips and falls as the main OHS concern, therefore 'slips and falls' were taken as an illustrative example of OHS concern to examine understanding of OHS risks using the framework of LTWE.

The initial data responses and textual notes describing the four elements of LTWE for 'slips and falls' were transformed into a network diagram as presented in Appendix 11 A and C for the owner/manager and employees, respectively.

Initial coding describing similar characteristics were grouped together as a category of characteristic, encompassed within the same shaded box, as shown in Appendix 11 B and D. Categories that were developed from the initial coding, that described similar characteristics of the elements of LTWE, were then formulated together which led to establishing emergent themes. The emergent themes for the four elements of LTWE are shown in bold letters within a box in Figures 6-3 and 6-4, respectively, for the owner/manager and employees.

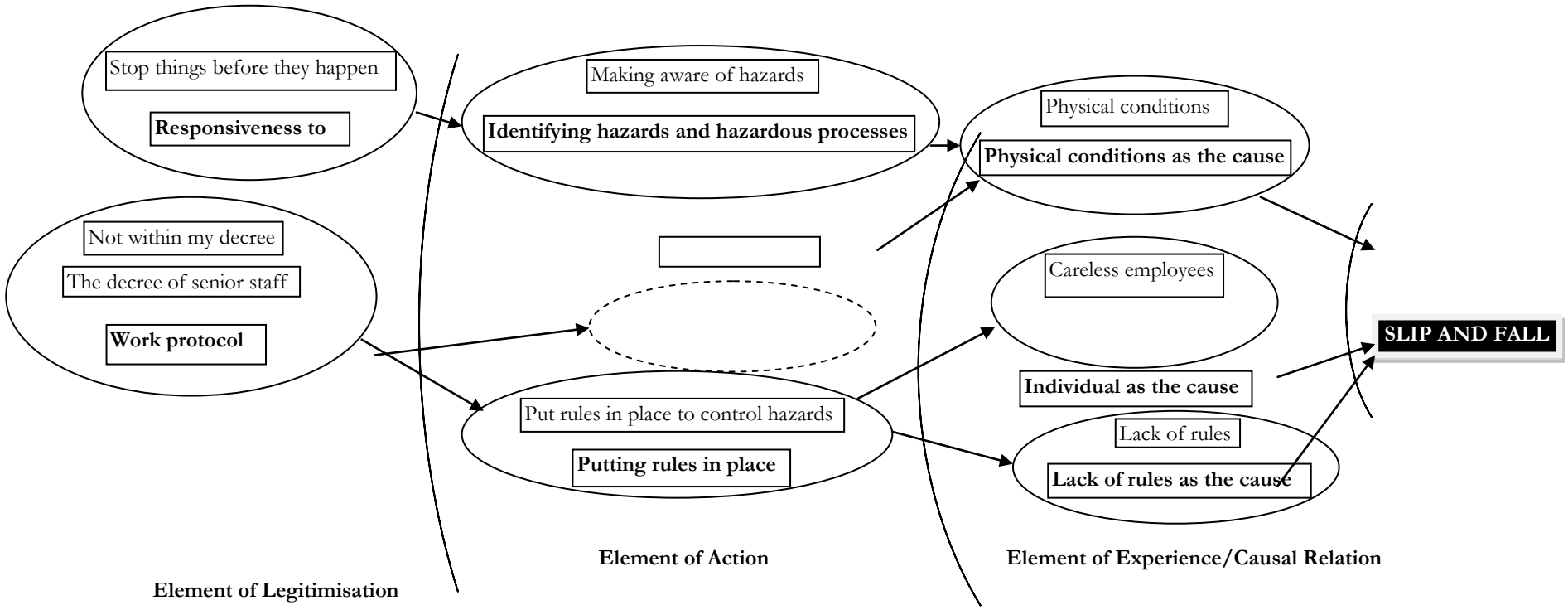

Figure 6-3: Categories of responses and developing emergent themes for employer – Case 3

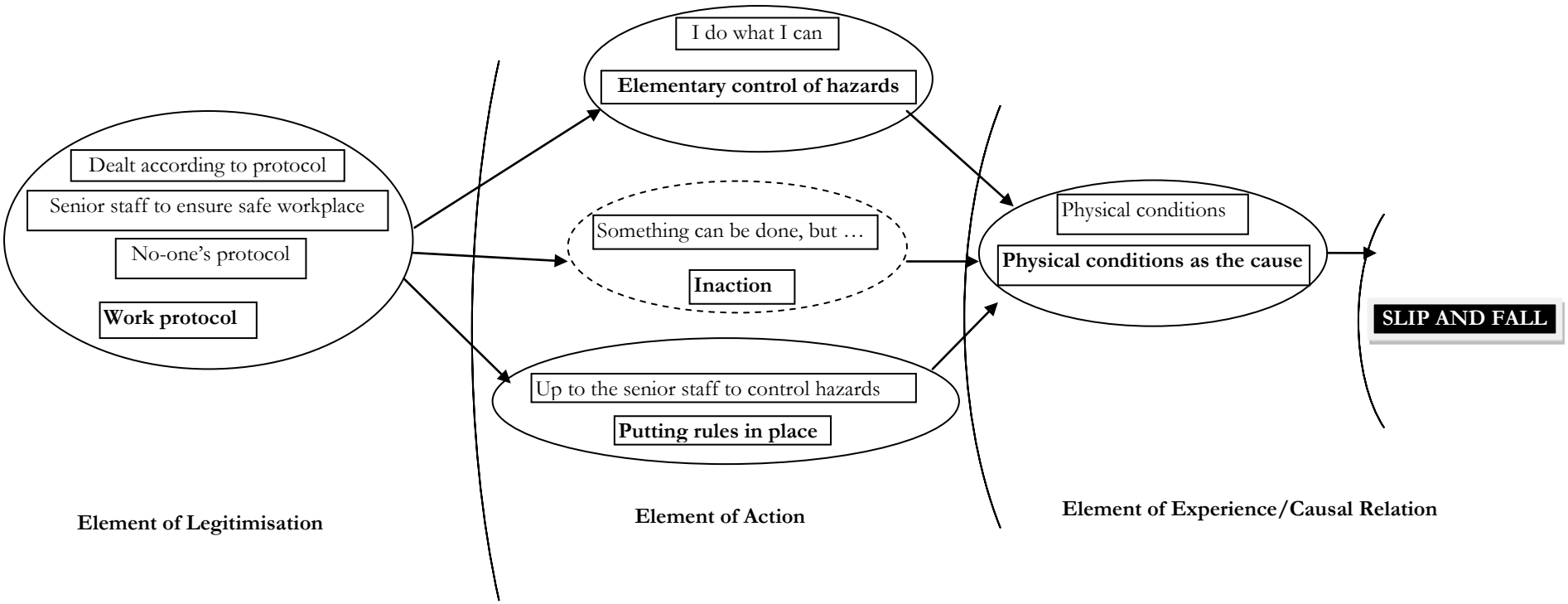

Figure 6-4: Categories of responses and development of emergent themes for employees – Case 3

6.2.1 Element of experience and element of causal relation

6.2.1.1 Employers' and employees' understanding of element of experience

As shown in Table 6-2, the owner/manager and employees considered 'slips and falls' as one of the widely experienced OHS problems in the workplace. The following responses from the employer and the managers illustrate their notion that slips and falls were one of the main concerns confronted at work:

"*… to be honest with you, I know about the floor … I had one girl fall over … she just slipped and it was nothing to do with the floor. Unfortunately it was more to do with flooding the floor with water to sweep, that's where the slipperiness comes. High heels, yeah that's the worst. But she didn't actually have high heels. She had you know those like boots …*" (Manager 2)

Similarly, as seen in Table 6-2, the employees' account of OHS risks revealed that employees considered 'slips and falls' as one of the OHS problems present in the workplace. Responses from two employees are replicated below as an illustration:

"*… we do put a bottle or something under it to catch all the oil that flows onto the floor. It's just when one forgets to get it done that makes up the problem … I have seen a few stumbling …*" (Employee 4)

"*… sometimes the floor out in the restaurant is very slippery. They do get people that slip over in the restaurant because of the wooden floor we have. The wooden thing outside the chiller that's always slippery. And then the concrete itself which is covered in black stuff from our shoes from walking back and forth, that gets pretty slippery and Ken has slipped over by the outside door …*" (Employee 1)

With 'slips and falls' as one of the OHS problems often experienced in the workplace, the employer and employees considered a number of causes behind these problems. The following two sections describe the employers' and employees' understanding of the causes behind this problem.

6.2.1.2 Employers' understanding of causal relation

The employer narrated the cause behind slip and fall, as an illustrative example of OHS problems, ascribing it to either physical conditions such as water or oil spilt on the floor (which contributed to increased hazardous conditions in the workplace augmenting the risk of slipping and falling) or the carelessness of the employees when performing tasks in haste or due to lack of concentration on their work which led to their losing effective

control of hazards and hazardous situations. On top of these, the owner/managers perceived lack of rules as another important cause behind hazards and hazardous exposure in the work environment in this business case.

The following excerpt, as reported by one of the managers, illustrates the owner/managers' ascription and understanding of lack of rules as the cause behind OHS problems:

"*... Generally, those things happen because you don't have proper rules. Or you know you're distracted and that's when you get accidents ... when you're doing two things half by, being hasty about it ... that's when you get floundered and accidents happen ... if you have got systems in place again and if people are aware of it, you shouldn't really have too many problems ... you have got to make sure that you don't walk away un-attending them or you just be a little bit aware of a problem. Maybe put a couple of more rules in place and generally that covers it ... it's all about having rules in place and keeping things consistent, and just professional attitudes ...*" (Manager, 1)

Similarly, examples of explanation given by one of the managers and the employer, replicated below, reflect the employer's/managers' notion that the actions of employees were the other cause behind OHS problems:

"*... if something gets spilt on the ground, generally what happens with junior staff members is that they don't tend to be aware of it as a hazard. And, you know, even when you tell them hundreds of times they tend to forget about it ...*" (Manager 1)

"*... we have kitchen hands that can be careless or things get broken ... well one it costs money, two they can get hurt when they are attending to things carelessly ...*" (Employer)

Finally, the physical conditions of work e.g. the wooden floor in the restaurant when combined with the oil or food scraps walked down onto it from the kitchen makes the floor hazardous in terms of slips and falls. As explained by one of the employers and a manager:

"*. we had a major floor as the flooring on this restaurant side where people were falling over … So that's my biggest or one of the biggest things that I am really conscious of all the time really. And making sure that things aren't walked down into the front by the staff from the kitchen to the front that people are going to slip on …*" (Employer)

"*... I know about the floor because of the oil leak near the door when the front of the house are walking onto the kitchen and coming out ...*" (Manager 2)

Thus three themes emerged for owner/managers for the element of causal relation: These were **physical condition as the cause**, **employees as the cause** and **lack of rules as the cause**.

6.2.1.3 Employees' understanding of causal relations

Unlike the employers/managers, the employees related the causes behind slips and falls, as OHS problems in the workplace, to the physical conditions. The following responses from the employees exemplify their ascription of the causal link behind OHS hazards in the work environment:

"*... The oil on the floor ... it still spills all over the floor ... That is a big issue. Because we will be coming in and because we have cups and plates and because the floor is already slippery when we stand up ... No, no-one's fallen but it's a risk that's right there at the door ...*" (Employee 6)

"*... sometimes the floor out in the restaurant is very slippery ... that's another one, is that our oil box that we have down in the corner, that drips so badly and so we try and keep that mess in that area. Because otherwise it gets trampled all throughout the restaurant and there is oil out in the floor out there ...*" (Employee 4)

Thus, **physical conditions as the cause** emerged as the theme for the element of causal relation for employees.

6.2.2 Element of action

6.2.2.1 Employers' understanding of the element of action

The owner/managers were found to have considered a number of different actions to remedy OHS problems in line with the understood causal relation. Obviously, for physical conditions as one of the causes behind OHS hazards and risks, making employees aware of such conditions as they ensue is considered an important action to minimise exposure to associated potential hazards. The following responses from the employer and one of the managers are illustrative of this notion of remedial action:

"*… we had a major floor as the flooring on this restaurant side where people were falling over … so we had to work with the cleaning company that we used and the flooring people ... and now we put out signs saying 'slippery floor' …*" (Employer)

"*… I know about the floor. But we've kind of rectify that by having a sign out front, saying 'hey, it is a slippery floor' … when it is slippery we do the sign out and that's the best throw we're going to do … but if there is something a bit obscure and you can't fix it straight away, I tell them watch out for this, which might affect the customers as well, so that people would know about where to start from risk ...* " (Manager 2)

Thus, **identifying hazards and hazardous processes** emerged as a theme for the element of action for the owner/managers.

In addition, the employer and managers considered the introduction of workplace rules, such as on the way the employees should perform tasks or on the do's and don'ts in the workplace, as the other measures to control hazards and hazardous exposure at work. The owner/managers perceived such remedial measures to typically subdue employee carelessness and minimise OHS hazards and control risks originating from such carelessness (individual as the cause) and lack of rules. The following responses exemplify such a notion:

"*… as the rules they do things. And it's just a matter of keeping eye on things and saying 'hey, you know you aren't doing it right. That's how we do it and if you don't change it you are going to end up cutting yourself like that' … it's much to the senior staff to do that … maybe put a couple of more rules in place and generally that should cover it …*" (Manager 1)

Thus, **putting rules in place** emerged as the other theme for the element action for the owner/managers.

Interestingly, there are instances where the owner/managers did not resort to any actions on controlling hazards. The oil box placed on the floor at the entrance between the kitchen and front of house that leaks from time to time making the floor hazardous with the risk of slips and falls is an obvious example of such inaction. The other obvious example is the piling up of materials delivered in the laundry area that poses a hazard for people and material movement that potentially raises a risk of trips and falls. However, no noticeable remedial actions were assumed by the owner/managers towards controlling hazardous exposure in both situations.

6.2.2.2 Employees' understanding of the element of action

Similar to the owner/managers, the employees considered a number of different remedial measures in controlling the OHS problems at work. The first and foremost was to adopt whatever action the employees could take at their individual level within the means available to them. A response from one of the employees, presented below, clearly illustrates such notion:

"… *because the oil is next to the door and we have issues with it spilling over, the dish hand usually puts out a container which should be good enough to pick all that stuff up … I think it would be better when we just put a bigger container underneath and make sure that if there is any spill it's always wiped up immediately, which the dish hand as a protocol is the one doing that and he tries to do anyway …*" (Employee 7)

In addition, employees considered that rules set out by the senior staff members on accomplishing tasks safely remedied most of the OHS problems experienced in the workplace. As reported by an employee:

"… *having set rules like yeah. Those things that you are not allowed doing and things you should do, which is what we all follow … ask Ken and say 'look this has to be dealt' and then Ken puts some form of practice in place that we all would have to follow to make sure it wasn't going to occur again … usually make the spill mopped up immediately, that's pretty standard …*" (Employee 6)

Thus two themes emerged for the element of action for employees. These were: i. **Elementary control of hazards;** and ii. **Putting rules in place**.

6.2.3 Element of legitimisation

6.2.3.1 Employers' understanding of the element of legitimisation

The employer and managers were found to accept OHS problems and their causes as requiring action to moderate the situation of hazardous exposure. The owner/managers sought to legitimise bringing up OHS problems and driving the remedial actions using a number of different reasons to do so. Important amongst these reasons were: the intent to prevent undesirable events such as slips and falls before they happened; and as senior members of the staff, to ensure a safe workplace maintaining consistency and thus control. The explanations given below illustrate these notions.

"*… there is always risk … there is water on the floor at times. But it's just making aware of it and making sure that you stop things before they happen basically …*" (Manager 1)

"*… Just for the system, really ... and make sure that they don't get out of control ... got to be aware of it as a senior staff member and not let things get out of control of what they do and keep things consistent.*" (Manager 1)

"*… If I find something I don't like, they get fixed and it gets fixed not because I don't like it but because it will affect the safety, safety of everybody ... we are here to do our best to make sure that these guys here come back tomorrow for the job … So if you feel unsafe in your workplace: (a) you fix it; or (b) you leave. Unfortunately some people leave whereas if I am working for a place and I feel unsafe, and depending on how unsafe in any situation, I see it as more of a challenge to fix it …*" (Manager 2)

Thus, two themes emerged for the element of legitimisation for the owner/managers. These were: i. Responsiveness **to risks**; and ii. **Work protocol**.

Interestingly, work protocol (the mandate as well as the sphere of control in relation to an action), or more precisely lack of work protocol, emerged as a reason for not bringing up OHS problems or the causes behind the problems and the remedial actions thereof. This further reinforced the influence work protocol, as an element of legitimisation, had on acceptance of OHS problems, their causes and the remedial actions. The following response from one of the managers illustrates this perception.

"*… that's one of those things … one of the inappropriate things I have seen here. But I am not too sure how and what they are going to do to freak that one. But I know that they have tea towels and they are typically doing their best but they have to have it there, I don't know what it is. Because I am not in the kitchen and I know that here, sort of, staff are aware of it. But the kitchen does their best to make sure that they are safe … I look after the front of house so I don't move my focus out of it. That's the kitchen priority which is between the head chef, the sous chef and the bosses …*" (Manager 2)

6.2.3.2 Employees' understanding of the element of legitimisation

The employees, similar to the employers'/managers' notion, appeared to have parallel perceptions about the reasons for bringing up OHS problems, dealing with the causes of the problems or putting less importance on controlling hazards and hazardous exposure in the work environment. The employees perceived and understood that OHS

problems in the workplace were dealt with according to the protocol and therefore it was the responsibility of senior staff members to ensure a safe working environment. Accordingly, they readily accepted their employer's/manager's manifestation of disposition towards dealing with OHS problems, their causes and control measures. Such understanding on the part of the employees is illustrated by following explanations.

"… *Usually it all gets dealt with according to the protocol … I guess, nobody's ever really been told about it (the oil next to the door), basically … that stuff does usually wet the floor in the other front of house. But I don't think that has really ever been brought to anybody's attention as a very important thing. But I can see that being a problem. But it's not really a problem (for me) because I don't pass that area. But I can see how it would be for front of house …* " (Employee 7)

"… *they (junior staff members) are kept under the eye of the head chef ... The higher staff members would just run through everything and just make sure that the employees are safe and comfortable … everything is pretty well and ordered here. The senior staff and, well, everyone, but particularly the senior staff, they make sure it's a safe environment …*" (Employee 2)

Thus, **work protocol** emerged as the theme for the element of legitimisation for employees.

Interestingly, similar to the owner/managers' outlook on the element of legitimisation, lack of protocol was found to be an accepted reason for not bringing up OHS problems for wider attention in the work environment. The following response from one of the employees exemplifies just such an outlook.

"… (with the oil next to the door) no-one's bothered to move it really … someone would have to talk to the senior staff to have some form of practice in place.. Ken always makes sure that we're always keeping it clean and safe ..." (Employee 1)

6.2.4 Common understanding of OHS risks and development of LTWE

'Slips and falls' as an illustrative example of OHS problems experienced in the workplace and the themes thus emergent for the four elements of LTWE for owner/managers and employees indicate the development of a common understanding of OHS risks between employers and employees. Table 6-3 presents the themes for the

four elements of LTWE that are common to owner/managers and employees and are indicative of a common understanding of OHS risks.

Table 6-3: Theme for the four elements of LTWE common to owner/managers and employees

Elements of LTWE	*Element of experience*	*Element of causal relation*	*Element of action*	*Element of legitimisation*
Employer	Slips and falls	Physical condition as the cause	Putting rules in place	Work protocol
Employees	Slips and falls	Physical condition as the cause	Putting rules in place	Work protocol

For 'slips and falls', an OHS problem that the owner/manager and employees reported to have experienced in the workplace, both groups associated the causes behind the problem to physical conditions in the workplace. The owner/managers and employees, in common, considered putting rules in place as the action to remedy the problem. In addition, they both gave an account of work protocol as the reason for legitimately bringing to wider attention OHS problems, their causes, and the remedial measures.

6.2.4.1 Development of LTWE

The themes for the four elements of LTWE common to owner/managers and employees that emerged suggest the development of a common understanding and thus development of LTWE (OHS risks). However, the development of a local theory is limited to physical conditions as the cause and is partially developed in the sense that the actions considered, although common, are not targeted at the same causal relation. Employees considered putting rules in place as a remedial measure to rectify the hazardous situation brought about by physical conditions, whereas the owner/managers considered that such hazardous situations, brought about by physical conditions, should be rectified through identifying hazards and hazardous processes. Further, employers were found to have resorted to putting rules in place, primarily to remedy individual behaviour emanating in the absence of such rules, which is likely to exacerbate hazardous exposure in the workplace.

6.3 Employers'/employees' participation on OHS risks prevention

Even though work protocol was found to determine who did what and guide daily task accomplishments, employees were not hindered in providing inputs and suggestions on improving work and the work environment such as work set-up and work flows in the workplace. In return, the owner/managers were responsive towards such employees' involvement. The following responses from two of the employees illustrate employee involvement in proffering opinions and ideas:

"*... Managers, they do let us suggest things, and they are good at listening to us and things ... Like setting up restaurants, the tables and things like that, they will have an idea of what they want to do. But they will listen to us if we have suggestions, and they will take that on board ... the same happens in the kitchen, because I have heard Ricky was saying the other day that he suggested a few things on the menu that they thought could work, and it has influenced the menu ...*" (Employee 5)

"*... we are asked out opinions – how we feel about, how it would go ... if there is anything we say they will take that on board make a decision from that ...*" (Employee 3)

Employees' participation in proffering opinions and suggestion encompasses identification of OHS hazards and improving working situations to reduce exposure to OHS hazards in the workplace. The following responses from employees exemplify such involvement:

"*... If we do have something we just go to the senior staff.... if one is aware of a hazard and you weren't sure the managers were there, you just go straight to the managers and talk to them ...*" (Employee 2)

"*... usually we, the staff itself, find the problem before they are sent out by Molly, Ken and Rob and we suggest it to them. Or 'how about if you do this?' or 'do you think this will work if we try like that?' And Molly and Rob are always open for our suggestions. They are always willing to listen. Sometimes they don't think of it themselves. So, if we go to them and say 'look I have got a problem with the oil', they would be, 'ok, try this and we'll see how it goes'. Then if it works, they are ok. But they're always very open to our suggestions. Not just the health and safety, but for anything ...*" (Employee 1)

The employees' notion and understanding that their participation extends to providing inputs and suggestions to their owner/managers on issues related to work and the work environment was corroborated by the employer's/managers' perception. For example, as stated by one of the managers:

"*.... if someone has a problem here, they know they could come up to management or if they want to talk about it to the bosses they can do depending upon what the situation is. They are just there and everyone knows that ... say if you've got a procedure that's not working, the staff will come up to us and say 'this isn't working. I have a better idea'. Or we go to the staff and say, 'do you like this? Does it need to be changed? Does it work for you?' ... because we are not the only ones working here or we're not the only ones to set it right ... we are the ones that take the responsibility of the work and stuff. But at the same time you've got to work with other people. So, you just can't have a procedure just works for you ... they know we are here to listen to what they're saying ... it's just to clarify things ..."* (Manager 2)

In addition to providing opinions and inputs, employees were found to participate in control of hazards and hazardous exposure in the workplace. However, such participation was limited to basic control of hazardous exposure which pertained mainly to administrative measures such as making each other aware of hazards, showing safer ways of doing tasks and on-the-spot correction of unsafe practices. Importantly, such participation was subsumed within employees' work protocols or their individual spheres of control. As stated by two employees:

"*… it could be like, when they're at the oven and they turn around and tell someone behind to get something they usually always say, 'behind you'… when they bring hot pans to the dish wash they either say 'hot pans' or spray cold water over it … they remind the dish hands always to use a tea towel … in the kitchen they reduce risk by the 'behind you' thing. They reduce risk by letting people know where they are, what they're doing and things like that, and same with us.... communicating with managers, and customers and each other sort of like reduce problems, risks or anything ..."* Employee 5)

"*… the place I came from, there were no protocols, there were no systems in place … Here, we all have our positions here and we all have descriptions of what our job is. And we all have to follow that … we definitely have job descriptions and we know exactly what we have to do every day that we come here* …" (Employee 1)

The examples replicated above reveal that employees' participation in OHS risk prevention extends to communicating to the owner/manager the hazards imminent in the workplace. Employee participation, apparent in the workplace in this case study, is driven by the opportunity for learning that is provided by such participation. For example, with such participation employees get to learn safety skills, workplace rules and the work procedures. As reported by one employee:

"*... when we are all so close, you know, working together, I suppose we always say that we are behind each other, or I'm just coming round you, or hot pot, you know if we are carrying something hot ... if there is no communication then things don't seem to flow as it should be ... making sure everyone knows what's happening with all the tables ... we talk to each other about what's happening ... in the kitchen we always make sure that they are clear about the orders ... it just gets everything such as any problems and everything solved smoothly ...*" (Employee 5)

Employer participation in the daily operation of the business was directed at working with the employees. As described by the owner/manager, such participation was characterised by the employer being receptive to what the employees had to communicate with the owner/managers and listening to them to find what they wanted. The owner/managers' exhibition of responsiveness to the opinions put forth by employees was intended to ensure employees involvement in the day-to-day operation and enhance further communication. As explained by the employer:

"… *I try to talk to them first and work with them as opposed to working against them ... I try to communicate with all my staff to make sure that they're happy or not happy or what needs addressing . or if I am not happy about something I definitely think it's better to address it now, and for that I am always open to listen to what they have to say* …" (Employer)

The employer's/managers' participation extended to, in general, controlling daily activities and in particular controlling hazards and hazardous exposure in the workplace. This involved taking in suggestions put forward by employees and deciding on the best way to deal with the issues raised. Establishing workplace rules and safe work practices for everyone to follow, and giving the employees the run-down of performing the routine work to ensure that the work and workplace is safe for everyone, are some examples of employee participation. The following descriptions by employees illustrate the participation of the owner/managers:

"… *everything is kept under the eye of the head chef and if he was busy then sous chef would. It's sort of the higher staff member would just run through everything and just make sure that the employees are safe and comfortable ... if they see say for instance someone running with knife, that's kind of dangerous. Just sort of put them under coverage nicely … the head chef and the senior staff would give an employee the run-down of the kitchen as a thing for safety reminders …*" (Employee 2)

"*… if there is a big problem the managers would organise something and talk to everyone … if we go to them with suggestions or something, they will talk over together with owners and they'll make decisions as to which best way to go ...*" (Employee 3)

"*… I guess somebody would have to talk to – I am sure immediately it would go to Molly, and Molly would go to Ken and say' look this has to be dealt' and then Ken puts some form of practice in place that we all would have to follow to make sure it wasn't going to occur again …*" (Employee 7)

Similarly, the owner/managers were found to maintain an understanding of their participation in the workplace that corresponded with their employees' notion. The employees' notion, to be precise, characterised their employer's/managers' participation as a demonstration of responsiveness to employees' suggestions to enhance the established systems and procedures. The owner/managers, as is evident from the comments below, described similar characterisation of their own participation in controlling hazardous exposure in similar terms:

"*… we've got plans in place, procedures and policies for both sides, really … and it's just the matter of them, the senior staff, making sure that the younger staff are following those things …*" (Employer)

"*... But if I see anything, if I hear anything that's dangerous to staff members I apparently get onto that procedure … if there is something we know about we fix it ...*" (Manager 2)

An important driver behind owner/manager participation in receiving suggestions and responsiveness to control of hazards was the desire to avoid the necessity of having to deal with problems later. An equally important driver for such participation, as envisaged by the owner/managers, was the opportunity such participation provided for making changes possible. In addition, the development of sense of being in control of what is happening in the work environment and how the employees accomplish work activities is another important driver for employer's/manager's participation. The following statements exemplify such a notion:

"*… I am one of those people that like to deal with the problems straight away … only because I feel that unless I deal with them straightaway they can't change it ...*" (Employer)

"*… I would train my staff members but I would train them to do it right if anything. So that they feel like they have a better control … I won't leave it to them. I personally want to feel safe for someone who is not experienced. Then I won't have the problem much to be dealt with later ... I find something that I*

don't like, they get fixed and it gets fixed, not because I don't like it but because it will affect the safety of others … if I see something that could cause a hazard I put it away straightaway because I see it as more of a challenge to fix it …" (Manager 2)

In addition, the owner/managers regarded themselves as the point of control and therefore seemed ready to be alert to react to problems arising in the workplace. The owner/managers perceiving themselves as the control point (based on their assumption that things would otherwise get out of control) seemed to be the other driver for owner/manager participation in controlling hazardous exposure in the workplace. Such a notion is exemplified by the following description provided by managers:

"*… so you sort – of it's kind of like a control point … If there is a hazard and there is hazard in every workplace, and you've just got to control them ... got to be aware of it as a senior staff member and not let things get out of control of what they do ... just a matter of keep an eye on things and saying, 'hey, you know you aren't doing it right. That's how we do it. And if you don't change it you are going to end up cutting yourself like that' …*" (Manager 1)

"*… you've got to make sure that the place is safe, the place is clean, the staff is trained, in all situations ... You as the management have got to know all of it. But you can slowly train them so that they know at the same time you know ... If you get the basics right and they understand what you want, what is needed from them to do to make sure that the place is as clean and safer for them, and not just them but the team that they work with as well … that's what we are really working on here … making sure if it's a threat as you do something that could cause a hazard, you put it away straight away ...*" (Manager 2)

Responses from owner/managers and employees typifying the characteristics of participation in identification and control of OHS hazards and risks are noted in the plain oval shapes in Figure 6-5 and are segregated into different groups. Segregation into these groups was based on the distinguished characteristics of participation typified by these responses. Noted in the shaded oval shapes are the categories or labels elucidated by these indigenous concepts collectively. The categories of participation that described an indigenous concept closely were linked with each other which led to the construction of typologies of participation, represented within the shaded octagonal shapes in Figure 6-5.

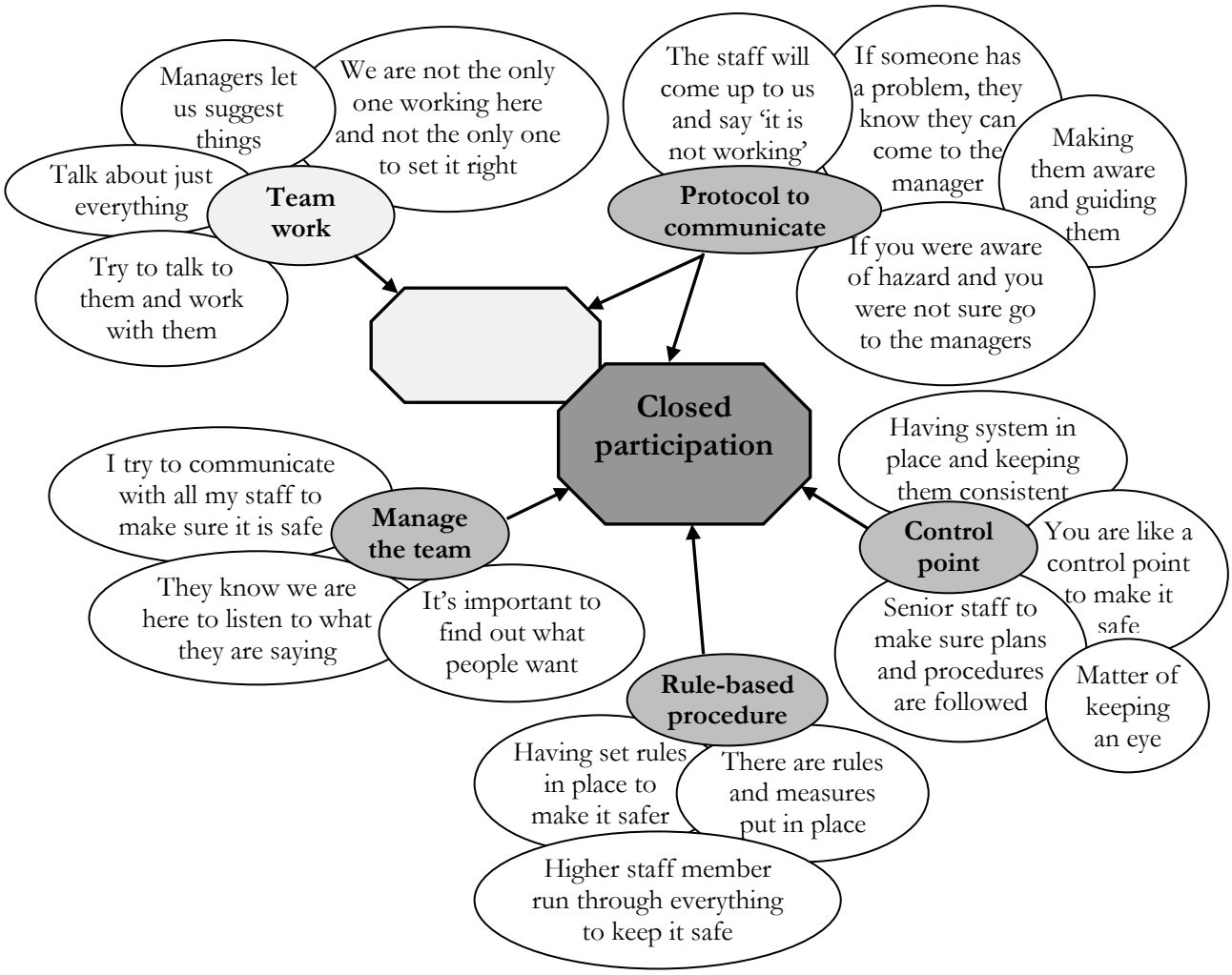

Figure 6-5: Indigenous concepts of participation and participation typologies

Closed participation emerged as the predominant typology (indicated by darker shade in Figure 6-5) for employer/employee participation. Closed participation was characterised by informal and discreet communication between the owner/managers and employees encompassed within their work protocols or sphere of control. Communication from the employee, within their work protocol, occurred in the form of suggestions and inputs regarding the identification and control of hazards and hazardous exposures. Communication from the owner/managers took the form of instructions, rules or standard practices to be followed by the employees in the workplace. Customarily, issues deemed not within one's work protocol were included in such communication, not was a work procedure established to control possible risk exposure. In the example of the oil spilt on the floor, it was not brought up as something that could be improved. Similarly, no ruling was ever made on tidying material deliveries in the laundry room. These examples illustrate that identification of

OHS hazards and control of risks are largely dictated by work protocol. Employee participation was found to be driven by the opportunity to learn and accomplish the task, whereas owner/manager participation was driven by their perception of themselves as the control as well their desire to avoid having to deal with problems later. A less predominant typology of participation (indicated by the lightly shaded octagonal shape in Figure 6-5) that emerged was **lead-through participation**, characterised by the sense of team work among the owner/managers and striving to lead the team by providing opportunities to employees to share their ideas in daily work performance to some extent.

The characteristics of and drivers for closed participation are summarised in Table 6-4.

Table 6-4: Closed participation – characteristics and drive

	Characteristics	*Drive*
Employer	Work with employees Establishment of rules as control mechanism Closed downward communication	Control point Don't have to deal with later
Employees	Closed upward communication Suggestion and inputs within the sphere of protocol Control actions within work protocol	Learning opportunity Get the job done

Closed participation, as the predominant typology of participation, has a number of obvious implications in relation to the identification and control of OHS problems. First, such closed participation as revealed in this business case is found largely to lead to the selective identification and control of OHS hazards and risks in the work environment. This means identification and control of OHS problems is a matter of who is bothered about it and who needs to be concerned about it. Second, and closely associated with selective identification and control of OHS problems, is the selective legitimate acceptance of the problems based on the work protocol or the sphere of control. These implications are obvious from the fact that some OHS problems are acted upon, while others are ignored irrespective of how obvious the problem is and how simple the control measures might be. The following field observation notes, Box 6-3, illustrate such selective identification and control of OHS hazards and risks.

Box 6-3: Observation notes, 9 July 2010

As scheduled, I arrived at the restaurant at 1:00 pm and went in through the back door that leads into the laundry room and then into the kitchen. As soon as I entered the laundry room, I could observe deliveries in boxes and packs piled up on top of each or scattered on the floor. It was not the first occasion to see the deliveries lying unattended on the floor in this room. It has been a regular observation from the first day I started my field observation. Interestingly, I have not heard anyone talk about these materials on the floor as something that obstructs peoples' movement or that needs tidying up, much less raising it as a safety hazards posing risks of tripping and falling. To be fair, the only occasions I have heard about these materials is from Ken, the head chef, who asked me a few times to tidy up the materials because they piled up so much that there remained no room for people to move in and out from the kitchen. The same thing happened today too.

I went into the kitchen not bothered about the materials myself. The kitchen seemed relatively busy today. I thought it could be because today was a Friday. I could see Ken, Charlie and Cecily busy attending to the orders coming through from the front of house. As usual I could see Scotty consumed in doing the dishes. As soon as I entered the kitchen, Ken turned to me and said, "Sorry Bikram, I am not able to attend to you now. But if you could clear the deliveries on the floor, for me, that would be great. They just look ugly".

I cleared the materials onto the shelves and the cupboards. The rush was still not over. I could see Scotty getting busy with washing the dishes, tidying them up onto the shelves for the chefs to access the right type of crockery at the right time. I offered to help him with shelving the dishes to which he agreed. At the dish wash area I could hear the chef telling Scotty "it's a hot pan" or "it's a really hot pan" whenever they brought pans directly from the oven to the washing basin. I could also see the dish hand mopping the floor around the dish wash area occasionally and attending to the oil in the corner from time to time changing the small container and wiping the floor with dry clothes. During these two weeks of my field observation, I have not heard anyone mention anything about the oil in that corner of the room. I have always wondered why that oil needed to stay in that corner and be left dripping onto the floor all the time, with no-one bothered about it except only the dish hand.

Closed participation, as discussed, implies selective communication and control of OHS problems and therefore less relevant and adequate control of OHS hazards and risks. This translates into addressing some OHS problems relevantly and adequately on the basis of legitimate acceptance, primarily based on work protocol/control of sphere while trivialising and ignoring others not conceived of as legitimate on this same basis.

6.4 Conclusion

'Slips and falls' were reported as a widely experienced OHS problem in the workplace, and thus emerged as the theme for the element of experience for the employer/managers. The owner/managers associated slip and falls with physical conditions, individual actions and lack of rules as the causes as discussed for the element of casual relations. As themes that emerged for the element of action, the owner/managers contemplated identifying hazards and hazardous processes and putting rules in place as remedial measures. Responsiveness to risks and work protocol (or sphere of control) emerged as the themes for the element of legitimisation. Interestingly, work protocol as an element of legitimisation was found to govern the ignorance hazards, thus de-legitimising OHS hazards and risks.

Similarly, for the employees, slips and falls (as the element of experience) were considered to be casually linked to physical conditions, which thus emerged as the theme for the element of casual relations. Elementary control of hazards and putting rules in place, as the remedial measures for OHS problems, were the themes for the element of action. Work protocol or sphere of control, as the primary reason for identification and bringing up OHS hazards and risks, emerged as the theme for the element of legitimisation. Similar to the findings for owner/managers, work protocol as an element of legitimisation was also found to de-legitimise OHS risks by contributing to ignorance of non-attendance to OHS problems and exhibition of inaction to such problems.

In considering the themes that emerged for the owner/managers, there was evidence to suggest development of LTWE. Similarly, development of LTWE was evident in relation to employees as well. The findings show at least one theme that was common to both owner/managers and employees for each elements of LTWE. From these findings it can be concluded that the owner/managers and employees in this case study had, to some extent, a common understanding of the four elements of LTWE. However, there

were differences between the two groups in aspects of non-emergence of the themes for LTWE. The non-emergence of themes does not translate into a fully developed LTWE. Hence, the absence of a fully developed LTWE largely resulted in the selective identification of hazards and control of OHS risks in the work environment.

Closed participation emerged as the typology for owner/managers and employees' participation in the communication/control of OHS risks. Informal upward communication from the employees by way of opinions and suggestions and downward communication from the owner/managers in the form of rules and practice generally characterised this closed participation. Importantly, such communication was closed within the sphere of the individual employee's work protocol. Based on this case study, it can be generally concluded that closed participation has an important role in the development of LTWE and largely led to the selective identification and control of OHS risks, where some risks are relevantly identified and controlled and some are not.

Chapter 7 Cross-Case Findings and Discussion

This chapter presents the findings of the study across the three business cases and the overarching results in relation to the stated objectives of the study. In doing so the chapter, first of all, highlights the business contexts and characteristics of the three businesses in relation to their operation and OHS practices. The chapter then presents the findings across the cases on understanding of risks by owner/managers and employees, the similarities and differences in their understanding utilising the LTWE framework, and the participatory process involved. Side by side, the chapter discusses these overarching results in relation to the existing literature, highlighting the contribution the study makes to the existing body of knowledge in the area of the study. The chapter also discusses the implications of those findings for occupational health and safety practices in cafes and restaurants. Areas for future research are also identified, as are the limitations of the study.

7.1 Business contexts of the three cases

The three business cases involved in the study were chosen from SBs defined as those employing less than 20 EC as the widely used definition in academic research (Laird, et al., 2009; Legg, et al., 2009). Despite the definitional similitude the three cases were uniquely different in relation to the context and characteristic nature of operation as well as OHS practices. Important of these contexts and characteristics influencing and shaping operation of the business are ownership, training and educational background of the owner/manager, involvement of the owner/manager in daily operation, decision relations and social relations (Bolton, 1971; Storey, 1994). Considering the prevalent OHS practices, the contexts and characteristics of the three business cases seem to influence and shape the process of identification and control of hazards and risk in the work environment. The business contexts uniquely characterising the three cases and the practice of identification and control of OHS hazards and risks are summarised in Table 7-1.

Table 7-1: Business context across three cases

	Case 1	**Case 2**	**Case 3**
Employee count	Eight	Thirteen	Nineteen
Ownership	Independent single ownership.	Independent single ownership.	Independent shareholding ownership
Background of the owner	Owner trained as an accountant; does not have a lot of experience in kitchen work and operating a cafe.	Owner trained as a chef; has more than 20 years of experience in the kitchen and operation of a restaurant and cafe.	The resident owner is trained in operating front of house; has seven years of experience in restaurant and bar operation; one of the other shareholders is trained as chef and takes an advisory role.
Owner's involvement	Owner involved in daily operation as one of the members of the team.	Owner involved in daily operation as the executive chef.	Owner involved in general overseeing of daily operation.
Mode of operation	Completely informal.	Transient to informal formality.	Informally formal.
Decision relations	Operational decisions made at team level.	Operational decisions made at executive level.	Operational decisions made at department manager's level based on work protocol.
Social relations	Employees think they work as 'one big happy family'. Owner contemplates the daily operation is run as a close team. Employer/owner and the employees have a close social relation portrayed as a 'one big family' or 'close team'.	Employees take the owner not as an employer but as a mentor who can teach, guide and lead the team in daily operation. Owner sees himself as a guide as well as the one responsible to make things happen the way it is expected.	Both employees and owner/managers are aware that there are hierarchical protocols to be followed, which define the social relations between them. Owner/managers see themselves as control points.
OHS practice of identification and control of hazards and risks	No formal plans and procedures on identification and control of hazards and risks in place. As a team, both employer and employees strive to make sure the environment is safe and healthy for each other. Any health and safety concerns are raised and discussed in the team as part of identification and control process.	No written plans and procedures on identification and control of hazards and risks in place. Employer/owner, as the executive chief, strives to ensure a safe and healthy environment at work is provided for all the employees. As such the executive chef takes the leading role in identification and control of hazards and risks.	Managers lay down rules to establish safe and healthy work environment. Such rules form the process of identification and control of hazards and risks. Managers have the protocol to establish such rules in the work environment and are based on the experience of hazards and risks in the workplace.

The business Case 1 which has relatively small number of employees (eight in total) has its owner and his parents involved in the daily operation of the cafe as one of the

members of the team and the team seems to work together as a family. Given these contexts, the identification and control of hazards and risks is found to occur at the team level casually and informally. Whereas in business Case 2, the owner/manager as the executive chef seem to be leading the team of 13 employees in daily operation as well as the practice of identification and control of hazards and risks. As such, decisions in relation to daily operation are made by the executive chef (or by the head chef in his absence with the executive chef's consent), including the practice of identification and control of hazards and risks. In comparison in Case 3, the employer/owner is found to be involved in general overseeing of the operation of the business such that decisions regarding the day-to-day operation of the business are usually taken by the managers and supervisors at the department level. As such, the practice of the identification and control of hazards and risks in the work environment is considered the protocol of the manager/supervisors and usually takes the form of laying down rules as part of the process.

The characteristic contexts of the business cases outlining the practice of the identification and control of hazards and risks puts into perspective a closer examination of understanding of OHS risks and participation in the identification and control of hazards and risks in these business cases.

7.2 Employer/employee understanding of OHS risks

7.2.1 Understanding of OHS risks

The employers and employees, in the business cases studied, reported a wide range of issues, which they understood as OHS risks. These have been divided into three characteristic groups – hazards, undesirable events and consequences – and are presented in Table 7-2 and Table 7-3. Table 7-2 lists the common OHS issues that were mentioned by the owner/manager and employee groups across the three business cases. Table 7-2 shows that some OHS issues that were raised by both owner/manager and employee groups across the three cases, whereas some were mentioned only by the employee group. Mentioning of OHS issues by both the owner/manager and employee groups across the three cases has been interpreted as indicating 'similar' understanding of OHS risks amongst the two groups. On the other hand, mentioning some OHS issues only by employees has been interpreted as illustrating 'differences' in understanding of risks in their work environment. For example, knives, slips and falls,

burns and cuts were reported by both owner/manager and employee groups across all the three cases, whereas hot pans, slippery floors and minor cuts were mentioned only by the employees as OHS concerns.

Table 7-2: OHS issues mentioned as OHS risks by owner/manager and employee groups – common across the cases

	Employer	*Employee*
Hazards	Knives	Knives Hot pans Slippery floor
Undesirable events	Slips and falls	Slips and falls
Consequences	 Burns Cuts	Minor cuts Burns Cuts

Table 7-3 shows OHS issues mentioned by owner/managers and employees, which were different between the two groups within each business case and/or across the cases, illustrating further differences in understanding of OHS risks. For example, even though the employers/managers in SB Case 1 and 2 mentioned hot jugs as an OHS concern, none of the employees across any of the cases perceived this as a risk. However, broken arms were reported by both the employer and employees as a major OHS concern only in SB Case 1.

Table 7-3: OHS issues mentioned as OHS risks – different across the cases

	Case 1		*Case 2*		*Case 3*	
	Employer	*Employee*	*Owner/ manager*	*Employee*	*Owner/ manager*	*Employee*
Hazards	Hot jugs	Spills Panini iron Milkshake machine	Hot pans Hot jugs	Hot pans Hot plates Knives Frying Oil Slippery floor Spills	Slippery floor Water on the floor Fire Heat Chip in the glass Oil	Oil next to the door Oil from deep fry Swinging door Knife handling Oven
Undesirable events					Pan catching fire Knocking into each other	Two fires in small period of time Tripping over people
Consequences	Broken arm	Broken		Stress	Nothing	Cut finger

	Broken back	arms			major Ended up bleeding Small cuts Little knick on the hand Stress	off No major burns Stress

The most interesting difference was the experience of stress. First, because neither the employer nor the employees reported stress as a concern during interviewing or mentioned this at work during observation in Case 1. In Case 2, on the other hand, one of the employees during the interview session mentioned it as something he had experienced at work but perceived it as a natural part of his job during peak hours. In Case 3, both the manager and employees mentioned experiencing stress during work but did not relate it to OHS risks. Second, and importantly, the employer and employees in Case 1 supported each other so closely in accomplishing the jobs during busy hours, and worked as such a strongly knit team, that no-one was observed to be suffering stress while accomplishing their job tasks. In comparison, in both Case 2 and 3, the division of labour established by individual job descriptions necessitated each individual to concentrate on his or her task reducing the possibility for team work and mutual support as a team. This meant, as reported by some of the employees during the interview and as observed in Case 2 and Case 3, that by nature the conditions of task accomplishment were stressful. However, neither the employees in Case 2 and 3 nor the owner/manager in Case 3 mentioned stress as an OHS issue understood to be an OHS risk in the work environment. The important reasons for the owner/manager and employees' understanding of stress as not an OHS risk could be their understanding that it is a natural occurrence at work in restaurant and cafes and hence the possible difficulty in relating stress with immediate effect injuries and harm.

This study found that whether the OHS problems the owner/manager and employees understood as OHS risks pertained to the physical hazards, undesirable events or consequences, their understanding primarily related to those OHS problems which: (a) they (employer/employees) had actually experienced in their day-to-day work; and (b) they were able to relate to immediate effect such as injuries or bodily harm. The present study found that the employer and employee groups understood the directly experienced, obvious, physical problems and undesirable events as well as their consequences as the OHS risks in their work environments. The term 'directly

experienced' meant being aware of obvious hazards, or experiencing an undesirable event themselves or one that occurred to someone else, which may have led to a consequence or immediate effect of injury or near-miss accident. This experience-based understanding of risks largely led to similarities or differences in the understanding of OHS risks between the two groups. Similarities in understanding of OHS risks related to the employer and employees having experienced the same hazards, events or consequences in the work environment that can be associated with immediate effect. Not having the same experience of the same hazard, event or consequence was exhibited in differences in their understanding of OHS risks.

This experience-based risk perception leads to two important suggestions in relation to understanding of OHS risks. First, such risk perception may not necessarily correspond with the technical meaning of risk, which is usually assessed as the product of probabilities and consequences of an undesirable event. Rather, it reflects the subjective assessment of whether the consequences arising from a hazard or an undesirable event, perceived as risk, are minor or major (Hasle, et al., 2012; Holmes, et al., 1997; O. H. Sorensen, Hasle, & Bach, 2007). Second, such understanding and subjective assessments, in fact, have a detrimental effect on appropriate and adequate identification and control of the perceived risks (Holmes, et al., 1999; Holmes, et al., 1997). For example, even though employers/managers and employees across the three cases perceived burns as undesirable events and a risk experienced in the workplace, their identification, communication and control was minimal, simply because they were generally perceived as a 'part of the job' (Eakin, 1992; Eakin & MacEachen, 1998) that resulted in minor consequences.

Previous studies that focused on SBs, in general, in relation to OHS risk perception revealed that the parties in SBs largely perceived the immediate effect hazards (physical and chemical hazards) as OHS problems in the work environment (Lamm, 2002; Legg, et al., 2009; O. H. Sorensen, et al., 2007). Even the studies which were focused on the restaurants and cafe sector (Jayaraman, et al., 2011; Suzman, et al., 2001), in particular, found that the employer and employee groups in restaurant and cafe businesses largely considered the physical problems present in the work environment as OHS hazards.

The findings of the present study, that the parties in the work environment understood directly experienced physical problems in the workplace as OHS risks, closely upholds the findings of the previous studies. These results endorse the previous findings that issues concerning psychosocial aspects of the work environment (i.e. stress and fatigue due to working under time pressure) are not perceived as OHS risks but rather as 'part of the job' (Holmes, et al., 1997; O. H. Sorensen, et al., 2007).

In addition, the findings support a recent major review of qualitative studies on workplace health understanding and processes in SBs by MacEachen et al. (2010), which showed that SB parties often considered OHS hazards either as 'par for the course' and therefore not really dangerous, or 'normalised' them (i.e. hazards were considered by both parties as acceptable and not preventable). Similar to the findings reported by MacEachen et al. (2010), the present study evidenced that despite both the employer and employee groups having experienced OHS hazards and risks (such as burns, cuts or stress) at work, they tended to consider them as minor and not having a major immediate effect. They therefore established a normalised acceptance of OHS hazards and risks in the work environment.

7.2.2 Understanding of OHS risks and a local theory

The understanding of OHS risks and development of a local theory for owner/managers and employee groups was examined by looking at the themes that were common (or different) between the two groups for the four elements of LTWE. The results for the themes for the four elements of LTWE that emerged as common to both owner/manager and employee groups within the three cases are shown in Table 7-4.

Table 7-4: Common themes for the elements of LTWE and the construction of a local theory

Elements of LTWE	*Element of experience*	*Element of causal relation*	*Element of action*	*Element of legitimisation*
Case 1	Slips and falls	Unaware exposure to hazards	Identifying hazards and hazardous process	Responsiveness to risks
Case 2	Burns	Individual as the cause	Identifying hazards and hazardous process	Norms of exchange relation
Case 3	Slips and falls	Physical condition as the cause		Work protocol

In Case 1, with 'slips and falls' as an example of the element of experience, the employer and employees had a similar LTWE based on their understanding that 'unaware

exposure to hazards' was the cause behind hazards and risks, as revealed by the analysis as the theme for the element of causal relation. Responsiveness to risks in the sense that both employer and employee groups felt the obligation to respond to the hazards so as to ensure safe work environment was the main motivation for the two groups to bring to attention and identify hazards and discuss control of risks in the work environment. 'Identifying hazards and hazardous processes' emerged as the theme for the element of action for both employer and employees. These results indicate the development of a coherent LTWE between employer and employees in Case 1 based on their common/similar understanding that 'unaware exposure to hazards' was the cause behind OHS problems and risks in the workplace.

In business Case 2, with burns as an example of element of experience, the owner/manager and employee groups established a similar LTWE, between the two groups, based on 'individual as the cause' – the theme for the element of causal relation. Their efforts towards the identification of hazards and control of risks were driven by 'norms of exchange relation' as the theme for the element of legitimisation. 'Identifying hazards and hazardous processes' was the theme for element of action for both the owner/manager and employees. Thus, these results indicate that in this business case, development of a coherent LTWE between the owner/manager and employees was based on a common understanding that individuals were perceived as the cause behind OHS problems.

In the business Case 3, slips and falls were taken as the element of experience to examine development of LTWE. In this case, 'physical conditions as the cause' emerged as the theme for the element of causal relation for both the owner/managers and employees. 'Work protocol', which was the theme in common for the element of legitimisation, determined their efforts towards the identification of hazards and control of risks. Both owner/managers and employees were concerned with identifying and/or controlling only those hazards and risks that fell within their remit as per their work protocol. Work protocol (outlining the sphere of control), as an element of legitimisation, appeared as the main reason for lack of remedial action, despite employers and employees having a common perception about the element of causal relation. For that reason, no common theme for the element of action resulted between the owner/managers and employees. However, despite the absence of a common theme

for the element of action, a coherent LTWE based on 'physical conditions as the cause' was developed between owner/managers and employees.

Although the illustrative example of the element of experience used to derive the themes for the other elements of LTWE and to illustrate understanding of OHS risks was not the same across all the cases, they are similar as they categorically relate to undesirable consequences. In that respect, the themes that emerged in common between owner/managers and employees within each of the cases show a coherent local theory between the two groups. However, no single LTWE was found to be the same between the two groups across the cases. The results suggest that each social group, depending on their local work environment context, developed their own local work environment theory on OHS problems of concern, which largely influenced the way hazards and risks were identified and controlled.

The context-dependency of understanding of OHS risks and development of LTWE by the owner/managers and employees can be further described by examining the different themes that emerged for these two groups for each of the four elements of LTWE. Table 7-5 presents the themes that were different for the three elements of LTWE for the two groups in the three SB cases in the present study. The illustrative example of the element of experience (being the same) has been omitted in Table 7-5 below.

In reference to Table 7-5, in Case 1, for slips and falls as an illustrative example of element of experience, 'physical conditions as the cause' emerged as the theme in common between employers and employees for the element of causal relation. However, 'modifying physical set-up', e.g. putting netting on the slippery steps, was the theme for element of action for the employer, different from 'elementary control of hazards', such as clearing spills and scraps on the floor immediately, as that emerged for employees. Similarly, there was a difference between the two groups in relation to the element of legitimisation, the reason for bringing up hazards and risks for identification and control: 'responsiveness to risks' was the theme for element of legitimisation for employer, different from the 'norms of exchange relation' that emerged for the employees. This indicated the construction of a different local theory between employer and employee groups in Case 1.

Table 7-5: Different themes for the elements of LTWE and the construction of a local theory

	Elements of LTWE	*Element of causal relation*	*Element of action*	*Element of legitimisation*
Case 1	**Employer**	Physical condition as the cause	Modifying physical set-up	Responsiveness to risks
	Employees	Physical condition as the cause	Elementary control of hazards	Norms of exchange relations
Case 2	**Employer**	Part of the job		Part of the job
		Individual as the cause	Unwritten rules	Safety reinforcement
	Employees	My fault	Using common sense	
		Part of the job		Part of the job
		Individual as the cause	Unwritten rules	Norms of exchange relations
			Elementary control of hazards	
Case 3	**Employer**	Physical condition as the cause	Identifying hazards and hazardous process	Responsiveness to risks
				Work protocol
		Individual as the cause	Putting rules in place	
		Lack of rules as the cause		
	Employees	Physical condition as the cause	Elementary control of hazards	Work protocol
			Putting rules in place	

Similar to Case 1, 'physical condition as the cause' emerged as one of the themes in common for the owner/manager and employees for the element of causal relation in Case 3 as well. However, the themes for the element of action between the owner/manager and employees were also different in Case 3. For the 'physical condition as the cause' in Case 3, the employer/managers considered 'identifying hazards and hazardous processes' as the element of actions, whereas the employees considered 'elementary control of hazards' and 'putting rules in place' as control action. Likewise, different themes emerged for the element of legitimisation. Employees considered 'work protocol' as the element of legitimisation, i.e. the reason for bringing up OHS problems for discussion and attention, whereas for owner/managers 'responsiveness to risks' in addition to 'work protocol' were the elements of legitimisation. These results also illustrate the development of different local theory within Case 3.

Comparing Case 1 and 3 in relation to 'physical conditions as the cause' as the emergent theme for the element of causal relation, it can be seen that there are instances of similar as well as different emergent themes for the other elements of LTWE between the

owner/managers and employees across the two cases. With 'responsiveness to risk' as the element of legitimisation in both the Case 1 and Case 3, the employer in Case 1 resorted to 'modifying physical set-up' as a control action whereas in Case 3 the owner/manager relied on 'identifying hazards an hazardous processes'. Again, for 'physical conditions as the cause', employees in Case 1 were shown to be driven by 'norms of exchange relations' as the element of legitimisation towards 'elementary control of hazards' as a control action on OHS risks. But for employees in Case 3, 'work protocol' as the element of legitimisation drove their understanding of action such as 'elementary control of hazards' or 'putting rules in place' or even inaction towards control of risks. These examples illustrate differences in the construction of a local theory across the cases based on the different themes emergent for an element of LTWE, despite having resulted in same theme(s) for other elements.

Similar comparisons can be made for 'individual as the cause' as the theme emergent for the element of causal relation for employers/managers in both Case 2 and Case 3. Interestingly, in Case 2 both the owner/manager and employees perceived 'employees' as one of the causes behind OHS hazards, whereas both the groups in Case 1 and 3 considered the physical conditions at work as one of the main causes behind such hazards. In Case 2, 'unwritten rules' was identified as the theme for element of action towards 'individual as the cause', whereas 'putting rules in place' was identified as the element of action by employer/managers in Case 3. Closely associated with 'unwritten rules' as an important action towards identification and control of hazards and risks, 'safety reinforcement' emerged as the theme for element of legitimisation and, importantly, the reason for owner/managers in Case 2 for frequently bringing up hazards and risks to wider attention in the work environment. In Case 3, the owner/managers' preventive action of 'putting rules in place' was driven by 'work protocol' as the element of legitimisation. In addition, 'individual as the cause' was the theme for the element of causal relation for employees only in Case 2. The employees were found to consider 'unwritten rules' and 'elementary control of hazards', which formed the element of action, driven by 'norms of exchange relation' as the reason for bringing hazards and risks to notice for identification and control.

In reference to Table 7-5, the results also show instances of themes emerging in common between employers and employee across some cases for some elements of

LTWE, while not for other elements or themes emerging only for owner/managers or only employees across the cases. For example, in Case 2 'part of the job' emerged as the theme for both the owner/manager and employees for the element of causal relation and the element of legitimisation. However, the analysis resulted in no emergent theme for the element of action for both the groups corresponding to 'part of the job' as the element of casual relation. Similar was the result for 'my fault' as the theme for the element of causal relation for employees in Case 2, with the analysis resulting in no corresponding themes emerging for the other elements of LTWE.

Taking the example of stress, neither the employer nor the employees expressed stress as a concern in the work environment in SB Case 1, whereas only the employees considered it as a concern in Case 2. But in Case 3, both the owner/managers and employees reported it as a matter of concern. The employer and employee understanding of stress as OHS risk in relation to their causal relation and legitimisation is summarised in Table 7-6.

Table 7-6: Understanding of stress as OHS risk across the three cases

	Observed*	**Identified as an issue (and causal relation)**		**Legitimisation (accepted to bring up as OHS risk)**
		Employer	**Employee**	
Case 1	No	No	No	No
Case 2	Yes	No	Yes (part of the job)	No
Case 3	Yes	Yes (part of the job)	Yes (part of the job)	No

* through observational field notes e.g. rushing, raised voices, demeanour

The SB context and characteristics (namely management style and involvement of the owner/manager in the daily operation of the business, skills and training of the owner/manager, decision relations and social relations) that are unique and different from one individual business to another may provide a possible explanation for the differences in the understanding of OHS hazards and risks and the establishment of a local theory of work environment. For example, in SB Case 1 the employer and employees worked together in a team closely supporting each other during busy hours (the most stressful time of the business day) as well all other times. On the other hand, in Cases 2 and 3 such close support was indicated to have diminished because of more or less defined task divisions and job descriptions, which consequently determined work protocols. Within their work protocol, each individual employee was under pressure to

accomplish his/her part of the job swiftly so as not to create a bottleneck in the delivery of service, and it was this pressure that largely contributed to staff experiencing stress at work. In addition, there is a general understanding that the work in restaurants and cafes generally requires coping under time pressures due to meeting the demands of customers. The combination of the factors that stress is accepted as a naturally occurring element of the job in a restaurant and cafe, and the need to accomplish a delegated task without raising the issue of stress so as not to show that one is complaining about the job, had the effect of de-legitimising stress as an OHS risk, where it was not brought up and consequently no action was taken.

Lack of action (generated as a theme for the element of action) can be interpreted in two ways. First, OHS problems that were considered 'part of the job' were generally accepted as something that cannot be acted upon in terms of prevention and control. For that reason some of the hazards and risks were not brought up for identification and control, which corroborates with the emergence of 'part of the job' as a theme for the element of legitimisation. Second, if OHS problems considered were within the responsibility of a person (as per 'work protocol') those hazards and risks were generally identified or brought to attention in the work environment (by that particular person) for discussion/control action. For that reason identification and control of hazards and risks were approached selectively based on the 'work protocol', the theme for the element of legitimisation.

In that respect, the study suggested that based on the employers' and employees' understanding of the causal relation behind the hazards, events and consequences, they had a similar or different understanding of the OHS risks. Therefore, experience or lack of experience of the same hazards, events and consequences in the work environment and what was perceived as the causes behind these hazards displayed the similar or different understanding of OHS risks. However, legitimisation appeared to be pivotal to the similarities and differences in understanding of the casual links behind hazards and risks and thus the development of similar or different local theory by the groups. These findings show that understanding of the element of legitimisation (i.e. the reasons deemed acceptable for bringing OHS problems to wider attention in the work environment) is core to the social construction of risks and development of understanding of OHS risks. The understanding of OHS problems, their causal relations

and the control actions constitutes the social construction of risks and subsequent construction of an LTWE by employer and employees group in SBs. The central relation the element of legitimisation holds as construction of understanding of risk and development of an LTWE is shown diagrammatically in Figure 7-1.

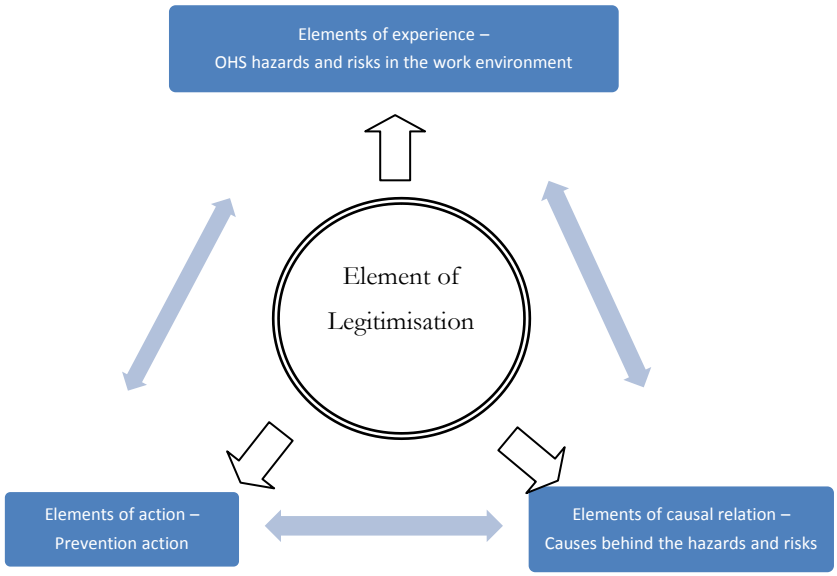

Figure 7-1: Illustrating the key role of element of legitimisation on identification and control of risks

Additionally, the circumstances under which OHS hazards were experienced varied from person to person and, importantly, between employer and employee groups which possibly played an important role in determining the similarities and differences in the understanding of the causal relation and thus the development of a local theory. The tasks and roles performed in a day's work, the way daily tasks and work were accomplished, the management style (i.e. the role taken by the owner/manager), the scale or size of the operation, and participation in the identification and control of hazards and risks constitute these circumstances.

In terms of size, the business in SB Case 1 employed eight staff and the employer and employees undertook daily routines as a team, which allowed an opportunity to participate openly in the process of identification and control of OHS hazards and risks. Such team work and participation reduced hierarchical differences and created the perception that employer and employees were on an equal standing and thus could raise, without any hesitation, the issues that they considered OHS hazards and risks. Such a

context possibly facilitated identification of the actual physical causes rather than fostering the perception that employees were the cause.

In SB Case 3, performance of daily tasks was determined by individual job descriptions and by work protocol. The individual work protocols created hierarchical differences, decision prerogatives and the need to maintain individual performance. This would have contributed to the ignorance of the causes behind the OHS hazards and risks until or unless such hazards and risks were perceived to fall within a person's protocol (and leading to obvious immediate effect such as injury). By comparison, in Case 2, where the discretion of the owner/manager was central to the identification and control of hazards and risks, the owner possibly tended to view OHS as a personal responsibility of the worker and did not consider themselves to have the legitimate authority over the workers' behaviours (Eakin, 1992), which could have led to their identifying an individual as the cause behind OHS hazards and risks.

The present study also showed that workers' views regarding identification and control of hazards and risks in the work environment were shaped by the type and quality of social relationships in the small workplace. As MacEachen et al. (2010) suggested, working relationships in SBs, generally, are typified by personal relations and minimal "we they" dichotomies between workers and employers (Eakin & MacEachen, 1998). Workers and employers in small firms, in general, tend to work alongside each other, have casual relations, and sometimes mixed roles by filling in for each other (Eakin, 1992; Eakin & MacEachen, 1998; Hasle, et al., 2009). These close working relationships between the owner/manager and employees enable workers to have a better understanding the financial standing of the business and appreciate the contribution of their labour for the survival of the business (Eakin, 1992; Hasle, et al., 2009). The case studies developed in the present study evidently showed that such close working relationships, in return, enabled the owner/manager to appreciate the importance of providing a safer working environment through appropriate identification and control of hazards and risks.

Although some previous studies found that workers in SBs tended to downplay health risks because of their close social relations with employers (Eakin & MacEachen, 1998), and injury attributions in SBs were contingent on the quality of the employment

relationship (Eakin & MacEachen, 1998; MacEachen, et al., 2010), the present study did not closely support these findings. The present study, however, showed that awareness of workplace risks and willingness to raise OHS hazards and risks was enhanced by the way both the owner/manager and employees were involved in the workplace including in the identification and control of hazards and risks and the established norms of social exchange in the workplace.

In analysing the workplace assessment in Danish firms through the framework of LTWE, Jensen (2002) suggested that either the explicit legislative demands or a specific OHS hazard and risks hampering task performance played an important role in legitimising OHS issues. However, in the present study, 'norms of exchange relation', as one of the themes for the element of legitimisation across the cases developed in this study, reflected the influence of social exchange on legitimisation of OHS hazards and risks. This is reflected by the emergent themes for the element of legitimisation for employers/managers – 'responsiveness to risks' – and for employees 'norms of exchange relation'. By definition, social exchange is the process of exchange of transactions between social groups or individuals induced by reciprocal reward expectations (Parzefall & Salin, 2010; Zafirovski, 2003). Such exchanges, which could involve economic rewards or non-economic relational transactions (Blau, 1964; Chadwick-Jones, 1976; Ekeh, 1974; Parzefall & Salin, 2010), occur in the absence of any formal norms, rules and values of exchange, and the social groups implicitly apply understood norms to the situation of social exchange at that moment (Ekeh, 1974; Parzefall & Salin, 2010).

In the present study, the employers were found to see themselves as obliged to provide their employees with a 'safe work environment' in exchange for customers and earnings they (the staff of the restaurant and cafe) bring in and also to guarantee their commitment at work. In the three cases, exchange obligation as a driver for acceptance of and action on OHS hazards and risks was reflected in the employers' view that being responsive to OHS risks was the reason that legitimised raising concerns regarding OHS and identifying hazards and risks. Similarly, employees perceived the obligation to 'ensure each other's safety in the workplace' as an important driver for acceptance of and action on OHS hazards and risks. The present study therefore strongly suggested that the social exchange relation had an important role in the identification and control

of OHS hazards and risks in the small workplaces. As shown by most of the previous studies, even if SB employers/managers are less knowledgeable of their legal obligations towards ensuring health and safety of their employees in the workplace (Laird, et al., 2009; Legg, et al., 2009), the social exchange expectations seem to play a bigger role in acceptance of the legitimacy of OHS risks in the workplace. The reciprocal exchange expectations based on the workplace social relation could have played an important role in bringing to notice the hazards and risks in the wider work environment context and exhibition of mutual social behaviour around OHS hazards and risks. As suggested by Hasle et al. (2009), this could be because the social groups in the context of SBs tend to have closer reciprocal relations and low polarisation of interests (Eakin & MacEachen, 1998), which provides a social context for reciprocal exchange of opinions and identification of common goals including those around OHS hazards and risks.

The finding in the present study that the employers/managers and employees considered obvious physical hazards and associated undesirable events, and their consequences as the main OHS risk in the work environment, supports the suggestion made by Jensen (2002) that perception and understanding of risks based on one's experiences would be primarily focused on a few physical aspects of work. Jensen came to this view by looking at workplace assessment (stepwise identification, assessment, evaluation and control of risks) using the LTWE framework (Jensen, 2002). As already pointed out, physical hazards and the risks associated with them were visibly obvious, easily perceptible and the consequences discernibly evident. These attributes may possibly have helped to legitimise these hazards and perhaps facilitated the development of a common understanding of the risks associated with them for both owner/managers and employees.

Experiencing the immediate consequences of an OHS hazard or incident was important to an understanding of OHS risks. The understanding of OHS risks constructed on their experiential perception was reflected in attributing the causal relations behind hazards and risks largely to the 'employees' factor. However, legitimisation (the ability to bring up OHS issues and the causal relation behind them) had an important influence on the attribution of the causal factors behind hazards and risk, which was shown in attributing the causes to 'work environment' factors to some extent. Legitimisation was the reason behind the similarities and differences in the understanding of OHS risks

between owner/managers and employees, and largely explained why some hazards in the work environment were identified and controlled while others were not.

7.2.3 Understanding of OHS risks and control of hazards and risks

In Case 1, with slips and falls as undesirable events and an element of experience, the result showed that both the employer and employee groups understood physical conditions as the causal relation behind the slips and falls. Even then, the remedial actions the two groups were found to consider towards controlling these risks and the reasons deemed acceptable for bringing these OHS risks to wider attention were completely different. The employer regarded OHS problems to be predominantly associated with the physical aspects of the work environment. Such understanding of the causal link was exhibited through the employer being responsive to risks and taking actions e.g. even modifying the physical work environment and not evading or devolving such OHS responsibilities. However, employees, driven by the norms of exchange relations (the responsibility to ensure the safety of each other as the social norm in the workplace), considered elementary control of hazards (e.g. clearing away spills and rubbish) as the main control action. This illustrated that even though employers and employees comprehended the same causes behind OHS problems, the reasons driving bringing the OHS hazards and risks to legitimised attention and reasons for implementing controls were distinctly different.

Similarly in Case 3, where the owner/managers and employees were found to understand the physical conditions as the cause behind OHS problems, both groups took different approaches to the identification and control of hazards and risks. For both groups, work protocol appeared to be an important reason for bringing to wider attention the OHS risks as part the effort on identification and control of these hazards and risks. Within their work protocols owner/managers saw themselves as having the 'responsibility' to become responsive to risks and preventive actions. Such responsibility was exhibited by resorting to the preventive actions of primarily 'identifying hazards and hazardous processes' to the persons exposed to such hazards. The employees within their work protocol considered elementary actions (such as clearing the floor or cleaning the spills and food scraps) as the appropriate actions for minimisation of hazards and control of risks. Likewise even though both the employer and employees considered the 'individual' as the cause behind hazards and risks in the workplace, and envisaged

unspoken understood rules as the action for prevention of hazards and control of risks, the driver and reason behind the identification and control of these were different.

In Case 2, in particular, it was found that the employer's actions were driven by the need to lay emphasis on unspoken and understood rules in the workplace from time to time to ensure that work safety was maintained. From the employees' perspective, their actions were driven by the obligation to ensure each other's safety at work largely as part of the social norms in the workplace. This was reflected in adhering to understood rules as the action in the prevention and control of hazards and risks, as well as taking simple and basic actions such as alerting each other to the obvious hazards or taking immediate action to remove such hazards (e.g. clearing the floor of any spills or food scraps, wiping the floor dry in case of oil spills etc).

The themes arrived at for owner/managers and employees for the four elements of LTWE in the three SB cases in the present study led to a number of suggestions. First, the results indicate that for the same OHS problems where the employer and employees envisaged the same cause behind them, hazard identification and risk control actions appeared to be different. Legitimisation (the ability and the accepted reasons allowing bringing hazards and risks for discussion/attention) appears to be crucial in having different understandings of the control action.

Second, the differences in understanding of the elements of LTWE, as reflected by the emergent themes for these elements, showed that the owner/managers and employees constructed different local theories based on their understanding of the elements of the LTWE.

Third, despite the differences in the emergent themes and consequently the local theory established by the owner/managers and employee groups, there are indications that both the groups approached the identification and control of hazards and risks in a way the groups deemed appropriate.

Fourth, the element of legitimisation (the reasons driving the two groups to bring OHS problems and their causes to wider attention) mainly influenced the construction of an LTWE and the local theory determined the approach taken for identification and control of hazards and risk. In other words, the construction of a local theory

determined what was deemed an appropriate approach towards the identification and control of OHS hazards and risks.

The approaches taken for the identification and control of hazards and risks – indicated by the emergent themes such as 'putting rules in place', 'identifying hazards and hazardous processes' or 'elementary actions' of clearing away spills and scraps on the floor – are easily comparable and relatable to hierarchy of hazard control strategies.

The hierarchy of hazard control strategies, as presented in Table 7-7, lists four basic approaches (mechanisms) for hazard control. This has been adapted from the New Zealand Health and Safety in Employment Act, 1992, ("Health and Safety in Employment Act 1992 Amendment Act ", 2002), Australia and New Zealand Standards, AS/NZS 4804:2001 (AS/NZS, 2001) and ILO Guide (Alli, 2001). The four basic approaches are presented in column two alongside the hierarchical order of preference for each in column one, with 1 as the most preferred and 4 as the least preferred control approach. Elimination of hazards is the most preferred control mechanism, whereas minimisation of exposure through the use of personal protective equipment is the least preferred. Column three identifies some techniques corresponding to the control approaches with examples in column four.

Table 7-7: Hierarchy of hazard control

Preference	Control	Techniques	Examples
1.	Elimination	Engineering and design	Design and redesign a process with built-in protection, mechanisation Technological change e.g. changing the process
2.	Substitution		Replacing a hazardous substance or process with a less hazardous one e.g. substituting a hazardous substance with a non-hazardous substance
3.	Isolation		Using protective guards – barriers or locking away substances under strict controls
4	Minimisation	Work organisation and administrative approaches	Adopting standard operating procedures (SOPs) or safe work practices to minimise magnitude, duration and number of exposures Providing appropriate training, instruction or information
		Personal protective equipment	The provision and use of personal protective equipment

Comparing the results for the element of action presented in column four in Table 7-4 with the hazard control hierarchy Table 7-7, most of the themes emergent for the element of action such as 'putting rules in place', 'identifying hazards and hazardous processes', or 'elementary control of hazards' relate to administration techniques of control of hazards that relate to minimisation approach.

Instances of themes that emerged for the element of causal relation such as 'part of the job' or that for the element of action such as 'unwritten rules' in Case 2 are not easily relatable to or comparable with the hierarchy of hazard control. These, however, can be related to either the owner/manager's tendency to exercise "avoidance strategy", as noted by Hasle et al. (2012, p. 11) in relation to taking the responsibility for OHS or the employee's tendency of "fatalistic resignation" to the hazards and risks as observed by Holmes et al. (1999) and Lingard and Holmes (2001). The present study found that both the employer and employees, to some extent, tend to downplay hazards and risks, not because of employment relations as suggested by Eakin (1992) or because it threatens the survival of the business (Eakin, 1992; Eakin & MacEachen, 1998). It is because either any immediate effect in terms of injury or harm is not discernible, or the consequence is assessed to be minor, or the responsibility is largely placed upon the individual employee.

These results simultaneously support previous findings that understanding of risk and risk controls directed at individual behaviour largely hinders the adoption of more appropriate risk control approaches, the effectiveness of which in controlling hazards and risks is largely questionable (Lingard & Holmes, 2001). This means that despite the employers/managers having adopted the approaches to identification and control of hazards and risks deemed appropriate based on their construct of the local theory, such approaches, as indicated by the present study, may not pertain to more preferred control through isolation, substitution or elimination. However, control actions such as putting netting on the steps and railings or changing the set-up of the work benches in the kitchen, or moving hot appliances to a corner of the kitchen (related to the theme of 'modifying the work environment' for element of action in Case 1) are examples of engineering and design techniques towards the control of hazards and risks. Therefore, the different construction of a local theory by the employers/managers and employees can be related to different approaches to the identification and control of hazards and

risks. In general, the approaches taken in the three cases in this study related to minimisation of hazards through work organisation and administrative techniques as the predominant approach to identification and control of hazards. This is explained by the tendency of SBs, in general, to rely largely on administrative risk control at the individual level as found by some previous studies such as Legg et al. (2009), Laird et. al. (2009) and Lamm (2002). The overall approaches taken in the three cases in this study for the identification and control of hazards and risks were clearly rather reactive and ill-defined hazard management systems that relied largely on supervisory coercion and peer pressure.

The absence of a hazard management system or a reactive approach to the identification and control of hazards and risks, as found in the major review by MacEachen (2010), may be because the employers/managers either did not see OHS as falling within their sphere of responsibility or they were not clear about their responsibilities. Such a nebulous hazard management system and reactive approach may also reflect an employer/management view that OHS is the personal responsibility of the individual employee (Eakin, 1992), or a tendency for the management to adopt their OHS practices to accommodate their limited resource availability (Legg, et al., 2009; MacEachen, et al., 2010).

The "one size fits all" strategy (Holmes, et al., 1997) to OHS management promulgated largely by enforcement agencies that lacked specificity with regard to outlining prevalent hazards and risks in SBs tend to promote the avoidance of having to deal with these hazards and risks (Hasle, et al., 2012) as opposed to SBs taking a formal structured approach to workplace health and safety (Laird, et al., 2009; Legg, et al., 2009; MacEachen, et al., 2010). Interestingly, Corneliusson (2005), in her case study of a biotech firm found that a lack of formal systems on OHS did not always mean a lack of satisfactory OHS practices. Her study showed that although managers appeared not to be knowledgeable of the firm's detailed policy on OHS, they adhered to safe practices because all the firm's employees were professionals with a high level of education and thorough training in safe laboratory procedures. In comparison with the findings in the study by Corneliusson (2005), the employees involved in the handling of food materials in the three cases in the present study had to undertake hygiene certification that to

some extent included knowledge of health and safety. The present study to some extent seems to validate the suggestion by Corneliusson (2005) that the industry and the professional area of a firm has an important role to play in the way the OHS management system is applied in practice and the approaches taken to the identification of hazards and their control.

The understanding of OHS risks based on objective experience of hazards and risks, and the influence legitimisation has on understanding of OHS hazards and risks, established the construct of LWTE. The local theory constructed by the employer and employee groups was reflected in the approach taken to the identification and control of hazards and risks in the work environment. Primarily, the understanding of OHS risks and the construction of a local theory by owner/managers and employee groups implied basically taking on reactive and intuitive approaches to the identification and control of hazards and risks. The predominant approach to the identification and control of hazards and risks adopted was minimisation through work organisation and administrative techniques of supervisory pressure. This explains why the hazard management approach was not clearly defined and was essentially reactive. The findings suggest a clear need to reform the approaches to control of hazards and risks and thus a gradual shift from a mere minimisation to the strategy of elimination on the control hierarchy. This corresponds to the need to shift the perception and understanding of the causes behind hazards and risks to wider causal factors and legitimisation to bring them up for wider attention in the work environment. The shift in the perception and understanding of the causes behind hazards and risks may be possible by changing the employers' and employees' understanding of risks through a more systematic and heuristic approach to the identification and control of hazards and risks.

7.3 Employer/employee participation in control of OHS hazards and risks

Typologies of participation that emerged for the three business cases involved in the study indicated the existence of different types of participatory practices in the identification and control of OHS hazards and risks. The findings showed that there existed one predominant typology of participation in each business case while displaying slight characteristics of other typologies of participation at the same time. The participation typologies that emerged across the three cases are summarised in Table 7-

8. Presented side by side in Table 7-8 are the themes identified for the owner/manager and employees for the three elements of LTWE. The element of experience has been intentionally omitted from the table since the illustrative examples taken for the element of experience of LTWE developed under the same category, which were undesirable events in each business case.

Table 7-8: Elements of LTWE and typologies of participation – cross-case comparison

	Elements of LTWE	*Element of causal relation*	*Element of action*	*Element of legitimisation*	*Typology of participation*
Case 1	**Employer**	Unaware exposure to hazards	Identifying hazards and hazardous process	Responsiveness to risks	**Open participation**
		Physical condition as the cause	Modifying physical set-up		
	Employees	Unaware exposure to hazards	Identifying hazards and hazardous process	Responsiveness to risks	Lead-through participation
		Physical condition as the cause	Elementary control of hazards	Norms of exchange relations	
Case 2	**Employer**	Part of the job		Part of job	Closed participation
		Individual as the cause	Unwritten rules	Safety reinforcement	
			Identifying hazards and hazardous process	Norms of exchange relation	
	Employees	My fault			**Lead-through participation**
		Part of the job		Part of job	
		Individual as the cause	Unwritten rules	Norms of exchange relations	
			Identifying hazards and hazardous processes		
			Elementary control of hazards		
Case 3	**Employer**	Physical condition as the cause	Identifying hazards and hazardous process	Responsiveness to risks	Lead-through participation
				Work protocol	
		Individual as the cause	Putting rules in place		**Closed participation**
		Lack of rules as the cause			
	Employees	Physical condition as the cause	Elementary control of hazards	Work protocol	
			Putting rules in place		

Highlighted with same coloured shadings in Table 7-8 are similar themes for the elements of LTWE for employers/managers and employees in each business case.

Although there are similarities in emergent themes for the elements of LTWE within each case, the themes are different to some extent across the cases. The differences in the themes emergent for the elements of LTWE across the cases can to some extent be linked to the typology of participation characterised in each of the three cases.

This can be illustrated by referring back to the themes that resulted for the elements of LTWE, and in particular the element of casual relation, for employers/managers and employees in the three cases (Table 7-8). In Case 1 and Case 3 the owner/manager and employee groups both considered 'physical conditions as the cause' for the element of causal relation. In comparison, the two groups in Case 2 either considered 'individual as the cause' or 'part of the job' as the causal relation behind OHS problems. In Case 1, in addition to 'physical conditions as the cause', both the employer and employees considered 'unaware exposure to hazards' as the addition causal relation behind the OHS problems. Unlike in Case 2, neither of the two groups in Case 1 considered 'individual as the cause' behind OHS problems. In Case 3, the owner/managers considered 'individual as the cause' behind OHS problems, in addition to regarding physical conditions as well as lack of rules as the causes of these problems.

Open participation (Section 4.3), the typology of participation predominantly observed in Case 1, was characterised by open, informal, two-way communications, unrestricted information flow and sharing of opinions between employer and employees. Such participation fostered team work that engendered a feeling that the employer and employees were equal and on a level standing with each other. In relation to OHS hazards and risks, as part of the whole team, everyone was aware of obvious hazards in the workplace and the risks of injuries such hazards may produce. This was associated with identifying the conditions of work, rather than seeing an individual as the cause of injuries and accidents. Such understanding of hazards and risks by the employer and employees is further exhibited through their responsive attitude towards the identification and control of hazards and risks. In that respect, employer and employees being 'responsive to hazards' and thus the hazardous exposure and the risks of injuries emerged as a dominant theme for the element of legitimisation. The attitude of the employer and employees towards hazards and risks, displayed by their responsiveness, largely confirmed acceptance of the hazards and risks raised and participation in their identification and control.

In Case 3, informal limited communication, limited flow of information and sharing of opinions between owner/managers and employees governed by their respective work protocols characterised closed participation as the predominant typology of participatory practice (Section 6.3). As such work protocol, as the main theme for the element of legitimisation, governed what was brought up and accepted as OHS hazards and risks in the workplace. Owner/managers, taking into account the work protocols of employees, construed individual employees as the cause behind OHS problems, whereas employees, allowing for the work protocols of their owner/managers, considered physical conditions as the cause. Thus, the closed participation typology may contribute to the differences in perceptions regarding employees as the cause behind OHS problems.

Interestingly, in Case 2 both the owner/manager and employees believed either that the employees were the cause of OHS hazards and risks or that such OHS problems were simply a part of the job. The case was found to exhibit lead-through participation as the predominant typology of participatory practice (Section 5.3), where the owner/manager was always present overseeing the daily operation, and most of communication was top down in the form of instructions, cautioning on hazards and training in safe practices. This characteristic in turn would likely have established the conviction that any mishap was the fault of the individual, leading to 'individual as the cause' as a major theme for both the groups for the element of causal relation.

Evidently, open, lead-through and closed participation were the three predominant participation characteristics observed in relation to the identification and control of OHS risks in the cases examined in the present study. Legitimisation – what is brought or not brought for attention and discussion as hazards and risks in the work environment (extent) and the reasons (themes for element of legitimisation) deemed acceptable to bring hazards and risks to attention (sphere) – as the key to the construction of a local theory seems to be closely related to participation typologies. With most of the issues brought for attention and discussion, and the intent to ensure a safe work environment as the reason for bringing up all-encompassing OHS hazards and risks for attention, as indicated in Case 1, it is shown to closely relate with open participation. Whereas with selected hazards and risks brought to attention driven by

the reason of what falls within one's prerogative and defined protocol, as evidenced in Case 3, is shown to relate to closed participation typologies.

The participation typologies and their characteristics in relation to the identification and control of hazards and risks are summarised in Table 7-9.

Table 7-9: Participation typologies in relation to identification and control of OHS hazards and risks

	Form	**Decision issues**	**Degree of participation**	**Example**
Open Participation	Open and informal participation in identification, communication and control of hazards. Concerns of hazards and risks are raised unselectively.	Working conditions and working environment such as work station design and set-up e.g. placement of equipment, work stations.	Employees can change a decision on conditions of work and working environment e.g. change, improve or repulse a decision. Owner/manager and employees equally take part in decision and action.	*There are a few bits that were not working so well. But we've just changed them and adopted them to find a system that works.*
Lead-through Participation	Identification, communication and control of hazards take the form of an informal process lead by the owner/manager.	Routine work and tasks such as schedule of daily tasks and routines to fit one's requirement. Owner is obliged to ensure health and safety in work place.	Opinions and ideas of employees are taken on board, which influence decisions to be made. Owner/manager leads the process of decision and action.	*We can always put in our opinion. He takes our opinion on board because obviously we are the ones who going to do this.*
Closed Participation	Selective identification, communication and control of hazards informally structured around protocols.	Routine work and tasks such as scheduling of daily tasks and routines to fit one's requirement. Training on hazard's and risks within one's work area and work protocol.	Employees can give opinions and ideas, which possibly are taken into account while making a decision. The extent of participation in identification and control of hazards determined by work protocols.	*Managers, they do let us suggest things, and they are good at listening to us and things that they thought could work, and it has influence on how we do something about things like food scraps on floor or the oven catching fire.*

Finally, through the application of LTWE, the study unravelled the relationship understanding of OHS risks has with typologies of participation and thus participatory practice in the identification and control of OHS hazards and risks. The development of a local theory for employer and employees is a clear reflection of how the employers/managers and employees, as two social groups, understand OHS problems, the causes behind the problems and the remedial/control actions. Therefore, a direct relationship can be seen between the LTWE developed, the understanding of OHS

risks, and the control of hazards and OHS risks. A fragmented LTWE (i.e. local theory that lacks themes for some elements of LTWE) is an indication of differences in the understanding of OHS hazards and risks and the possibility that OHS hazards and risks are not appropriately controlled. A fully developed LTWE is an indication of the understanding of OHS risks and that efforts are applied to the appropriate control of OHS hazards and risks. As discussed in Section 7.2.3, the key factor in the appropriate identification and control of hazards and risks is the element of legitimisation. Legitimisation is equally pivotal to participation in the process of the identification and control of hazards and risks.

The findings of the present study indicate that more increased the legitimisation of OHS hazards and risks in the work environment through the open flow of information, sharing of ideas and involvement in discussion and decision making, more enhanced is participation by both employers/managers and employees in the process of identification, and control of hazards and risks taking the form of open participation. The study suggests that legitimisation of OHS hazards and risks improved local understanding of OHS risk and thus increased participation i.e. endorsement of open participatory practice as opposed to restricted participation as characterised by a closed or lead-through participation typologies in identification and control of risks. The influence legitimisation has on participatory practice in the identification and control of hazards and risks (typologies of participation) and the gradual shift from minimisation as control approach towards approach of elimination is schematically shown in Figure 7-2.

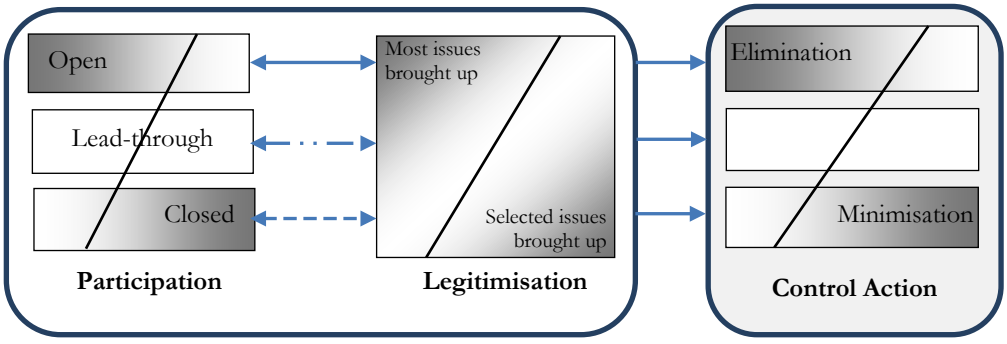

Figure 7-2: Effectual relation between participation, legitimisation and hazard control action

Arguably, the findings also suggest that participation typologies reciprocally influence legitimisation (i.e. what was brought up or not brought up for discussion as hazards and

risks in the work environment). The example of the way stress is understood (as a natural part of the job which is not expected to be brought as an OHS issue denoting legitimisation that stress is not OHS risk) and dealt with in the three cases studied (Section 7.2.2) to some extent explains the close relationship between legitimisation, as the contextual factor, and participation typology in identification and control of hazards and risks (Section 7.3). Based on the suggestion that participation typologies could have a close effect on legitimisation, it can be argued that open participation typology possibly broadened the extent and sphere of legitimisation whereas closed participation potentially limits the sphere of legitimisation. Open participation allowed bringing most of the OHS issues to attention and discussion whereas lead-through and closed participation typologies allowed selected issues to be brought to discussion. Thus, the study suggests that legitimisation has a major influence on the form, extent, decision sphere and issues of participation typologies.

Looking back at the characteristic contexts of the three business cases, the typologies of participation, extent and issues of participation as well as the approaches deemed appropriate in the identification and control of these hazards and risks were indicated to be context-dependent. As presented in Section 7.1, the main contextual factors in the three SB cases were their sizes, and employers'/managers' role and involvement in the operation, decision relations and social relations. In addition, the extent of legitimisation of hazards and risks in the work environment itself is another contextual factor such that legitimisation and typologies of participation collectively determine the actions the social groups deemed appropriate in the identification and control of hazards and risks.

The other contextual factors influencing participatory typologies in SBs are the size, organisational structure and management style. These are outlined in Table 7-1. Even though the operational structure in SBs is generally informal, as the size of the business grows in terms of EC the operational structure tends to become more formal and based on work protocols. With such growth the role of the employer is observed to evolve from supporting the team in their daily routine work, to managing the operation through a more formalised command and control system. Such changes in the organisational structure and management style, as suggested in this study (Table 7-5), indicated the influence participatory practice has in the identification and control of OHS hazards, so that participation tended to become closed in terms of identification

and discussion of OHS hazards and risks and decision on preventive actions, as opposed to open participation where employer and employees as members of the 'team' interacted spontaneously and participate in decision making. The participation typologies could be also visualised on a participation continuum (Figure 7-3) with open participation and closed participation at the two extremes of the continuum and lead-through as one of the participation typologies in between the two. Lead-through participation can take a varied form depending upon the contexts of operational structure, management style and delegation-distribution of roles between the owner/manager and employees.

Figure 7-3: Participation continuum

In their study of OHS management practices in small size enterprises in Quebec (Canada), Champoux and Brun (2003) clearly evidenced the impact of contextual factors such as size and the various aspects of operation on the way OHS was managed. In their study of small firms employing fewer than 50 employees, the profiling of OHS management resulted in four types of profiles indicating different types of participatory OHS management in terms of identification and control of OHS hazards and risks. In their study few firms employing between one and five employees and some others that employed 26-50 employees were found to have active participatory OHS management, whereas those with 11-25 employees were inactive in relation to OHS management (e.g. inspection of the premises, accident investigation, noise evaluation, workstation modification etc). The context-dependency of type of participation in the identification and control of hazards and risks is evident in the present study closely supporting the findings by Champoux and Brun (2003).

The context-dependency of participation to some extent may be explained by the analogy of the 'open system paradigm' developed under the general systems theory of organisations (Von Bertalanffy, 1969). The general systems theory explains the complex phenomenon of a system e.g. an organisation, a business or an institution, through understanding of the crucial elements of the system. The crucial elements are the set of entities (e.g. an individual, a group of individuals or department), the set of relations

among the entities and deduction of such relations among the entities to the behaviour of the system (Kramer, 2007). The system theory distinguishes an 'open system paradigm' from a 'closed system'. In an open system the entities or the component of the system are constantly in a dynamic relationship with the environment in which they are located. By contrast, in a closed system, the entities or the components process and proceed independently of the environment. Analogously, in an open participation, the individual employer and employees have a dynamic relationship with each other and with the work environment they are in which is reflected in their endeavour to make the work environment safer for each other. By contrast, in closed participation, the individuals have not shown a dynamic relationship with each other and with the work environment, which is reflected in their not bothering to act on the hazards despite these being obvious, easily rectifiable or even affecting them as posing risk of incidents. In between the two typologies of participation is the lead-through participation where the interaction between the employer and employees is largely dependent on the role the employer takes in the daily tasks as well as what is delegated to the employees. The nature of employees' interaction with the employer is dependent on how much overlapping occurs in the delegated tasks and, as pointed out by Hasle and Limborg (2006) in their review of literature on preventive occupational health and safety activities in small enterprises, the position of the owner/manager in this regard determines what preventive approaches are fostered.

The participatory typologies identified in the present study could possibly be related to 'relative effectiveness' in the identification and control of OHS hazards and risks in the work environment. Open participation by the employer and employees reinforces legitimisation of hazards and risks in the work environment by making it more acceptable to bring to attention issues in the work environment, whereas closed participation restricts legitimisation of OHS hazards and risks. Open participation possibly facilitates an all-embracing approach to identification and control of OHS hazards and risks, as opposed to selective identification, communication and control as found to occur in a closed participation environment. Additionally, with open participation, as evidenced in this study, employers and employees tend to be more likely to adopt techniques such as changes to the work environment set-up and layout that do not require big physical changes, but obviously pertaining to the isolation and or elimination approaches to hazard control in the hazard control hierarchy (Alli, 2001;

Lingard & Holmes, 2001). In contrast, with closed participation, employers and employees tend to take selective perspectives on the identification and communication of hazards and risks. Such perspectives adhere largely to a hazard minimisation approach through administrative techniques.

7.4 Implications of the findings to OHS practice

This section presents a summary of the findings of the study. The summary of the findings in relation to the study objectives are presented in Table 7-10.

Table 7-10: Summary of findings related to the objectives of the study

Research Objectives	*Findings*
1. To determine the understanding of OHS risks by employers and employees.	▪ Directly experienced obvious, immediate effect and physical hazards, events or consequences are understood as OHS risks.
2. To identify whether employers and employees have a common or a different understanding of OHS risks utilising the four elements of the LTWE (Jensen, 2002) framework.	▪ Similar understanding of OHS risks related to directly experienced OHS hazards and risks that can be associated with immediate effects. ▪ Differences in their understanding of OHS risks related to those OHS hazards and risks that cannot be associated with immediate effects
3. To establish the explanations for the similarities and differences in the understanding of OHS risks between employer and employee groups through the LTWE (Jensen, 2002) framework.	▪ Legitimisation i.e. what is or can be brought up for discussion was crucial to development of similar or different construct of local theory or local understanding of OHS risks.
4. To examine the usefulness of the LTWE (Jensen, 2002) framework in relation to the approaches taken towards identification and control of hazards and risks in SBs.	▪ The local theory determined what was considered an appropriate approach towards identification and control of hazards and risks. ▪ Therefore, the hazard management approach was not clearly defined. Hazard management approach was reactive. ▪ What was considered an appropriate approach to the identification and control of hazards and risks was context-dependent. Participation formed an important element of such context.
5. To determine the influence of participatory characteristics on the identification and control of OHS hazards and risks.	▪ Open participation, lead-through participation and closed participation emerged as three predominant typologies of participation. ▪ The typologies of participation were context-dependent – size of SB, knowledge and experience of the owner/manager, decision relations, social relations and extent of legitimisation being important aspects of such context.
	▪ Legitimisation determines which OHS hazards and risks are brought up for attention and discussion determining local understanding of OHS risks and thus participation in the process of their identification and control. ▪ Open participation led to a broader approach to the identification and control of hazards and risks with generally no restriction on what was brought and discussed. ▪ Closed participation was more related to the selective approach to the identification and control of hazards and risks with work protocol putting restrictions on what they brought and discussed in the work environment.

The implications of these findings in relation to identification and control of hazards and risks and subsequent management of OHS in SBs are also discussed.

The study found that obvious physical hazards, which could be associated with immediate effects, were understood as OHS risks in the work environment. This implies that the first stages of the hazard management process (hazard identification and assessment) in SBs appear to be performing conjointly as one activity. Additionally, such a process (identification and assessment) appears to be experiential in nature i.e. based on the experience of consequences and importantly the perceived severity of such consequences. Because of the experiential nature of the hazard management process, the SBs studied appeared to lack a clearly defined hazard management system and relied on a 'reactive' or 'intuitive' approach to the identification and control of hazards and risks. For such a reactive hazard management system, the identification and control of hazards has to be immediate and effective or the hazards and risks remain. It is thought that to develop and re-focus a reactive approach of hazard control (to meet legislative standards), the SB owners first need to identify all actual and potential hazards in a systematic way, determine which of those hazards are significant, and put in place effective controls in line with the control hierarchy. In addition, owners and employees need access to available information and training opportunities in order to establish a clearly defined and more proactive and predictive hazard management system.

Having a proactive and predictive system in place would mean the identification of hazards and risks before they occur. To create a proactive and predictive system two things need to happen. First, the sphere of legitimisation of OHS problems needs to be expanded. Second, the process of identification, assessment and control of hazards and risks needs to be undertaken as independent consecutive activities.

To achieve this, it is suggested that more emphasis on hazard management in cafes and restaurants could be promoted at the industry sector level and through enforcement agencies nationally. Industry sector wide strategies towards greater legitimisation and acceptance of broader issues of OHS hazards and risks could be developed through information and training interventions, which could include the more hidden work issues (e.g. psychosocial issues related to stress and working under time pressures). Such strategies could create a more open work environment for raising and discussing a wider range of hazards and risks at the industry and organisational levels. This would allow the

social groups to determine if the issue was a problem or not at the local level and to act accordingly. A key strategy at the local work environment level could be a greater formalisation of recognition of hazards and risks through the development and maintenance of a hazard register, which focuses on incidents and near misses as important elements of OHS management. A more systematic and formalised recognition of hazards and risks could provide the knowledge base at the local work environment level to move control options from the more common administrative techniques to control levels higher in the hierarchy.

The finding that the local theory constructed determined the approaches deemed appropriate in relation to the identification and control of hazards and risks, and that the constructs of local theory were based principally on the elements of legitimisation, suggests that the approaches deemed appropriate are context-dependent. As evidenced in the present study, the reasons deemed appropriate to allow bringing OHS hazards to attention contributing to the understanding of OHS risks are context-dependent.

The existing literature identifies the size of the business, the knowledge and attitudes of owner/managers (Champoux & Brun, 2003; Legg, et al., 2009) and important contextual factors that influence the process of the identification and control of hazards and risks. The present study indicated that in addition to these factors, the task/role definition of the owner/manager, social relation, decision relation and consequently the form and extent of participation by employer and employees (Walters & Frick, 2000) are crucial to the process of the identification and control of OHS hazards and risks. The study showed that these characteristics contextualise understanding of OHS hazards and risks and the construction of a local theory of work environment. Given the situation where the SBs (due to factors such as geographic dispersion, difficulty to access and resource constraints) are left to their own devices by regulation and compliance, LTWE is proven to be a useful and appropriate tool to comprehend the process and practice of the identification and control of hazards and risks. The LTWE is indicated useful in understanding the practice of identification and control of OHS hazards and risks in SBs because it is shown provide the opportunity to look at understanding of hazards and risks, and participation in the construction of local theory holistically and concurrently. This possibility has unravelled the centrality of legitimisation in a participatory approach to the identification and control of OHS hazards and risks in SBs. Therefore, it is useful to reiterate that extending and expanding the sphere of

legitimisation would lead to a shift from a closed participation typology to open participation, which potentially could lead to the identification of broader issues concerning OHS hazards and risks and possible adoption of more appropriate approaches to the control of hazards and risks through approaches of elimination as opposed to reliance on minimisation.

The experience-based understanding of risks and their causal relations that indicated minimisation as the predominant approach to control of hazards and risks suggests that there is a lot of work needed to be done, particularly through the promotion and enforcement agencies.

Finally, the findings of this study disclosed mainly two areas of usefulness of the LTWE framework (Jensen, 2002) in the identification and control of OHS hazards and risks. First, the study showed that the LWTE could be used to comprehend the different theories the social groups construct around an OHS problem in the work environment and the element that underpins the similarities or differences in the local theory constructed, particularly in SBs given their characteristic contexts. As this study has shown, the local theories constructed determined approaches considered appropriate by the social groups in the identification and control of hazards and risks in their work environment. Understanding the elements that lead to the construction of similar and different theories could provide a useful basis for the promotion and enforcement agencies to develop comprehensive strategies for hazard management. Second, and closely related to comprehending the different theories constructed, the LWTE (Jensen, 2002) could be a useful tool to understand the elements that are influencing and driving participation by the social groups in the identification and control of hazards and risks and thus establishing participatory strategies for SBs to manage hazards and risks.

Chapter 8 Conclusions

The objective of the study, in broad terms, was to use qualitative case study methods to explore understanding of OHS risks by employer and employee groups in a local work environment context using the framework of LTWE and explaining participatory practice in the identification and control of OHS hazards and risks in light of the two groups' (employer and employee) local understanding of OHS risks. Three SBs from the restaurant and cafe sector were subjected to qualitative examination using the methods of semi-structured interviews and participant-as-observer ethnographic field observation to accomplish the envisaged objectives. The three SB cases were unique and contextually different in terms of their size, ownership, owner's involvement in the operation of the business, operational modality, decision relations and social relations.

In spite of a significant body of knowledge on participatory practices and understanding OHS risks (predominantly in large enterprises) in the literature, little research had been undertaken exploring these issues in SBs. Despite the unique and different characteristics of operation from one SB to the other, the distinctive context of informal social relation between the owner/manager and employees reinforced by them working alongside each other on a daily basis, creates a positive opportunity and environment for these two groups to effectively work together to manage OHS hazards and risks.

The findings of the study led to the conclusion that experiencing the immediate consequences of the OHS incident forms a crucial tenet of understanding of OHS risks in the local work environment context. Importantly, if the consequences (of an incident) were not immediate, then it is likely that employers and employees have a different perspective and understanding of risks. The finding is important in comprehending the approaches taken to the identification and control of OHS hazards and risks. Generally, the first stages of the hazard management process (hazard identification and risk assessment) in SBs appear to be performed conjointly as one activity and that obvious physical hazards which could be associated with immediate effects were understood as OHS risks in the work environment. Because of the experiential nature of the understanding of OHS hazards and risks, and consequently the hazard management process, the SBs studied appeared to lack a clearly defined hazard management system and relied on a 'reactive' or 'intuitive' approach to the identification and control of hazards and risks.

It is concluded that the SBs' owner/managers, to develop and re-focus a reactive approach of hazard control (to meet legislative standards), first need to: identify all actual and potential hazards in a systematic way; determine which of those hazards are significant; and put in place effective controls in line with the control hierarchy. Additionally, owners and employees need access to available information and training opportunities in order to establish a clearly defined and more proactive and predictive hazard management system.

Two things need to happen to create a proactive and predictive hazard management system. First, the sphere of legitimisation of OHS problems needs to be expanded. Second, the process of identification, assessment and control of hazards and risks needs to be undertaken as independent consecutive activities. This is achieved, in particular in cafe and restaurants, through promoting more emphasis on hazard management at the industry sector level and through enforcement agencies nationally. The most important component of industry sector wide strategies towards hazard management is greater legitimisation and acceptance of broader issues of OHS hazards and risks. This could be developed through information and training interventions, which could include unveiling the more hidden work issues (e.g. psychosocial issues related to stress and working under time pressures).

A key strategy at the local work environment level could be a greater formalisation of recognition of hazards and risks through the development and maintenance of a hazard register, which focuses on incidents and near misses as important elements of OHS management. A more systematic and formalised recognition of hazards and risks could provide the knowledge base at the local work environment level to move control options from the more common administrative techniques to control levels higher in the hierarchy and enhanced participatory practice in the identification and control of hazards and risk. The experience-based understanding of risks and their causal relations indicated minimisation as the predominant approach to the control of hazards and risks, which suggest that there is a lot of work still needed to be done, particularly by the promotion and enforcement agencies.

The unprecedented use of the LTWE framework (Jensen, 2002) brings us to the conclusion that there were two main areas of usefulness of the framework in the identification and control of OHS hazards and risks. First, the study showed that the

LTWE could be used to describe the different theories that the social groups construct around an OHS problem in the work environment and the element that underpins the similarities or differences in the local theory constructed, particularly in SBs, given their characteristic contexts. Second, and closely related to comprehending the different theories constructed, the LTWE (Jensen, 2002) could be a useful tool to understand the elements that are influencing and driving participation by the social groups in the identification and control of hazards and risks and thus in establishing participatory strategies for SBs to manage these.

8.1 Limitations of the study

The present study focused on three cases from the restaurant and cafe sector. The SB cases selected for the study happened to vary in nature and context, particularly their size (in terms of number of employees), involvement of the employer/owner in the daily tasks in the business and the management style. Further the methodological framework adopting an ethnographic field observation and semi-structured interview for data collection and network diagram using LTWE framework (Jensen, 2002), and developing typologies as analytical techniques, made the present study unique and novel. Despite the interesting findings in relation to the owner/manager and employee understanding of risks and participation in the identification and control of hazards and risks, there are a number of limitations and shortcomings that need to be highlighted and discussed.

One of the noteworthy limitations of the present study is the possible data shortcoming that may have implications for data analysis and interpretation. Importantly, the data were gathered through participant-as-observer ethnographic field observation and semi-structured interviews. Analysis and interpretation of meanings, particularly in relation to an understanding of OHS risks and participation in the identification and control of OHS hazards and risks by employers and employees, pertained to the data responses obtained through only one round of semi-structured interviews and lacked a follow-up interview session. Although time and accessibility to the interviewees were some of the reasons for the difficulty with follow-up interviews, reliance on a single round of interview data responses possibly implied over-interpretation of data to some extent. For example, the findings on understanding of OHS risks by employers and employees

was arrived at through interpretation of the OHS issues mentioned by the respondents during interviews, which would have been substantiated by data from follow-up interviews if that had been possible. In addition, it is possible that interviewees did not mention specific issues, because of their belief that nothing could be done to resolve them, which could have influenced the results arrived at in relation to understanding of OHS risks and the process of legitimisation. On the other hand, there were instances of obtaining data rich in information but that did not fit the LTWE framework. Initial segregation and coding of data, as part of the analytical process, extracted from the bulk the data that fitted the LTWE framework and left behind all the other data that was transcribed and saved as part of data recording. Similarly, was the instance with the typologies of participation, where the present study established a simplistic relationship between participation and understanding of OHS risks based on the interview responses and observation data that included few contextual factors only. Substantiating the results by looking at a wider range of internal as well as external contextual factors could have had the possibility of extensive generalisation of the results of the present study.

The ethnographic observations covered a period of just over a month in each case, which was a little shorter than the usually recommended period for field observations (Patton, 1990) and this was another limitation of the present study. A longer period of observation might have been desirable, as it would have given wider and deeper insight into understanding of risks and participation in the identification and control of hazards and risks in each of the cases. Nevertheless, the time spent for field observations in each case (overall just over three months) was thought to be sufficient to gather adequate data. The data gathered within the period spent in the field has allowed the objectives of the present study to be met.

The technique of a network diagram utilised in the present study used only one element of experience as the 'problem' under scrutiny to comprehend the understanding of OHS risks in each of the three cases. Use of two or more work environment problems would have increased the internal validity of the results in terms of the themes that emerged and the understanding of OHS risks evidenced by the social groups in the SB cases. Such possibility, in addition, would have allowed a wider and deeper understanding of the development of LTWE. An alternative analytical approach could have been to look in-depth into the six causal factors, as conceptualised in the original Ishikawa diagram

(Ishikawa, 1985), and establish the themes for the elements of LTWE. The use of the original concept of the network diagram by looking at the six cause factors could have possibly made the analysis extensive in terms of generating themes for the elements of LTWE and thus extensively establishing the understanding of OHS risks and the construction of a local theory. In that respect, the study has unravelled areas for future studies.

8.2 Future research

This present study looked at understanding of OHS risks and participation in the identification and control of hazards and risks by the owner/manager and employees in SBs using the framework of LTWE. In doing so, the study suggested that the organisational structure and management style were important business contexts for the three cases. The findings of the study suggest a number of areas for future research.

The first important area of future research could be to examine the understanding of OHS risks by employer and employees and exploring the implication of a local understanding of OHS risks on their participation in the identification and control of hazards and risks in an SB work environment in other sectors of industry. Such research could further explore the usefulness of the LTWE framework and test the typologies of participation manifested in the present study.

The second area could be to study the influence of larger businesses on understanding OHS risks and participation in SBs. Larger firms have formal systems in place in relation to the identification and control of hazards and risks. A study of the influence such systems have on SBs down the supply chain could identify the gaps in relation to the strategies towards hazard control and risk management in SBs.

Third, a comparative study of understanding of OHS risks and participation in the identification and control of hazards and risks by the owner/manager and employees in SBs, using the framework of LTWE (Jensen, 2002) in a high-risk versus a low-risk industry (e.g. construction industry compared to retail businesses), would possibly contribute towards identifying the gaps in the risk prevention strategies taken mainly by promotion and enforcement agencies. Identifying such gaps in the prevention strategies could lend insight to discussion regarding necessary changes in these strategies for facilitating the establishment of systems in SBs that support their context.

Finally, using the six cause factors as conceptualised in the original Ishikawa diagram to explore the cause-effect relation behind an OHS risk could provide an opportunity for any future research to comprehend the construction of a local theory and understanding of OHS risks from a different and possibly more extensive perspective.

In conclusion, future research should explore: an understanding of OHS risks and participatory practices in other industry sectors; the influences larger businesses have on these features in high and low-risk industry sectors; and lastly, further applications of the LTWE.

Appendices

Appendix 1: Information sheet for owner/manager

Massey University
COLLEGE OF BUSINESS
Kaupapa Whai Pakihi

CENTRE FOR ERGONOMICS, OCCUPATIONAL SAFETY AND HEALTH (CErgOSH)
Department of Management
Private Bag 11 222
Palmerston North
New Zealand
T 64 6 356 9099
F 64 6 350 5796
www.massey.ac.nz

Understanding Participation in Occupational Health and Safety Practices in Small Businesses

INFORMATION SHEET FOR OWNERS/MANAGERS

My name is Bikram Raj Pandey. I am a PhD student in the Department of Management, Massey University, Palmerston North, conducting research project on "understanding participation in occupational health and safety in small businesses". The research is supervised by Dr. Ian Laird, Senior Lecturer in the Centre for Ergonomics, Occupational Safety and Health, Massey University, Palmerston North.

I would like to invite you to take part in my study.

Your involvement

I would like to arrange an interview with you, which would last approximately 30 minutes. The interview would be conducted at a time that suits you the most. It is possible that I may wish to arrange another interview with you at a later date. Participation is entirely voluntary (your choice) and you may withdraw from the study at any time. You will be given time to consider whether you wish to participate in the study.
I would also like to arrange interviews with 6 of your employees. Each would last approximately 30 minutes. The interviews would be conducted during work hours with your approval. It is possible that I may wish to arrange follow up interview(s) with your employees at a later date.
Your rights as a participant are explained in full below.

The project's aims

The aims of the research are to identify how OHS is managed in small businesses, and to understand how participation in OHS in small businesses works. Specifically, I would like to find out:

- What are the health and safety issues in your workplace and how are they identified?
- How are decisions on OHS issues made at work?
- How are OHS issues managed or controlled in your workplace?
- What involvement do staffs have in this process?
- What factors influence the process of managing hazards at work?

How we selected your business?

The study focuses on cafes and restaurants in the Central and Lower North Island employing between 6-19 people. A letter of invitation was sent to you as the owner/manager of your business and this was followed up by a telephone call to confirm participation in the study.

Collecting and storing information

With your approval, I would like to make a digital recording of our interview. The recording allows me the future access and reference to your comments and responses to a range of questions about participation in health and safety in your workplace. This recording will be completely confidential. I will transcribe (write down) your responses after the interviews are complete. This information will be stored in locked cabinets in my office at Massey University.

Confidentiality and anonymity

As indicated, all the information obtained during the course of the interview will be kept confidential. I will ensure that you will not be able to be identified by allocating your written responses a personal code number, and the interview will be conducted in a manner (behind closed doors) that will prevent anyone else from overhearing your responses. All of the information (data) will be stored for a period of five years. After this time, if data destruction is appropriate, hard copies of all data will be shredded and computer files will be deleted.

Use of the information

Your responses to the interview questions will form the basis of the data that will be used for writing my thesis, and possibly at some future time, journal articles. At the completion of the study, the owner/manager of each business involved will be given a short report summarising the main findings of the study. As only summarised or grouped data will be included in the report, no individual(s) will be identified.

Participant's Rights

Your participation in this study is voluntary, meaning that you are under no obligation to accept this invitation. If you do decide to participate, you have the right to:

- Decline to answer any particular question or set of questions
- Withdraw from the study at any time,
- Decline to have your responses recorded
- Ask any questions about the study at any time during participation,
- Anonymity and confidentiality being maintained in reporting and presentation of information and results of the study.
- Provide information on the understanding that your name will not be used unless you give permission to the researcher;
- Be given access to a summary of the project findings when it is concluded

Project Contacts

If you have further questions regarding the present study, please do not hesitate to contact:

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Compulsory Statements

MUHEC APPLICATIONS

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 09/19. If you have any concerns about the conduct of this research, please contact Dr Karl Pajo, Chair, Massey University Human Ethics Committee: Southern B, telephone 04 801 5799 x 6929, email humanethicsouthb@massey.ac.nz.

Appendix 2: Screening Questionnaire for Low Risk Notification

Massey University

Te Kuenga ki Pürehuroa

SCREENING QUESTIONNAIRE

TO DETERMINE THE APPROVAL PROCEDURE

(Part A and Part B of this questionnaire must both be completed)

Name:
Project Title:

This questionnaire should be completed following, or as part of, the discussion of ethical issues.

Part A

The statements below are being used to determine the risk of your project causing physical or psychological harm to participants and whether the nature of the harm is minimal and no more than is normally encountered in daily life. The degree of risk will then be used to determine the appropriate approval procedure.

If you are in any doubt, you are encouraged to submit an application to one of the University's ethics committees.

Does your Project involve any of the following?
(Please answer all questions. Please circle either YES or NO for each question)

Risk of Harm

1. Situations in which the researcher may be at risk of harm.	YES (NO)
2. Use of questionnaire or interview, whether or not it is anonymous which might reasonably be expected to cause discomfort, embarrassment, or psychological or spiritual harm to the participants.	YES (NO)
3. Processes those are potentially disadvantageous to a person or group, such as the collection of information which may expose the person/group to discrimination.	YES (NO)
4. Collection of information of illegal behaviour(s) gained during the research which could place the participants at risk of criminal or civil liability or be damaging to their financial standing, employability, professional or personal relationships.	YES (NO)
5. Collection of blood, body fluid, tissue samples, or other samples.	YES (NO)
6. Any form of exercise regime, physical examination, deprivation (e.g. sleep, dietary).	YES (NO)
7. The administration of any form of drug, medicine (other than in the course of standard medical procedure), placebo.	YES (NO)
8. Physical pain, beyond mild discomfort.	YES (NO)
9. Any Massey University teaching which involves the participation of Massey University students for the demonstration of procedures or phenomena which have a potential for harm.	YES (NO)

Informed and Voluntary Consent

10. Participants whose identity is known to the researcher giving oral consent rather than written consent (if participants are anonymous you may answer No).	YES (NO)
11. Participants who are unable to give informed consent.	YES (NO)
12. Research on your own students/pupils.	YES (NO)
13. The participation of children (seven (7) years old or younger).	YES (NO)
14. The participation of children under sixteen (16) years old where parental consent is not being sought.	YES (NO)
15. Participants who are in a dependent situation, such as people with a disability, or residents of a hospital, nursing home or prison or patients highly dependent on medical care.	YES (NO)
16. Participants who are vulnerable.	YES (NO)
17. The use of previously collected information or biological samples for which there was no explicit consent for this research.	YES (NO)

Privacy/Confidentiality Issue

18. Any evaluation of Massey University services or organisational practices where information of a personal nature may be collected and where participants may be identified.	YES (NO)

Deception

19. Deception of the participants, including concealment and covert observations.	YES (NO)

Conflict of Interest

20. Conflict of interest situation for the researcher (e.g. is the researcher also the lecturer/teacher/treatment-provider/colleague or employer of the research participants or is there any other power relationship between the researcher and research participants?)	YES (NO)

Compensation to Participants

21. Payments or other financial inducements (other than reasonable reimbursement of travel expenses or time) to participants.	YES (NO)

Procedural

22. A requirement by an outside organisation (e.g. a funding organisation or a journal in which you wish to publish) for Massey University Human Ethics Committee approval.	YES (NO)

Part B

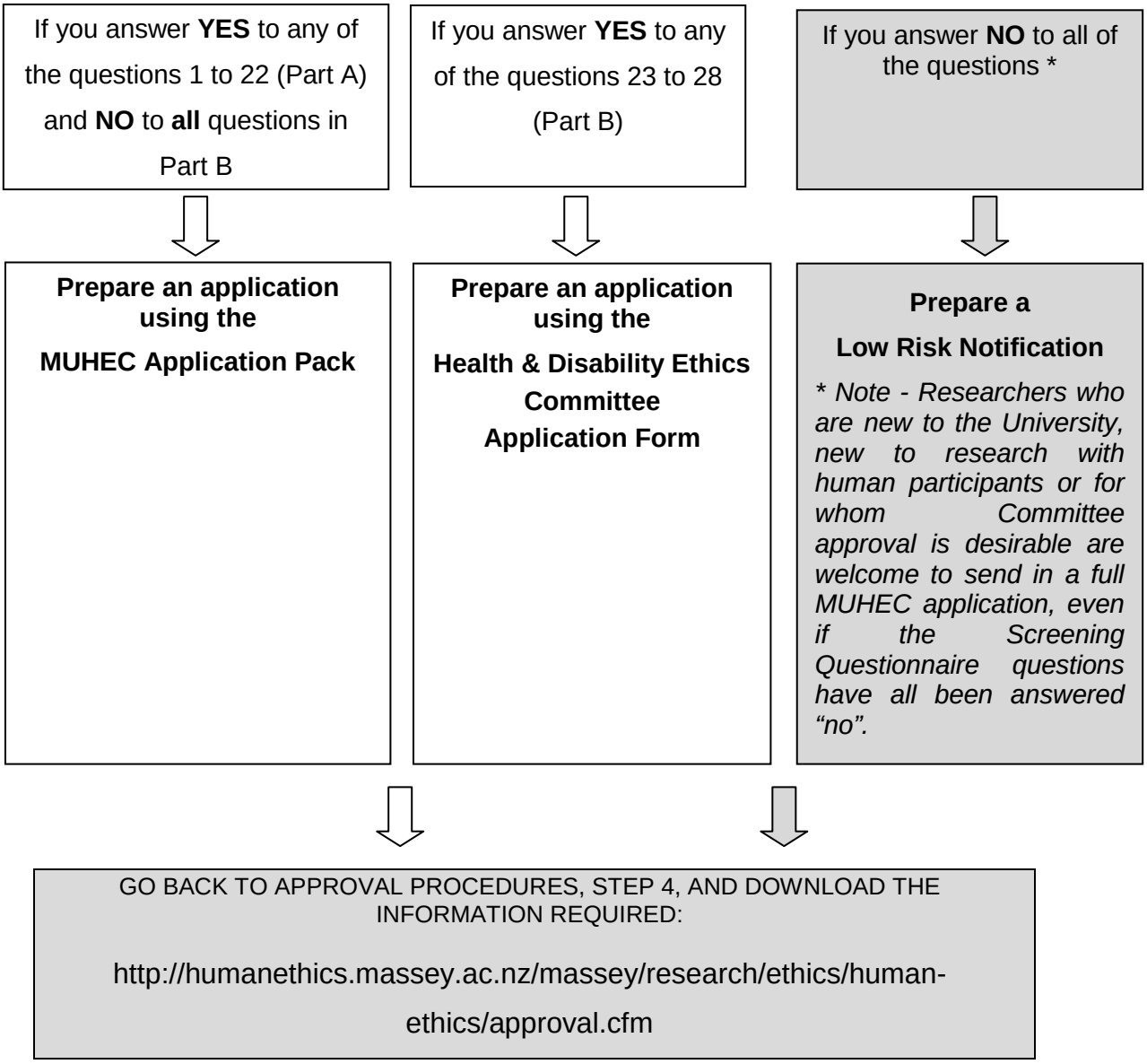
The statements below are being used to determine if your project requires ethical approval by a Regional Health and Disability Ethics Committee. The statements are derived from the document, "Guidelines for an Accredited Institutional Ethics Committee to Refer Studies to an Accredited Health and Disability Ethics Committee" prepared by the Health Research Council Ethics Committee.
(http://www.hrc.govt.nz/assets/pdfs/policy/ReferralGuidelines.pdf)
In situations where you are not sure whether the research needs approval by an HDEC, you should seek an opinion from the Administrator of the relevant HDEC.
(http://www.newhealth.govt.nz/ethicscommittees/)
Include a copy of your written response from the Administrator with your application.

Does your Project involve any of the following?

(It is important that you answer all questions. Please circle either YES or NO for each question)

23. The use of staff or facilities of a health provider.	YES (NO)
24. Support, directly or indirectly, in full or in part, by public health funds.	YES (NO)
25. Participants who are patients/clients of, or health information about an identifiable individual held by, an organisation providing health services (for example, general practice, physiotherapy, occupational therapy, sports medicine), disability services, or institutionalised care.	YES (NO)
26. Requirement for ethical approval to access health or disability information about an identifiable individual held by the Ministry of Health, or held by any public or private organisation whether or not that organisation is related to health.	YES (NO)
27. A clinical trial which: requires the approval of the Standing Committee on	
28. Therapeutic Trials; requires the approval of the Gene Technology Advisory Committee; is sponsored by and/or for the benefit of the manufacturer or supplier of a drug or device.	YES (NO)
29. Research in categories 23-27 involving New Zealand agencies, researchers or funds and undertaken outside New Zealand.	YES (NO)

Determine the type of approval procedure to be used (choose one option):



Appendix 3: Low Risk Notification for Research Involving Human participants

Massey University
Te Kunenga ki Pürehuroa

NOTIFICATION OF LOW RISK RESEARCH/EVALUATION INVOLVING HUMAN PARTICIPANTS

(All notifications are to be typed)
(Do not modify the content or formatting of this document in any way)

SECTION A:

1. **Project Title** Participatory practices in occupational safety and health in small businesses
   Projected start date for data collection December 2008 **Projected end date** December 2009

2. **Applicant Details** *(Select the appropriate box and complete details)*

ACADEMIC STAFF NOTIFICATION

Full Name of Staff Applicant/s

School/Department/Institute

Region *(mark one only)* **Albany** [ ] **Palmerston North** [√] **Wellington** [ ]

Telephone **Email Address**

STUDENT NOTIFICATION

Full Name of Student Applicant Bikram Raj Pandey

Postal Address 3/18 Douglas Street, West End, Palmerston North 4412

Telephone 354 7855 **Email Address** bikram_pandey@hotmail.com

Employer (if applicable)

Full Name of Supervisor(s) Dr. Ian Laird

School/Department/Institute Department of Management

Region *(mark one only)* **Albany** [ ] **Palmerston North** [√] **Wellington** [ ]

Telephone 350 5799 **Email Address** I.S.Laird@massey.ac.nz

GENERAL STAFF NOTIFICATION

Full Name of Applicant

Section

Region *(mark one only)* **Albany** [ ] Palmerston North [ ] **Wellington** [ ]

Telephone **Email Address**

Full Name of Line Manager

Section

Telephone **Email Address**

3. Type of Project *(mark one only)*

Staff Research/Evaluation:		***Student Research:***		***If other, please specify:***	
Academic Staff		***Qualification***	√		
General Staff		***Credits Value of Research***	***120***		

4. Describe the process that has been used to discuss and analyse the ethical issues present in this project.
(Please refer to the Low Risk Guidelines on the Massey University Human Ethics Committee website)

- This notification is for a pilot study to be undertaken prior to a more comprehensive study to be conducted later.
- The ethical issues related to human participants in the research have been discussed with the research supervisors, peers and other researchers.
- The research aims and objectives have been presented and discussed in research presentation forums - mainly a Student Research Conference on Work on 29th May, 2008 in Rotorua and a forum at the Centre for Ergonomics, Occupational Safety and Health, CErgOSH in the Department of Management, Massey University.
- For the present pilot study, the screening questionnaire has been completed and a low risk assessment has been made.
- An application for ethical approval will be submitted for the more comprehensive study in March 2009.

5. Summary of Project
Please outline the following (in no more than 200 words):

1. **The purpose of the research**
   This notification is for a pilot study for a subsequent more comprehensive study that will investigate occupational safety and health participatory practices amongst small businesses in New Zealand. The purpose is the development of an assessment tool. More specifically it is to check whether the interview questions being developed are consistent in eliciting reliable responses from participants and to determine if the questions are appropriate for acquiring the responses that will allow the research questions to be answered.
2. **The Research methods**
   The owner/manager and at least one full time employee from three small businesses selected from the restaurants and cafe sector of class H451 of the Australia and New Zealand System of Industrial Classification (ANZSIC) will be asked to participate in a semi structured interview. Questions will ask about the health and safety problems at their work or workplace, the causal factors, acceptance on doing something about the problem and subsequent actions. The responses from the participants will be treated confidentially and the anonymity of the respondents will be maintained.

   The responses from the manager and the employee(s) of the participating business will be treated as one set of data. The data will be subjected to content analysis to identify the commonality on understanding between the manager and employee(s) on health and safety issues identified. The content analysis will be followed by an examination of the reasons why the action is undertaken and the processes of how it is undertaken. The anonymity of the respondents will be maintained throughout the process of data analysis.

(Note: ALL the information provided in the notification is potentially available if a request is made under the Official Information Act. In the event that a request is made, the University, in the first instance, would endeavour to satisfy that request by providing this summary. Please ensure that the language used is comprehensible to all)

Please submit this Low Risk Notification
(<u>With the completed Screening Questionnaire</u>) to:

The Ethics Administrator
Research Ethics Office
Old Main Building, PN221
Massey University
Private Bag 11 222
Palmerston North

SECTION B: DECLARATION (*Complete appropriate box)*

ACADEMIC STAFF RESEARCH

Declaration for Academic Staff Applicant

I have read the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants. I understand my obligations and the rights of the participants. I agree to undertake the research as set out in the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants. My Head of Department/School/Institute knows that I am undertaking this research. The information contained in this notification is to the very best of my knowledge accurate and not misleading.

Staff Applicant's Signature ..... Date: .....

STUDENT RESEARCH

Declaration for Student Applicant

I have read the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants and discussed the ethical analysis with my Supervisor. I understand my obligations and the rights of the participants. I agree to undertake the research as set out in the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants. The information contained in this notification is to the very best of my knowledge accurate and not misleading.

Student Applicant's Signature Bikram Raj Pandey Date: 15/01/2009

Declaration for Supervisor

I have assisted the student in the ethical analysis of this project. As supervisor of this research I will ensure that the research is carried out according to the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants.

Supervisor's Signature ..... Date: .....
Print Name Dr. Ian S. Laird

GENERAL STAFF RESEARCH/EVALUATIONS

Declaration for General Staff Applicant

I have read the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants and discussed the ethical analysis with my Supervisor. I understand my obligations and the rights of the participants. I agree to undertake the research as set out in the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants. The information contained in this notification is to the very best of my knowledge accurate and not misleading.

General Staff Applicant's Signature ..... Date: .....

Declaration for Line Manager

I declare that to the best of my knowledge, this notification complies with the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants and that I have approved its content and agreed that it can be submitted.

Line Manager's Signature ..... Date: .....
Print Name .....

Appendix 4: Information sheet for employees

CENTRE FOR ERGONOMICS, OCCUPATIONAL SAFETY AND HEALTH (CErgOSH)
Department of Management
Private Bag 11 222
Palmerston North
New Zealand
T 64 6 356 9099
F 64 6 350 5796
www.massey.ac.nz

Understanding Participation in Occupational Health and Safety Practices in Small Businesses

INFORMATION SHEET FOR EMPLOYEES

My name is Bikram Raj Pandey. I am a PhD student in the Department of Management, Massey University, Palmerston North, conducting research project on "understanding participation in occupational health and safety in small businesses". The research is supervised by Dr. Ian Laird, Senior Lecturer in the Centre for Ergonomics, Occupational Safety and Health, Massey University, Palmerston North.

I would like to invite you to take part in my study.

Your involvement

I would like to arrange an interview with you, which would last approximately 30 minutes. The interview would be conducted in work time, with the approval of your employer. It is possible that I may wish to arrange another interview with you at a later date. Participation is entirely voluntary (your choice) and you may withdraw from the study at any time. You will be given time to consider whether you wish to participate in the study. Your rights as a participant are explained in full below.

The project's aims

The aims of the research are to identify how OHS is managed in small businesses, and to understand how participation in OHS in small businesses works. Specifically, I would like to find out:

- What are the health and safety issues and how are they identified in the workplace?
- How are decisions on OHS issues made at work?
- How are OHS issues managed or controlled in your workplace?
- What involvement do staffs have in this process?
- What factors influence the process of managing hazards at work?

How we selected your business?

The study focuses on cafes and restaurants in the Central and Lower North Island. A letter of invitation was sent to the owner/manager of your business and this was

followed up by a telephone call to confirm participation in the study. The study aims to cover cafes and restaurants employing between 6-19 employees.

Collecting and storing information

With your approval, I would like to make a digital recording of our interview. The recording allows me future access and reference to your comments and responses to a range of questions about participation in health and safety in your workplace. This recording will be completely confidential. I will transcribe (write down) your responses after the interviews are complete. This information will be stored in locked cabinets in my office at Massey University.

Confidentiality and anonymity

As indicated, all the information obtained during the course of the interview will be kept confidential. I will ensure that you will not be able to be identified by allocating your written responses a personal code number, and the interview will be conducted in a manner (behind closed doors) that will prevent anyone else from overhearing your responses. All of the information (data) will be stored for a period of five years. After this time, if data destruction is appropriate, hard copies of all data will be shredded and computer files will be deleted.

Use of the information

Your responses to the interview questions will form the basis of the data that will be used for writing my thesis, and possibly at some future time, journal articles. At the completion of the study, the owner/manager of each business involved will be given a short report summarising the main findings of the study. As only summarised or grouped data will be included in the report, no individual(s) will be identified.

Participant's Rights

Your participation in this study is voluntary, meaning that you are under no obligation to accept this invitation. If you do decide to participate, you have the right to:

- Decline to answer any particular question or set of questions
- Withdraw from the study at any time,
- Decline to have your responses recorded
- Ask any questions about the study at any time during participation,
- Anonymity and confidentiality being maintained in reporting and presentation of information and results of the study.
- Provide information on the understanding that your name will not be used unless you give permission to the researcher;
- Be given access to a summary of the project findings when it is concluded

Project Contacts

If you have further questions regarding the present study, please do not hesitate to contact:

Bikram Pandey Centre for Ergonomics, Occupational Safety and Health Department of Management Massey University Private Bag 11 222 Palmerston North Telephone: +64 6 350 5799 ext 7532 Email: B.R.Pandey@massey.ac.nz or bikram_pandey@hotmail.com	*OR*	Dr. Ian Laird Centre for Ergonomics, Occupational Safety and Health Department of Management Massey University Private Bag 11 222 Palmerston North Telephone: +64 6 356 9099 ext 2377 Fax: +64 6 3505661 Email: I.S.Laird@massey.ac.nz

Compulsory Statements

MUHEC APPLICATIONS

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 09/19. If you have any concerns about the conduct of this research, please contact Dr Karl Pajo, Chair, Massey University Human Ethics Committee: Southern B, telephone 04 801 5799 x 6929, email humanethicsouthb@massey.ac.nz.

Appendix 5: Areas of enquiry and general probes for semi-structured interviews

General background

Type of business:
Position of the respondent:
Age of the respondent:
Gender of the respondent:
Ethnicity of the respondent:
Number of years in business:
Number of staff

Permanent, full time:
Permanent, part time:
Casual, full time:
Casual, part time:
Family members or other relatives:

Areas of enquiry and general probes

Work environment in general

Briefly job responsibilities,
The good thing about working in this place,
Things that are working well in the workplace,
Things that is not working well in the workplace,
Issues that are of concern in the workplace,

Work environment hazards and risks

Any occupational health and safety area of concern,
The reason for the concern,
Potential OHS risks at your work that is of concern,
Hazards and risks that could be eliminated,
Hazards and risks that should be eliminated,
Possible causes of hazards and health and safety risks.

Practice of identification and control of these hazards and risks

Process of identifying hazards and health and safety risks,
Identifying the causes behind hazards and risks,
Possible effects of OHS risks,
Addressing potential hazards and OHS risks,

Involvement from the owner/manager and employees in these practices

The individuals' involvement in addressing the concerns,
Any incident or accident that has happened previously,
The cause of the incident,
The effect/result of the incident,
Action taken to prevent recurrence of the incident,
The drive behind the action,

Appendix 6: Participant Consent Form for owner/managers

CENTRE FOR ERGONOMICS, OCCUPATIONAL SAFETY AND HEALTH (CErgOSH)
Department of Management
Private Bag 11 222
Palmerston North
New Zealand
T 64 6 356 9099
F 64 6 350 5796
www.massey.ac.nz

Understanding Participation in Occupational Health and Safety Practices in Small Businesses

PARTICIPANT CONSENT FORM FOR OWNERS/MANAGERS

This consent form will be held for a period of five (5) years

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree that my participation in the interview is completely voluntary.

I agree to participate in this study under the conditions set out in the Information Sheet.

I agree to have my employees interviewed.

Signature: ..... **Date:** .....

Full Name - printed .....

Appendix 7: Participant Consent Form for Employees

CENTRE FOR ERGONOMICS, OCCUPATIONAL SAFETY AND HEALTH (CErgOSH)
Department of Management
Private Bag 11 222
Palmerston North
New Zealand
T 64 6 356 9099
F 64 6 350 5796
www.massey.ac.nz

Understanding Participation in Occupational Health and Safety Practices in Small Businesses

PARTICIPANT CONSENT FORM FOR EMPLOYEES

This consent form will be held for a period of five (5) years

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree that my participation in the interview is completely voluntary.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: ..... **Date:** .....

Full Name - printed .....

Appendix 8: Interview guide – Areas of enquiry for semi-structured interview

The working environment

- The things that are working well
- The reason for it working well
- The things that are not working well
- The reasons for it not working well
- The things that you like most about your workplace
- The thing that you like least about your workplace
- OHS hazards in the workplace
- Associated risks in the workplace

Hazards and risks in the workplace

- Most concerning OHS hazard
- Most concerning OHS risks
- The reason for them being most concerning
- The causes of hazards and risks
- Anything that concerns you but not an OHS hazard or risk

Identification and control of hazards and risks

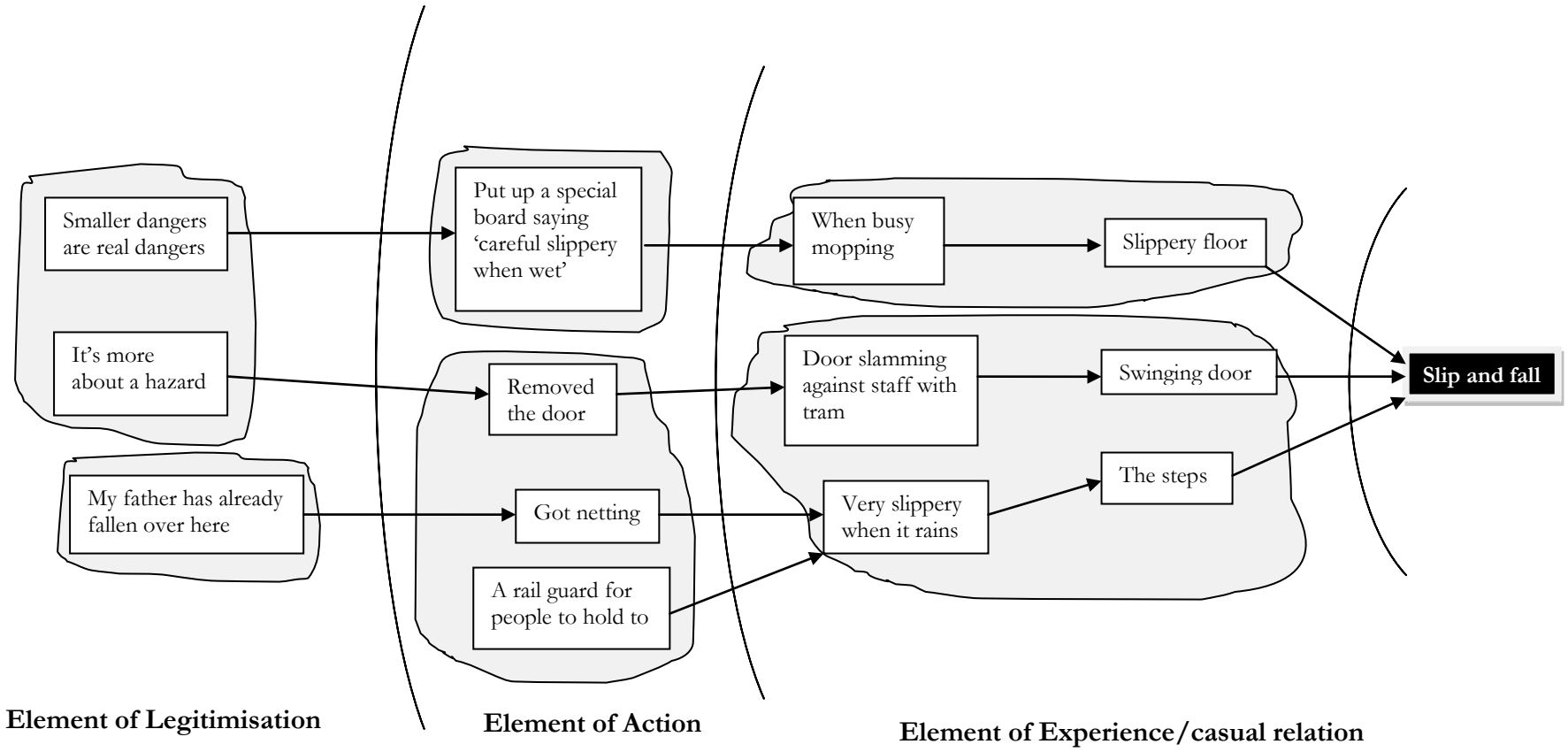
- The way OHS hazards and risks are identified
- The way hazards and risks are identified to other people
- People involved in identifying hazards and risks
- Incident that has occurred
- The possible causes behind the incidents
- The normal way of keeping the workplace safe
- Action on hazards and risks once they are identified

Employer's employee's participation

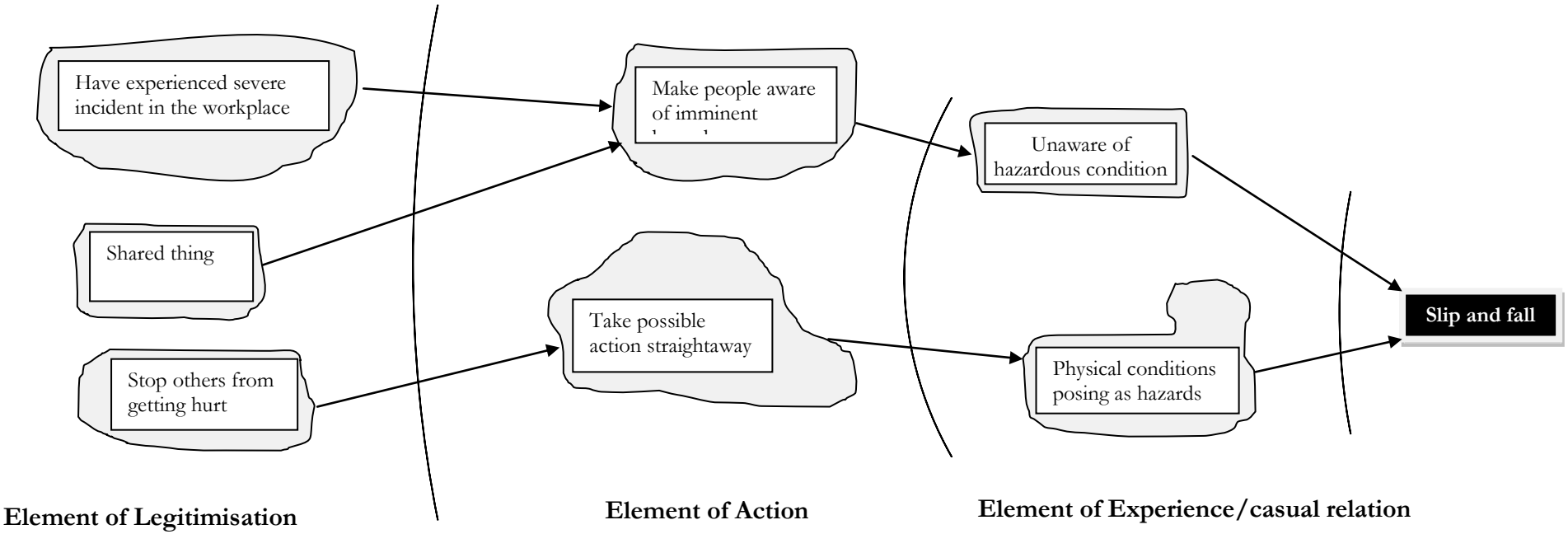
- The actions taken after an incident
- Action taken to prevent recurrence of the incident
- The way particular hazards and risks are controlled
- The people involved in these actions
- The way owner/manager is involved
- The things that are normally discussed in the work environment
- The things that are not discussed normally
- Any OHS hazards and risks brought up and discussed
- The reason for not discussing these things

Appendix 9: Network diagram for the four elements of LTWE – Case 1

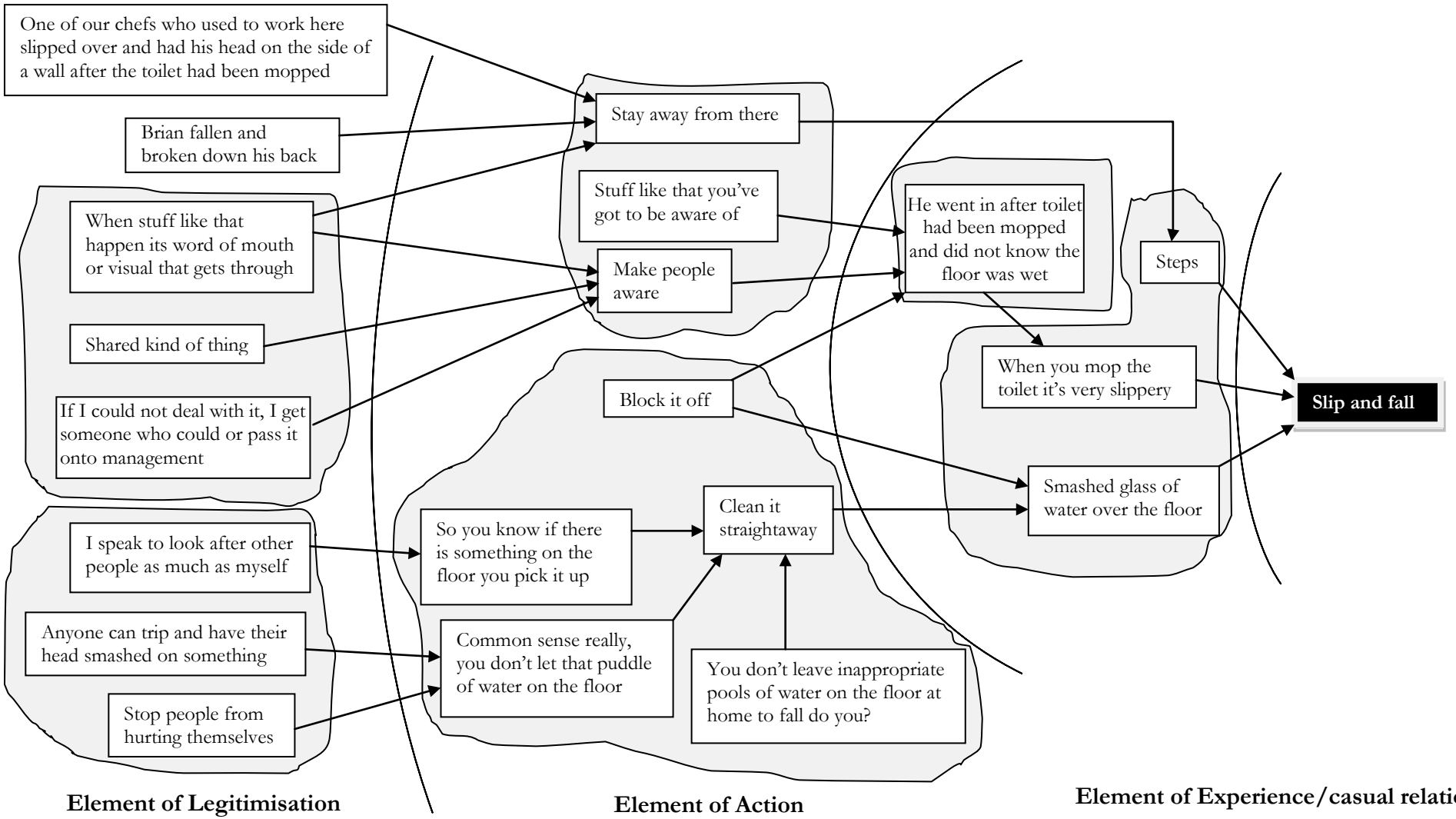
A. Initial coding - Employer



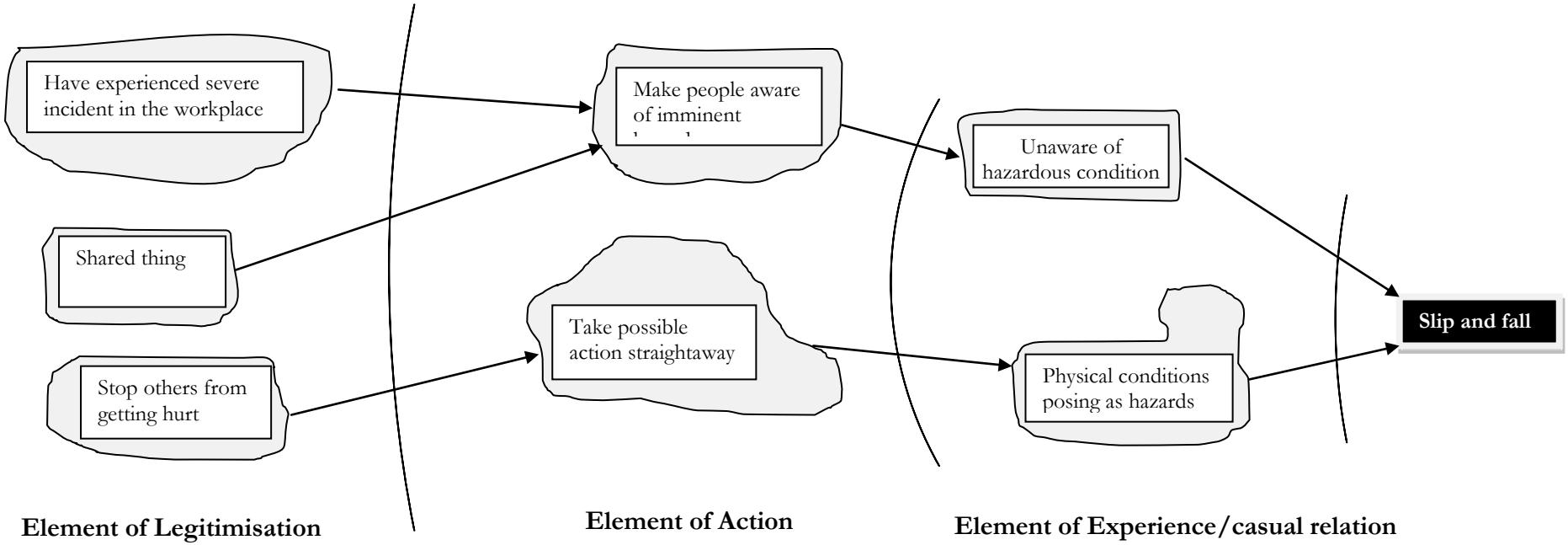
B. Developing categories - Employer



C. Initial coding - Employees

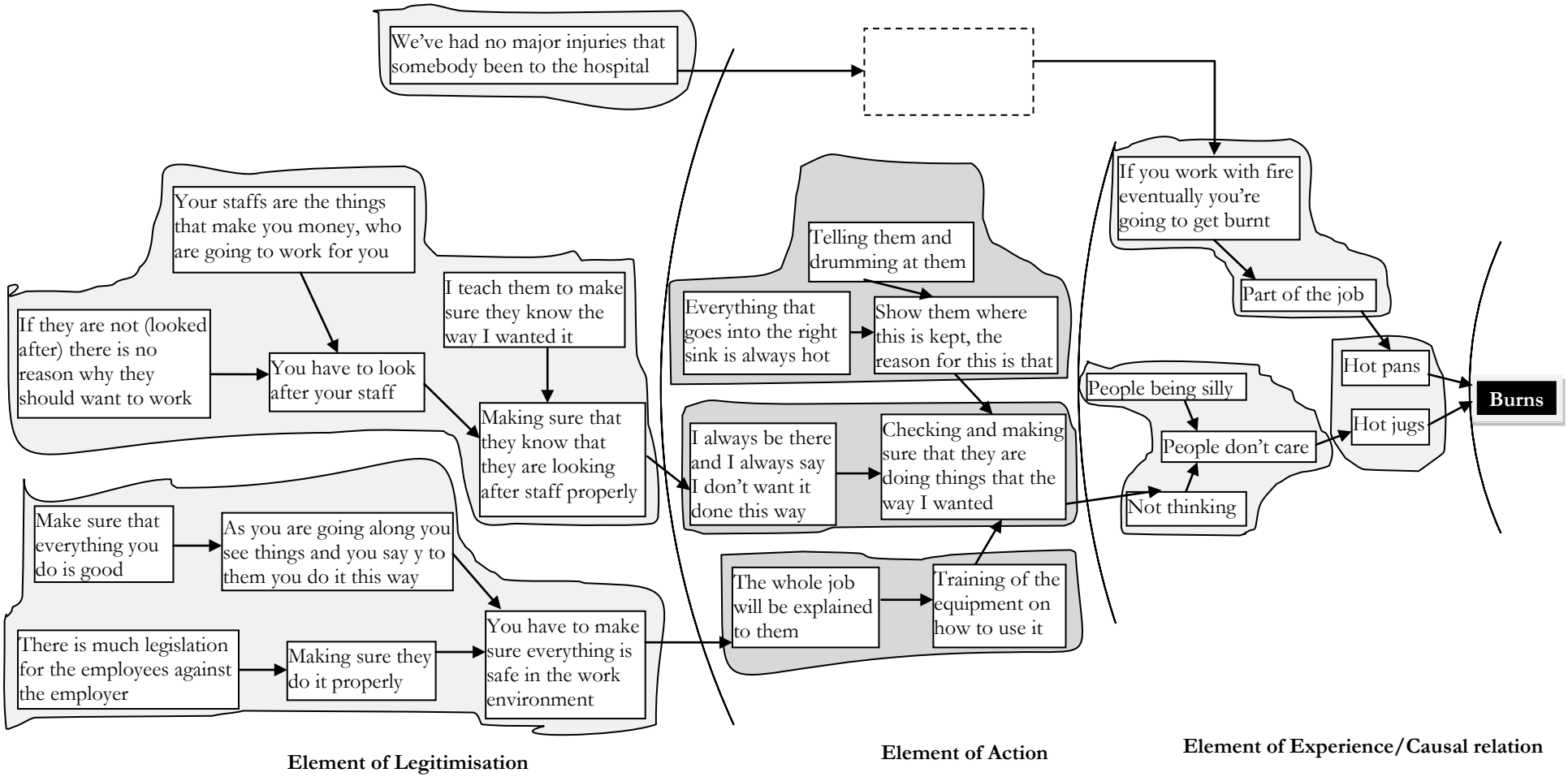


D. Developing categories - Employees

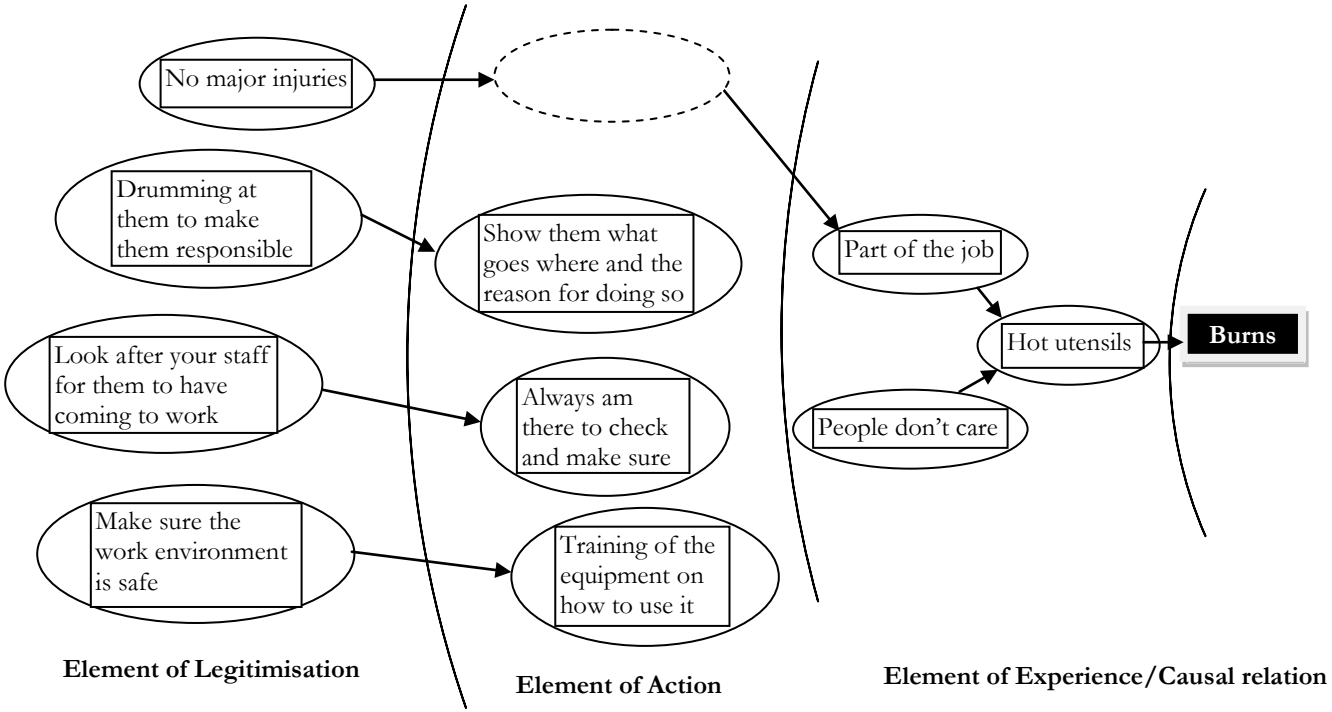


Appendix 10: Network diagram for the four elements of LTWE – Case 2

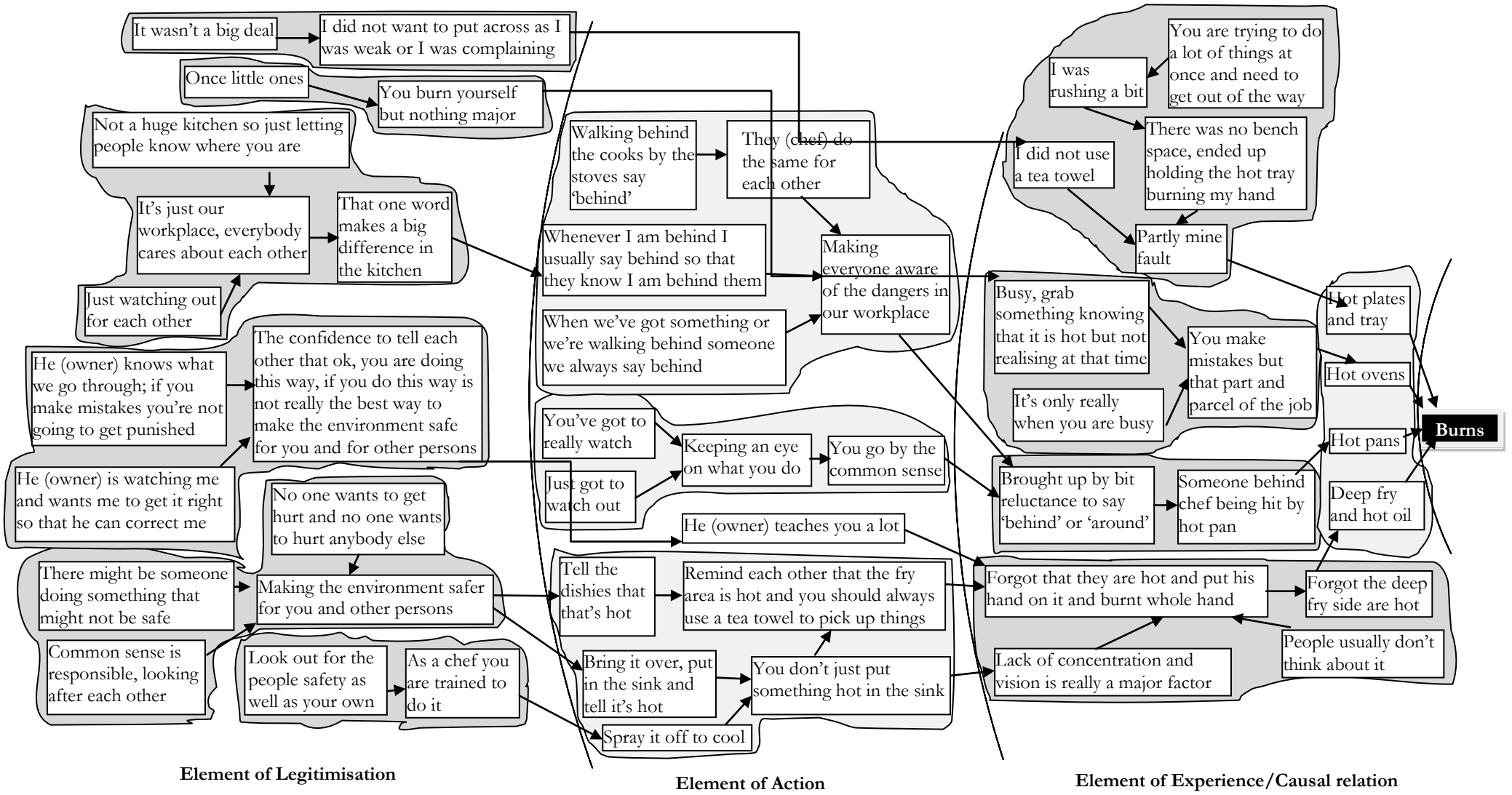
A. Initial coding – Owner/manager



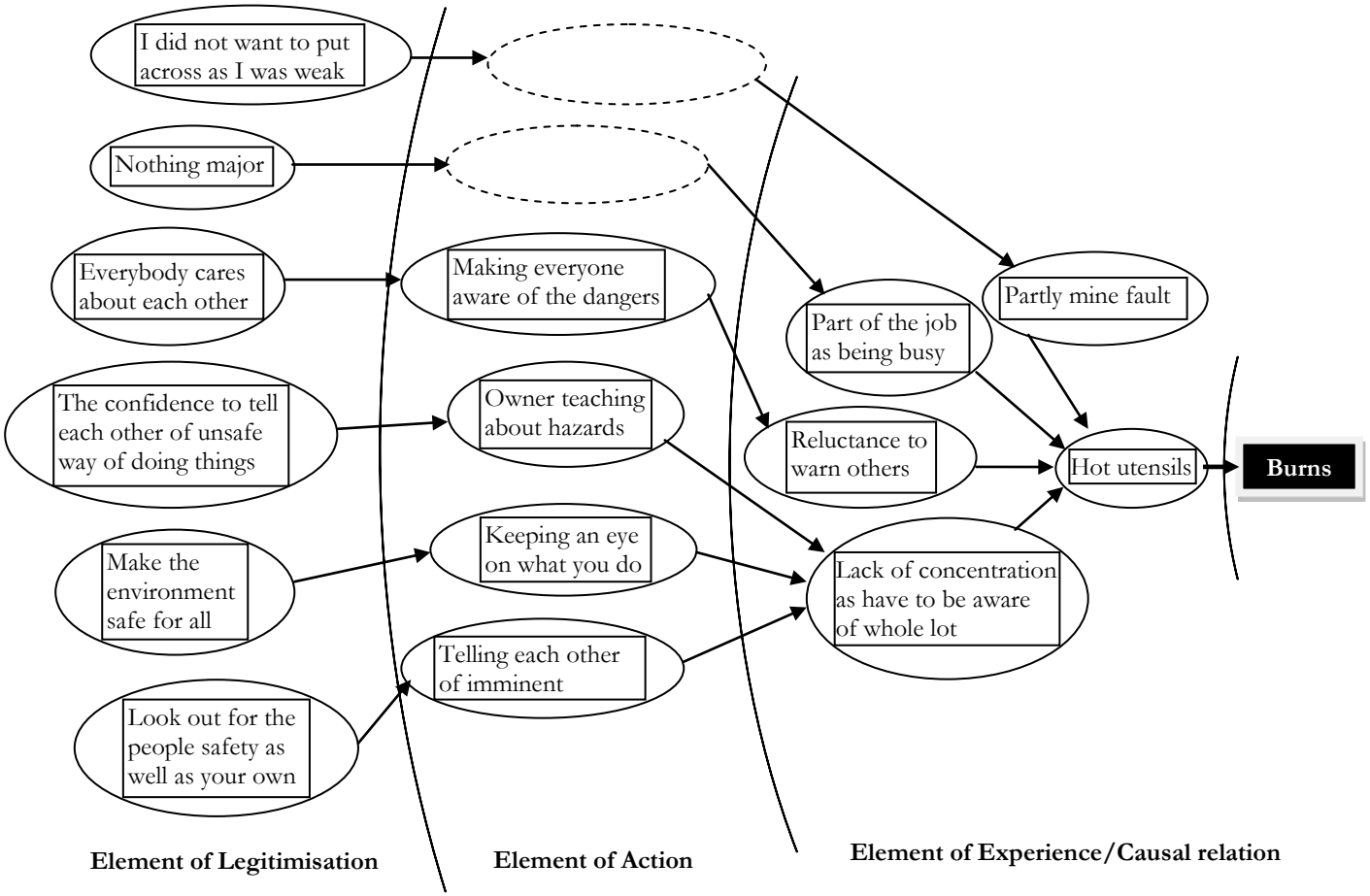
B. Developing categories – Owner/manager



C. Initial coding - Employees

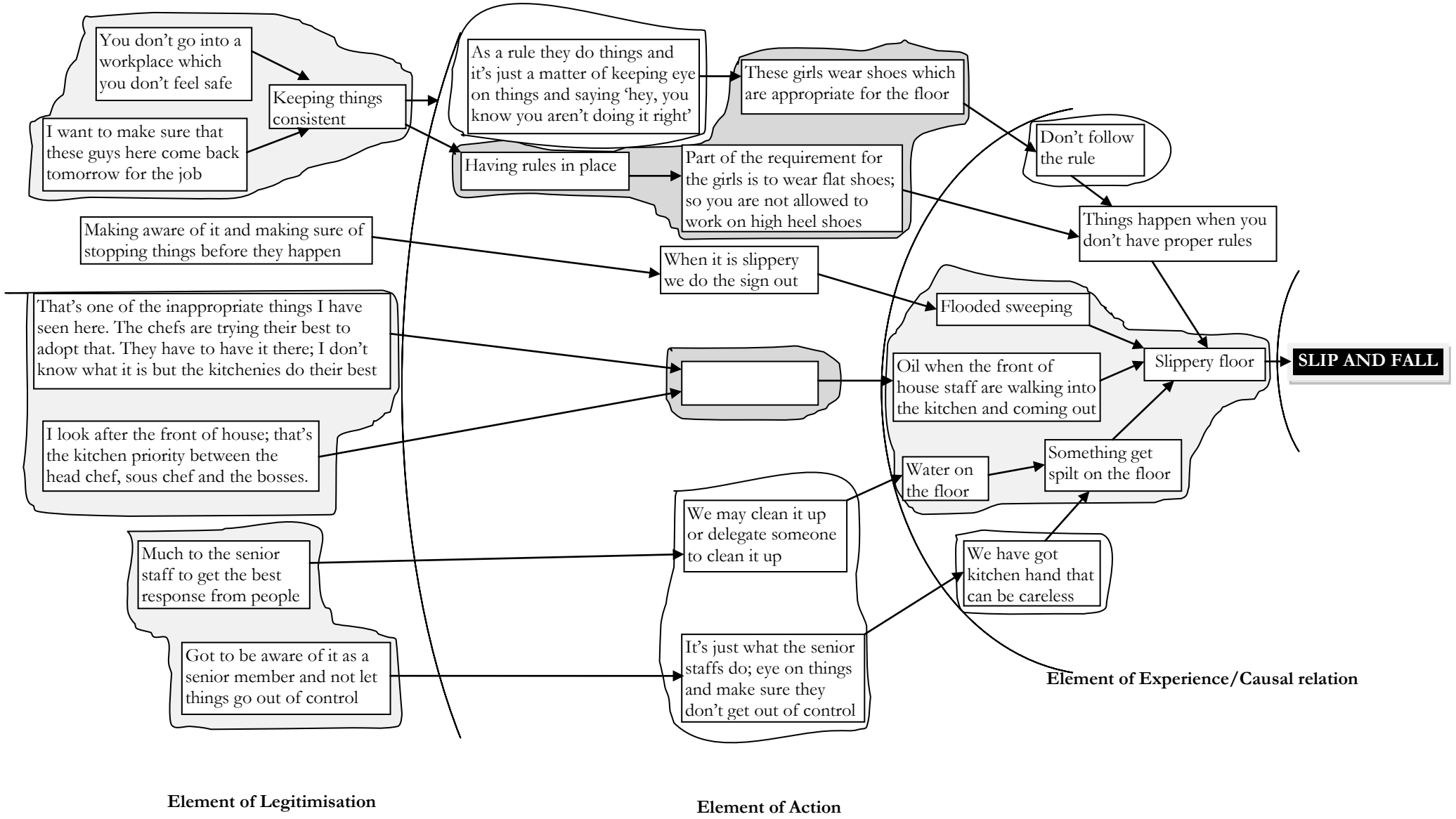


D. Developing categories – Employees

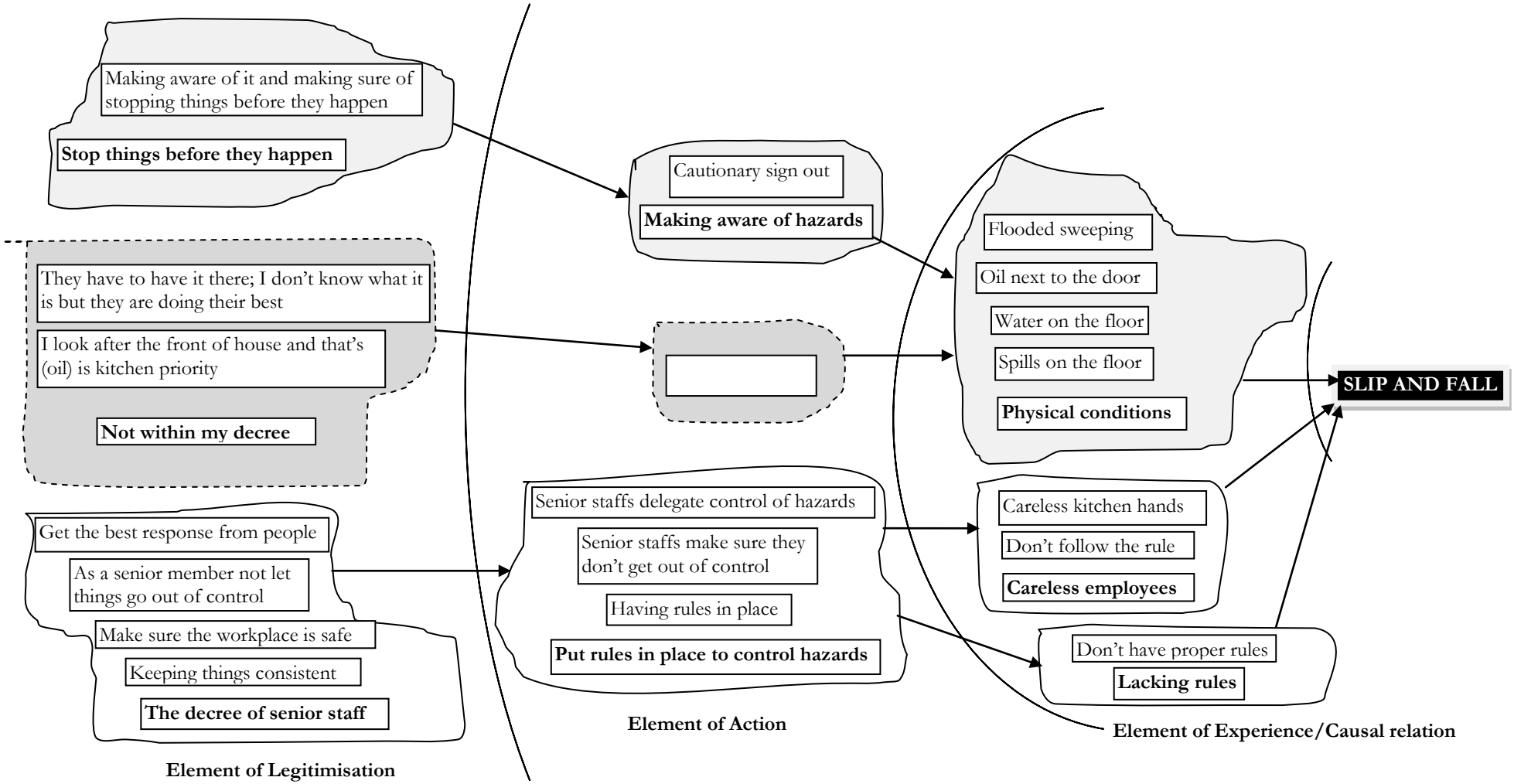


Appendix 11: Network diagram for the four elements of LTWE – Case 3

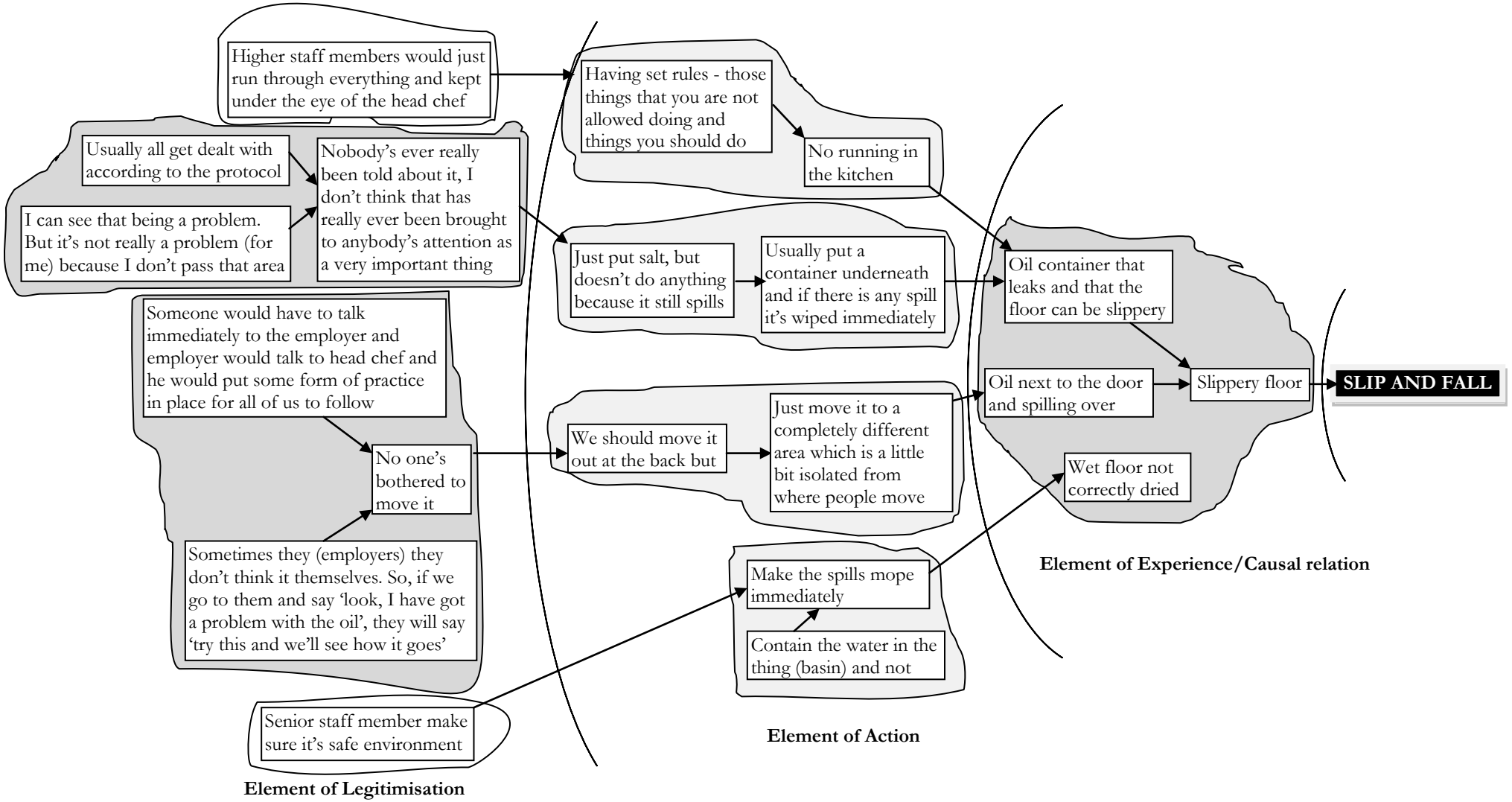
A. Initial coding – Owner/managers



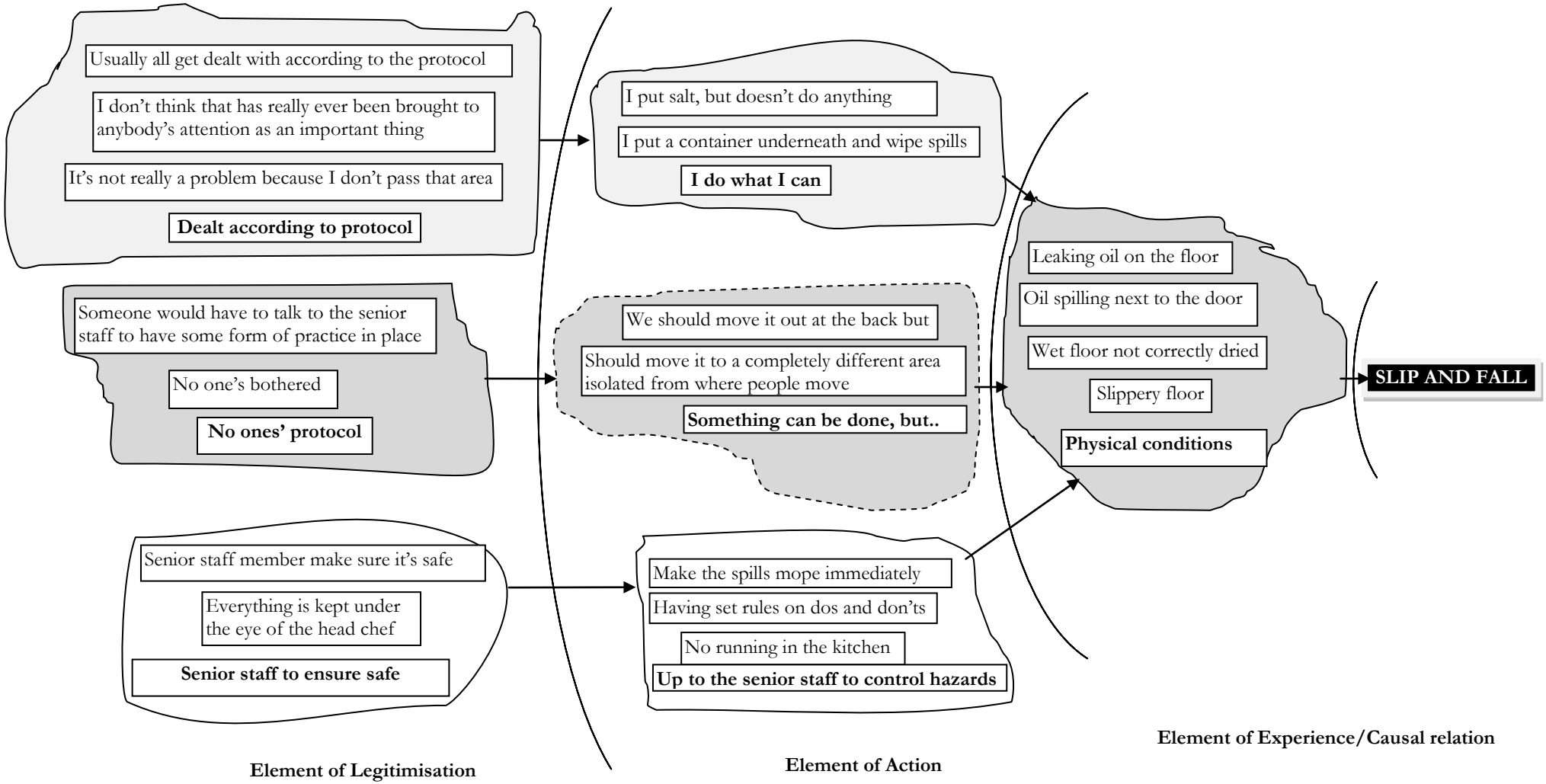
B. Developing categories – owner/managers



C. Initial coding - employees



D. Developing categories - employees



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