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Does organisational myopia mediate the effect of occupational health and safety practices on the risk of occupational accidents in Turkish healthcare institutions?

Hasan Sadık Tatli[1], Kübra Sezen Erküvün[2], and Mesut Can Türkoğlu[3]

[1] Istanbul Beykent University Faculty of Economics and Administrative Sciences, Department of Logistics Management, Istanbul, Turkey
[2] Istanbul Beykent University Faculty of Engineering and Architecture, Department of Industrial Engineering, Istanbul, Turkey
[3] Istanbul Beykent University Faculty of Health Sciences, Department of Health Management, Istanbul, Turkey

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Occupational health and safety (OHS) policies in healthcare institutions must be well managed, because healthcare practice involves many physical, biological, ergonomic, chemical, and psychosocial hazards that can affect the health of healthcare workers. In addition, their work performance may be affected by the so-called organisational myopia. In this context, the aim of our study was to determine how organisational myopia affects OHS practices in healthcare institutions and whether it increases the risk of occupational accidents. The study population consisted of a convenience sample of 420 healthcare professionals working throughout Turkey who completed a questionnaire addressing these three domains: organisational myopia, OHS practices, and risk of occupational accidents. Their responses were analysed with exploratory factor analysis, reliability analysis, and Spearman's correlation to assess the adequacy of measurement tools and identify relationships between variables, followed by mediation analysis. We found that OHS practices mitigate organisational myopia and the risk of occupational accidents. We also found no significant effect of organisational myopia on the risk of occupational accidents. Our findings underscore the importance of OHS practices in healthcare institutions and that organisational myopia should be evaluated in special contexts such as working time, experience, or routinisation.

KEY WORDS: healthcare professionals; occupational accidents; OHS; routinisation; safe working environment

In Turkey, healthcare is one of the sectors most affected by poorly managed OHS policies (1). Healthcare involves many physical, biological, ergonomic, chemical, and psychosocial hazards that can increase the incidence of occupational accidents, threaten the safety and health of patients and healthcare workers, and affect the productivity and performance of the latter (2, 3).

In the context of occupational health and safety (OHS), healthcare professionals, whose workloads increased more than ever during the COVID-19 pandemic, have suffered from a number of stressors (including intense work tempo, poor wages, communication issues with patients and relatives, mobbing, managerial problems, and working in the same place for a long time), burnout, sleep disorders, depression, and a variety of ailments (4, 5). All this can lead to desensitisation and organisational myopia, which is understood as a limited capacity of an organisation to evaluate facts as they are and to see how they can develop (6). Organisational myopia often characterises workers who are set in a rut of routine work at the same job for long, who are overconfident in what they do, and who disregard occupational hazards and risks at their workplace.

Even though the healthcare sector is considered hazardous and often associated with occupational accidents (7–10), studies examining the effect of routine and organisational myopia on occupational accidents are rare (11–14). In addition, no research so far has addressed the effect of organisational myopia on occupational accidents in the healthcare sector or investigated the link between OHS practices, organisational myopia, and occupational accidents. The aim of this study was therefore to address this gap and determine the link between organisational myopia, OHS practices, and occupational accidents in healthcare institutions.

CONCEPTUAL FRAMEWORK

Occupational health and safety and occupational accidents

OHS is a multidisciplinary field that prevents work-related accidents, injuries, and diseases and protects and promotes workers' health (15). The World Health Organization (WHO) has examined the concept of OHS in the context of four basic objectives: protecting and improving employee health by preventing occupational accidents and occupational diseases, providing a healthy and safe working environment, increasing the physical, mental and social well-being of employees, and maintaining socioeconomically productive lives of employees (16). Occupational accidents occur

Corresponding author: Mesut Can Türkoğlu, Istanbul Beykent University Faculty of Health Sciences, Department of Health Management, Cumhuriyet District, Beykent, Büyükçekmece, 34500 Istanbul, Turkey
E-mail: *canturkoglu@beykent.edu.tr*, ORCID: 0000-0001-7955-0520

when a safe working environment cannot be provided (17) and the causes are often explained by the 4M (man, machine, media, and management) rule (18). Occupational accidents are mostly caused by the human factor and most often related to inexperience (lack of professional competence and adequate training) or, if the workers are experienced, to organisational myopia (12, 14).

Organisational myopia

Organisational myopia is the inability of employees to notice errors and deficiencies in the methods and techniques they currently use in their work arrangements and to perceive potential opportunities and risks (6, 19). It particularly seems to affect workers who have long worked routine jobs in the same workplace (12).

According to Catino (6), organisational myopia involves individual, organisational, and sectoral dimensions, while Seymen et al. (20) add routine as the fourth dimension. The individual dimension is mostly related to the employees' sociodemographic characteristics, personality traits, and psychological characteristics (6). The organisational dimension involves corporate culture, type of capital, hierarchical structure, and business processes (6), and myopia is reflected in the lack of communication within the organisation, strict hierarchy, and unwillingness to change and adapt to new circumstances (21). The sectoral dimension refers to the structure of the sector, competition, dynamism, and interaction with other sectors (6). Employees in relatively stagnant sectors, unchallenged by competition, tend to succumb to organisational myopia over time. Routine, in turn, is often associated with monotony and reluctance to accept innovation or rotation. In fact, Kayikci et al. (22) claim that job rotation counters organisational myopia effectively, as do short working hours (23).

Employees who experience organisational myopia cannot get out of their comfort zone, fail to realise the risks of their working environment, their own shortcomings, and have the illusion that there is nothing wrong about how their work is organised (24). In the healthcare sector, factors such as excessive workload, long working hours, shifts, routine, and the same working environment for a long time particularly contribute to organisational myopia (20).

Hypothesised relations between OHS practices, occupational accidents, and organisational myopia

Our first hypothesis (H1) was that OHS practices mitigate or reduce organisational myopia. OHS practices ensure that employees avoid risky behaviours, recognise hazards and accidents, and maintain close attention to hygiene and safety issues (25). The benefits of OHS practices in healthcare institutions are manifested in increased awareness of physical, biological, chemical, and other hazards in the workplace (26). In this context, increased awareness and attention will help healthcare workers overcome myopia in their routine tasks.

Our second hypothesis (H2) was that organisational myopia increases the risk of occupational accidents, as "myopic" workers fail to notice the hazards and risks in their work environment (27). Horozoğlu (11) claims that monotony and boredom stemming from work routines are important factors in occupational accidents. Tezcan and Aktaş (28) add that the risk of occupational accidents due to organisational myopia and carelessness increases at repetitive jobs with time. According to Ropponen et al. (29), this risk is further increased by long working hours and insufficient rest. Employees routinely performing the same task for a long time may ignore background risks. Aslan and Çelik (14) claim that experienced workers tend to get organisationally myopic over time and underestimate or ignore the hazards and risks in their working environment.

Our third hypothesis (H3) was that OHS practices lower the risk (incidence) of occupational accidents, considering that this is their main purpose. This hypothesis is profusely supported by literature reports (8, 30–40). OHS measures in hospitals include elements such as risk assessment, recording of workplace accidents, OHS training, and the use of personal protective equipment (PPE) (31, 33, 34, 36, 41), and the latter two have been proven as effective in reducing workplace accidents (36, 42).

Our fourth and last hypothesis (H4) was that organisational myopia mediates the effects of OHS practices on workplace accidents by being reduced by OHS practices, as they facilitate risk recognition and promote safe behaviours. Feedback and continuous improvement also improve employees' attention and prevent accidents (12). Organisational myopia, on the other hand, may have an undermining effect on the OHS practices and OHS awareness of employees. This is because employees, especially those who have been working in the same organisation and position for many years, may have a problem recognising the risks in their work environment (6, 11, 12). In the light of this information, we hypothesised that OHS practices would reduce organisational myopia and thus lower the risk of accidents among healthcare workers.

Investigating the mediating role of organisational myopia in the effects of OHS practices on occupational accidents is an approach developed to understand safety culture and strategies in the healthcare sector more comprehensively. Organisational myopia results from the tendency of organisations to "not see" existing risks and vulnerabilities. Effective OHS practices can indirectly affect occupational accident risks by reducing this myopia. The mediating role of organisational myopia offers an innovative and holistic framework for understanding and improving the effectiveness of OHS practices.

PARTICIPANTS AND METHODS

Population sample

Our study population consisted of workers in healthcare institutions across Turkey, which includes medical and administrative staff, as we believe that administrative staff also faces various

occupational risks in healthcare institutions such as risks of infection, chemical exposure, radiation, stress, and ergonomic risks. In addition, administrative staff in Turkey, especially medical secretaries, establish direct one-to-one contact with patients.

We relied on convenience sampling, which is practical due to ease of access but may have limitations in terms of generalisability and representation.

The participants were asked to complete an online form sent in advance. Eventually, the study included 420 participants who provided full information and responses to our questionnaire between March and May 2023. Each participant gave informed consent to participate. The study was approved by the Istanbul Beykent University Publication Ethics Committee for Social and Human Sciences (approval No. 90705 of 27 January 2023).

The questionnaire used in this study consists of three parts. The first part, "Organisational Myopia Scale", described in detail by Seymen et al. (20), consists of 24 questions and evaluates statements about organisational myopia. The second part, "Occupational Health and Safety Practices Performance Evaluation Scale", adopted from Üngüren and Koç (43), consists of 30 questions and measures self-reported protection from occupational accidents in the context of OHS measures. Both use a 5-point Likert scale (from 1 – strongly disagree to 5 – strongly agree). The third part collects demographic and work data such as age, gender, and marital status, work experience, job position, and questions about occupational accidents and near-miss incidents.

In the first two scales (domains), the range 1.00–2.33 is considered low for both organisational myopia and OHS practices, 2.34–3.66 medium, and 3.67–5.00 high (44).

Self-perception of the risk of occupational accident was determined with four questions about occupational accidents by averaging their scores ranging from 1 to 2. Average range 1.00–1.20 denotes very high accident risk, 1.21–1.40 high, 1.41–1.60 medium, 1.61–1.80 low, and 1.81–2.00 very low.

Statistical analysis

The collected data were analysed with the IBM SPSS version 25 (New York, USA) program and the PROCESS 2.16.3 macro for SPSS (45). We employed exploratory factor analysis (EFA) to identify the underlying structures within our multivariate dataset and to understand the complex relationships between the data (46). To assess the validity of the analysis, we utilised the Kaiser-Meyer-Olkin (KMO) and Bartlett's test. The KMO test measures the adequacy of the sample size, while Bartlett's test confirms that the dataset is suitable for factor analysis (47). Additionally, factor loadings and explained variance calculations play a critical role in determining the impact of factors on data and their relationship with variables (48).

Reliability was determined with Cronbach's alpha coefficient, which measures internal consistency among scales (46, 49).

Factor and reliability analyses and threshold values all tested valid. The thresholds for the Kaiser-Meyer-Olkin (KMO) were >0.70, for the Bartlett's sphericity test $p<0.05$, for the total variance explained >60 %, for the factor loading scores >0.40, and for the reliability coefficient >0.70. Correlations between variables were analysed as described by Karahan (50) and Kocaay (51), according to the following criteria: 0 – no correlation; 0.01–0.19 – very low correlation; 0.2–0.39 – low correlation; 0.4–0.59 – moderate correlation; 0.60–0.79 – high correlation; 0.80–0.99 – very high correlation; and 1 – full correlation.

Model 4, developed by Hayes (45), was used for mediation analysis, as it examines the relationships between the independent variable (x), the mediating variable (m) and the dependent variable (y). It assesses the effect of x on y indirectly through m.

Indirect effect is determined if the confidence interval does not contain zero, which was the case in our evaluation, as the confidence interval of the indirect effect calculated using the bootstrapping method did not contain zero, which confirms some level of mediation (45, 52). We then determined whether the mediation level was significant ($p<0.05$).

The conceptual model of our study is shown in Figure 1. The independent variable (x) is OHS practices, the dependent variable (y) is occupational accidents, and the mediator variable (m) is organisational myopia.

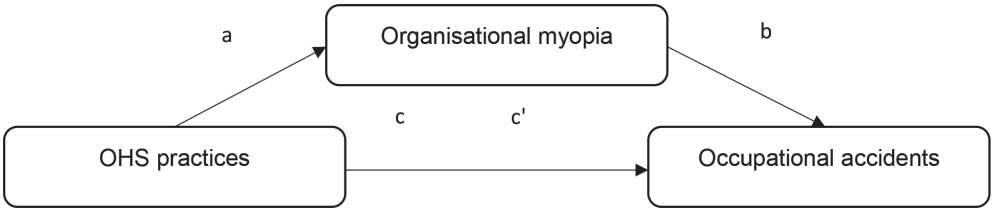

Figure 1 Conceptual model of mediation analysis. Path a represents the direct effect of the independent variable x (OHS practices) on the mediating variable m (organisational myopia). Path b represents the effect of m on the dependent variable y (occupational accidents). This effect is expressed as the coefficient obtained by testing x, y, and m in the same model. Path c indicates the total effect of x on y. Path c' indicates the controlled effect of x on y, and is expressed as the coefficient obtained by testing x, y, and m in the same model

RESULTS

Table 1 shows the demographic data of the healthcare professionals participating in this study.

Table 2 shows the results of exploratory factor and reliability analysis confirming adequate factor structure, that is, validity and reliability of the organisational myopia scale. Item O1 was excluded due to inappropriate factor loading.

Table 3, in turn, confirms the validity and reliability of the OHS practices scale. Items M7, M8, OH6, OH7, and A5 were excluded from the analysis due to inappropriate factor loading and distribution to irrelevant factors, as recommended by Hair et al. (46). Items removed following the exploratory factor analysis were not used in correlation and mediation analyses

Table 4 shows the distribution of self-reported occupational accidents and near-miss incidents among our participants and suggests that occupational accidents and hazardous situations are common in the healthcare sector and should raise serious concern.

Our correlation analysis reveals a significant negative ($p<0.01$), very low-level (-0.177) correlation between OHS practices and organisational myopia and a significant negative ($p<0.01$), low-level (0.262-reverse coding) correlation between OHS practices and the risk of occupational accidents. However, no significant correlation was found between organisational myopia and the risk of occupational accidents (Table 5).

Descriptive statistics indicates that our participants have low organisational myopia (mean score: 2.67/5), assess the effectiveness of their OHS practices as moderate (mean score: 3.60/5), and find the risk of occupational accidents low (mean score: 1.76, on a scale of 1 to 2 with reverse coding).

The results of mediation analysis (Table 6), have confirmed our first and third hypotheses that OHS practices reduce organisational myopia and the risk of occupational accidents but has declined the second and the fourth hypotheses that organisational myopia increases the risk of occupational accidents or that it mediates the effect of OHS practices on such risk (Figure 2).

DISCUSSION AND CONCLUSION

Our findings confirm that OHS practices reduce organisational myopia and the risk of occupational accidents in healthcare workers in Turkey and are in line with earlier reports from similar studies (30, 42).

Considering previous reports (11, 28, 29), however, we have found no significant mediating role of organisational myopia in the effects of OHS practices on the risk of occupational accidents nor have we found that it directly increases or lowers the risk of occupational accidents. This suggests that organisational myopia should be evaluated in contexts other than working time, experience, routinisation, and workload and perhaps focus on separate groups of healthcare workers, such nurses and physicians, who provide healthcare services that involve occupational accidents with pins and needles, exposure to body fluids, and alike.

Our findings are important as they demonstrate the key role of OHS practices in ensuring a psychologically and biologically safe working environment. However, they should be taken with some reserve, as healthcare workers, especially in developing countries, may refrain from reporting occupational accidents for fear of receiving poor performance appraisal or even being fired. To remove this fear, healthcare institutions, organisations, and trade unions need to raise the awareness of the issue and provide unequivocal support.

Besides possible underreporting, our findings may have other limitations. One is that the sample consists of younger participants with little work experience, who may not have yet experienced the negative effects of organisational myopia. Another important limitation is that the sample mixes different professions (medical and administrative staff at the hospital), which involve different routines and occupational risks and, therefore, a different degree of organisational myopia.

Regardless of its limitations, this study encourages a proactive approach to understanding how OHS practices lower the risk of accidents and organisational myopia in the healthcare sector. It also suggests that organisational myopia has no role in such effects of

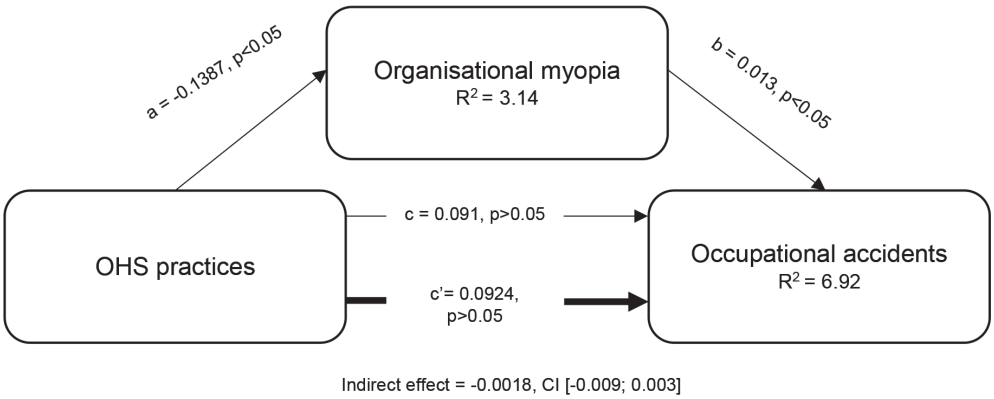

Figure 2 Mediating effect of organisational myopia between OHS practices and self-reported occupational accidents

Table 1 Demographic characteristics of participating healthcare workers in Turkey

Variables	Categories	N	%
Gender	Female	295	70.2
	Male	125	29.8
Age (years)	18–25	123	29.3
	26–33	141	33.6
	34–41	81	19.3
	42–49	58	13.8
	50 and above	17	4
Education level	High school	51	12.1
	Bachelor	285	67.9
	Postgraduate	84	20
Marital status	Married	183	43.6
	Single	237	56.4
Work experience in the current workplace (years)	1 and below	119	28.3
	2–5	160	38.1
	6–9	52	12.4
	10–13	43	10.2
	14 and above	46	11
Total work experience (years)	1 and below	63	15
	2–5	136	32.4
	6–9	59	14
	10–13	48	11.4
	14 and above	114	27.1
Current position	Physician	56	13.3
	Nurse / midwife	115	27.4
	Health technician	83	19.8
	Hospital administrative staff	129	30.7
	Manager	19	4.5
	Support services staff	18	4.3
Have you had an occupational accident before?	Yes	69	16.4
	No	351	83.6
Have any of your colleagues had an occupational accident in the last year?	Yes	139	33.1
	No	281	66.9
Have you had a near-miss incident in your work environment before?	Yes	156	37.1
	No	264	62.9
Are the OHS measures at your workplace adequate?	Yes	248	59
	No	172	41
Are the occupational safety specialist and occupational physician services sufficient in your workplace?	Yes	285	67.9
	No	135	32.1
How often do you receive OHS training?	None	8	1.9
	Once in six months	120	28.6
	Once a year	231	55
	Once in two years	19	4.5
	Once in three years	27	6.4
	Other	15	3.6

Table 2 Factor and reliability analysis of the organisational myopia scale

Rotated component matrix				
Items	**Components**			
	Organisation structure	**Degree of routine**	**Individual indifference**	**Individual resistance**
O5: My managers are not flexible.	0.744			
O3: Feedback about the organisation is not evaluated.	0.732			
O2: Our workplace does not provide an environment where employees can share their ideas.	0.723			
O6: The rules in our organisation are strict.	0.717			
O4: In our workplace, work is always done the traditional way.	0.713			
O7: There is very little innovation in our organisation.	0.679			
R5: I have a standard job.		0.786		
R4: My work lends itself to routinisation.		0.783		
R2: My work is not open to innovation.		0.671		
R1: I do not have the opportunity to improve myself at work.		0.651		
R3: I always solve problems at work with the same methods.		0.511		
R6: My job is not suitable for rotation.		0.424		
I2: I am not curious about the developments around me.			0.820	
I1: I do not follow innovations related to my work.			0.750	
I3: I don't recognise my own shortcomings easily.			0.713	
I4: I don't pay attention to the criticism of others.			0.646	
IR2: I can't give up my habits easily.				0.813
IR1: When I do something, I always use the methods I have used before.				0.783
IR3: Different environmental conditions scare me.				0.576
Variance explained	18.738 %	14.869 %	13.342 %	9.933 %

Note: extraction method – principal component analysis; rotation method – varimax rotation; Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy – 0.846; Bartlett's test of sphericity – 0.000; approximately $\chi 2$ – 2888.375; degree of freedom – 171; total variance explained – 56.882 %; Cronbach's alpha – 0.865; number of items – 19

Table 3 Factor and reliability analysis of OHS practices performance evaluation scale

Rotated component matrix					
Items	**Components**				
	Managerial measures	**OHS awareness**	**Cooperation**	**OHS training**	**OHS criteria**
M3: Necessary health and safety measures are implemented in my workplace.	0.753				
M4: My workplace has the necessary protective health and safety equipment.	0.749				
M1: Employees at my workplace are provided with the necessary protective health and safety equipment.	0.723				
M2: We comply with health and safety measures at my workplace.	0.702				
M6: Risk assessments are carried out at regular intervals at my workplace.	0.626				
M5: Any work assignment at my workplace takes into account health and safety.	0.566				
A3: My colleagues are familiar with the measures of protection from occupational diseases.		0.831			
A1: My colleagues are familiar with occupational diseases and their causes.		0.806			
A2: My colleagues are familiar with the legal rights and responsibilities related to their work.		0.775			
A4: My colleagues are familiar with protection from health and safety risks at my workplace.		0.767			
A6: My colleagues know how to use protective equipment.		0.585			
C4: Information obtained by risk assessment is shared with the employees.			0.761		
C2: At my workplace, employees can easily express their concerns about health and safety issues.			0.743		
C3: Experts, management, and employees cooperate in regards to occupational health and safety at my workplace.			0.731		
C1: Management takes into account the health and safety concerns of employees.			0.697		
T3: Occupational health and safety trainings are implemented at my workplace.				0.748	
T2: Training in occupational health and safety is delivered in an understandable language.				0.705	
T1: Occupational health and safety training is announced to employees within a specific plan and programme.				0.696	
T5: If my workplace gets a new tool or equipment, training is provided on how to use it correctly.				0.576	
T4: Training in occupational health and safety includes practical demonstration.				0.569	
OH4: My colleagues do not jeopardise the health and safety of other staff while doing their work.					0.791
OH3: My colleagues do not jeopardise their own health and safety while doing their work.					0.720
OH5: My colleagues follow instructions to use machines, tools, and equipment at my workplace.					0.684
OH1: When my colleagues encounter a threat to health and safety at work, they inform the management.					0.593
OH2: At work, my colleagues apply the information they have learned from occupational health and safety training.					0.579
Variance explained	16.945 %	15.636 %	14.007 %	13.952 %	13.926 %

Note: extraction method – principal component analysis; rotation method – varimax rotation; Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy – 0.960; Bartlett's test of sphericity – 0.000; approximately $\chi 2$ – 8684.524; degree of freedom – 300; total variance explained – 74.466 %; Cronbach's alpha – 0.965; number of items – 25

Table 4 Self-assessed risk of occupational accidents by study participants (N=420)

Statements		N	%
Have you had an occupational accident before?	Yes	69	16.4
	No	351	83.6
	Total	420	100.0
Have you had an occupational accident at your current workplace?	Yes	46	11.0
	No	374	89.0
	Total	420	100.0
Have any of your colleagues had an occupational accident in the last year?	Yes	139	33.1
	No	281	66.9
	Total	420	100.0
Have you had a near-miss incident in your work environment before?	Yes	156	37.1
	No	264	62.9
	Total	420	100.0

Table 5 Correlation analysis between participant scores on organisational myopia, OHS practices, and self-assessed risk of occupational accidents

Scales	Mean	Standard deviation	Organisational myopia	OHS practices	Occupational accident risk
Organisational myopia	2.67	0.652	1		
OHS practices	3.60	0.832	**-0.222***	1	
Occupational accident risk	1.76	0.288	-0.029	**0.255***	1

* p<0.01

Table 6 Results of mediation analysis

Scales	R2	p	B	p	LLCI	ULCI	Hypotheses
OHS practices (x)	3.14 %	0.0003	-0.1387	0.0000	-0.2128	-0.0646	H_1 Confirmed
Organisational myopia (y)			3.1729	0.0003	2.8987	3.4470	
OHS practices (x)	6.92 %	0.0000	0.0924	0.0000	0.0597	0.1251	H_2 Rejected
Organisational myopia (m)			0.0130	0.5413	-0.0288	0.0547	
Occupational accident risk (y)			1.3882	0.0000	1.2102	1.5662	
OHS practices (x)	6.84 %	0.0000	0.0906	0.0000	0.0584	0.1227	H_3 Confirmed
Occupational accident risk (y)			1.4294	0.0000	1.3105	1.5483	

Path	Indirect Effect	Boot SE	Boot LLCI	Boot ULCI	
OHS Practices → Organisational Myopia → Occupational Accident Risk	-0.0018	0.0029	-0.0091	0.0031	H_4 Rejected

R2 – measure of effect size for mediation analysis; p – value of statistical significance; LLCI – lower limit confidence interval; ULCI – upper limit confidence interval; Boot SE – standard error estimate

OHS practices accident risk and points to a need for more targeted research strategies. By focusing directly on improving OHS practices, this study emphasises the importance of proactive safety measures rather than relying on indirect factors like organisational myopia. In other words, our findings underscore the need for direct, robust OHS interventions to mitigate these risks effectively and enhance worker safety.

Conflict of interests

None to declare.

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Organizacijska kratkovidnost posredno ne utječe na rizik od profesionalnih ozljeda koje su posljedica provedbe zaštite na radu u zdravstvenim ustanovama u Turskoj

Provedbom politike zaštite na radu u zdravstvenim ustanovama treba upravljati dobro, budući da zdravstvena praksa uključuje mnoge fizičke, biološke, ergonomske, kemijske i psihosocijalne rizike koji mogu loše utjecati na zdravlje zdravstvenih radnika. Usto, na njihov rad može utjecati i takozvana organizacijska kratkovidnost (engl. *organisational myopia*). U tom je smislu cilj ovoga ispitivanja bio utvrditi utječe li organizacijska kratkovidnost na provedbu zaštite na radu u zdravstvenim ustanovama te povećava li rizik od nezgoda na radu. Ispitivanje je obuhvatilo prigodni uzorak od 420 zdravstvenih radnika diljem Turske, koji su ispunili upitnik o ovim trima pitanjima. Njihove smo odgovore analizirali pomoću eksploracijske analize čimbenika, analize pouzdanosti i Spearmanove korelacije kako bismo utvrdili prihvatljivost mjernih instrumenata i odnose između varijabli, nakon čega je uslijedila analiza posredovanja (engl. *mediation analysis*). Utvrdili smo da praksa zaštite na radu smanjuje organizacijsku kratkovidnost i rizik od nezgoda na radu, kao i da organizacijska kratkovidnost ne utječe značajno na taj rizik. Naši rezultati ističu važnost provedbe zaštite na radu u zdravstvenim ustanovama i potrebu za ocjenom uloge organizacijske kratkovidnosti u specifičnim kontekstima poput radnog vremena, staža i rutinizacije.

KLJUČNE RIJEČI: nezgode na radu; rutinizacija; siguran radni okoliš; zaštita na radu; zdravstveni radnici