Chapter 9
Physical and Psychosocial Safety Climate Among Malaysian Healthcare Workers: A Qualitative Study

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Abstract The importance of organisational context in shaping employee outcomes and motivation has been studied over many years. Psychosocial Safety Climate (PSC) is proposed as the crucial element for building a psychologically safe environment. However, the literature describing PSC has been mostly derived from quantitative data. Yet, some unavoidable disadvantages of quantitative data approaches might limit our full understanding of the role of PSC and how it helps to protect employees. The current study aims to investigate the phenomenon of PSC among Malaysian healthcare employees by determining how the level of PSC influences their resource utilisation in coping with their job demands and psychological health issues. By using semi-structured interviews, the current study reveals that high levels of PSC encourage employees to retrieve more resources from their working environments and also personal lives. This can be explained as PSC acting as a resource ecology, which helps in creating resources caravan (i.e., a collection of resources). The findings provide additional support for the crucial role of promoting high PSC in healthcare settings.

Keywords Psychosocial safety climate · Resources · Healthcare setting · Qualitative research

9.1 Introduction

Psychosocial safety climate (PSC) is a concept closely related to Zohar's safety climate (Dollard & Bakker, 2010; Zohar, 1980). Safety climate refers to the shared perception of employees regarding (physical) safety related policies, practices, and procedures of an organisation. PSC is similarly defined but focally concerned with

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M. F. Dollard et al. (eds.), *Psychosocial Safety Climate*,
https://doi.org/10.1007/978-3-030-20319-1_9

worker psychological health. Although both constructs address safety, they are different in several respects including their theoretical frameworks and targeted outcomes. While safety climate is strongly associated with safety outcomes (e.g., injuries and accidents) and physical health, PSC researchers are more interested on psychological strains including burnout and depression. Due to its nature in focusing on physical health and safety arising from physical hazards, hence we use the term 'physical safety climate' in this chapter. Theoretically, similar to physical safety climate (Zohar, 2010), PSC is conceived as a social cue that signals, (1) the kinds of psychosocial work conditions (cf. physical hazards) to be experienced in the future, and (2) the kinds of employee behaviours that will be rewarded and supported (e.g., teamwork), or sanctioned (e.g., bullying behaviour). Moreover, high PSC levels provide cues that it is a psychologically safe environment for employees to utilise resources (Law, Dollard, Tuckey, & Dormann, 2011). Nonetheless, most of the studies on physical safety climate and PSC focus on self-reported questionnaires, yielding quantitative evidence (Idris, Dollard, & Tuckey, 2015; McCaughey, DelliFraine, McGhan, & Bruning, 2013; Yulita, Dollard, & Idris, 2017; Zadow, Dollard, McLinton, Lawrence, & Tuckey, 2017), but lack detailed information on how exactly safety climate (i.e., both physical and psychosocial) is reflected in workplaces. Hence, the current study aims to investigate safety climate, specifically PSC among Malaysian healthcare workers using a qualitative study design.

Compared to quantitative research, a qualitative design allows us: (1) to have more open and deeper exploration on any possible variables beyond the proposed theoretical frame; and (2) to understand the unique experience of employees in their working environment. Thus, we conceive that by using a qualitative design, this study can contribute to the literature in several aspects. This is the first study using qualitative methods to understand how physical and psychosocial safety climate are perceived and reflected in a Malaysian healthcare workplace. Research has revealed that service-line workers, especially healthcare workers are most vulnerable to workplace safety and health issues (Trade Union Congress, 2018). The stressful work context of healthcare workers is also identified in a global report of country-based case studies by the International Labour Organization (ILO) which found that healthcare workers are exposed to long working hours, double shift work, extra duties, and personnel shortages (Messenger & Vidal, 2015). Authoritative policy influencers have also highlighted the importance of providing support and resources due to the tremendous increase in the need of healthcare professionals (World Health Organization, 2016). In addition, evidence from developing countries is limited (International Labour Organization, 2016). Although researchers have shown increased interest in workplace safety issues in recent times as response to these calls, despite psychosocial risks in the workplace not being considered a management priority due to the imperatives of productivity and economic growth.

While PSC, as well as physical safety climate, have been developed within Western-based cultures, there is little research conducted to cross-validate the PSC model and its theoretical constructs across different cultures. Only one cross-cultural study between Malaysia and Australia tested physical safety climate and PSC simultaneously and revealed that the level of physical safety climate is higher than the PSC

in both countries (Idris, Dollard, Coward, & Dormann, 2012). However, since this research used quantitative data, there are inevitable limitations. First, since the development of the PSC scale was conducted in a Western-based culture, it may suffer from a degree of cultural response bias. Indeed, researchers have argued that perceptions at work may vary across cultures (Iwata, 2014). Empirically, some studies have shown that theoretical models of work related concepts may not be consistent while testing within a non-Western background (Bahari & Clarke, 2013). Secondly, quantitative data may not be able to capture the complexity of the nature of work and unique experience of the individuals involved. Consequently, in this study we adopt a qualitative design to reduce the bias and provide more knowledge on the differences of cultural influence (Spector, Liu, & Sanchez, 2015).

Next, as we are interested in the effect of social cues on employees' behaviours and coping strategies, we compare the role of resources utilisation in reducing psychosocial problems between workers experiencing high versus low PSC. Generally, there are four types of resources, namely condition resources (e.g., social support at work), personal resources (e.g., personal skills), energy resources (e.g., technical knowledge), and object resources (e.g., utilities provided at work). According to the conservation of resources (COR) theory (Hobfoll, 2011, 2014), resources would tend to connect and link with one another, forming a resource caravan while a positive environment or resources ecology could enhance this formation by accumulating resources and encouraging the utilisation of the resources. Hobfoll (2014) termed the resource ecology as the resource caravan passageway. Hence, by comparing the PSC level, this will allow us to better understand how exactly PSC works to create a resource ecology in reducing the onset of psychological health.

9.2 PSC as a Resource Ecology

Similar to physical safety climate, PSC is considered a shared perception of workers on the extent to which an organisation or a work team protects and supports worker's psychological health to avoid work stress (Dollard & Bakker, 2010, p. 580). It suggested that work stress is an outcome from distal influences in the external environment including organisational policies, management practices, and the specific design of a job (Zadow & Dollard, 2016). PSC theory has posited two main functions of PSC which have been supported by empirical evidence. The first function is the main effect of PSC as the precursor of worker's health and motivation. So far empirical studies on PSC have found at least three pathways between PSC and its outcomes, such as exhaustion, injuries, performance, etc. (Dollard, Dormann, & Idris, 2019, Chap. 1, this volume). First, PSC as the direct influence on the social-related issues such as bullying. Secondly, PSC influences job performance, emotional exhaustion, work engagement, physical health problems via job design (Idris & Dollard, 2011; Yulita et al., 2017). In addition, PSC also improves safety behaviours (Bronkhorst, 2015; Bronkhorst & Vermeeren, 2016) and reduces workplace injuries (Zadow et al., 2017) through emotional exhaustion. The second function of PSC

works as a moderator to buffer the detrimental impact of demands and as a resources network that accumulates other resources (Bronkhorst, 2015; Dollard, Tuckey, & Dormann, 2012; Hall, Dollard, Winefield, Dormann, & Bakker, 2013). Of the interest in current study, we focus on the role of PSC in influencing resource utilisation among Malaysian healthcare workers.

In general, there are two mechanisms which can be used to explain the process of PSC in encouraging resources usage at the workplace, namely safety signal theory (Lohr, Olatunji, & Sawchuk, 2007) and resources caravan passageway of the COR theory (Hobfoll, 2014). For the former, several studies on PSC revealed that PSC provides a social hint to employees on their security to utilise resources at workplaces (Dollard, 2012). Comparatively, Loh, Idris, Dollard, and Isahak (2018) argue that PSC is a 'resource caravan passageway' which encourages the formation of a resources caravan in other words, the accumulation and linking of resources. Despite different theories used to explain the phenomenon, both mechanisms suggest that a high PSC context may allow greater resource usage. The notion about resources caravan and resources caravan passageway has so far been little studied especially in relation to PSC, hence it requires further exploration.

9.3 Healthcare Workplaces in Malaysian Context

Malaysia is a unique country located in South East Asia. Compared with other South East Asian countries, Malaysia is a Muslim dominated population. Although religion is valued and Islam is the official religion, other religions are also accepted. The uniqueness of Malaysia also includes its multi-ethnicity and multi-cultural society. Generally, Malaysia consists of three main ethic groups, including Malays, Chinese, and Indians. Malays, who are mostly practising Islam, form the majority of the society. However, even though Malay and Islam culture is the dominant culture of Malaysia, as a Commonwealth country, Malaysia is largely influenced by the British-based common law and some Western cultures. Similar to some Western countries such as Canada, United Kingdom, and the United States, the Malaysian healthcare system has a two-tier healthcare structure which comprises the government and private healthcare system.

Whilst a shortage of staff and high levels of occupational health problems occur among Malaysian healthcare workers, there has been little attention given to investigating the organisational context within Malaysian healthcare workplaces. In addition, research in Malaysia seems to have overlooked the role of safety climate especially PSC among healthcare workers, despite the salience of safety climate as an antecedent and key ingredient of safety intervention (Bronkhorst, Tummers, & Steijn, 2018). PSC may well be the external context that builds up a resources pool to help workers reduce the effect of the emotionally demanding healthcare workplace where workers often deal with negative emotions from patients and to protect these healthcare workers from exhausting themselves, not only physically but psychologically. In addition to develop a group norm of importance of psychological health

(Bronkhorst et al., 2018). Some studies adopting a multilevel approach to measure safety climate and/or PSC in Malaysia have not focused on healthcare workplaces as their sample (Bahari & Clarke, 2013; Idris et al., 2015; Yulita et al., 2017). Despite the numbers of studies conducted among healthcare settings, concern remains when the issues of staff shortage and work overload are chronic. In addition, it is found that healthcare workers, around the world, are suffering with high risks of work injuries. Considering the importance of investigating the safety climate in healthcare settings (Dollard & McTernan, 2011), we generate two research questions in current study:

(1) What is the healthcare workers perception towards the current physical and psychosocial safety climate within Malaysian healthcare workplaces?
(2) What are the differences in employees' resources utilisation in dealing with psychosocial risks between high and low PSC contexts?

9.4 Method

9.4.1 Participants

This study largely used a qualitative interview design. Participants were recruited by using purposive random sampling. After permission was obtained from the top management of the hospital and the head nurses of the respective workgroups, the first author randomly approached the nurses or nursing assistants who were working in the workgroup. Details and purpose of the study were explained to the employees and they were invited to participate. An appointment was made to conduct the interview at a later time. Semi-structured interviews were conducted with 18 healthcare workers including 16 nurses and 2 nursing assistants. Ethical approval was obtained from the Medical Centre Research Ethics Committee of the participatory hospital.

9.4.2 Interview Process

A semi-structured interview was conducted by the first author in a meeting room with each participant. Prior to the interview, the participants were given an information sheet related to the study and also an informed consent form. The interview was guided with eleven questions which centred on the research questions. The interview session ranged from 15 to 45 minutes focusing on the experience and perception of the employees towards the safety climate and working conditions at their workplaces. The interviews were recorded for later transcription. Participants were advised about their rights to withdraw or terminate the interview session at any time. Some participants requested to terminate recording during the interview. The recording was later coded with the date and interview number on the day (e.g., Participant 21_001; Participant 13_003).

9.4.3 Materials

Participants were requested to complete a demographic and job details question sheet before the interview, including their age, gender, job role, and how long they have been working in the current workplace. The researcher then started the interview with several questions. Those questions were also presented to the participants to help them follow the flow of the interview and also to guide their thoughts. An example interview question is: "What typically happens if there is a staff safety incident in this unit?" (see Appendix). Since our interview largely used the Malay language, the interview questions were translated into Malay by the first and second authors before the interview. However, as most Malaysians are bilingual or multilingual, the interview questions sheet presented to the participants was written in two languages (i.e., English and Malay).

9.4.4 Data Analysis

All recordings were transcribed manually and then analysed by using NVivo 11 software. While analysing the data, the theoretical framework of safety climate and PSC were used to guide classification of themes. Since theory has developed several important features of safety climate including management priority, communication, involvement and support, it is important to examine how well these theories describe PSC in a Malaysian healthcare context. The interviews were carefully reviewed and coded into key themes by using the "nodes" function in the software. After all the conversations were coded, we reviewed the content of each key theme and created new nodes if necessary. For those who gave an unsure answer (such as "I don't know", "I am not sure", "Maybe") in relation to safety climate features and resources, we did not include these in the nodes. Using the PSC score obtained from the PSC-12 from co-workers, we grouped the interviews into two groups according to the level of PSC of their workgroup: high PSC versus low PSC following the benchmark proposed by Bailey, Dollard, and Richards (2015). This mixed method has been proved useful in analysing qualitative data in previous research (Kwan, Tuckey, & Dollard, 2016).

9.4.5 Psychosocial Safety Climate Measure

To understand better about the role of PSC, we used a quantitative tool to assess the PSC level of the participants' work team by involving 5–20 randomly selected co-workers from each team with a total of 167 from 11 work teams.

PSC was assessed by using 12 items from PSC-12 (Hall, Dollard, & Coward, 2010) using a version translated into Malay by Idris et al. (2012). Four domains of PSC were assessed in this scale: organisational communication, organisational participation,

management priority, and management commitment. Each was examined with three items. PSC-12 has been used widely in previous PSC studies and has shown adequate psychometric properties including for Malaysian samples (Yulita et al., 2017; Loh et al., 2018) as well as in the current study (Cronbach alpha, $\alpha = 0.93$). A five-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*) was used. An example item is "Psychological well-being of staff is a priority for this organisation".

Since PSC has been theorised as a concept with multilevel properties, in this current study, we conducted several tests on PSC to measure its suitability as a climate construct. First, we calculated the within-group inter-rater agreement, r_{WG} (James, Demaree, & Wolf, 1984). Results revealed high agreement among the workers within the hospital, $r_{WG} = 0.96$ (SE = 0.02) which corresponded to very strong agreement (LeBreton & Senter, 2008). Next, we tested the between-group variance by using intra-class correlation (ICC [1]) and one-way analysis of variance (ANOVA). We found 18% of variance was due to upper-level factors with ICC (1) = 0.18 and a significant F value from the ANOVA, F (40,338) = 3.01, $p < 0.001$ (Mathieu, Aguinis, Culpepper, & Chen, 2012; Scherbaum & Ferreter, 2009). All tests showed good evidence regarding the shared properties of PSC and good justification for viewing PSC as a climate construct, supporting aggregation of the data. The score of each item is summed to generate a total score of PSC. We then used these scores to categorise the workgroups into high or low PSC. Using a cut-off of 41 (Bailey et al., 2015), teams were assigned as high or low PSC (High PSC, $n = 6$; Low PSC, $n = 5$). This procedure ensured that we captured the shared climate perceptions of PSC independent of those of our focal participants, thereby accounting for any perceptual bias.

9.5 Results and Discussion

We intended to understand the current status of physical and psychosocial safety climate among Malaysian healthcare workers by using a qualitative approach. In general, our main findings showed that Malaysian healthcare workplaces have a higher priority for physical safety compared with psychological safety issues. This is aligned with what has been revealed in previous quantitative research (Idris et al., 2012). However, our study also revealed that Malaysian healthcare workers share common challenges such as high workload and staff shortages, and adopt similar coping strategies, such as talking to their leaders or seeking help from their co-workers while dealing with psychological issues. These responses were similar regardless of the PSC condition (either high or low PSC) in their workplaces. Nevertheless, a high PSC working environment appeared to enable workers to feel more comfortable to voice out their concern about their own well-being, including reporting bullying cases, and to seek resources such as requesting promotion, asking for social support and help, as well as complaining about unfair treatment from authorities.

Table 9.1a Safety climate features and themes reported by Malaysian healthcare workers

	No. of statements (Percentage of total response %)	
	Physical safety climate	Psychosocial safety climate
Safety procedures	94.44%	–
Clear guidelines	11 (64.70)	–
Reporting system	6 (53.29)	–
Safety communication	88.89%	33%
Discussion and reminders on safety issues	11 (68.75)	4 (66.67)
Regular updates on safety information	9 (56.25)	–
Easy access of safety information	15(93.75)	–
Activities related to safety	4 (25.00)	4 (66.67)
Management involvement	72.22%	33%
Immediate response	3 (23.08)	–
Policies improvement	2 (15.38)	–
Training	6 (46.15)	3 (50.00)
Safety and health unit	2 (15.38)	–
Counselling services	–	6 (100.00)

Note The discrepant total percentage is due to some participants who mentioned more than one theme/sub-theme during the interviews

9.5.1 The Physical and Psychosocial Safety Climate Among Malaysian Healthcare Workers

Through the content analysis, we identified several themes related to safety climate in healthcare workplaces. Given the definition of safety climate is largely based on the policies, procedures, and practices of a workplace (Schneider, Ehrhart, & Macey, 2013), we asked the participants questions about typical procedures, safety knowledge, and practices undertaken in the hospital/unit. From the interviews, we identify several themes (as shown in Table 9.1a and 9.1b) related to safety procedures, safety communication, and management involvement in safety-related issues.

In relation to the first theme "safety procedures", the participants revealed that there are "clear guidelines and reporting systems" in the hospital in regard to safety incidents such as needle-stick injuries, falls, and medical errors. A participant said that "*If there is a needle prick injury, in our hospital, we do have our protocols which is very good.* (Participant 05_001)". Another participant said: "*We have a log book for incidents, any incidents like falls, patient violence, needle prick, lost materials. And also we have to fill up an incident report online.* (Participant 04_003)". However, these responses focus on physical safety but not psychological safety issues. When the researcher asked about psychological related safety climate, one of the participants

Table 9.1b Safety climate features, themes and quotes reported by Malaysian healthcare workers

	Example of quotes	
	Physical safety climate	Psychosocial safety climate
Safety procedures		
Clear guidelines	*We have guidelines which help us not to panic when any safety incident happens. That's why we have cardex, our medication cardex, to ensure that we don't make mistakes, to ensure how many gram or milligram the medicine should be. So we have to follow the steps*. (P23_002)	*But for psychological aspects such as work stress, I think no. Erm…I am not sure if these psychological aspects safety guidelines exists, never been exposed before. If you ask me, honestly I don't think there is any. Sometimes we do complain and argue that there is too much patients and work overload. But no one concerns.* (P18_001)
Reporting system	*We have a log book for incidents, any incidents including falls, patient violence, needle prick, lost materials. And, also we have to fill up incident report online*. (P07_003)	–
Safety communication		
Discussion and reminders on safety issues	*For any safety information, headnurse will share with us in the daily meeting. How to take care, if there is any incident, we will have discussion with our headnurse*. (P07_003)	*For psychological safety, we regularly have meetings in the ward. But every time we spoke out our issues, nothing happened. At the end, it is seems no point to speak it out. For example, we have staff shortage here and have discussed with head nurse for many times. We only can speak to the head nurse, if we talk to matron or someone with higher position, they will say our staff here is more than enough.* (P19_001)

(continued)

Table 9.1b (continued)

	Example of quotes	
	Physical safety climate	Psychosocial safety climate
Regular updates on safety information	*If any safety incident happened in this hospital, our authority will let us know. So next time if this happen, you have to do this and that. When we read the email, we understood. They told us* via *email. Every staff will get the email, so we read about the situation, know about it and next time we will know what to do.* (P23_001)	–
Easy access of safety information	*We have our work instruction, about steps to take in order to avoid safety issues. If patients fall, what action should we take. Everyone can read it from the system online.* (P17_001)	–
Activities related to safety	*The Infection Control Department in this hospital will often have some courses or workshops. Specially regarding to needle injuries. Sometimes we have exhibition. It is open for everyone, the public. But if it is specially for nurses or healthcare providers, it is in form of courses or workshops.* (P06_001)	*We do have some courses like stress management, one or two- day courses. But that was long time ago.* (P18_002)
Management involvement		
Immediate response	*If any incident happens, we will report to ward manager and she will handle it immediately. If the issue is too serious and cannot be solved, or bring effects to the patients, we will bring the issue to the nursing department.* (P23_002)	–
Policies improvement	*As for incident happened, headnurses will make a report. Report will help for improvement. So they (the authority) will plan for any improvement.* (P15_003)	–

(continued)

Table 9.1b (continued)

	Example of quotes	
	Physical safety climate	Psychosocial safety climate
Training	*We also have CNE (Continuous nursing education) talk, education talk. They will share about the cases which often occur such as needle prick injuries. Patient fall, we also do that. Presenter will tell us about the standard precaution, what we should do. So we will discuss about* it. (P18_002)	*In this hospital, we do have some stress management, or pain management course. We have it every year. But not for all staffs. Only some will be selected by the head nurses to attend.* (P15_003)
Safety and health unit	*I know we have OSH (occupational health and safety unit). It seems that they really highlight this.* (P03_001)	–
Counselling services		*For psychological issues, we have counselling. Let say if someone is contaminated after needle injuries, HIV or whatsoever, we will refer to counsellor. But it will be better if they have more mental health practitioners assigned to each ward. Now we have very few counsellors take care of all staffs in the hospital, they may not able to cover all. I think so.* (P15_002)

responded that "*We are more on physical. If psychological, we go to meet psychiatrist ourselves. As I know, we have to settle it by our own, find out a way to motivate ourselves*. (Participant 03_001)". In this study, one of our participants also revealed their frustration about the lack of psychological protection policies and procedures in the workplaces: "*But that's about physical safety, not psychological. That's why I am curious to who should I refer to if there is mental stress at workplaces. That's what we want to know* (Participant 04_003)". This reflects a similar finding where physical safety climate has been reported as higher compared to PSC in quantitative multi-level research among Malaysian employees (Idris et al., 2012).

Secondly, another theme emerged from the data on "safety communication". Employees told us about how they gain safety-related knowledge and information and how this information can be exchanged in the hospital/unit. We found that most of the safety communication centred on physical safety issues such as falls, needlestick injuries, and other incidents. Participants agreed that their workplaces often provide the latest information and knowledge on safety issues but less information was given on psychological safety. In fact, some participants admitted that they were not sure whether any of this information was available as they never heard from either the supervisor or co-workers about it. In addition, they did not search for such information. One of the participants said: "*But for psychological aspects such as work stress, I think no. Erm…I am not sure if these psychological aspects in safety guidelines exist, never been exposed before. If you ask me, honestly, I don't think there is any. Sometimes we do complain and argue that there are too many patients and work overload. But no one is concerned* (Participant 04_005)".

The third theme that arose from the conversation with the participants was "management involvement" in promoting and protecting safety. The participants said there was some training provided in order to ensure that the employees are prepared with knowledge and skills in handling safety equipment and incidents. One of the participants said: "*… we have a lot of information in the portal … Basically [it] is about our safety, perhaps during handling patients and equipment. We also have CNE [continuous nursing education] talks, education talks. They will share about the cases which often occur such as needle prick injuries, patient falls, we also do that. Presenters will tell us about the standard precaution, what we should do. So we will discuss it* (Participant 18_002)". Several participants told us that their management team are efficient in handling safety related issues. While similar to other themes, however, this involvement was limited to physical rather than psychosocial risks. In fact, some participants revealed that there is no response or specific action from the top management in solving psychosocial related issues including work overload: "*Regarding psychological aspects, sometimes the management will ask how we are, and our work, but all these do not come with any real solution. In the end of the conversation you have to do the work anyway. Although we complain, there is no action. The top management don't understand our situation. Even when we give feedback it is no use. We cannot tell them that we are busy. We have to do our work* (Participant 18_001)". Six of the participants said that there are counselling services provided for the staff, however one stated: "*In this hospital… we have counsellors…but only*

for serious cases. Only very stressed staff will be sent to them … Most of the time we don't go by ourselves. We will try to handle it first (Participant 23_002)".

Taken from these conversations, we found that physical safety climate within Malaysian healthcare workplaces was emphasised much more than PSC. As proposed by the both physical safety climate and PSC researchers, safety climate consists of some common factors including the management priority, organisational communication, management support, and organisational involvement but with different foci. It is believed that high safety climate is created when an organisation prioritises workers' safety and health, always talks about safety issues, supports worker safety protection by taking proper action, and is involved in promoting safety awareness and safety decision making. Referring to the proposed factors of safety climate formation, we found that the themes within each factor reflected the alignment between proposed theorised constructs and the reality as reported by the workers. Specifically, participants revealed that they are working in an environment where physical safety is prioritised where adequate training, information, and communication is provided, and there is management involvement in improving and protecting employees' and patients' safety. As for psychological issues, most of the participants noted efforts to support and promote employees' psychological well-being, however efforts remains at an early stage and mostly occurs when employees request it.

9.5.2 Comparison Between the Resources in Low and High PSC Context

In order to understand how the employees' reaction to stressful situations differ according to the PSC context, we categorised the interview transcripts into high and low PSC context according to their co-workers' rating of the PSC of their unit. The quanitative tool for measuring PSC (i.e., PSC-12) has been constantly used in several other countries including Malaysia (Idris et al., 2015; Yulita et al., 2017) and seems to work well in reflecting the level of PSC. Hence, it is believed that the Malaysian employees could understand the PSC concept and were able to relate it to their workplaces. Table 9.2a and 9.2b show the themes related to the resources used in high and low PSC context. The themes for all the dimensions emerged for both high and low PSC work teams (see Table 9.2b) but differences in the numbers of statements were found.

After detailed reading of the transcripts from each category, we found that similar challenges and coping strategies were applied to the employees. For example, the most common complaints from the employees were work overload and staff shortages. Participants commented: "*workload is really high. At this moment, we have* 3 *staff only, we have* 12 *patients. So for the daily morning shift,* 2 *seniors and a* 6 mon *junior. Among them there is one staff member who has only worked for* 4 *or* 5 *days* (Participant 03_001)". Hence, in order to overcome these challenges, these participants tried to obtain and retrieve some resources from the organisation and

Table 9.2a Resources utilisation between high and low PSC context

	No. of statements (Percentage of total response %)	
	High PSC context	Low PSC context
Organisational resources		
Hospital counselling services and training	9 (0.82)	2 (14.54)
Co-worker support	9 (33.50)	3 (7.69)
Talk to leaders	1 (2.66)	2 (12.30)
Personal resources		
Detachment from work	12 (56.01)	3 (14.67)
Rely on God	2 (14.56)	–
Self regulation	10 (34.56)	1 (0.66)

their personal life. "*if I return home, I will just forget what my work involves and I will …maybe take a rest, have some leisure time. This is a must. And then, you have religion. Hold on to our religion and something outside of your job. I am a Christian, so I will go for bible study and do some prayers…And, if you have good relationship (with your colleagues), even though it is not your job, but lets say you have good relationship with them, your friends will help you even that is not their assignment. And you will feel being appreciated by them. Then you will be happy* (Participant 03_001)".

Resources were found to be crucial for coping with stressors. Although more than half of the participants mentioned resources in dealing with psychological issues (67% of the participants), not all of them were willing to approach and utilise available resources. As aligned with the theoretical framework of PSC, employees working within a context where psychological health is appreciated are more likely to approach colleagues and use available resources. Taking PSC as the resources passageway, resources are created, maintained, and fostered in such conditions (Hobfoll, Halbesleben, Neveu, & Westman, 2018). By using NVivo 11 to calculate the coverage of resource utilisation (Table 9.2a and 9.2b), we found that employees who work in a high PSC context are more likely to use workplace resources, such as social support from the supervisor and colleagues. For example, participants from high PSC contexts admit that they will usually approach their direct manager or the ward manager when they feel stressed: "*If you have some troubles, you have to talk to your colleagues. You have to talk about it. That's the way you can express yourself* (Participant 23_001)". Another participant said that when there are any cases related to conflict or aggression from patients' relatives, "*if there is any relative issue, usually head nurses will meet with the relatives and try to discuss about what they are not satisfied with* (Participant 04_002)". Some participants recognised the importance of teamwork and support from their co-workers: "*I don't think all people in one team*

Table 9.2b Examples of quotes for resources utilisation between high and low PSC context

	Example of quotes	
	High PSC context	Low PSC context
Organisational resources		
Hospital counselling services and training	*We have counselling team. Staff counselling. If anybody who experiences stress will go there, will be refered to them.* (P23_001)	*For psychological, we have counselling.* (P15_002)
Co-worker support	*Sometimes when we work, we stress but we can meet our colleagues, chatting with them. That makes us feel happy and forget what we feel.* (P04_002)	*I will release my stress by telling my colleagues* (P19_001)
Talk to leaders	*If you feel over burden, you can meet with the headnurses.* (P07_003)	*So far, if a quarrel happens, usually we refer to headnurses, headnurse will meet the staff and the patient. Sometimes it is not from the staff but the patient or the relative scold at us.* (P15_001)
Personal resources		
Detachment from work	*You have to separate your work from life, especially we as women. If we tired at home, we tired at home. We come here, your aim is to work. If you bring along your emotions, your stress from home to work, it's going to make it worse. You have to…clear your mind, before you go to work.* (P23_001)	*For example, if I return to home, I will just forget about my work and I will do…maybe take a rest, have some leisure time. This is a must.* (P18_001)
Rely on God	*As for Muslims, we call redha. Means accept it.* (P07_003)	
Self regulation	*For me, follow our heart. Because we are…how should I say, our feelings, if you have the passion to work and whatever is coming, you can still adapt with it (i.e., stressful environment).* (P03_001)	*Some people cannot cope. But I think for them, they should not work here, they should change their workplaces.* (P17_001)

will stress at the same time. Some may be ok, some may be not. We help each other. Team work is important (Participant 15_001)".

Interestingly, participants from high PSC units were also more likely to utilise their personal resources such as detachment from work. According to what PSC theory proposes, employees who are embedded in a resourceful environment should have less need for personal resources investment as there are adequate resources provided in the work environment. This showed that the Malaysian hospital employees are more likely to use both organisational resources and personal strategies such as recovery when encountering psychological safety issues. A participant who works in a psychiatric ward said: "*Because we work with psychiatric patients, it is stressful if we do not stop for a while. Usually we will take one or two days off to reduce our stress* (Participant 17_001)". Similarly, another participant from a high PSC context shared similar coping strategies in handling workplace stress and psychological health issues: "*I will just take some time to relax. Maybe taking some leave, going somewhere that we think can help us to release our stress. If we stress during our work, we can meet our colleagues, chat with them. That makes us feel happy and forget what we feel* (Participant 04_002)".

In contrast, participants from the low PSC group were less likely to utilise resources, either the organisational or personal resources. In fact, most of them replied that they are not sure about what to do "*sometimes psychological stress comes from the environment. We have to change the environment, the people, patients and so on…but…it is hard. We do not know what to do* (Participant 04_003)". Another participant showed her reluctance to approach the hospital counselling services: "*I don't think that this hospital has the protection for workers' psychological health. We do have a psychological department, wards, and officer. But I don't feel to meet my psychologist after shift. No, because after work, I feel very exhausted* (Participant 19_001)".

9.6 Implications

Our study provided information on the current status of safety climate among Malaysian healthcare workplaces and how PSC applies to their working conditions. As the theoretical framework of PSC has documented the importance of PSC as a safety signal and source of job resources, our study provides a better understanding about how PSC of a work environment may help individuals in approaching and utilising resources, either organisational or personal resources.

First, we aimed to understand the experience of Malaysian workers of the physical safety climate and PSC at their workplaces. To better understand the theoretical concept and the exact experience, we categorised the themes as they emerged from the interviews and mapped them to the proposed PSC framework. As compared to physical safety issues, not much attention was given to promoting psychological health among the Malaysian healthcare workers. However, from what the employees shared with us, similar to McLinton, Dollard and Tuckey (2018), we found the interaction

between the management and employees is important to improve PSC context. We found that 44% of participants are looking for more direct communication between employees and top management as well as gaining support and understanding from them. One of the participants said: "*We know that they may not be able to do anything (about staff shortages), however, if they could be a good listener to us, give us some recognition and rewards, then that's good enough* (Participant 04_005)."

We have also contributed to the current PSC theoretical framework by understanding the pathway of how PSC would help alleviate the effect of a harmful working environment. Previous PSC research and also supported by findings in this current study showed high PSC environments would allow employees to feel safer and secure in seeking resources including talking to their direct manager and co-workers in order to reduce their psychological burden (Kwan et al., 2016). Drawing on COR theory, the current PSC framework focuses more on condition resources, in other words, the work conditions and organisational context, with little attention given to personal resources. However, Kwan et al. (2016) suggested a two-part mechanism of how PSC could prevent bullying at work that the right climate, i.e., high PSC, could assist employees take personal initiative in raising the bullying issues (e.g., voicing out in the right climate). However, we found that high PSC might do more than this by also encouraging the use of personal resources. As shown in Table 9.2a and 9.2b, apart from obtaining the support from their workplaces, we found that Malaysian workers often rely on religion and self-regulation coping strategies, some of them using detachment to recover themselves from psychological issues (e.g., work stress). Researchers argue that resources are not functional on their own but tend to accumulate and link with each other (Salanova, Schaufeli, Xanthopoulou, & Bakker, 2010). It is very important to note that the ecology of an environment is a crucial element in creating this resource caravan (e.g., organisational and personal resources) (Hobfoll, 2011). From our research, we found that participants from a high PSC context are more likely to use both organisational resources and personal initiatives when encountering safety incidents. We believe that this is because high PSC context created an ecology in which psychological health is appreciated and resources are allowed to be fully sought and utilised, either the resources at workplaces or personal regulating strategies.

In addition, our research has provided additional evidence on how PSC could be perceived consistently across different nations and cultures. Empirically, previous PSC research from different regions revealed that the positive effect of PSC in reducing psychological strains shows similar patterns across these countries. Our research again confirms this notion. The concept of PSC in highlighting psychological safety and health may reflect the universal human needs of safety (Maslow, 1943). Although the meaning of safety might differ, the central idea is that human beings seek protection and try to avoid any form of harm including psychosocial risks despite their origin of cultures and nationalities (Gelfand, Erez, & Aycan, 2007; Mearns & Yule, 2009).

9.7 Limitations

The study has shown that the elements shaping safety climate in Malaysia are aligned to the proposed PSC theory. More importantly, our study revealed how PSC can be applied in the work context and is instrumental in supporting and encouraging resources utilisation to reduce workplace psychological safety issues, particularly in the healthcare sector. As expected from a collectivist society such as Malaysia, we also found that teamwork and/or co-worker support are highly valued by the employees. Despite this, most employees continued to use personal strategies while dealing with stress. This may be due to the lack of organisational resources available in an unsupportive ecology that fails to promote broader resource utilisation, as seen in low PSC contexts.

One of the limitations of the current study is that our participants were not active in expressing their feelings and opinions, especially when relate questions related to management who are perceived as authority figures (one participant replied to the question on management role: "*what can we do? So we just have to work. I don't have comments on that*"). Responses were usually brief and lacking detailed information, and most of the time detailed responses relied on researchers' prompt questions. This is expected as Malaysians are considered as collectivists and have high power distance. In other words, Malaysians emphasise ingroup relationships (in this case, the social relationships within the hospital they work with) and always believe that the authorities should know what to do. Hence, they might try to avoid any behaviours or oral statements that might lower group dignity and be reluctant to question perceived authority. Nonetheless, by building participant rapport through informal discussion and seeking examples, useful information was obtained. In addition, by using a mixed-method approach, a more nuanced understanding of the safety climate phenomenon in Malaysian context was possible.

A second limitation of this study is that we only chose to focus on workers in a healthcare setting. Although this might limit our understanding about how PSC is perceived in other sectors, our findings might be generalisable to other workers who encounter similar demands with healthcare workers (e.g., emotional engagement with people, long working hours, and so on) such as teachers, firefighters, and policemen.

9.8 Conclusion

Our study revealed that Malaysians largely depend on their personal strategies or resources. Cultural factors, such as Muslim culture, high power distance, and collectivism are likely to also influence the difference in choosing resources in alleviating stressful work experiences. While Malaysian employees highlighted teamwork, they were less likely to take the initiative to approach their supervisor for assistance. Most of the time, they choose to accept the situation or detach from their job rather than look for any more resources from the organisation. Nevertheless under high levels

of PSC employees retrieved more resources from personal lives and their working environments. Future research should consider conducting interventions that promote greater communication between the management and employees, thereby providing greater resource pools for access by healthcare workers.

Key Messages

- Physical safety climate has been emphasised more than PSC in Malaysian healthcare workplaces.
- High PSC context encourages more resources utilisation among Malaysian healthcare workers.

Appendix: Interview Questions

Section One: Recent experience at work

1. Can you tell us about a specific incident at work (which has occurred in the past two weeks) that affects your safety/psychological condition?
2. Can you tell us about a specific incident at work (which has occurred in the past two weeks) where *a patient's safety* was at risk?

Section Two: Safety system of the hospital

3. Where do you go for information or advice on work, health, and safety?
4. How is safety information exchanged in this hospital and your unit?
5. In this unit, how are safety processes/procedures rolled out and put into practice?
6. How is safety information kept up to date in this unit?
7. What typically happens if there is a *patient safety* incident in this unit?
8. What typically happens if there is a *staff safety* incident in this unit?
9. Has workplace change (such as staffing or procedures) affected your safety or the safety of others?

Section Three: Safety climate

10. Do you think that top level management practices affect the psychological safety of workers?
11. Would you tell me about one thing that you would like to change about the work that would make a positive difference to your job?

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