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**PATIENT SAFETY AND RISK MANAGEMENT AT HEALTHCARE
ORGANISATIONS**

STUDY PROGRAM: Medicine (English)

Supervisor of the Master's Thesis

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1. SUMMARY

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The title: Patient Safety and Risk Management at Healthcare Organisations

The aim: Evaluate organisational punishment culture effect on reporting adverse events in healthcare organisations.

The objectives: 1. To investigate if the organisational culture of punishment is beneficial to patient safety in healthcare organisations. 2. To analyse healthcare professionals reporting adverse events in relation to organisational punishment. 3. To evaluate if organisational culture is affecting patient safety and risk management negatively or positively.

Methodology: Scoping review has been performed, according to the preferred reporting items for systematic reviews and meta-analyses extension for a scoping review (Prisma- ScR). This included the search of databases (ScienceDirect and PubMed) for research articles related to the study questions and the data yielded (1283 articles) was later analysed after evaluation for eligibility, exclusion and inclusion criteria. 31 articles were included in the detailed analysis of this research.

Study Participants: There are no human participants in this study.

Results: The initial search in both databases produced a total of 1283 articles and after the removal of duplicates, and application of inclusion and exclusion criteria there were left 31 articles which were included in this research. The included articles all shared a common notion that better reporting of adverse events (AE) or patient safety incidents is related to the knowledge of the healthcare provider on errors. Senior doctors had a tendency not to report AE. Lack of feedback about reported AE leads to a decreased reported AE in the future. Most of the research articles relate reporting of AE to a fair or just culture in the institution which promotes AE and error reporting, in turn, improving patient safety.

Conclusions: From the three objectives of this research aimed to prove the hypotheses that organisational punishment culture influences the reporting of AE in healthcare organisations. It is concluded as follows 1) organisational culture of punishment is not beneficial to the reporting of AE, and this leads to a decreased improvement in PS 2) Healthcare providers report AE based on the culture of the organisation 3) PS and risk management can be affected negatively or positively based on the organisational culture. From the objectives of this research, it is proved that the organisational culture of punishment influences the reporting of AE in healthcare organisations.

Recommendation: An additional system could be developed for patient experiences and incident reporting; patients should be included in their treatment management, educated on safety and encouraged to report any bad experiences, errors or AE.

2. SANTRAUKA

Autorius: Richie Pereowei Barugu

Pavadinimas: Pacientų sauga ir rizikos valdymas sveikatos priežiūros įstaigose

Tikslas: Įvertinti organizacinės bausmių kultūros poveikį pranešimams apie nepageidaujamus įvykius sveikatos priežiūros įstaigose.

Uždaviniai: 1. Ištirti, ar organizacinė bausmių kultūra yra naudinga pacientų saugai sveikatos priežiūros įstaigose. 2. Išanalizuoti sveikatos priežiūros specialistų pranešimų apie nepageidaujamus įvykius sąsajas su organizacijose taikomomis nuobaudomis. 3. Įvertinti, ar organizacinė kultūra neigiamai ar teigiamai veikia pacientų saugą ir rizikos valdymą.

Metodika: Buvo atlikta apžvalga (angl. *scoping review*, *ScR*), taikyti ataskaitų teikimo elementai, skirti sisteminėms apžvalgoms ir metaanalizei su išplėtimu (angl. *Prisma-ScR*). Tai apėmė tyrimų straipsnių, susijusių su tyrimo klausimais, paiešką duomenų bazėse (ScienceDirect ir PubMed), o gauti duomenys (1283 straipsniai) vėliau buvo analizuojami, jei jie atitiko tinkamumo, atmetimo ir įtraukimo kriterijus. Į šio tyrimo išsamią analizę buvo įtrauktas 31 straipsnis.

Tyrimo dalyviai: šiame tyrime žmonės nedalyvavo.

Rezultatai: Pirminės paieškos abiejose duomenų bazėse metu iš viso buvo gauti 1283 straipsniai, o pašalinus dublikatus ir pritaikius įtraukimo ir atmetimo kriterijus liko 31 straipsnis, kuris buvo įtrauktas į šį tyrimą. Visuose įtrauktuose straipsniuose buvo bendra nuomonė, kad geresnis pranešimų apie nepageidaujamus įvykius (NĮ) arba pacientų saugos incidentų pateikimas yra susijęs su sveikatos priežiūros paslaugų teikėjo žiniomis apie klaidas. Pastebėta tendencija, kad gydytojai su ilgesne praktine patirtimi nepranešinėjo apie NĮ. Trūkstant grįžtamojo ryšio apie praneštus NĮ, ateityje pranešimų apie NĮ sumažėja. Dauguma mokslinių straipsnių pažymi sąsajas tarp pranešimų apie NĮ ir sąžiningos ar teisingos organizacijos kultūros, kuri skatina informavimą ir pranešimus apie NĮ ir klaidas, savo ruožtu, gerindama pacientų saugą.

Išvados: Remiantis trimis šio tyrimo tikslais buvo siekiama įrodyti hipotezes, kad organizacinė baudžiamoji kultūra daro įtaką NĮ ataskaitai sveikatos priežiūros organizacijose. Dėl tos priežasties prieinama prie tokių išvadų: 1) organizacinė baudžiamoji kultūra nėra naudinga teikiant ataskaitas apie NĮ, dėl to jaučiamas pacientų saugos pagerėjimo sumažėjimas 2) Sveikatos priežiūros specialistai praneša apie NĮ, remdamiesi organizacijos kultūra 3) PS ir rizikos valdymas gali būti neigiamai arba teigiamai paveiktas atsižvelgiant į organizaciją. Remiantis šio tyrimo tikslais, įrodyta, kad organizacinė baudžiamoji kultūra turi įtakos ataskaitoms apie NĮ sveikatos priežiūros organizacijose.

Rekomendacija: Galima būtų sukurti papildomą pacientų patirties ir pranešimų apie incidentus sistemą; pacientai turi būti įtraukti į gydymo valdymą, mokomi apie saugumą ir skatinami pranešti apie bet kokią blogą patirtį, klaidas ar NĮ.

3. ACKNOWLEDGEMENTS

I would like to express my sincere gratitude to my supervisor Lolita Šileikienė, PhD, MD for continuous support and encouragement throughout the process of writing this thesis.

4. CONFLICTS OF INTEREST

No conflict of interest exists concerning this study.

5. ETHICS COMMITTEE APPROVAL

The study “Patient Safety and Risk Management at Health Care Organisations” was approved by Ethics Committee at the Lithuanian University of Health Sciences on 2022-12-02 with the number: BEC-MF-120.

6. ABBREVIATIONS

AE- Adverse Events

BON- Board of Nursing

DPSI- Disclosing patient safety incident

IR- Incident Reporting

LSMU – Lithuanian University of Health Sciences

ME- Medical Errors

MERIS- Medical Error Reporting Information System

PRISMA-ScR - preferred reporting items for systematic reviews and meta-analyses extension
for a scoping review

PAE- Preventable Adverse Events

PS- Patient Safety

PSC- Patient Safety Climate

7. TERMS

Adverse Event - an unintended injury or complication that results in disability at discharge, death or prolonged hospital stay and is caused by healthcare management rather than the patient's underlying disease.

Just Culture - an environment of trust and staff are encouraged or even rewarded for giving important safety-related information, but there is also a clear line between acceptable and unacceptable behaviour due to accountability.

Learning Culture - a culture where changes are made due to learning by the organisation from mistakes. Staffs want to and are competent to get the right conclusion from the safety information available, and the zeal to initiate mitigating corrections/changes.

Organizational Culture - the pattern of shared basic assumptions-invented, discovered or developed by a given group as it learns to cope with its problems of external adaptation and internal integration and to teach new members the correct way to perceive, think and feel in relation to those problems.

Patient Safety - patient safety is a coordinated framework that builds a culture, process, procedure, behaviour, technology and environment in healthcare which regularly and sustainably reduces risks, the occurrence of avoidable harm, makes errors less likely and decreases the impact of harm when it does occur.

8. INTRODUCTION

PS and AE are serious public health problems, and it is true that as humans we are imperfect, with errors sometimes the common saying “to err is human“ has led to some unreported ME but it should be recognized, analysed, lay down a strategy for improving, learn from them, and work towards preventing them, PS can be improved once we follow through on a precise strategy [1-6].

The healthcare system and procedure is a huge and complex system that is comprised of various individuals, but PS or risk management is the collective responsibility of every individual coming together to work as a team for the sole purpose of reducing risk and increasing PS. Likewise, when a ME occurs by an individual, but organisation should develop a teamwork approach to identify this error, learn from it, and improve preventive measures towards PS. The process should enhance systemic policy changes rather than focusing on individual performance [7-10].

ME or AE are unpredictable occurrences in healthcare organisations and the aim of any healthcare practitioner is to do no harm or threaten the safety of a patient but sometimes this goal is not reached for various reach. As an organisation working together as a team, A well-organised reporting system should be initiated which aims to analyse such events whether mild, moderate, or severe AE to induce organisational learning and improvement in patient safety culture [1-4,11].

PS is incredibly challenging and complex to achieve because different individuals play a key role ranging from the patient, family or friends, healthcare professionals, healthcare administrative staff etc and any of these persons can compromise PS. So, organisations should see PS as a generalised issue which needs to be overcome and create an improved system which works to enhance safety results rather than having a culture of blaming, shaming and punishment of an individual which causes more pressure on healthcare staff and leads to underreporting of AE.

Psychological effects such as stress, anger, guilt, depression, burnout, enormous working hours and pressure of giving answers or solutions to every medical problem and the fear of impending legal actions cause medical professionals to lose clinical confidence leading to a compromise in PS. Also, an adversary environment in many healthcare organisations or the fear of punishments, shaming or blaming leads to the reluctance of reporting AE or errors. [12-21].

Organisational and behavioural learning plays a key role in improving PS. It is important for an organisation to continue learning from daily work routines and incidents and this can be improved by increasing personnel’s skills and knowledge based on incident reports and analysis. Moreover, inexperienced, or junior colleagues can be paired with experienced or senior staff with vast knowledge in a particular field of a medical procedure or relative calmness in a stressful situation. In this way, PSC is improved not just for individuals but for the entire organisation [8-9, 22-27].

Error is part of human behaviour; it is universal and inevitable but when this happens in a high-risk organisation or industry it should be studied, and strategies should be set up to limit the reoccurrence of these errors. The fact that errors in a healthcare organisation can lead to the deaths of patients' organisations should put a huge amount of time and resources into understanding, identification, and error prevention training to minimise errors and maximise PS. To understand and avoid errors resulting in AE, it is paramount to create a PSC approach with some critical elements: acknowledging the epidemiology of AE and developing methods for risk management: incorporating improved principles and techniques into daily work routines: and creating customization and applying evidence and context-based PS solutions. These elements can be included in risk management and solution development [23].

This research aims to evaluate the organisational punishment culture's effect on reporting AE in healthcare organisations.

9. AIM AND OBJECTIVES

Aim:

Evaluate Organisational punishment culture effect on reporting adverse events in healthcare organisations.

Objectives:

1. To investigate if the organisational culture of punishment is beneficial to patient safety in healthcare organisation.
2. To analyse healthcare professionals reporting adverse events in relation to organisational punishment.
3. To evaluate if organisational culture is affecting patient safety and risk management negatively or positively.

10. LITERATURE REVIEW

PS is a coordinated framework which builds a culture, process, procedure, behaviour, technology and environment in healthcare which regularly and sustainably reduces risks, and occurrence of avoidable harm, makes errors less likely and decreases the impact of harm when it does occur. The global patient safety action plan strives to eliminate avoidable harm in healthcare with the goal of achieving the maximum possible reduction in unavoidable harm due to unsafe healthcare globally [16]. PS is the responsibility of everyone and requires active participation ranging from patients and families to governmental, nongovernmental and professional organisations. With this in mind, the global patient safety plan set up 7 guiding principles which include engaging patients and families as partners in safe care, achieving results through collaborative work, analysing and sharing data to generate learning, translating evidence into actionable and measurable improvement, base policies and action on the nature of the care setting, use both scientific expertise and patient experience to improve safety and instil a safety culture in the design and delivery of health care [16].

According to Ausserhofer D et al Patient safety climate (PSC) is an important work environment factor determining PS and quality of care in healthcare organizations. Presently healthcare organisation patient care is likely unsafe as between 2.9% and 16.6% of hospitalized patients are affected by adverse events such as medication errors, healthcare-associated infections, or patient falls [12]. These adverse events can lead to temporary or permanent disability which between 3% and 20.8% of patients experiencing AE can lead to death. 37% and 70% of AE are considered preventable which means patient trauma due to AE, lack of trust in the healthcare system and cost could be avoided [12]. Patient harm prevention is a critical step in improving the quality of care and achieving a high level of safety. It is important to identify errors and violations within healthcare organisations for PS to improve and high numbers of AE are related to organisational factors such as heavy workloads, inadequate expertise, stressful environments, or poor communication. Thus, understanding organizational behaviour is foundational to reducing the incidence of adverse events and improving PS [12, 24-25, 28].

10.1. What are Adverse Events and Types

The two most used AE definitions are the Harvard method and the Global trigger method. AE can be defined respectively as “An unintended injury or complication that results in disability at discharge, death or prolonged hospital stay and is caused by healthcare management rather than the patient’s underlying disease” Harvard method. Or “Unintended injury resulting from or contributed to

by medical care that requires additional monitoring, treatment or hospitalization, or that results in death” Global trigger method [24].

Observing AE is understandably important for healthcare organisations, not because of the outcome on PS but also because it can give an awareness of the quality of care and provide an avenue for learning and improvement. Moreover, many AE occurring are avoidable and are therefore referred to as preventable adverse events (PAEs).

Different methods of analysing and estimating PAEs have been developed and adapted to various healthcare conditions, and each method has its strength and weakness.

One method is to analyse or systematically search patients’ medical records for clues or triggers which indicate a point of deviation from the normal route of care and therefore identify events and methods that eventually caused injury or harm [19, 25, 29-32].

This method is limited or has a negative impact on PS because medical records do not entail everything that happened to a patient. It is dependent on the awareness and wilfulness [5, 25, 33, 31] of healthcare professionals to identify and document the care and treatment of patients accurately and completely. This is often not the case and leads to imperfect standards.

Another approach is a computerized system of incident reporting (IR) in which healthcare professionals are required to report if errors have occurred or the possible risk of errors occurring. It is aimed to broaden the knowledge of the frequency, style, and trends of AE and to serve as a warning system. However, for this approach to be successful quality feedback is crucial for learning, encouraging continued reporting and enacting trust in the system. While the limitations of this approach are underreporting, blaming and non-consensus on what to report [25, 34].

The third approach is daily safety briefings which consist of a short meeting in which issues that have happened in the previous 24 hours such as AE and anticipated disruptions in the next 24 hours are reviewed to resolve identified issues and to take steps for correction of newly identified problems. This is a non-anonymous reporting system which requires a supportive environment where everyone avoids blaming but holds a collective responsibility to PS. A great challenge for this method is getting everyone together and finding time for the meeting [25].

It identified 19.9% PAEs using the record review approach; the IR system, 3.4% PAEs; and daily safety briefings, 5.4% PAEs per 1000 patients in a day. The most prevalent PAEs by the record review approach were drug-related PAEs, pressure ulcers, and hospital-acquired infections [25].

The most prevalent PAEs by the IR system approach and daily safety briefing approach were fall injuries and pressure ulcers, followed by skin/superficial vessel injuries for the IR system approach and hospital-acquired infections for the daily safety briefing approach. The incident reporting and daily safety briefing identified 7.8% and 31.9% near misses per 1000 patients per day, respectively. The most prevalent near misses were related to how care is organised [25].

There are two major errors leading to PAE:

- Errors occurring due to actions not taken and,
- Errors occurring due to the wrong actions being taken [12].

Healthcare professionals are reluctant to report errors due to the fear of punishment [18, 21, 30, 34-36]. Although they care about the safety of the patient and have sworn an oath to “do no harm” they dread disciplinary actions, including the loss of jobs if they report an incident. The failure of reporting AE increases the likelihood of serious patient harm because many healthcare organisations have a rigid policy which creates an adversarial atmosphere and tends to make staff hesitant to report errors, minimize the problems, or even intentionally fail to document the issues [3, 12, 21, 36]. These actions by both the staff and organisation contribute to an evolving cycle of PAE (preventable adverse events) and ME. There are multiple contributing factors that come together which eventually leads to an error [12, 25]. Not all errors can be preventable with current technology or resources available to healthcare professionals, and this shows a lack of understanding due to public and legislative intolerance for ME [3, 12, 25]. There are always human factors which constitute a problem, and identification of these factors leads to improvement strategies to be undertaken. Particularly, blaming or punishing individuals for systemic causes of errors does not solve the causes nor will it prevent the error from happening again [3, 12].

The goal is to focus on improving the safety of healthcare systems to decrease the probability of errors and mitigate their effects rather than focusing on individual actions. Error is an avenue for constructive change and improving healthcare delivery education. There should be a collaboration between the government, legal and medical organisation to replace the culture of blame while retaining accountability. Once this is achieved healthcare institutions will hit the targets of improving the process which includes patient safety and risk management [12].

10.1.1. Types of Adverse Events

The most common and most reported types of AE are 1) operative/ surgical-related events resulting from post-op bleeding or return to surgery. 2) medication or drug/fluid-related events such as medication errors and, 3) healthcare-associated infections and allergic reactions [24].

10.1.2. Severity and preventability of AEs

Temporary and minimal effect or caused no harm to the patient was the most consequences of AEs having a median of 53.3% (Range: 16.1% to 73.4%). On the other hand, 21.2% of patients affected suffered from moderate impairment (Range: 4.1% to 56.5%). An average of 7.3% of affected patients developed a permanent disability (Range: 3.9% to 17%). The occurrence of death was 7.3% of patients affected by at least one AE (Range: 0.6% to 30%). An average of 51.2% of events were considered preventable adverse events (Range: 34.3% to 83%) [24-25].

10.2. Culture of blame or punishment and its effect on reporting of adverse events

Organisational culture can be explained as the way daily activities are carried out in an institute which includes shared values, beliefs and attitudes among colleagues in the organisation leading to an influence on the day-to-day activities [15].

There are some factors in an organisation that influences the culture within, and these are hierarchy, litigation/punishment, professional identity and conforming to culture [13-15, 27]. In professional identity various professionals relate to PS based on their sense of their role in PS, for example, a doctor will relate to PS differently from a nurse. Litigation/punishment has shown to be a big influencer on organisational culture as an open or non-punitive response to errors encourages more reporting and a safe environment for healthcare workers while the opposite has shown a decrease in reporting [3,15,19-20,32,37-38]. Hierarchy is another aspect that influences the culture as junior colleagues are scared to raise concerns challenging more senior colleagues. Lastly, conforming to a culture of fear already in an organisation by new recruits hinders PS [13-15].

The idea of safety culture must be received and understood for shifting from blame to learning culture in healthcare organisations [32]. The procedural protocols and reports are only parts of the solution, emphasis must move from an individual perspective to the system by promoting learning rather than punishment, blame and disciplinary sanctions [4, 32].

The system of healthcare is a huge and complex system with large interdependent parts, influenced by numerous dependent forces. For example, a patient can be moved from department to department and at any time the safety of a patient can be compromised either by the actions of the patient himself/herself or the actions of the healthcare provider. Therefore, we need to shift from a blame culture to learning and improving PS [4, 13-15, 32, 34].

According to Brattebø G et al., there are various types of organisational cultures but two were described:

A learning culture: A culture where changes are made due to learning by the organisation from mistakes. Staffs want to and are competent to get the right conclusion from the safety information available, and the zeal to initiate mitigating corrections/changes.

A just culture: An environment of trust and staff are encouraged or even rewarded for giving important safety-related information, but there is also a clear line between acceptable and unacceptable behaviour due to accountability [13, 39, 26].

The culture of learning from mistakes or adverse events is faced with challenges of underreporting due to fear of sanctions and punishment but healthcare organisations should also use the just culture system in which individuals are genuinely eager to learn from events that may have safety threats because there is no wish for blaming [13-15, 21, 39].

A general reaction to AE may fall into either of the following reactions such as self-blame, blaming others or reluctance to accept that an AE has occurred. Frequently there is a lack of organisational view, but an individual health provider is at the receiving end and is investigated, rather than the system or environment in which health services are provided [39]. Underreporting of ME is still a common challenge in healthcare organisations even when it is mandated to report errors, and this is referred to as the lack of reports on significant ME events [13].

According to Aljabari et al, there are 7 most common causes or factors leading to underreporting of ME in a healthcare organisation and these are named below.

10.2.1. The Fear of Consequences

It is the leading barrier or factor for underreporting and there can be different reasons for a healthcare provider to be afraid of reporting ME. They care about not harming the patient and providing patients with safety but the thoughts of potentially losing their jobs or even worst hindering the reporting of ME. Here are the most reported fear staff has that leads to underreporting fear of blame, which is the most reported fear, fear of losing one's job, fear of the patient's or family's response to the ME, fear of being seen as incompetent, fear of legal actions, fear of punishment, and fear of losing respect from colleagues.

The fear factor is not just the most common barrier leading to underreporting but also a significant factor and this has not changed over the years. This leads to underreporting which in turn leads to less growth or learning to improve PS [14-15, 18, 21, 36].

10.2.2. Lack of feedback

Another reason for underreporting is a lack of feedback and/or negative feedback. It was proven that feedback and open communication about errors has improved reporting of ME. This is a way of supporting the provider who may have caused the error and in so doing making them feel a need for improvement [14, 31].

10.2.3. Work Climate/Culture

Another factor that may have an influence on reporting ME is the organisational culture towards ME and the work environment. An organisational or administrative culture that focuses on the individuals, rather than the system experiences a decrease in reporting ME. The lack of safety culture and error prevention programs leads to underreporting while a culture of strong teamwork and psychological safety measures amongst colleagues in the work environment leads to better reporting of ME [6, 14, 32].

10.2.4. Poor Understanding of ME and the Importance of Reporting ME

There is a poor understanding of what is classed as a ME by providers, and this has led to underreporting. Also, a lack of clear protocol as to what incidents need to be reported or not reported has constituted to be a common barrier in ME reporting. In general, a poor or lack of understanding of the importance of reporting any incident whether big or small is a huge limitation as well [14,18,33].

10.2.5. Time-Consuming

This is one of the major limitations of reporting ME as healthcare providers are faced with busy schedules and high workloads. Adding reporting of incidents to the already busy schedule is too much and most providers just altogether skip this which eventually leads to underreporting [5, 14].

10.2.6. Lack of the Reporting System

Some organisations have no reporting system, probably they just developed a new system for reporting incidents which most or no healthcare providers know about the system. This is another limitation to reporting ME. Every organisation should educate every healthcare provider and promote the use of an electronic reporting system as it shows to be more efficient [14, 29, 33].

10.2.7. Personal Factors

Some reasons such as Younger and/or less experienced healthcare workers or the period of employment or the personal experiences of ME all affected the rate of reporting medical errors [13-14].

PS is a collective responsibility and to achieve a good safety culture healthcare organisation should develop a just, learning culture rather than a culture of shame, blame and punishment [44-46].

11. RESEARCH METHODOLOGY AND METHODS

Arksey and O'Malley's scoping review framework was utilised, and this includes four stages: identifying the research question and relevant studies, selecting the studies, charting the information and reporting the results [40]. Scoping review methodologies have been used in recent years within the patient safety literature [41-43] and are useful in enabling a mapping of a broad field of research including study designs and identifying gaps in literature [44]. Although later modifications of scoping review methodology have aimed to include a quality assessment stage [45-47], this was not included to ensure that relevant studies were included.

The systematic review for this literature review adheres to the preferred reporting items for systematic reviews and meta-analyses extension for scoping review (PRISMA- ScR) statements [17]. The sources for the review were gotten from the university (LSMU) library which included PubMed and ScienceDirect. All the searches were within the area of PS, AE, reporting systems, organisational punishment culture, and generally under safety in a healthcare organisation.

Table 1. The use of following keywords below was utilised for the search of relevant articles

Keywords 1	“Organisational culture” OR “Healthcare Professionals
Keywords 2	“Punishment” OR “Reporting Adverse Events”
Keywords 3	“Risk Management” OR “Patient Safety”
Search	#1 AND #2 AND #3

In the search for relevant research articles based on the keywords, as shown in Table 1, keyword1 + keyword2 + keyword3 was used for each of the research objectives.

Eligibility criteria were used on the articles published within the last 10 years and the articles were found based on the keywords (keyword1 + keyword2 + keyword3) in Table 1. This narrowed down the search and then had to meet the inclusion criteria; namely,

- (a) Published within the last 10 years.
- (b) Applied to a hospital or healthcare organisation setting.
- (c) Described patient safety and culture.
- (d) It was written in English and described reporting systems.

The exclusion criteria; namely,

- (a) Studies not relevant to the research question.
- (b) Describing a single department or unit.
- (c) Abstracts, book chapters only and review articles.

The articles were screened based on the inclusion and exclusion criteria stated above. A search of the databases sprung up a total of 1283 publications initially. PubMed (9) and ScienceDirect (1274) were searched and after further analysis, duplicate articles were eliminated, this resulted in 208 duplicates eliminated.

This was followed by using the exclusion criteria which discarded 568 publications and left 507 for further analysis. After evaluation in accordance with the inclusion criteria, 476 were removed for not meeting them, and 31 articles which fulfilled all the required inclusion criteria for the research, were analysed and reported in the results.

12. RESULTS

31 research articles were selected for the review after the removal of duplicates, screening and eligibility as shown in (Fig. 1), with 27 from ScienceDirect and 4 from PubMed. All the articles are summarised in Table 2. The research articles focused mainly on reports from healthcare professionals such as nurses, nursing students, nursing interns, doctors and pharmacists.

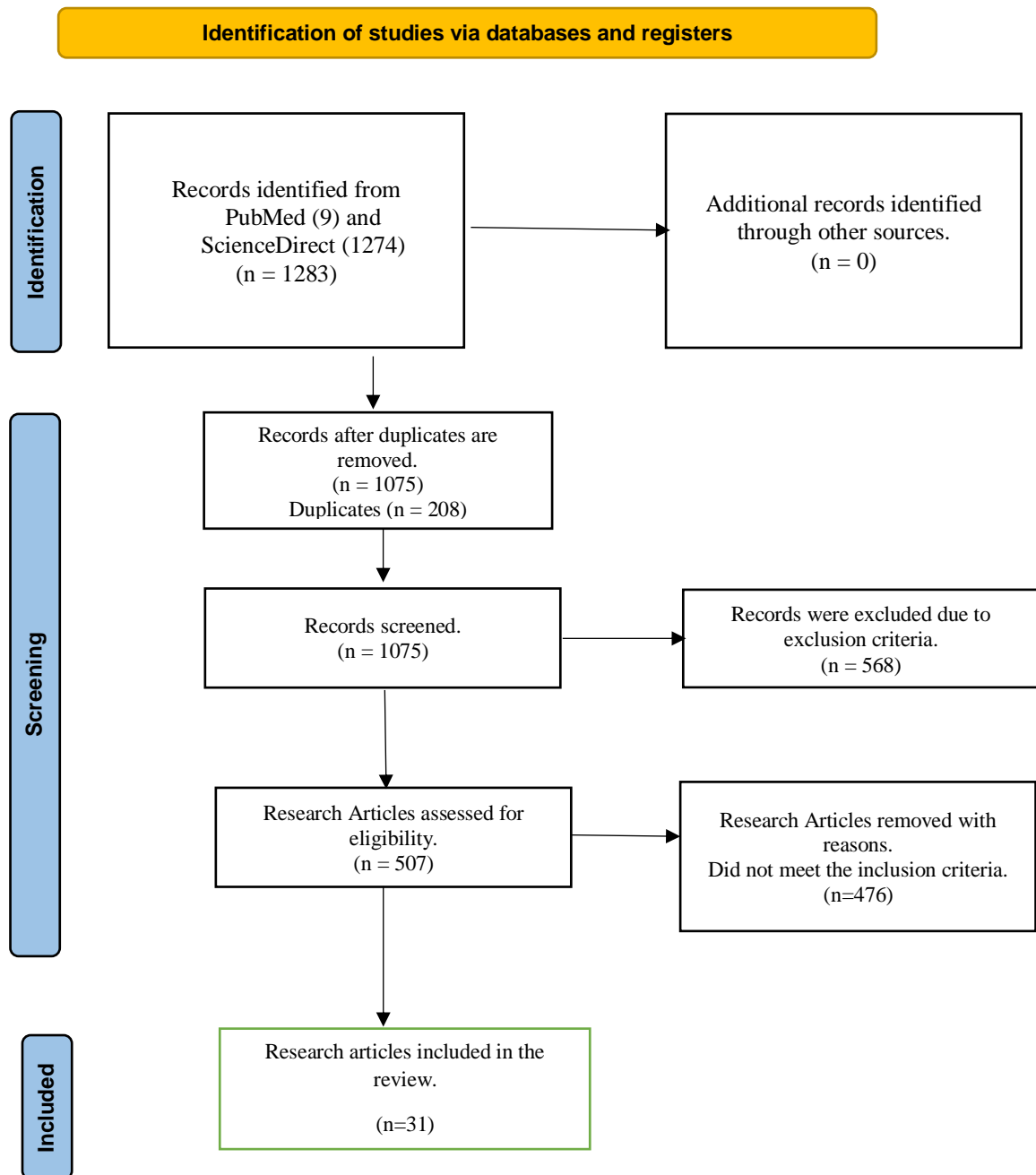


Figure 1. Flow diagram of the methodology and selection process

Table 2. List of all included studies in the review

Article	Country	Year	Healthcare Professional	Patient Safety Role and Reporting
Dolansky et al [3]	USA	2013	*Nursing Students	“Most healthcare organizations agree that shame, blame, and punishment for mistakes do not decrease medication errors. A new approach to dealing with medication errors is characterized by a culture of fairness and justice, where individuals are viewed as a part of a complex system. A fair and just culture is the balance between the need to take disciplinary action and the need to learn from mistakes. In this environment, employees are comfortable voicing safety concerns without fear of being blamed for errors”.
Choi et al [48]	Korea	2019	*Nurses	“A closed organizational culture, fear of deteriorating relationships with patients, and concerns about additional work burdens were suggested as barriers to DPSI. However, the establishment of DPSI guidelines and improving the hospital organization culture were raised as facilitators of DPSI”.
Walsh et al [49]	Canada	2018	*Nursing students	“Students in both groups (those who made an error and those who did not make an error) indicated an intention to report errors based upon professional attitudes, behaviours and/or values. The research concluded that professional socialization, in combination with supportive learning environments, may increase student comfort in reporting medication errors”.

Kaur et al [2]	USA	2019	**Healthcare practitioners	“Blame and guilt after ME are common and affect all providers. Practitioners have identified methods which may help mitigate adverse feelings after medical errors, including debriefing and talking with colleagues. Hospitals may benefit from developing these types of strategies after medical errors”.
Robertson et al [4]	USA	2017	*Doctors	“Physicians and other providers may feel a variety of adverse emotions after ME, including guilt, shame, anxiety, fear, and depression. Studies have found that despite physicians’ desire for support after ME, many physicians feel a lack of personal and administrative support. This may further contribute to poor emotional well-being. Potential solutions in the literature are proposed, including provider counselling, learning from mistakes without fear of punishment, discussing mistakes with others, focusing on the system versus the individual, and emphasizing provider wellness”.
Song et al [5]	China	2019	*Nursing Interns	“Barriers to nursing safety event reporting had five major themes: “Lack of knowledge,” “Inconvenience of the reporting system,” “Feeling of uncertainty and dishonour,” “No benefit from reporting,” and “Social influence.” Incentives had three major themes: “Nursing safety event education,” “Optimization of the reporting system,” and “Anonymous reporting.”

Kirwan et al [6]	Ireland	2013	*Nurses	This article shows an “effective nurse staffing levels, nurse education levels, and a positive work environment for nurses are factors which are known to impact patient safety outcomes”.
Feeser et al [34]	USA & Canada	2020	*Doctors	“Punitive reports have important implications for reporting systems because they may reflect a culture of blame and a failure to recognize system influences on behaviours. Nonpunitive wording better identifies factors contributing to safety concerns. Reporting systems should focus on patient outcomes and learning from systems issues, not blaming individuals”
Mattson et al [50]	Sweden	2015	**Healthcare practitioners	“It suggests that leader communication plays a vital role in improving organizational and patient safety and that different communication approaches seem to positively affect different but equally essential employee safety behaviours”.
Kiegaldie et al [7]	Australia	2016	**Healthcare practitioners	“Knowledge gaps and different orientations toward error management and open disclosure between the two professional groups were evident. Interprofessional education specifically targeting junior doctors and nurses and promoting the concept of team disclosure is needed. Such training should form an essential part of a health organization's response to medical error”.

Savage et al [8]	USA	2018	*Doctors	“Greater awareness of factors that contribute to physician burnout and implementation of strategies that promote physician resilience are both positive developments that will help reduce medical errors”.
Halperin et al [9]	Israel	2019	*Nursing students & Clinical instructors	“Despite efforts to increase patient safety, medical incidents and near misses occur daily. Much is still unknown about this phenomenon, especially due to underreporting”. A healthcare organisation should promote teaching and learning to improve patient safety
Halpern et al [26]	USA	2016	*Nurses	“A just and fair culture is a nonpunitive environment in which health care providers feel comfortable reporting near misses, errors, and/or adverse events knowing they will receive fair treatment. A just culture is one in which there is no blame, but there is always accountability”.
Claxton et al [27]	Australia	2022	**Healthcare practitioners	The article identified 3 themes to improve safety culture 1) the role of new employees 2) absence of a proactive approach example reporting safety issues without any fear and 3) the need for a No-blame culture
Abukhalil et al [33]	Palestine	2022	**Healthcare practitioners	“This study revealed differences in healthcare professionals’ awareness of medication errors. The study’s findings emphasize the urgent need to adopt appropriate measures to raise awareness about medication errors among healthcare providers in Palestine. Furthermore, establishing a regulatory

				policy and a national medication error reporting system to improve medication safety”.
Martin et al [51]	USA	2018	*Nursing executives	“Nurse executives encounter barriers to BON reporting. Ongoing BON education and outreach will help facilitate serious adverse event reporting, which can enhance patient safety”.
Amarneh et al [52]	Jordan	2022	*Nurses & Physicians	“Physician-nurse collaboration positively impacts patient safety culture. To get this aim, there should be a focus on building effective inter-professional collaboration and building a blame-free culture among healthcare providers, and these organizations should receive the needed support from healthcare leaders in the country. To help strengthen the health care system, raise patient safety culture levels.”
Brborovic et al [35]	Croatia	2019	*Doctors & Nurses	“The Nonpunitive Response to Error dimension had low values, indicating the ongoing culture of blame. The Staffing dimension had low values, indicating the ongoing shortage of doctors and nurses. Healthcare workers do not report HAE because they fear they will be punished by management or by law”.
Rodziewicz et al [12]	USA	2022	**Healthcare practitioners	“Medical errors and near misses should be reported when they are discovered. Healthcare professionals are usually the first to notice a change in a patient's condition that suggests an adverse event. A cultural approach in which personal

				accountability results in long-term increased reporting reduces errors”.
Koehn et al [36]	USA	2016	*Nurses	“When nurses make, discover, or observe an error during the course of their practice, they must decide whether or not to make a formal report. Although nurses are the health care professionals who most frequently report errors, many continue to harbour fears about reporting them. In many institutions, the workplace culture regarding error reporting remains one of blame, and nurses are often concerned about personal repercussions associated with reporting errors”.
Riga et al [29]	Greece	2015	**Healthcare practitioners	A system called MERIS was developed because it was noticed “the majority of ME are the result of systemic problems in the overall health system and not from the poor performance of medical practice of health professionals”. This was developed to track the ME and improve the general PS.”
Chakravarty [30]	India	2013	*Doctors and Nurses	“Medical science has a tendency to react to a medical error as an anomaly, for which the solution lies in blaming and shaming an individual to ensure that the error never happens again. Paradoxically, this approach not only discourages clinicians from owning up to adverse events but diverts attention from systemic improvements that may actually decrease incidents of ME”.

Farag et al [31]	USA	2017	*Nurses	“Emergency nurses’ willingness to report ME decreased as the nurses’ years of experience increased. Their willingness to report ME increased when they received more feedback about errors and when their managers used a transactional leadership style”.
Albrecht et al [32]	USA	2015	**Healthcare practitioners	“To improve reporting, resolution, and feedback, institutions need to develop a safety culture, not just a safety climate. A climate is shared perceptions or attitudes about policies and procedures as related to safety by members of a team. Culture is the values and beliefs on how individuals perceive and act on safety issues within the institution. Most commonly errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them”.
Kaldjian [18]	USA	2021	**Healthcare practitioners	There are barriers to communication or reporting of ME which hinders improving PS. Such barriers are lack of knowledge and skill, lack of role models, lack of peer and institutional support, fear of consequences and repercussions, feelings of helplessness, lingering questions about usefulness, prioritizing peer relationships over patient safety, and resistance to open disclosure in the professional culture of healthcare”.

Ring et al [19]	USA & Canada	2013	**Healthcare practitioners	“Adequate error and event reporting is necessary to trend health care system issues and establish a safe reporting environment for staff members. A balance can be achieved by creating a healthcare culture based on a learning environment, provision of constructive feedback, and delivery of appropriately targeted discipline when substandard performance is revealed”.
Yang et al [20]	China	2021	*Nurses	“The study highlighted the importance of developing a near-misses based education and establishing learning, supportive working environment, thus improve the learning effect from near misses and promote patient safety”.
Günes et al [37]	Turkey	2016	*Nurses	“Many Turkish nurses have negative perceptions towards patient safety culture within their institution. No participants indicated their affiliated institution had a protocol or policy concerning event reporting. Nurse managers need to create a positive safety culture by open communication, mutual trust, shared perceptions of the importance of safety and confidence in the efficacy of preventative measures”.
Ramos et al [38]	Philippines	2018	*Nurses	“The first step should be obtaining the support of the administration and assuming a non-punitive approach to those who make and report medical errors”.

Machen et al [15]	United Kingdom	2019	**Healthcare practitioners	“Four key themes were identified which influenced medication safety: professional identity, fear of litigation and punishment, hierarchy and pressure to conform to established culture”.
Granel et al [21]	Spain	2020	*Nurses	“Safety incidents are not always reported due to fear of punishment, reflecting a lack of positive safety culture. It is necessary to design and implement strategies that promote a positive culture to avoid punitive responses and apply and evaluate these changes”.

* As referred in the articles; **doctors, nurses, pharmacists

This Research is aimed to evaluate organisational punishment culture’s effect on reporting AE. Of the 507 research articles assessed, 476 were excluded as the research articles did not focus on the study questions or discussed culture not in a healthcare setting and in that case not related to the research.

All included 31 research articles are briefly explained in Table 2 (their year of publication, country of research, author of the research article, healthcare professional focus group and summary of the article in relation to my aim and objectives) above and the results were achieved by the objective of this research in order to prove the aim (hypotheses) of this research. Each of these objectives is elaborated further below.

12.1 Results of investigations of if an organisational culture of punishment benefits patient safety in healthcare organisations

The following articles [2-6, 34, 48-49] were found and assessed based on the first objective of this research. These articles showed study participants that included nurses, nursing students, nursing interns, doctors and healthcare practitioners (nurses, doctors, pharmacists) as shown in Table 2 with 5 of the articles focusing on nurses/nursing students/nursing interns and 3 focusing on doctors/healthcare providers. The general explanation from the analysed articles is that an organisational culture built on fear, punishment, shame or blame receives decreasing reporting of AE or ME and this is not beneficial. As PS is improved by increased reporting to learn and to avoid repetition of AE or ME.

From the finding and results of these articles regarding the first objective, it is concluded that an organisational culture of punishment is not beneficial to the reporting of AE, and this leads to a decreased improvement of PS.

12.2 Results of analysing healthcare professional reports of adverse events in relation to organizational punishment

The following articles [5, 7-9, 12, 26-27, 29-31, 33-36, 50-52] were found and assessed based on the second objective. These research articles showed participants such as nurses, nursing students, clinical instructors, nursing executives, doctors and healthcare practitioners (doctors, juniors doctors, nurses, and pharmacists) as shown in Table 2. All the included research articles showed a strong relationship between healthcare providers reporting AE and the culture in the organisation. If it is a punitive culture there is a decrease in reporting but a non-punitive culture experiences high AE reporting and improves PS [5, 9, 12, 26-27, 30, 34-36, 52]. Other factors that affect AE reporting are leadership, communication or support [8, 50], knowledge gaps or unawareness of reporting system [7, 29, 33, 51].

The result of the included analysed research articles concludes that healthcare providers report AE based on the culture of the organisation and healthcare providers report less or nothing in a punitive organisational culture. PS is compromised because the same mistakes happen without no changes or learning. Whereas a non-punitive organisational culture experiences an increase in AE reporting and improvement in PS as the organisation learns and improves from reported AE.

12.3 Results of evaluating if organizational culture is affecting patient safety and risk management in a positive or negative way

The organisational culture could affect PS and risk management either in a positive or negative way. The fact has been established that error is inevitable, and it must be recorded so that the same error should not happen again and therefore enhance PS. So, from the research articles [7-9,18-21, 26-27, 29-38, 50-52] a just or fair culture experiences increase reporting and enhances PS while a blame or shaming culture experiences decreased reporting and hinders improving PS.

So, from the included research articles it is concluded that PS and risk management can be affected negatively or positively based on the organisational culture.

13. DISCUSSION OF RESULTS

The scoping review was set out to evaluate the organisation's culture of punishment effect on the reporting of adverse events in healthcare organisations. To achieve the aim (hypotheses) three objectives were analysed: a) organisational culture of punishment is beneficial to patient safety in the healthcare organisation b) to analyse healthcare professionals reporting adverse events in relation to organisational culture and c) to evaluate if organisational culture is affecting patient safety and risk management positively or negatively.

Firstly, organisational culture is the pattern of shared basic assumptions-invented, discovered or developed by a given group as it learns to cope with its problems of external adaptation and internal integration and to teach new members the correct way to perceive, think and feel in relation to those problems [15]. It is understood that there can be a Just, learning, non-punitive culture [4, 13, 27] or blame, shaming, punishment or punitive culture in healthcare organisations [3, 21, 26, 34-36].

It is established that errors are inevitable [12]. For any healthcare organisation to learn and improve from AE or errors there should be a system for tracking the errors that occur and ultimately improving PS with these recorded events [12, 19, 25, 33]. So, for the enhancement of PS and risk management which is greatly reliant on the reporting of AE or errors which itself is then reliant on the culture of the healthcare organisation. A healthcare organisation should move from a blame, shaming, and punitive culture to a just, learning, fair or non-punitive culture [3, 9, 14, 21, 26, 34, 38]. There are barriers to reporting adverse events [14, 18] which are greatly influenced by the organisational culture. There are factors which influence the organisational culture such as hierarchy, litigation/punishment, professional identity, and pressure to conform to existing culture [13, 15].

Finally, there are other areas to improve if PS should get better and it should include areas of awareness of reporting system and convenient and easy reporting systems, leadership communication and support, support for healthcare professionals as second victims, better relationships between departments and personnel, effective staffing level, and good feedback system so healthcare workers would see the need of reporting [4-7, 32-33, 52].

14. CONCLUSIONS

The research has strongly shown that AE and errors in healthcare are high, and it is something inevitable, but we should report every event and try to reduce it or completely eradicate errors if possible. The scoping review also shows that a culture of punishment, shame and blaming is negatively affecting the reporting of AE.

Healthcare professionals need to feel supported and safe in the environment before they can report any error even if they have the obligation to do no harm. Also, healthcare providers suffer from errors, lose confidence and need the support of colleagues and organisations rather than shame and blame. Every organisation should develop an easily accessible and convenient reporting system, and an emotional support group for healthcare professionals and move from a culture of punishment to a culture of fairness and accountability if they want an increase in reporting AE and ultimately improving PS and risk management.

From the three objectives of this research set up to prove the aim (hypotheses) that organisational punishment culture influences the reporting of AE in healthcare organisations we can conclude the following from the results:

- 1) Based on the first objective of the research, it is concluded that an organisational culture of punishment is not beneficial to the reporting of AE, and this leads to a decreased improvement in PS.
- 2) Regarding the second research objective, it is concluded that healthcare providers report AE based on the culture of the organisation and healthcare providers report less or nothing in a punitive organisational culture. PS is compromised because the same mistakes happen without any changes or learning. Whereas a non-punitive organisational culture experiences an increase in AE reporting and improvement in PS as the organisation learns and improves from reported AE.
- 3) Finally, the third research objective concludes that PS and risk management can be affected negatively or positively based on the organisational culture.

From the conclusions above gotten through the three objectives to prove the aim (hypotheses), we can conclude that this research proved that the organisational culture of punishment influences the reporting of AE in healthcare organisations.

15. PRACTICAL RECOMMENDATIONS

- 1) Patients should be encouraged and educated in reporting AE or errors which will be investigated further.
- 2) An additional system could be developed for patient experiences and incident reporting.
- 3) Patients should be included in their treatment management in order to have more safety and inclusiveness.

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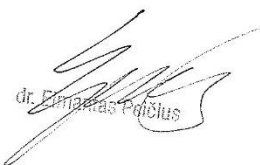
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DĖL PRITARIMO TYRIMUI

LSMU Bioetikos centras, įvertinęs Richie Pereowei Barugu pateiktus dokumentus, studento tiriamajam darbui tema „Patient Safety and Risk Management at Health Care Organisations“ pritaria*.


dr. Eimantas Pajūsis

* Pastaba: šis pritarimas neatleidžia tiriamąjį mokslinį darbą vykdančių asmenų nuo prievolės laikytis Bendrojo duomenų apsaugos reglamento nuostatų ir nuo atsakomybės gauti nacionalinio arba regioninio bioetikos komiteto leidimą, jei toks leidimas būtinas pagal LR Biomedicininį tyrimų etikos įstatyme numatytus reikalavimus.