Exploring Organizational Culture, Leadership and Patient Safety in Secondary Care Hospitals, Sri Lanka: A Qualitative Study

Rajiya Mohamed Muyees*

Base Hospital Muthur, Ministry of Health, Sri Lanka

***Corresponding author**

DOI: https://doi.org/10.51244/IJRSI.2026.1309000210

Received: 01 October 2026; Accepted: 06 October 2026; Published: 21 October 2026

ABSTRACT

Patient safety is influenced by organizational culture, leadership, communication, teamwork, learning systems and the conditions under which healthcare workers deliver care. This study explored organizational culture and leadership-related influences on patient safety in selected base hospitals of Trincomalee District, Sri Lanka. We conducted a focused qualitative thematic analysis using key-informant interview data from 20 participants across Base Hospitals Kanthale, Kinniya, Muthur, and Pulmoddai. Participants represented hospital administration, Quality Management Units and nursing leadership or supervision. The interview material was examined for meanings related to culture, leadership, trust, teamwork, learning, communication, supervision, workload, and patient safety, using organizational-culture and clinical-leadership concepts as interpretive lenses. Four interconnected themes were developed: culture of fear, blame and psychological safety; leadership, trust, supervision and communication; organizational learning, attitudes and feedback; and work systems and conditions shaping safe care. The accounts showed bureaucratic features in formal procedures and duplicated processes, clan-related influences through peer norms and mutual understanding, and entrepreneurial features through improvement activity and learning. Evidence corresponding to market culture was limited. Participants described fear of blame, shame, litigation concerns, lack of trust in superiors, inadequate supervision, communication problems, limited feedback, workload and staffing constraints, while training, mutual understanding and Work Improvement Teams were described as enabling influences. The findings suggest that patient safety is shaped by the interaction of visible organizational systems with less visible cultural assumptions and leadership relationships. Strengthening trust, non-punitive learning, communication, feedback, teamwork, service improvement and workable processes may support a stronger patient-safety culture.

Keywords: organizational culture; clinical leadership; patient safety; safety culture; qualitative research

INTRODUCTION

Patient safety is not produced by clinical competence alone. It is also influenced by the culture, processes, behaviours and working environment of healthcare organizations. The World Health Organization (WHO) describes patient safety as a framework of organized activities that creates cultures, processes, procedures, behaviours, technologies and environments that consistently reduce risk and avoidable harm [1]. WHO further emphasizes leadership commitment, a safe working environment, staff competency, teamwork and communication as core components of a safe health system [1].

Organizational culture refers to shared beliefs, assumptions, values and norms that shape how people behave and interpret events. In the organizational-culture teaching framework used for this analysis, culture is described as “the way we do things around here.” Culture has visible elements—such as practices, language, symbols and socialization—and hidden elements, including norms, values and assumptions. This cultural-iceberg perspective is especially relevant to patient safety because formal rules can coexist with informal expectations about blame, authority, peer reactions and whether it is safe to speak up.

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XIII Issue IX September 2026

The same framework classifies organizational culture into four broad types: bureaucratic, clan, market and entrepreneurial. Bureaucratic culture is characterized by formal rules, standard operating procedures and stability. Clan culture emphasizes loyalty, personal commitment, socialization, self-management and strong peer norms. Market culture emphasizes measurable goals, individual performance and rewards. Entrepreneurial culture emphasizes creativity, experimentation, innovation and willingness to take risks. These types are used here as interpretive lenses, not as formally measured culture profiles.

Leadership provides an important pathway through which organizational culture can be maintained or changed. The clinical-leadership framework used in this study describes leadership as influencing individuals toward a common goal and emphasizes supportive and trustworthy environments, open communication, fair decisions and ethical conduct. It identifies credibility, communication, empowerment, conflict resolution, collaboration, administrative skills and strategic capability as important attributes. It also frames clinical leadership across five domains: knowing and managing oneself, working with others, managing services, improving services and setting direction for the future. Good clinical leadership is explicitly linked with healthy workplaces, cultural change, quality care and patient safety.

These concepts have contemporary relevance in Sri Lanka. In March 2026, a Ministry of Health and WHO-supported national capacity-building programme emphasized leadership, values, communication, just culture, psychological safety, learning systems and non-punitive approaches as central to strengthening safety culture [2]. International safety-culture frameworks similarly highlight communication openness, management support, organizational learning, teamwork, staffing, feedback and non-punitive response as core dimensions [3].

The available key-informant interviews were originally concerned with staff experiences around a safety-related organizational process. However, the accounts contain a broader organizational story involving fear and blame, trust in superiors, supervision, communication, peer resistance, workload, learning, feedback and improvement. The present analysis therefore focuses on what these accounts reveal about organizational culture, leadership and the patient-safety environment rather than treating the reporting process itself as the principal outcome.

Objective

To explore organizational culture and leadership-related influences on patient safety in selected base hospitals of Trincomalee District, Sri Lanka.

CONCEPTUAL FRAMEWORK

The analysis was guided by two complementary frameworks: the four organizational-culture types and the clinical-leadership pathway. The arrows below show the proposed interpretive pathway used to organize the qualitative findings; they do not represent a statistically tested causal model.

Figure 1. Interpretive pathway linking organizational culture, leadership and patient safety

ORGANIZATIONAL CULTURE
Bureaucratic | Clan | Market | Entrepreneurial
↓
CLINICAL LEADERSHIP ENVIRONMENT
Trust • supervision • communication • teamwork • empowerment • service improvement
↓
PSYCHOLOGICAL SAFETY & ORGANIZATIONAL LEARNING
↓
PATIENT-SAFETY ENVIRONMENT

Figure 2. Clinical-leadership progression used as an interpretive lens

Knowing & managing yourself	→	**Working with others**	→	**Managing services**	→	**Improving services**	→	**Setting direction for the future**

In the leadership presentation, the intended outcomes of good clinical leadership include quality patient care, healthy workplaces, cultural change, job satisfaction and wellbeing, satisfied patients and colleagues, and ensuring patient safety. This provides the rationale for examining leadership together with culture rather than as a separate organizational variable.

METHODS

Study Design and Setting

A qualitative thematic analysis was conducted using existing key-informant interview material from four base hospitals in Trincomalee District: Base Hospital Kanthale, Base Hospital Kinniya, Base Hospital Muthur and Base Hospital Pulmoddai.

The parent study was conducted from 1 March 2026 to 25 April 2026.

Key Informants

The dataset comprised 20 key informants occupying formal administrative, quality-management and nursing leadership or supervisory roles. These roles were appropriate for exploring organizational culture and leadership because they spanned senior management, Quality Management Units and ward-level supervision.

Hospital	Key-informant roles represented	Codes
BH Kanthale	Medical Superintendent; MO-QMU; NOIC-QMU; two Matrons; Ward Sister	KI1–KI6
BH Kinniya	Medical Superintendent; MO-QMU; NOIC-QMU; Matron; Ward Sister; Ward Master	KI7–KI12
BH Muthur	Medical Superintendent; MO-QMU; NOIC-QMU; Matron; Ward Sister	KI13–KI17
BH Pulmoddai	Medical Superintendent; NOIC-QMU; Matron	KI18–KI20

Analytical Approach

A focused analysis of the available interview material was undertaken. First, quotations were reviewed for explicit and implicit meanings relevant to culture, leadership and patient safety. Second, codes were grouped around fear/blame, trust/supervision, communication, attitudes/knowledge, feedback/learning, peer relationships, workload/staffing and organizational processes. Third, these codes were synthesized into higher-order themes. Finally, the themes were interpreted against the four culture types and the clinical-leadership framework. The analysis remained grounded in the participants' wording; the theoretical frameworks were used to explain patterns rather than to replace the empirical data.

Because no validated organizational-culture or leadership instrument was administered, the analysis does not assign a dominant culture type to any hospital and does not score leadership performance. References to bureaucratic, clan, market or entrepreneurial features indicate conceptual correspondence only.

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XIII Issue IX September 2026

Ethical Considerations

Administrative permission was obtained for data collection. Participants received an information sheet explaining the study and their rights, and written informed consent was obtained before participation. Participation was voluntary, withdrawal was permitted without effect on service, and interview data were handled confidentially and stored securely.

RESULTS

Overview of Themes

Theme	Interview evidence	Culture/leadership interpretation	Patient-safety relevance
1. Fear, blame and psychological safety	Fear, shame, litigation concerns, guilt, peer opposition and resistance	Hidden norms/assumptions; clan-related peer influence; leadership trust	May inhibit speaking up, learning and open safety communication
2. Leadership, trust, supervision and communication	Trust in superiors, routine supervision, responsibility, communication, mutual understanding	Credibility; working with others; managing services	Shapes whether staff feel supported and whether safety concerns are acted upon
3. Organizational learning, attitudes and feedback	Training, knowledge, attitudes, analysis, feedback, perceived value, WITs	Improving services; entrepreneurial learning; culture reinforcement	Determines whether safety information becomes learning and improvement
4. Work systems and conditions for safe care	Workload, staff shortage, absenteeism, time burden, duplicated systems, unavailable forms	Bureaucratic process burden; managing services; staffing context	Can constrain safe practice and staff participation despite positive intentions

Theme 1: Fear, blame and psychological safety

Fear and blame were among the most recurrent cultural signals in the interviews. Participants did not describe these only as individual emotions; they described shared expectations that disclosure could lead to blame, shame, discussion by others, litigation or other problems. This pattern is consistent with hidden cultural elements—norms, values and assumptions—that influence behaviour even when formal safety procedures exist.

> “The staff is scared to report any incidents of patient safety.” (KI1)
>
> “Presence of a culture of blame is a barrier to reporting any risk to the patient that happened by mistake.” (KI3)
>
> “The belief that there will be a problem after informing any patient safety discussion .” (KI4)
>
> “Fear of blame, fear of superiors, and fear of litigation, especially among consultants.” (KI5)
>
> “They are shamed if the mistake that they made will be revealed.” (KI11)
>
> “Fear of blame, fear being discussed in other places….” (KI14)
>
> “..fear of blame, …culture of blame…” “..unsupportive culture for reporting.” (KI17)
>
> “..guilty feeling because of the incident..” “Fear of blame..” “Less job satisfaction..” (KI19)

Peer reactions also mattered. KI2 stated that “Other staff members oppose the discussion of any errors,”

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XIII Issue IX September 2026

while

KI13 described “Resistance from the other staff.” These accounts suggest that group norms can exert pressure on individual behaviour. This is conceptually relevant to clan culture, where socialization, loyalty and peer pressure can be powerful. In this dataset, however, peer influence was not uniformly positive; it could either discourage openness or, where mutual understanding existed, facilitate safer behaviour.

From a patient-safety perspective, the finding is important because contemporary safety-culture frameworks emphasize non-punitive response, communication openness and the ability to question authority. AHRQ safety-culture dimensions include non-punitive response, communication openness, feedback, organizational learning and management support [3].

Theme 2: Leadership, trust, supervision and communication

The interviews contained a clear leadership-relational theme. Trust in superiors, routine supervision, communication and responsibility were repeatedly connected with staff behaviour. These concepts closely match the clinical-leadership framework, particularly credibility, working with others, communication, collaboration and managing services.

> “Lack of trust on superiors is also another barrier to discuss the patient safety issue.” (KI3)

> “Lack of routine supervision is also a barrier.” (KI1)

> “Lack of responsibility for taking care of patients. " (KI3)

> “Communication problems act as barriers.” (KI3)

> “Responsibility is not adequately given to them to report in the administration.” (KI11)

> “In some units, mutual understanding is there and it facilitated good communication with superior.” (KI5)

The contrast between lack of trust and mutual understanding is particularly informative. Leadership appears in the interviews not simply as positional authority, but as the quality of relationships through which staff receive guidance, communicate problems and interpret how the organization will respond. The leadership presentation describes credibility as trustworthiness and identifies communication, empowering others, conflict resolution and collaboration among the skills of a clinical leader. These concepts help explain why supervision and interpersonal trust emerged so strongly in the interviews.

The data do not support classification of individual leaders into leadership styles. They do, however, support a conclusion that everyday leadership practices—trust, supervision, communication, clarity of responsibility and mutual understanding—are part of the patient-safety environment.

Theme 3: Organizational learning, attitudes and feedback

Training and knowledge were repeatedly identified as factors shaping staff engagement with safety processes. The data also showed that learning was weakened when staff believed that information would not be analysed or when feedback was absent. Conversely, training, mutual understanding and Work Improvement Teams were described as enabling factors.

> “All the relevant officials were trained to identify patient safety.” (KI1)

> “Lectures are done to promote early detection of errors and any near miss.” (KI2)

> “Training programs are effective as enablers to early identification, action, and prediction.” (KI5)

> “Lack of knowledge is a barrier to finding the problem about the risk before it occurs.” (KI4)

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XIII Issue IX September 2026

"Information is lacking regarding patient safety among assistant staff." (KI12)

"Poor attitudes contribute to lack of taking action against error ." (KI13)

"Nursing officers believe that incidents are usual cases and therefore it is not worthwhile to report." (KI18)

"..lack of knowledge, lack of honesty.." "Less perceived value on early detection and prevention of patient risk..." (KI19)

"..lack of feedback." (KI5)

"Belief among the nursing officers that …… analysis will not be done and therefore it is not worth informing quality unit." (KI8)

"The following factors affect as enablers for the patient safety: Conducting Work Improvement Teams." (KI5)

These findings fit the "improving services" domain of clinical leadership and the concept of organizational learning. They also have some correspondence with entrepreneurial culture, which values experimentation, innovation and change. Work Improvement Teams may represent a practical mechanism through which staff move from identifying problems to collective improvement. However, the interviews do not establish an entrepreneurial culture at hospital level.

The absence of feedback is equally important. A learning culture requires visible organizational response: staff need to know that concerns are analysed, discussed and translated into improvement. This interpretation is consistent with WHO's system approach to patient safety and with safety-culture frameworks that treat organizational learning and feedback as core dimensions [1,3].

Theme 4: Work systems and conditions shaping safe care

The interviews showed that organizational culture and leadership operate within material and operational constraints. Workload, staff shortages, absenteeism, time pressure and complex processes were repeatedly described. These conditions may make it difficult for staff to participate in safety activity even when they understand its importance.

"The ward is understaffed, and therefore, high workload is present." (KI12)

"Too much work among the nursing officers prevents them from noticing any preventable ." (KI9)

".., heavy workload in the ward, lack of nursing staff, inadequate labourers, … inability to inform on time…" (KI14)

"..increased workload," "..limited number of staff members." "High absenteeism…" "Sense of extra burden to the nursing officers.." (KI18)

"There are too many steps in the reporting process of any incidents." (KI8)

"There are two processes which lead to unnecessary time wastage. As a consequence, they cannot get off at 7 am if they report an incident during the night shift." (KI6)

"There are two processes to report an incident; i.e. an incident reporting form has to be filled and it should be written on a separate book which is available in the section matron's office." (KI7)

"…. unnecessarily lengthy process and waste of time ……" "Getting off from the duty at 7am will not be possible. It will be 8am or 9 am to get off from the duty if they report an incident at night." (KI15)

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XIII Issue IX September 2026

"Unavailability of incident reporting forms in the ward.." (KI18)

These accounts provide the clearest correspondence with bureaucratic culture. Formal rules, documentation and standard processes can provide consistency and accountability, but the interviews show how excessive steps, duplication and rigid procedures can create burden. The problem is therefore not the existence of structure itself, but whether structure is designed to support safe and workable care.

The data contained comparatively little evidence of market culture. KI16 noted that "There are no rewards for patient safety reporting," but a single statement about rewards is insufficient to infer a market orientation. Market culture is therefore retained in the conceptual classification but not presented as a dominant empirical finding.

Mapping the findings to the four culture types

Table 3. Culture classification as an interpretive map (not a measured hospital profile)

Culture type	Defining concept from framework	Interview correspondence	Interpretation for patient safety
Bureaucratic	Formal rules, SOPs, stability	Established systems; multiple steps; duplicated form/book processes; time burden; unavailable forms	Structure can standardize safety, but over-complex processes can create friction and disengagement.
Clan	Loyalty, socialization, personal commitment, peer norms	Peer opposition/resistance; shame; fear of discussion; mutual understanding	Peer norms can suppress openness or, when supportive, strengthen teamwork and psychological safety.
Market	Measurable goals, performance and rewards	Very limited evidence; one statement on absence of rewards	Insufficient evidence to characterize this orientation in the participating hospitals.
Entrepreneurial	Experimentation, innovation, creativity	Training, improving analysis, Work Improvement Teams, learning/improvement orientation	Improvement structures may support adaptive learning and service change.

DISCUSSION

This study reinterprets key-informant accounts through the combined lenses of organizational culture, clinical leadership and patient safety. The central finding is that patient safety is shaped by more than formal systems. Visible procedures coexist with hidden assumptions about blame, authority, trust and peer response. Leadership relationships influence whether those cultural assumptions are reinforced or challenged, while staffing and process design determine whether staff have practical capacity to participate in safe care.

The cultural Iceberg: Formal Systems Versus Hidden Assumptions

The cultural-iceberg model is strongly reflected in the data. Visible elements included training, forms, registers, supervision structures and Work Improvement Teams. Hidden elements included fear, shame, guilt, perceived blame, distrust of superiors, peer resistance and beliefs that raising a problem could lead to unwanted consequences. This distinction helps explain why the presence of a formal system does not necessarily create a strong safety culture.

The finding is consistent with the broader patient-safety literature. WHO emphasizes moving from traditional blame toward system thinking while retaining appropriate accountability [1]. AHRQ likewise treats non-punitive response, communication openness, feedback, teamwork, staffing and management support as dimensions of safety culture [3].

Four Culture Types and Patient Safety

The four-culture classification adds nuance rather than a single label. Bureaucratic features were most visible in standardized processes and documentation, but the interviews also showed the downside of procedural duplication and delay. Clan-related features appeared in the power of peer norms: opposition, shame and fear of being discussed could discourage openness, while mutual understanding could facilitate it. Entrepreneurial features were suggested by training, Work Improvement Teams and an orientation toward improving analysis. Market features were minimally represented. This mixed pattern is plausible because healthcare organizations rarely operate through one cultural orientation alone.

Leadership as the Bridge between Culture And Safety

The leadership framework provides a useful bridge between culture and patient safety. "Working with others" is reflected in trust, mutual understanding and communication; "managing services" is reflected in supervision, responsibility, staffing and process design; and "improving services" is reflected in training, feedback and Work Improvement Teams. The interviews therefore support a view of leadership as a practical mechanism through which culture becomes visible in everyday work. This interpretation is particularly relevant in the current Sri Lankan context. The 2026 Ministry of Health-WHO safety-culture initiative emphasized leadership, values, communication, just culture, psychological safety and learning environments, and highlighted transformational leadership in sustained culture change [2]. The alignment between those priorities and the present interview themes strengthens the practical relevance of these findings without implying that the national programme was evaluated in this study.

Learning Culture, Feedback and Patient Safety

Participants' concerns about lack of feedback and lack of analysis suggest that staff judge safety systems partly by whether they produce visible learning. When staff believe that information disappears without action, the perceived value of participation declines. Conversely, training and Work Improvement Teams offer a route from information to collective improvement. The UK-focused review supplied as a model for this manuscript similarly identified organizational culture, positive staff attitudes, communication and service/environment quality as linked with patient safety [4].

Workload and Process Design are Cultural and Leadership Issues

Heavy workload and staffing constraints should not be interpreted simply as individual barriers. They are organizational conditions that influence whether safety expectations are realistic. Similarly, duplicated or lengthy procedures reflect design choices. Leadership for patient safety therefore requires not only encouraging staff to behave safely but also redesigning work so that safe behaviour is feasible. WHO explicitly includes safe working environments, effective processes, teamwork and leadership commitment within a safe health system [1].

Proposed Model Arising From the Qualitative Findings

Figure 3. Culture–leadership–learning pathway for patient safety

CULTURAL CONTEXT
Visible: rules, systems, training, WITs | Hidden: norms, values, assumptions, fear, trust
↓ leadership shapes how culture is experienced
LEADERSHIP PRACTICES
Trust • supervision • communication • responsibility • teamwork • feedback
↓
PSYCHOLOGICAL SAFETY + ORGANIZATIONAL LEARNING
Speaking up • shared learning • improvement • reduced blame
↓ modified by workload, staffing and process design
SAFER ORGANIZATIONAL ENVIRONMENT
Potential contribution to patient safety

This model is a qualitative interpretation generated from the interview themes and the study frameworks. It should be treated as a proposition for future testing rather than as proof of causal effects on patient outcomes.

Implications for Hospital Management

- Build a just and learning-oriented culture in which staff can raise safety concerns without automatic blame, while maintaining clear professional accountability.
- Make leadership visible through regular supervision, fair decision-making, respectful communication and follow-up.
- Strengthen mutual trust between senior staff, supervisors and frontline teams and explicitly address peer behaviours that discourage speaking up.
- Provide structured feedback so staff can see how safety information leads to analysis, learning and service change.
- Use multidisciplinary Work Improvement Teams as a mechanism for clan-like teamwork and entrepreneurial improvement.
- Review duplicated, lengthy or inaccessible administrative processes and simplify them where safe to do so.
- Treat staffing, workload and absenteeism as patient-safety and service-design issues.
- For future research, prospectively use validated culture and leadership instruments if the objective is to compare hospitals or formally classify culture types.

STRENGTHS AND LIMITATIONS

The study includes 20 key informants from four hospitals and draws perspectives from hospital administration, Quality Management Units and nursing leadership/supervision. The use of participants' own words provides a detailed account of organizational experiences, while the culture and leadership frameworks permit interpretation beyond a single administrative process.

The four culture types are interpretive categories rather than hospital classifications, and leadership performance cannot be scored. The interview guide was originally anchored in a safety-related organizational process; therefore, some quotations retain that context even though the present research question is broader. The analysis also examines perceived influences on the patient-safety environment and does not directly measure patient harm or clinical outcomes.

CONCLUSION

The key-informant accounts portray patient safety as an organizational phenomenon shaped by culture, leadership and work design. Formal procedures and training were only one part of the environment; fear, blame, shame, peer norms, trust in superiors, supervision, communication, feedback and workload were equally important. Bureaucratic, clan and entrepreneurial features were identifiable within the narratives, whereas market-culture evidence was limited. Leadership emerged as a bridge between culture and patient safety through trust, communication, supervision, service management and learning. Hospitals seeking stronger patient safety should therefore combine reliable systems with psychologically safe relationships, visible leadership, feedback, teamwork, learning and workable processes.

Declarations

Conflict of Interest

The author declares no conflict of interest.

Funding

No external funding was received for this qualitative analysis.

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XIII Issue IX September 2026

Data Availability

The qualitative interview data are not publicly available because they contain potentially identifiable contextual information from a small number of key informants. De-identified supporting information may be considered on reasonable request, subject to ethical and institutional requirements.

Consent to Participate

Written informed consent was obtained from participants before data collection.

REFERENCES

1. World Health Organization. (2023). Patient safety. WHO Fact Sheet.
2. World Health Organization Sri Lanka. (2026, March 27). Empowering health leaders: Sri Lanka advances safety culture through WHO collaboration.
3. Jones, K. J., Skinner, A., Xu, L., Sun, J., & Mueller, K. (2008). The AHRQ Hospital Survey on Patient Safety Culture: A tool to plan and evaluate patient safety programs. In K. Henriksen, J. B. Battles, M. A. Keyes, & M. L. Grady (Eds.), Advances in Patient Safety: New Directions and Alternative Approaches. Agency for Healthcare Research and Quality.
4. Nadarajah, N., Gnanakunalan, P. R., Sivagnanasuntharam, S., & Seralathan, T. (2022). Impact of healthcare quality on patient safety in UK hospitals. Book of Abstracts, MSF Asia Scientific Days & International Conference on Medical Sciences, 44.
5. Cameron, K. S., & Quinn, R. E. (1999). Diagnosing and changing organizational culture: Based on the Competing Values Framework. Addison-Wesley.
6. American College of Healthcare Executives & Institute for Healthcare Improvement/NPSF Lucian Leape Institute. (2017). Leading a culture of safety: A blueprint for success. Institute for Healthcare Improvement.