Health Governance Review Volume 30, Issue 4: Governance for patient safety

The landscape of health care is changing rapidly, and governance must keep pace with this innovation and social change. While we have always realized the "pre-eminence of patient safety for health care governance" (MacVane Phipps, 2017), the updated journal's scope (2022) specifically emphasized, among other topics, the need for new approaches to strengthen patient safety.

Our authors have explored many of the eight strategy domains of risk management that constitute patient safety governance (Buja *et al.*, 2022):

(1) Transformational leadership (Ree *et al.*, 2021; Avery *et al.*, 2021; Lucas *et al.*, 2022);

(2) Patient engagement (Aase *et al.*, 2021; Øyri *et al.*, 2023);

(3) Human resources management quality (Kable and Spigelman, 2018; Avery *et al.*, 2021; Ree *et al.*, 2021; Fourar *et al.*, 2021; Øyri *et al.*, 2023; Magerøy and Wiig, 2023; Kil *et al.*, 2024)

(4) Innovation technology (Wilson, 2022);

(5) Teamwork (Canty and George, 2018; Shawer *et al.*, 2019);

(6) Effective communication (Wilson, 2022).

Our authors have also argued the need for nursing-specific patient safety definition (Chatzi and Malliarou, 2023) and discussed misconception of quality and safety in healthcare (Chatzi and Kourousis, 2024) showing the differentiators and common aspects: "quality is all about having better and more efficient services (e.g. low and/or no waiting lists, low and/or no infections, etc.) and safety is having ultimately no adverse events in the meantime (e.g. patient and/or staff injuries, patient deaths, misdiagnoses, etc.)". Both publications made a significant contribution to the discussions around patient safety within the context of health governance and attracted a lot of attention from our readers (based on the number of downloads and Altmetric score).

This year *IJHG* has published three research articles which examined governance of patient safety in different countries and health care settings (specialist hospitals, long-term follow-up clinics and at systems level). This *IJHG* Review section is based on those three articles.

Quality of care and patient safety for post-cancer older adults in long-term follow-up clinics in Norway

It is expected that the increase in the number of post-cancer older adults will place greater demands on healthcare services in many countries of the world. "Decision-makers across the globe are searching for models to redesign long-term care to become more responsive to changing health and care needs" (Rostad *et al.*, 2023). The aim of the study under review (Bergerød *et al.*, 2025) was to examine healthcare professionals' perspectives on quality and safety in services provided to post-cancer older adults in long-term follow-up clinics in Norway. The authors also explain the need for this kind of research stating that, despite an increasing number of older adults with cancer, this patient group is underrepresented in research literature. The need for such research was underscored by other researches (Fitch *et al.*, 2022): specifically, "a clear need for further research relating to tailored intervention and health care provider knowledge and education".

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Previous research done in Norway questioned whether the chosen survivorship model in that country "with long-term follow-up clinics and GP-led follow-ups in the municipalities, are sufficiently effective to provide appropriate treatment and care" (Rostad *et al.*, 2023). Norwegian general practitioners have also expressed concern for patient safety (Malterud *et al.*, 2020).

Data analysis, conducted in the reviewed study (Bergerød *et al.*, 2025), revealed two overarching themes:

(1) The first theme being that "the long-term follow-up clinics had extensive tasks and responsibilities indicating that the clinics lacked the capacity to fulfill all of them": much more expertise on late effect treatment and care in the municipalities is needed; late effects of this patient group seem to be a blind spot in post-cancer care; healthcare professionals did not often discuss patient safety in relation to older adults' cancer and late effects;

(2) The second theme reflected concerns regarding the future of long-term follow-up clinics: "marginal resources and financial insecurity create priority dilemmas caused by external circumstances, resulting in the older adults becoming a lower priority."

The results are in line with recent research from other countries. System-level gaps, including ageism and lack of tailored geriatric assessment, were noted in research among older cancer-survivors in Canada (Fitch *et al.*, 2021). A multinational investigation of healthcare needs, preferences and expectations in supportive cancer care, conducted for co-creating the LifeChamps digital platform, revealed that healthcare professionals from Greece, Spain, Sweden and the UK identified the need "for support and information in key areas of practical and day-to-day living of older cancer survivors such as managing fatigue, increasing physical activity and psychological support". They also highlighted the importance of time to provide "information" and to explain "adverse effects that the patient may not be aware of because they are not treatment related" (Marshall-McKenna *et al.*, 2023). LifeChamps is a multinational Horizon 2020 project involving 14 partners in healthcare, academia and industry the an aim to develop an innovative, digital platform to enhance supportive cancer care for "older" adult cancer survivors (aged 65 years or more) who require ongoing assistance. This will be directed using artificial intelligence and big data analytics (Marshall-McKenna *et al.*, 2023).

The study under review has important implications for research and practice: it adds to evidence "by describing how all of Norway's currently operating long-term follow-up clinics have adopted late-effect quality and safety challenges for older adults; it also conveys important information on how long-term cancer services lack long-term commitment from hospitals and government bodies to continue to provide late-effect services to this patient group and thus "adds to the international discussion on which model is most effective for clinical practice to enhance and offer sound and safe patient care to older adults with late effects after cancer treatment" (Bergerød *et al.*, 2025). The authors recommend that future research should prioritize targeted areas such as international comparison of patient-centered models and implementation and evaluation of their impact on quality and safety.

Organizational factors and compliance with patient safety incident reporting at two specialist hospitals, Ghana

The next article in this review looks into how organizational factors in two specialist hospitals in Ghana affect reporting patient safety incidents (Adomah-Afari and Kwaffo, 2025).

Research on patient safety incident reporting in African healthcare organizations reveals significant challenges and opportunities for improvement. A new systematic integrative review by Fekadu *et al.* (2025a) identified five key factors influencing reporting practices: fear of reprisal within safety culture, attitudes toward reporting, knowledge and skills gaps, system availability and attributes and managerial support levels. The pooled prevalence of patient

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safety incident reporting across African organizations was 48%, with compliance rates ranging from 16% to 87% based on WHO criteria (Fekadu *et al.*, 2025a).

The article under review showed that compliance with reporting was fairly good at about 69% and that personal factors like gender, education and patient safety training influenced reporting. The research revealed the following organizational factors to be most strongly associated with compliance to patient safety incident reporting: organizational learning and continuous improvement, communication about error, communication openness and handoffs and information exchange. The authors underscored that "among these, communication openness ($p = 0.001$) and organizational learning and continuous improvement ($p = 0.002$) show particularly significant associations, indicating they have the strongest links to reporting" (Adomah-Afari and Kwaffo, 2025).

The results of this paper align with findings from other studies in Ghana and international settings, indicating that organizational factors such as communication openness, organizational learning and effective handoffs are consistently associated with improved patient safety incident reporting. For example, within Ghana, similar perceptions of organizational safety culture and the importance of communication about errors have been reported in several recent scholarly publications. Hospital managers reported positive safety behaviors including open communication and organizational learning, but noted barriers such as blame culture, staff shortages and lack of standardized reporting policies (Tenza *et al.*, 2022). A recent cross-sectional study in Ghana found that teamwork, communication openness and effective handoffs were significant predictors of patient safety incident response, accounting for 28.3% of variance in outcomes (Poku *et al.*, 2023).

Internationally, research from very different countries like Lithuania, Ethiopia, Indonesia and Qatar also highlights the significance of training, communication and organizational learning in fostering incident reporting behaviors. A systematic literature review, conducted in 2017 (Archer *et al.*, 2017), identified factors affecting patient safety incident reporting and constructed a theoretical framework of factors acting as barriers and facilitators to incident reporting to guide implementation of interventions to increase engagement and also to determine the prevalence of factors to guide the development of interventions and policies to improve incident reporting. The top two barriers cited were fear of adverse consequences (representing 21.52% of barriers) and process and systems of reporting (representing 14.71% of barriers) (Archer *et al.*, 2017). In comparison, the top two facilitators were organizational (representing 26.08% of facilitators) and process and systems of reporting (representing 20.16% of facilitators). The authors of the suggested framework concluded that a wide range of factors contributing to engagement in incident reporting existed. Efforts that address the current tendency to under-report must consider the full range of factors in order to develop interventions as well as a strategic policy approach for improvement.

A recent systematic review of patient safety incident reporting systems and reporting practices in Africa has identified eight patient safety incident reporting and learning systems, with compliance rates ranging from low (16%) to high (87%) based on the WHO criteria (Fekadu *et al.*, 2025b). The authors of that review recommended establishing robust patient safety incident reporting and learning systems as an imperative, as none of the existing systems fully meet WHO criteria: "Optimizing the existing systems and encouraging healthcare professionals to improve reporting practices will enhance patient safety and outcomes" (Fekadu *et al.*, 2025b).

A framework for integrated safety in safety-management systems in healthcare

While the first two articles examined patient safety issues in specific settings and countries, the third one looks at the problem from a different perspective. Four types of integrated patient safety frameworks are available and used globally: educational and/or competency frameworks, organizational maturity and/or safety culture frameworks, information system

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and/or incident reporting frameworks and multi-level integration approaches, operating across micro, meso and macro health system levels.

The purpose of the article under review (Vella Bonanno *et al.*, 2025) was to develop and present a comprehensive framework for integrated safety in healthcare systems. It aims to facilitate a systemic, collaborative approach to patient safety across all levels of healthcare – from clinical practices to organizational and system-wide policies. The paper mentions the adoption of a systems approach aligned with international initiatives like the OECD health system pillars and the WHO Global Patient Safety Action Plan (2021–2030) (WHO, 2021).

The European Researchers' Network Working on Second Victims (ERNST) is a multidisciplinary international network established in 2020 with funding from the European Cooperation in Science and Technology. Its primary aim is to facilitate discussion and share scientific knowledge, perspectives and best practices related to adverse events in healthcare. ERNST focuses on implementing joint efforts to support second victims – healthcare professionals who experience emotional or psychological distress following involvement in patient safety incidents – and encourages open dialog among stakeholders from various disciplines and countries to address the complex interdependence between patient safety and the second victim phenomenon.

The authors leverage ERNST in their research as a principal source of professional expertise and collaborative insights for developing their conceptual framework of integrated safety in healthcare systems: the network's diverse composition, which includes professionals from healthcare, legal, academic and policy backgrounds across different countries, allows for a rich, multi-perspective discussion on safety issues (Vella Bonanno *et al.*, 2025).

While the framework is designed to be generic and flexible, the authors acknowledge that "the evidence underpinning it is limited and sourced from specific contexts, which may restrict its effectiveness when applied to different countries, cultures and organizational structures" (Vella Bonanno *et al.*, 2025). Additionally, the framework's validation is still ongoing, mainly through initial case studies within the ERNST consortium. There is a need for broader validation across various healthcare practices and settings to ensure its robustness and adaptability globally.

Another limitation noted by the authors is that most of the existing literature and evidence focuses on micro and meso levels of patient safety, potentially underrepresenting macro-level factors such as legislation, policy and environmental influences: "This bias might hinder comprehensive understanding and implementation of safety interventions at the systemic or national levels" (Vella Bonanno *et al.*, 2025).

Conclusion

The scoping review by Buja *et al.* (2022) presented eight strategy domains that constitute governance for patient safety. Since this journal changed its title and scope in 2016 (from Clinical Governance to Health Governance), our authors have investigated six of those domains. We did not find any research specifically devoted to skills certification and education in patient safety. Such research could be of particular interest, as it was shown that literature on skills certification was scarce and also produced conflicting results (Buja *et al.*, 2022). The same review revealed that research on innovation technologies in patient safety also presented contradictory conclusions. While patient safety issues were investigated by our authors in a variety of article categories (viewpoints, conceptual papers, literature reviews and research papers), we have published only one organizational case study (Shawer *et al.*, 2019). This type of qualitative research could apply new methodologies to investigate complex organizational phenomena that contribute to risk management in different health care settings and also increase the impact of research (Côté-Boileau *et al.*, 2020).

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