Health and safety in the catering industry

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There is evidence that the catering industry has high levels of work-related injury and disease. This study examined the incidence, nature and causes of work-related injury and disease among 315 catering students, at a large school of catering in the west of Ireland, over a 10 month academic year. A high incidence of accidents that caused injury was found. Cuts and lacerations, arising from accidents with knives, were the most common injuries seen, followed by burns and scalds from handling hot liquids. A significant level of work-related dermatitis was also recorded. Trainee chefs were identified as an occupational group with a high risk of occupational injury and disease. This group would benefit from vaccination against tetanus. Work-related injuries and disease generated a significant workload for the student health unit, which in itself is a good reason for catering establishments to make use of occupational health services. Health and safety procedures need to be audited and constantly reviewed at a local level. Further research is necessary to more accurately determine the incidence, nature and leading causes of work-related injury and disease in the catering industry in Ireland. This would help in the planning and implementation of an effective health and safety management system.

Key words: Catering industry; disease; injury; occupational injury incidence rate; workplace hazards.

Introduction

Risks and hazards in the catering industry

There is evidence from the Health & Safety Authority (HSA) in Ireland and the Health & Safety Executive (HSE) in the UK that the catering industry has high incidences of work-related injury and disease. However, most injuries and illnesses are not reported [1–3]. Work-related injury and disease are costly to employees, employers and taxpayers. The HSE estimates that workplace accidents cost UK employers 8.5% of annual turnover [4]. There are no comparable Irish data available.

A survey by the Irish Business and Employers Confederation (IBEC) concurred with the accident analysis by the HSE [3,5]. The author could find no other research available on the incidences or causes of occupational injury or disease in the catering industry in Ireland.

The leading causes of accidents identified by the HSE included slips and trips, manual handling, exposure to hazardous substances, hot surfaces and steam, being injured by moving articles, e.g. hand tools, walking into objects, falls, fire, explosion and electric shock [3]. Typical injuries reported included cuts, lacerations, scalds, burns, blunt injuries, musculoskeletal injuries and eye injuries [1,3]. Despite the apparent high injury rate, there is a relatively low fatality rate, and this may be one reason why the industry has not received the same attention as other hazardous industries with higher fatality rates [1].

Health hazards in catering identified by the HSE and IBEC include exposure to irritants, allergens, polycyclic aromatic hydrocarbons in cooking fumes, noise, smoke, temperature extremes, overcrowding, violence, stress, an unhealthy lifestyle and unsociable working hours [3–5].

There is evidence that workers in the catering industry have increased levels of dermatitis [6,7], asthma [8–10], back pain [3,11], work-related upper limb disorder [12–14], psychosocial disorder [15–18], and oral and pharyngeal cancer [19–21].

The catering industry in Ireland

Despite the known high risks from health and safety
hazards, there is evidence that in many catering establishments in Ireland health and safety procedures are not always given the priority they deserve, and that many establishments have no formal occupational health services [22]. In 1996, the HSA reported that only 37% of hotels and restaurants inspected had a safety statement prepared and only 13% had selected a safety representative [23]. CERT, the state tourism and training agency, has acknowledged these problems and targeted training in health and safety as a priority for the new millennium [22,24].

In addition, there are features of employment in the catering industry in Ireland that have particular implications for workers’ health, safety and well-being. Surveys on employment trends in the catering industry in Ireland, conducted by CERT and the Central Statistics Office (CSO), illustrate that Ireland’s recent economic growth has led to a rapid expansion of the catering industry [22,24,25]. Figure 1 illustrates this rapid growth in employment. A report by CERT confirms high levels of staff shortages, skills deficits and staff turnover in all sectors of the catering industry. The rapid growth in employment has involved many untrained workers. CERT estimates that only 32% of permanent staff in the catering industry are formally trained [22,24]. In addition, as in other EU countries, there are high proportions of seasonal workers, temporary workers and young workers in catering in Ireland. The net effect of these employment trends is that many catering workers in Ireland are overworked and lack experience, training and job security, and therefore are at increased risk of work-related injury and disease [22,24,26].

The catering establishment in this study

This study was carried out against the background of an industry with many known physical and psychosocial hazards. The school of catering at a tertiary level institute of technology was studied. There are over 5500 students on campus at any one time. The students at the school of catering work a rota system from 07:00 to 21:00 h and provide all the meals for the college canteen. In addition, they operate the college bar and a restaurant.

The catering courses are full time and practical, with 85–90% of time spent working in the kitchen, bar, restaurant or canteen. The catering activities include preparing and cooking meals, pastry work, serving food and drink, cleaning duties and stocktaking.

The school of catering is considered to have a good safety culture. The school has a safety policy and statement, which are reviewed and updated regularly by the safety committee. Accidents, injuries and work-related diseases are reported to the safety committee. Students are given instruction on health and safety matters. All of the tutors are trained in first aid. Students with work-related injuries or disease are referred to the student health unit for assessment; however, very minor injuries or illnesses may not present for treatment. Nurses and general practitioners, who are trained in occupational health, staff the unit. The student health unit provides a primary health care service to the student community.

The student year begins in September and ends in June, with short breaks for Christmas and Easter. Some of the courses involve time off-campus in industrial placements; furthermore, the courses vary in length. These factors were taken into account when calculating the statistics.

The aim of this study was to determine the incidence, nature and causes of work-related injury and disease among catering students in a large school of catering, over a 10 month academic year. In addition, the study was designed to ascertain the workload generated for the student health unit by occupational injury and disease.

The results of this study will help to predict the health and safety needs of this and other catering establishments in Ireland and thereby aid in the implementation of effective health and safety management systems.

Materials and methods

A prospective study of the occupational injuries and diseases of a cohort of catering students over the 10 month academic period from September 1998 to June 1999 was carried out.

Students enrolled in the professional cookery year 1 and 2, bar skills, advanced bar skills and restaurant services courses were included in the study, giving five occupational groups. The cohort size was 315 students.

Table 1 describes the number of students in each occupational group and the time they spent training in college. Only episodes of disease or injury occurring during this time were included in the study. The time period of study for each group was calculated from the number of days spent training in the college. This gives a common denominator (days worked) in order to make valid comparisons between the different occupational groups in the cohort.

In this study, work-related injury or disease refers to an
episode of injury or disease caused or aggravated by exposure to a hazard in the working environment. Visits to the student health unit for work-related injury or disease were recorded and analysed for the following:

- The occupational injury plus disease incidence rate.
- The occupational injury plus disease frequency rate.
- The occupational injury incidence rate.
- The occupational injury frequency rate.
- The age and sex of students attending for treatment.
- The nature of the injury or disease.
- The workplace hazards responsible and the history of the accident or illness.
- The severity of the occupational injury or disease.
- Treatment received.
- The number of surgery visits (to doctor or nurse) required.
- Hospital or specialist referral.
- The outcome.

Results

Incidence and frequency of occupational disease and injury recorded for each occupational group

Thirty-seven of the total population of 315 students (12%) received treatment for 51 episodes of work-related injury or disease. These 51 episodes required 70 separate visits to the student health unit for treatment and review. Eight students suffered more than one episode, one student had five separate episodes and many episodes required more than one visit to the student health unit for treatment and follow-up.

There were 43 injuries arising from accidents in the workplace. Eight episodes of work-related disease were recorded: five cases of dermatitis and three fainting spells.

The number of students presenting for treatment, the number of episodes of work-related injury and disease combined and separately, and the number of visits to the student health unit required for treatment are presented in Table 2 according to each occupational group.

The occupational injury incidence rate and the occupational injury frequency rate for each group are presented in Table 3. Statistics were calculated for episodes of injury and disease combined and for injury alone.

The occupational injury incidence rate refers to the total number of injuries per 100 workers over a specific time period. In this study, the time period varies for each occupational group according to the length of time spent training on campus. The occupational injury frequency rate refers to the total number of injuries per 1000 days worked.

The 1997 Irish Labour Force Survey of all occupations published an occupational injury incidence rate of 12.4 per 1000 workers per annum, or 0.05 per 1000 work days [1]. This figure applied to injuries leading to three or more working days lost; minor injuries were therefore not included. Furthermore, due to problems with reporting, this figure probably underestimates the true incidence of occupational injury in Ireland. However, the Labour Force Survey provides the only useful national benchmark and is included in Table 3 for comparison.

Age and gender of students presenting with occupational disease and injury

The sample population was mainly young people. The age–sex profile of the students in the sample population and those presenting with injury or disease is shown in Table 4.

The students suffering occupational ill-health (disease

<table>
<thead>
<tr>
<th>Occupational group</th>
<th>Consultations for treatment of occupational injury/disease</th>
<th>Students presenting with occupational injury/disease</th>
<th>Episodes of disease and injury</th>
<th>Injury</th>
<th>Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional cookery 1</td>
<td>52</td>
<td>27</td>
<td>37</td>
<td>31</td>
<td>6</td>
</tr>
<tr>
<td>Professional cookery 2</td>
<td>14</td>
<td>10</td>
<td>10</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Bar skills</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Advanced bar skills</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Advanced restaurant services</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>All groups</td>
<td>70</td>
<td>41</td>
<td>51</td>
<td>43</td>
<td>8</td>
</tr>
</tbody>
</table>
and injury) were predominantly male. This was significantly different from the sample population of 315 ($\chi^2 = 3.92, df = 1, P < 0.025$). There was no difference in the age range between the students presenting with occupational ill-health (disease and injury) and those with no recorded episodes.

The nature of occupational disease and injury

Of the work-related episodes recorded, 41% were cuts, lacerations or amputation of fingertips. Burns and scalds accounted for 27%, contact dermatitis for 10% and musculoskeletal disorders for 10% of episodes.

The causes of injury and disease

In this study, there were 43 injuries recorded and eight episodes of occupational disease. These are presented in Table 5 according to the hazards responsible.

The HSE provides statistics on the leading causes of accidents in the catering industry [2]. The injuries recorded in this study are categorized according to the HSE injury categories in Table 5 and compared with HSE figures in Table 6. There are no comparable data with which to compare occupational disease.

Severity of disease or injury

The severity was determined by the type of injury or disease, the number of visits to the student health unit required for treatment, whether or not referral to hospital was necessary, and longer-term sequelae, e.g. scarring.

Only three (5.8%) episodes were considered severe:

1. An intractable irritant contact dermatitis requiring referral to a dermatologist, who advised the student to change career.
2. A burn from a hot plastic chopping board. The burn developed a secondary infection and required surgical referral. The student was left with a noticeable scar on his right hand.

3. A scald in a student with psoriasis, who developed a Koebner phenomenon (aggravation of his underlying skin condition) at the site of the scald; this delayed healing and required surgical referral.

Table 3. Occupational disease and injury statistics for each occupational group

<table>
<thead>
<tr>
<th>Occupational group</th>
<th>Occupational disease and injury incidence rate (%)</th>
<th>Occupational disease and injury frequency rate per 1000 days worked</th>
<th>Occupational injury incidence rate (%)</th>
<th>Occupational injury frequency rate per 1000 days worked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional cookery 1</td>
<td>29% in 30 weeks</td>
<td>1.96</td>
<td>24.6% in 30 weeks</td>
<td>1.64</td>
</tr>
<tr>
<td>Professional cookery 2</td>
<td>8.6% in 16 weeks</td>
<td>1.08</td>
<td>6.9% in 16 weeks</td>
<td>0.86</td>
</tr>
<tr>
<td>Bar skills</td>
<td>8.33% in 13 weeks and 3 days</td>
<td>1.23</td>
<td>8.33% in 13 weeks and 3 days</td>
<td>1.23</td>
</tr>
<tr>
<td>Advanced bar skills</td>
<td>5.5% in 10 weeks</td>
<td>1.11</td>
<td>5.5% in 10 weeks</td>
<td>1.11</td>
</tr>
<tr>
<td>Advanced restaurant services</td>
<td>0% in 10 weeks</td>
<td>0</td>
<td>0% in 10 weeks</td>
<td>0</td>
</tr>
<tr>
<td>Labour Force Survey 1997</td>
<td>No data available</td>
<td>No data available</td>
<td>1.24% in 52 weeks</td>
<td>0.05</td>
</tr>
</tbody>
</table>

Table 4. Age–sex profile

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Students with occupational disease/injury</th>
<th>All students in the cohort</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average age (years)</td>
<td>21</td>
<td>22</td>
</tr>
<tr>
<td>Age range (years)</td>
<td>18–41</td>
<td>18–41</td>
</tr>
<tr>
<td>% male</td>
<td>71</td>
<td>56</td>
</tr>
<tr>
<td>% female</td>
<td>29</td>
<td>44</td>
</tr>
</tbody>
</table>

Table 4. Age–sex profile

<table>
<thead>
<tr>
<th>Demographics</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Average age</td>
<td>21</td>
<td>22</td>
</tr>
<tr>
<td>Age range (years)</td>
<td>18–41</td>
<td>18–41</td>
</tr>
<tr>
<td>% male</td>
<td>71</td>
<td>56</td>
</tr>
<tr>
<td>% female</td>
<td>29</td>
<td>44</td>
</tr>
</tbody>
</table>

Treatment and outcome of occupational disease or injury

Of the cuts/lacerations, four required sutures and 10 required steri-strips. In four cases there was difficulty arresting the haemorrhage.

Thirty-eight conditions required dressings.

Ten students were referred to hospital: two to a dermatologist and eight to the accident and emergency department.

In all, 17 conditions required at least one drug prescription. Twenty-one scripts were issued, mostly for steroid creams, anti-inflammatory agents, antibiotics, antifungal creams and antihistamine tablets.

There was a high secondary infection rate of skin injuries. One burn, three scalds, one cut and one embedded fish bone became infected and required antibiotic therapy. This accounted for 21% of burns/scalds and 14% of cuts/lacerations/foreign bodies.

Two cases of dermatitis required antifungal therapy.

Students with cuts/lacerations or burns/scalds were offered vaccination against tetanus.
The workload generated for the student health services

Occupational injury and disease created a significant workload for the student health services during the time period studied. In fact, 14% of the total primary care consultations to the student health unit among the study sample were for the treatment of occupational injury or illness.

Nearly half (45%) of the 51 work-related episodes of ill-health (injury and disease) required more than one visit to the student health unit, over one-third (37%) were managed by the nursing staff alone.

Discussion

A high incidence of occupational disease/injury was recorded for the cohort of catering students over the 10 month period of study. However, the true incidence is probably higher. First, only disease and injury presenting to the student health unit were recorded. It is possible, but unlikely, that students may have received medical attention elsewhere. The students were encouraged to use the student health services, particularly for work-related problems. Secondly, there may have been minor incidents, which did not present for treatment and therefore were not recorded. Thirdly, the healthy worker effect, whereby workers who suffer ill-health leave the industry, so that only healthy workers are left behind, is an unlikely, but possible source of bias in this young population. None of the students left or transferred to other courses during the study period.

The study sample was young, the average age being 22 years. An older population would be expected to have more allergic disease due to sensitization and more musculoskeletal problems, but probably lower injury rates as a consequence of their experience and training.

Of the cohort under study, 77% were trainee chefs and therefore handled knives and hot liquids, and worked with ovens, hobs and grills. This partly explains the high proportion of accidents caused by moving articles (hand tools) and exposure to hazardous substances (hot surfaces and liquids), as demonstrated in Table 5.

The study population had a high occupational injury plus disease incidence rate and a high occupational injury plus disease frequency rate. The statistics referring to injury alone can be compared with the Irish Labour Force data (1997) [1], as shown in Table 3. The high occupational injury incidence rate recorded in this study exceeds the national benchmark, which indicates that catering in Ireland, as in other countries, is a hazardous industry [2,3].

Given their high risk of cuts/lacerations and burns/scalds, it would be sensible to offer chefs and catering assistants vaccination against tetanus. Furthermore, occupational first-aiders working in the catering industry should be offered vaccination against hepatitis B. Other authors have identified bar workers as being at risk for hepatitis B infection, owing to injury caused by glassware [27].

Comparison of injury/disease incidence and frequency rates between the different occupational groups in Tables 2 and 3 shows that the first-year trainee chefs

<table>
<thead>
<tr>
<th>Disease/injury</th>
<th>n</th>
<th>Hazard</th>
<th>HSE injury category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cuts/lacerations/amputations</td>
<td>21</td>
<td>20 knives, 1 oyster shell</td>
<td>Struck by moving articles including hand tools</td>
</tr>
<tr>
<td>Scalds</td>
<td>9</td>
<td>1 tea, 2 hot oil, 6 soup</td>
<td>Exposure to hazardous substances, hot surfaces and steam</td>
</tr>
<tr>
<td>Burns</td>
<td>5</td>
<td>1 chemical dye, 1 chilli burn, 3 dry heat</td>
<td>Exposure to hazardous substances, hot surfaces and steam</td>
</tr>
<tr>
<td>Contact dermatitis</td>
<td>5</td>
<td>5 allergy/irritant</td>
<td>(Disease)</td>
</tr>
<tr>
<td>Back strain</td>
<td>3</td>
<td>3 manual handling accidents</td>
<td>Handling</td>
</tr>
<tr>
<td>Faint</td>
<td>3</td>
<td>1 heat fatigue, 1 heat fatigue and</td>
<td>(Disease)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>tonsillitis, 1 menses and heat fatigue</td>
<td></td>
</tr>
<tr>
<td>Blunt injury</td>
<td>2</td>
<td>2 falling objects</td>
<td>Handling</td>
</tr>
<tr>
<td>Foreign body</td>
<td>1</td>
<td>1 embedded fish bone</td>
<td>Struck by moving articles including hand tools</td>
</tr>
<tr>
<td>Wrist sprain</td>
<td>1</td>
<td>1 lifting heavy pot</td>
<td>Handling</td>
</tr>
<tr>
<td>Shoulder injury</td>
<td>1</td>
<td>1 fall on wet floor</td>
<td>Falls</td>
</tr>
</tbody>
</table>

Table 5. Work-related diseases and injuries; hazards responsible

<table>
<thead>
<tr>
<th>Relative importance</th>
<th>This study (%)</th>
<th>HSE data [2] (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slips and trips</td>
<td>1</td>
<td>30</td>
</tr>
<tr>
<td>Handling</td>
<td>14</td>
<td>29</td>
</tr>
<tr>
<td>Exposure to hazardous substances,</td>
<td>33</td>
<td>16</td>
</tr>
<tr>
<td>hot surfaces and steam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Struck by moving articles including</td>
<td>51</td>
<td>10</td>
</tr>
<tr>
<td>hand tools</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking into objects</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Machinery</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Falls</td>
<td>2</td>
<td>1.8</td>
</tr>
<tr>
<td>Fire and explosion</td>
<td>0</td>
<td>1.6</td>
</tr>
<tr>
<td>Electric shock</td>
<td>0</td>
<td>0.5</td>
</tr>
<tr>
<td>Transport</td>
<td>0</td>
<td>0.3</td>
</tr>
</tbody>
</table>

Table 6. Leading causes of accidents in the school of catering

The workload generated for the student health services

The study population had a high occupational injury plus disease incidence rate and a high occupational injury plus disease frequency rate. The statistics referring to injury alone can be compared with the Irish Labour Force data (1997) [1], as shown in Table 3. The high occupational injury incidence rate recorded in this study exceeds the national benchmark, which indicates that catering in Ireland, as in other countries, is a hazardous industry [2,3].

Given their high risk of cuts/lacerations and burns/scalds, it would be sensible to offer chefs and catering assistants vaccination against tetanus. Furthermore, occupational first-aiders working in the catering industry should be offered vaccination against hepatitis B. Other authors have identified bar workers as being at risk for hepatitis B infection, owing to injury caused by glassware [27].

Comparison of injury/disease incidence and frequency rates between the different occupational groups in Tables 2 and 3 shows that the first-year trainee chefs
carried the highest rates of disease and injury. It must be noted, however, that the first-year chefs were the only group to spend 10 full months training on campus, thus giving more opportunity to record their episodes of injury and disease. However, more likely reasons for their higher incidence and frequency of work-related ill-health (both disease and injury) are first, that kitchen work is probably more hazardous than bar or restaurant work; and secondly, that this group was the youngest and least experienced of the five groups studied. This is an important fact, bearing in mind that many catering workers in Ireland are young and lack training and experience, and therefore would be quite similar to this group [22,24]. It is interesting to see in Tables 2 and 3 the sharp decline in injury and disease statistics from the first-year chefs to the second-year chefs. This is probably a benefit of their training and experience. 

There is evidence from this study that some workers are more accident prone than others. Some students had more than one injury. Accident reporting and investigation helps to identify such at-risk individuals, who may require extra supervision and training. Interestingly, significantly more male students suffered occupational injury and disease.

Each catering establishment needs to assess its own health and safety needs rather than rely entirely on data from outside sources, which may not reflect local needs. This is demonstrated in Table 6, where the leading causes of accidents in the catering school studied differ widely from the HSE data. The low incidence of slips, trips and falls, electric injury, gas injury and manual handling accidents, for example, suggests that certain health and safety procedures in the school are effective.

The study period was limited to a 10 month academic year. Due to the latency period for many occupational diseases, a longer time frame would probably reveal greater numbers and types of diseases. However, the first year of exposure to a sensitizer is recognized as being a high-risk period for the development of allergic disease. This may explain why four of the five cases of dermatitis occurred among the class of first-year chefs.

Working in the catering industry increases the risk of dermatitis by 3-fold [28]. The prevalence of work-related skin disease (irritant and contact dermatitis, protein contact urticaria) in the industry is estimated to be ~15% [6]. Five of the 315 students in this study developed dermatitis; all of these were trainee chefs whose work involved daily exposure to irritants (e.g. water, temperature extremes) and allergens (e.g. citrus fruits, spices, proteinaceous foods).

Skin scrapings were positive for fungal infection in two of the five dermatitis cases, and there was a high secondary infection rate of skin injuries. These findings probably reflect the wet nature of catering work.

Three of the students attended the student health unit following a faint in the workplace. All of these were trainee chefs. All three mentioned excessive heat and workloads as factors leading to their collapse at work. High temperatures, crowds and physical exertion contribute to heat fatigue. The workloads in catering can be unpredictable, with periods of high work activity, which are physically and mentally demanding. In addition, the working times are unsociable, with most workers working through normal mealtimes. All of these factors may contribute to vasovagal episodes.

Catering establishments would benefit from access to occupational health services, not only to provide treatment of injury and disease, but also for advice in the implementation of an effective health and safety management system. In this study, work-related injury and disease generated a significant workload for the student health unit and, although most episodes recorded were of a minor nature, 5.8% of episodes were regarded as severe (career change being recommended in one case). This is a significant finding in terms of litigation, insurance and other costs.

Sickness absence was not recorded; however, students with cuts, dressings, rashes or difficulties with manual handling are not permitted to work. The school’s policy is that students certify themselves fit or unfit and do not require a certificate from the student health unit.

In Ireland, as in other EU countries, a comprehensive legal framework exists for preventing and managing health, safety and welfare in the workplace, under The Safety, Health and Welfare at Work Act (1989) and subsequent Regulations [29,30]. Although there is no legislation specific to the catering industry, there are industry-specific guidelines and quality management procedures [5]. There is a constant need for vigilance and the regular review of health and safety procedures in every catering establishment, in order to ensure compliance with these guidelines.

Conclusion

The catering industry has many workplace hazards that can lead to injury and disease. Young, untrained workers are most at risk of occupational injury and disease. In the catering establishment studied, many of the workers were young, inexperienced and untrained. They were found to have high occupational injury and disease incidence rates and occupational injury and disease frequency rates.

Cuts, lacerations, burns and scalds were the most frequent injuries recorded in this study.

In view of this, kitchen workers, particularly chefs and their assistants, should be offered vaccination against tetanus. Occupational first-aiders in the catering industry should be offered vaccination against hepatitis B.

Occupational disease and injury in this study generated a significant workload for the occupational health
services. Occupational health practitioners can offer clinical expertise and advice to catering establishments in order to improve health, safety and well-being. There is significant potential for litigation against employers in the catering industry.

There is a lack of quality data on injury and disease statistics in catering in Ireland. A larger study involving a wider spectrum of catering establishments would more accurately determine the incidence, nature and causes of work-related disease in the catering industry in Ireland. This would benefit the planning and implementation of an effective health and safety management system.

Every catering establishment would benefit from auditing its own injury and disease statistics, in order to identify its health and safety needs. A system of hazard identification, risk assessment, control measures and ongoing surveillance should be in place in every catering workplace.

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References