

fifty seven (94%) patients knew their HIV status and a 617 (68%) were HIV positive. The TB treatment outcomes showed that 86% were successfully treated, 79 (8.6%) not evaluated and 44 (4.4%) died.

Conclusion Mine health facilities have TB Control programme performs well but an opportunity for strengthening exists.

526 ADVERSE EFFECTS OF SMOKING; QUITTING TOBACCO

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Introduction Tobacco use is the leading preventable cause of death in the world. Smoking is a real cardio-vascular risk-factor. Risk of death from coronary heart disease is much higher at smokers. One of the most important things is understanding.

I set up a 100 patients sample being more and less „heavy smokers’ from the region of Székesfehérvár and the nearby areas.

Methods I applied both the „behavioural support’ (advice, tobacco withdrawal, etc.) and pharmacotherapy (nicotine replacement therapy, bupropion, varenicline, etc.).

In both cases I followed the Prohaska’s stages of change-theory: No thought of quitting; Consider quitting; Get ready to quit; Quit; Maintain tobacco-free status; Slip and try again. **Results** A 4 × 3 months period of therapy is being applied. For the time being I’m in the second quarter of my experimental help and support method.

Only a few patients succeeded to stop smoking (less than 10%) during the first 3 months.

They are now in the „Maintain tobacco-free status’ stage.

Afer the summer holidays the treatment will be continued.

Hopefully by the beginning of the Dublin-congress I can update this section of my presentation.

Conclusions Obviously I can draw the final conclusions at the beginning of the next year (March-April, 2018.). My presentation will comprise all these conclusions and the updated results, as well.

As a preliminary experience of mine: this therapy is not easy.

Understanding is not enough. Personal stories and one-to-one counselling can help a lot.

536 DATA IN THE WORKPLACE SURVEYS OF OCCUPATIONAL HEALTH SERVICES

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Introduction The purpose of workplace surveys is to investigate the hazards, exposures and strains of the work environment and evaluate their impact on employees’ health and safety. In addition, occupational health service (OHS) propose actions to improve health and safety at work. The Occupational Health Act (1383/2001) sets the framework for systematic and target-oriented cooperation between OHS, employers and employees. An essential component in cooperation is the exchange of relevant data.

Methods We used the Delphi method to evaluate which data is considered relevant for information exchange in workplace surveys and how it should be documented in the information systems. Altogether thirty-seven OH physicians, OH nurses, OH physiotherapists and OH psychologists participated in the three rounds of the survey. The response rates were 76%, 73% and 73%, respectively. The data was analysed with the content analysis.

Result The most relevant data for information exchange between OHS and workplace in the workplace surveys were work-related health and safety risks, work load and recovery factors, recommendations for further actions and the information about the work environment, staff, professional titles and changes in the workplace.

Discussion OHS professionals use regularly information systems for documenting workplace survey data. The way the data is stored and made available in the information systems do not support enough planning and monitoring of the OHS activities and collaboration with the workplace. In order to improve the situation, better understanding of what is the relevant data for information exchange and the way the data should be structured, is needed.

539 SHARED DECISION MAKING IN A PREVENTIVE CONSULTATION ON PREGNANCY AND WORK, AN EXPERIMENTAL VIGNETTE STUDY AMONG OCCUPATIONAL PHYSICIANS

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Introduction In Occupational Health (OH), the application of shared decision making (SDM) is not very well developed. As high level evidence on effectiveness of many OH interventions is scarce and often different options for OH interventions are available, preference-sensitive decisions in OH are prevalent. We studied a theoretical preference-sensitive decision in a preventive consultation by an occupational physician (OP): prevention of preterm birth in nurses exposed to physically demanding work during pregnancy. The aim was to investigate whether a more closed recommendation in one guideline (‘if a work-related risk factor exists, action should be taken’) versus a more open formulated recommendation (‘no mandatory intervention but if distress is experienced, the worker should be advised to discuss it with her employer’) in another guideline on pregnancy and work lead to differences in attitude of the OP to SDM in this case, in risk perception by the OP, and in self-efficacy to deliberate with the worker about this topic.

Methods OPs working in the health care sector were invited to participate in an online survey. We constructed vignettes about a voluntary preventive consultation by a nurse with her OP with two different recommendations on exposure to heavy physical work during pregnancy and two different case scenario’s. The main issue for this consultation is if the nurse can continue her work during pregnancy in a regular way or that she should be advised to reduce or adapt her tasks. Within-subject differences in attitudes, perception and self-efficacy,

comparing the four experimental settings, were tested with paired sample t-tests.

Result The online questionnaire was completed by 25 OPs (16 women and 9 men). As analysis is ongoing, the results of this experiment will be presented.

Discussion More attention for SDM in OH is needed. Experimental studies like this one may give clues to the use of SDM in the field of OH.

63 CREATING A HEALTHY WORKPLACE AT A SCHOOL OF PUBLIC HEALTH, NATIONAL UNIVERSITY OF SINGAPORE – USING THE TOTAL WORKPLACE SAFETY AND HEALTH (WSH) TOOLS

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Introduction Many health promotion programs are introduced without first conducting a proper risk assessing of the workplace. As such, it is difficult to evaluate the usefulness of the programs. We have developed a tool, Total WSH, which consider safety, health and wellbeing holistically at the workplace. This tool was used in this study.

Methods We conducted the study on 245 staff of our School of Public Health in June 2015 using the Total WSH tools which consist of

- Workplace Safety & Health Services Questionnaire (WSHQ) – assess Elements of basic WSH Management System;
- Workplace Safety and Health 360 Questionnaire (WSH360) – evaluate Perception and communication of WSH priorities, services and integration;
- Basic Health Survey (BHS) – determine basic health of workers; and
- Walk through assessment.

Based on the findings, we implemented targeted health programs which were evaluated using the BHS again 1 year after the implementations.

Results Assessment revealed the School's health and safety management system were robust. However, some health and well-being needs of the staff were unmet.

We implemented interventions programs to address these health issues and evaluated the outcomes. Fitness Friday, posters to increase stair, provision of adjustable working tables to encourage standing during work, office ergonomic pregame to address bodily pain, and education on healthy eating were introduced.

22% reported bodily pain in the past 4 weeks – this was reduced to 17.2%. 64% did not meet the national recommended physical activity level (WHO's) – this was reduced to 55.6%. The daily average consumption of fruits and vegetables (national recommendation of 2 servings) have also increased from 31.7% to 35.7% and 61.1 and to 64.1%, respectively. In addition, the daily consumption of sweetened drink has decreased from 27% to 19.6%.

Discussion Total WSH tool is effective in assessing the safety and health at the workplace and also an evaluation tool to determine the outcomes of programs that are being implemented at the workplaces.

635

INTEGRATED HEALTH PROGRAMS FOR HEALTHCARE WORKERS – LESSONS LEARNED FROM IMPLEMENTATION AND EVALUATION IN A TERTIARY HOSPITAL IN SINGAPORE

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Introduction The National University Hospital is a tertiary hospital with around 6400 employees. A 'Total Workplace Safety & Health' program was started in 2014 by assessing organisational and individual health risks using a health survey, workplace visits, accident reports, results of staff health screening and an internet-administered survey regarding health, stress, behaviour, and program engagement. Interventions included evidence-based health screening, a 'healthy-eating' campaign introducing a traffic-light system identifying healthier food at worksite canteens, needle-stick injuries reduction programs and motivational campaigns to increase physical activity. In spring 2017 the impact evaluation started. We report on lessons learned on program implementation, methodology and results of this impact evaluation.

Methods Barriers to program success and evaluation were assessed through quantitative and qualitative methods focus-group discussions, employee survey, vendor interviews and direct observations for *Healthy-Eating* and *Physical-Activity Interventions*, including environment assessment, plate-counts of meals, sedentary and eating behaviours, activity habits, acceptance of messages.

Result Feedback for lifestyle/behavioural interventions suggests modest participation and unknown impact. Participation in medical programs increased (vaccination +30%), previously undiagnosed chronic diseases were identified (unclear/pathological results 5% high blood-pressure, 5% high blood-glucose, 11% cancer screenings), a follow-up process was implemented. Organisational and environmental barriers for long-term program success were identified. Great enthusiasm got the programs started but lack of planning for evaluation hinders impact assessment. Survey, focus-groups and observations are completed in July 2017.

Discussion Lessons learned include: Clarify responsibilities and reporting lines, plan for monitoring/evaluation at the beginning, get a baseline, define program goals. Clearly defined and medical-style programs showed more positive results and participation. Lifestyle interventions need to set realistic targets. 'Asking' people on behaviour is notoriously biased. Unplanned evaluations 'ex-post' are unsatisfactory or impossible. Only some programs are open for cost-effective evaluation on hindsight and coordination from the top is crucial for impactful interventions and their evaluation.

644

RISK FACTORS FOR WORK RELATED MUSCULOSKELETAL DISORDERS AMONG PHYSIOTHERAPISTS

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