

DEVELOPING AND EVALUATING A NATIONAL NEAR-MISS REPORTING SYSTEM FOR SAFER HEALTHCARE IN SRI LANKA

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Abstract: Near-miss reporting systems are essential for strengthening patient safety yet remain underdeveloped in many low- and middle-income countries. This pilot study assessed the feasibility of implementing a structured near-miss reporting system in a public hospital in Sri Lanka and examined its effects on staff knowledge, perceptions, and reporting behaviour. A pre-post intervention study was conducted at a district general hospital. The interventions included development of a reporting form and guidelines, expert consultation, staff training, distribution of reporting materials, and establishment of a reporting box with periodic reminders. Knowledge, perceptions, and self-reported behaviour were assessed before and after implementation using a validated questionnaire. Reported near-misses during the intervention period were categorized and analyzed descriptively. Knowledge and perception scores improved among both medical and nursing officers following implementation, with larger gains among those who attended the training programme. Reporting behaviour showed only moderate improvement, and eight near-misses were reported during the three-month intervention period, most of which were related to radiology, laboratory processes, and patient monitoring. This pilot demonstrates that a structured near-miss reporting system can be introduced successfully in a resource-constrained public hospital, improving foundational knowledge and perceptions. However, reporting behaviour remained limited, underscoring the need for stronger feedback mechanisms, continuous case-based learning, and a supportive organizational culture. These findings provide an important foundation for national scale-up and further refinement of near-miss reporting within the Sri Lankan health system.

Keywords: near-miss reporting, patient safety, incident reporting systems, health systems, quality improvement, Sri Lanka

1. Introduction

Near miss events are incidents that could have resulted in patient harm but were prevented before reaching the patient, either by chance or through timely interception. Although these events do not lead to adverse outcomes, they provide valuable insights into underlying system weaknesses and opportunities for learning and prevention before serious harm occurs (World Health Organization, 2005). As a result, near miss reporting is widely considered an important component of patient safety and quality improvement initiatives.

Studies in patient safety have revealed that near miss events occur far more frequently than adverse events, making them particularly useful indicators for proactive risk identification and system improvement (Tanaka et al., 2010; Park et al., 2016). Consequently, many high income and several

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middle income countries have implemented structured near miss reporting systems that allow healthcare organizations to collect, analyze, and learn from such events at both institutional and national levels (Fujita et al., 2021). These systems are typically supported by broader patient safety frameworks that emphasize non punitive reporting, feedback mechanisms, and organizational learning (World Health Organization, 2005).

In contrast, Sri Lanka's publicly funded healthcare system functions within a context characterized by financial and infrastructural constraints, high patient volumes, and sustained workforce pressures. Therefore, investments in patient safety initiatives must often compete with essential service delivery priorities, while digital infrastructure to support routine incident reporting and analysis remains limited in many public hospitals (Ministry of Healthcare and Indigenous Medicine, 2020). In addition, hierarchical professional structures, heavy clinical workloads, and insufficient exposure to formal patient safety training may influence healthcare workers' engagement with voluntary reporting practices. These contextual factors are particularly important when considering the design and utilization of near miss reporting systems in resource constrained public healthcare settings.

At present, Sri Lanka does not have a comprehensive national near miss reporting system that covers all major clinical services. Existing reporting mechanisms are largely limited to specific areas, such as maternal health and blood transfusion services, leaving most hospital based care without formal pathways for systematic near miss learning (Samaranayaka et al., 2023). Furthermore, empirical research on near miss reporting in Sri Lanka remains limited and has focused predominantly on maternal care, with little attention given to hospital wide reporting systems or healthcare workers' reporting behaviour across clinical settings (Jayathilake et al., 2022).

Considering this background, the present study aimed to address these system level and contextual gaps by developing, implementing, and evaluating a comprehensive near miss reporting system within a tertiary care public hospital. By examining changes in healthcare workers' knowledge, perceptions, and reporting behaviour following implementation, this study contributes evidence to inform the strengthening of patient safety systems in Sri Lanka and in similar resource constrained healthcare contexts.

Objectives

Accordingly, this study is expected to:

1. Identify system-level and workforce-related gaps in existing issue-specific near-miss reporting mechanisms in Sri Lankan public hospitals.
2. Develop and pilot a comprehensive near-miss reporting system tailored to the operational realities of a tertiary-care public hospital.
3. Evaluate changes in healthcare workers' knowledge, perceptions, and reporting behaviour following implementation of the reporting system and associated training.

2. Materials and Methods

This study was conducted in three phases: pre-interventional, interventional, and post-interventional. Several qualitative and quantitative research methods were employed during the pre- and post-intervention phases. Ethical clearance was obtained from the Ethics Review Committee, Post Graduate Institute of Medicine, University of Colombo. Permission to carry out the project was obtained from the Ministry of Health, Deputy Director General – Medical Services I, Director- Directorate of Healthcare Quality & Safety (DHQS), Director- FHB, Director -NBTS, Provincial Director of Health Services – Western Province, Regional Director of Health Services – Colombo, and the Head of the Institution of DGH Avissawella.

The study was conducted from February 2022 to December 2022 in the District General Hospital (DGH) – Avissawella, the only District General Hospital in Colombo district, the capital of Sri Lanka. This hospital provides a wide range of medical and surgical services, including intensive care facilities, and was selected as a pilot site based on service scope, feasibility, and availability of institutional support for implementation (Ministry of Healthcare and Indigenous Medicine, 2020).

2.1 Pre-intervention Phase

During the pre-intervention phase, existing topic-specific near-miss and incident reporting systems were critically analyzed to identify structural and operational limitations. Input was obtained through consultative discussions with senior clinicians and healthcare administrators from multiple specialties, who highlighted limited awareness of near-miss concepts and unfavourable perceptions towards reporting as key barriers. These insights informed the subsequent assessment of healthcare workers' baseline knowledge, perceptions, and reporting behaviours.

Therefore, as the initial step, the level of knowledge and the perception level were assessed among a random sample of frontline healthcare workers, medical officers(n=109), and nursing officers(n=193)(Sample Size Calculator by Raosoft, Inc, n.d.) using a validated, pre-tested, self-administered questionnaire that was developed after an extensive literature survey (Smith *et al.*, 2014; Etchegaray *et al.*,2016) and further refined by expert opinion. The questionnaire assessed four key domains: participant socio-demographic characteristics, knowledge of near-miss concepts, perceptions towards near-miss reporting, and self-reported reporting behaviour. Knowledge items consisted of multiple-choice questions, perception items used Likert-scale responses, and reporting behaviour was assessed using categorical response options; full details of the instrument are provided in Annexure 1.

The reporting behaviour was assessed by questions 41 and 42, and the frequencies and percentages were calculated. The number of respondents who answered "Yes" to question number 41 and the number of respondents who selected any of the 05 answers to question number 42 were counted. All these quantitative data were coded, entered, and analyzed using Statistical Package for Social Sciences (SPSS) version 26.0.

2.2 Intervention

A process mapping exercise followed by a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis was carried out to identify bottlenecks in existing reporting systems and to determine feasible strategies for system strengthening. The intervention comprised four interrelated components: (1) refinement of existing reporting processes, (2) development of a standardized near-miss reporting form

and accompanying guidelines, (3) structured training sessions for medical and nursing officers, and (4) establishment of feedback and reminder mechanisms to encourage reporting.

The interventions were developed iteratively using findings from the pre-intervention assessment and informed by a targeted, non-systematic review of the peer-reviewed literature. A draft near-miss reporting form and guidelines were subsequently reviewed and finalized through national-level consultative meetings. Implementation involved conducting training programmes for medical and nursing officers to improve knowledge and address negative perceptions regarding near-miss reporting, during which the newly developed reporting tools and guidelines were introduced. To ensure ongoing engagement, feedback on reported near-misses and periodic reminders about reporting were shared via the existing hospital communication and quality management practices.

2.3 Post-intervention Phase

After three months of implementation, a post-intervention assessment was conducted using the same validated, self-administered questionnaire administered during the pre-intervention phase. A random sample of medical officers (n = 109) and nursing officers (n = 193) was surveyed to assess changes in knowledge, perceptions, and near-miss reporting behaviour. Mean knowledge and perception scores were calculated for each professional group. Independent-sample t-tests were used to compare pre- and post-intervention scores, as well as to assess differences between participants who attended training programmes and those who did not. Statistical analyses were performed separately for medical and nursing officers, with a p-value of < 0.05 considered statistically significant.

The key activities carried out at each phase are summarized in Figure 1.

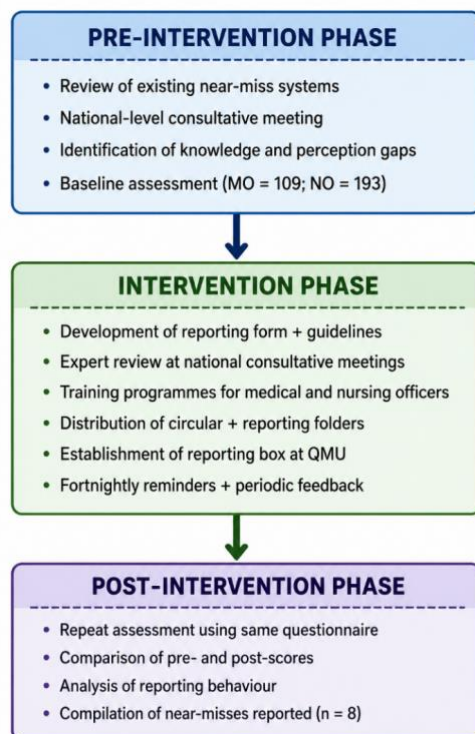


Figure 1: Flow diagram of the pre-intervention, intervention, and post-intervention phases

3. Results

3.1 Knowledge and Perception Scores of Medical Officers

Table 1 Comparison of Pre- and Post-Score Values of Variables of Medical Officers

Name of the independent variable score	Mean score (SD)	Sample size	df	t value	p-value
Knowledge score	Pre- 69.38 (10.41)	81	80	-05.249	p<0.001
	Post- 78.68 (11.7)	76	75		
Perception score	Pre- 67.95 (08.02)	81	80	-04.377	p<0.001
	Post-73.01 (06.42)	76	75		

Following implementation of the near-miss reporting system, medical officers showed notable improvements in both knowledge and perceptions. Mean knowledge scores increased from 69.38 to 78.68 ($p < 0.001$), while perception scores increased from 67.95 to 73.01 ($p < 0.001$) (Table 1). Medical officers who participated in the training programme demonstrated substantially higher post-intervention knowledge (82.37 vs 65.88; $p < 0.001$) and perception scores (73.98 vs 69.65; $p = 0.018$) compared with those who did not attend (Table 2).

Table 2: Comparison Between Core Values of Variables of Medical Officers Who Participated in the Training Programme and Those Who Did Not Participate in the Training Programme

Name of the independent variable score	Mean score (SD)	Sample size	df	t value	p-value
Knowledge score	Participated – 82.37 (08.37)	59	74	05.02	p<0.001
	Not participated- 65.88 (12.77)	17			
Perception score	Participated- 73.98 (06.20)	59	74	02.534	0.018
	Not participated- 69.65 (06.21)	17			

3.2 Knowledge and Perception Scores of Nursing Officers

Nursing officers also showed significant improvements. Their mean knowledge score increased from 67.20 to 78.04 ($p < 0.001$), and perception scores improved from 72.00 to 73.54 ($p = 0.030$) (Table 3). Similar to medical officers, training participation was strongly associated with higher post-intervention scores. Nursing officers who attended training scored higher in both knowledge (82.73 vs 66.30; $p < 0.001$) and perceptions (75.14 vs 69.49; $p < 0.001$) (Table 4).

Table 3: Comparison of Pre- and Post-Score Values of Variables of Nursing Officers

Name of the independent variable score	Mean score (SD)	Sample size	df	t value	p-value
Knowledge score	Pre-67.20 (16.27)	150	149		
	Post- 78.04 (13.00)	138	137	-06.27	p<.001
Perception score	Pre- 72.00 (05.55)	150	149		
	Post-73.54 (06.34)	138	137	-02.19	0.030

Table 4: Comparison Between Score Values of Variables of Nursing Officers Who Participated in the Training Programme and Those Who Did Not Participate in the Training Programme

Name of the independent variable score	Mean score (SD)	Sample size	df	t value	p-value
Knowledge score	Participated-82.73(09.67)	99	98		
	Not participated- 66.30 (12.98)	39	38	07.161	p<0.001
Perception score	Participated-75.14(04.38)	99	98		
	Not participated- 69.49(08.49)	39	38	03.954	P<0.001

3.3: Detailed Knowledge Assessment

In spite of overall improvements, only a small percentage of participants were able to correctly identify all six near-miss and adverse-event scenarios after the intervention. Among medical officers, this increased from 0% to 7.9%, while the proportion among nursing officers decreased slightly from 16.0% to 13.0%. Only 3.9% of medical officers and 6.5% of nursing officers correctly answered all components of the knowledge assessment (Table 5).

Table 5: Comparison of Pre- and Post-Interventional Detailed Analysis Results of the Participants' Knowledge of Near Misses

Component of Knowledge	Medical Officers Frequency (%)		Nursing Officers Frequency (%)	
	Pre-interventional	Post-interventional	Pre-interventional	Post-interventional
Correctly knows the definitions of near misses and maternal near misses	57 (70.37%)	65 (85.5%)	80 (53.33%)	93 (67.4%)
Correctly identifies all 06 near-miss events and adverse events	00 (0%)	15 (07.9%)	24 (16.0%)	18 (13.0%)
Knows that there is a maternal near miss reporting system in the hospital and there is no reporting system to report all kinds of near misses	29 (35.80%)	44 (57.9%)	28 (18.67%)	87 (63.0%)
Correctly responds to all the components of the knowledge aspect	00 (0%)	03(03.9%)	04 (2.67%)	09 (06.5%)

(Pre-interventional: Number of medical officers= 81, Number of nursing officers= 150; Post-interventional: Number of medical officers=76, Number of nursing officers= 138)

3.4: Reporting Behaviour

Self-reported near-miss reporting behaviour showed moderate improvement. The proportion of medical officers who had never reported a near miss decreased from 45.5% to 40.0%, while those who reported most of the time increased slightly to 5.0%. Among nursing officers, the proportion who had never reported decreased from 43.5% to 41.7%, and 16.7% reported doing so most of the time post-intervention. No participant in either cadre reported always reporting near misses in either phase (Table 6).

Table 6: Comparison of Participants' Pre and Post-Interventional Reporting Behaviour of Near Misses

	Medical Officers Frequency (%)		Nursing Officers Frequency (%)	
	Pre-interventional	Post-interventional	Pre-interventional	Post-interventional
Never reported any of the near misses	15 (45.5%)	08 (40.0%)	10(43.5%)	10(41.7%)
Rarely reported some near misses	07 (21.2%)	05(25.0%)	00(0%)	05 (20.8%)

Have reported near misses sometimes	11 (33.3%)	06 (30.0%)	09(39.1%)	05(20.8%)
Have reported near misses most of the time	00(0%)	01(05.0%)	04 (17.4%)	04(16.7%)
Have always reported near misses	00(0%)	00(00.0%)	00 (0%)	00(0%)

(Pre-interventional: Number of medical officers= 33, Number of nursing officers= 23; Post-interventional: Number of medical officers=20, Number of nursing officers= 24)

3.5: Near-Misses Reported During the Intervention

During the three-month intervention period, eight near-misses were reported at the hospital. Radiology and laboratory-related events were the most frequently reported (n = 3), followed by patient-monitoring-related events (n = 3). One event involved detecting a wrong drug dosage or infusion rate, and one involved a lapse in ECG monitoring for a critically ill patient (Table 7).

Table 7: Summary of Near-Misses Reported at DGH Avissawella from 01.07.2022 to 30.09.2022

Category	Type	Category number	Frequency
Drug administering process	Detecting a wrong dosage before administering/Detecting a wrong drug infusion rate set before administering	DA3	01
Radiology/ Laboratory	Detecting delayed/missed important/critical radiological or laboratory investigation	RL3	03
Patient monitoring process	Detecting circulatory problems on time and preventing patient harm	PM1	02
	Detecting airway problems on time and preventing patient harm	PM2	01
Other	A critical patient missed ECG monitoring for a brief period.		01
Total			08

The key outcomes of pre- and post-interventional phases are illustrated in Figure 2.



Figure 2: Summary of key pre- and post-intervention outcomes.

4. Discussion

4.1: Impact of the Intervention on Knowledge and Perceptions

This pilot in one hospital suggests potential for national scale-up, pending multi-site testing. Following implementation at DGH Avissawella, medical and nursing officers demonstrated significant improvements in knowledge and moderate improvements in perceptions (Table 1 & Table 3). These improvements were more evident among those who attended the training programme, who consistently achieved higher post-intervention knowledge and perception scores than non-participants. (Table 2 & Table 4). These findings are consistent with international literature that emphasizes education, confidentiality, and a blame-free culture as enablers for reporting systems (World Health Organization, 2005; Dyab *et al.*, 2018).

Despite the substantial improvement in overall knowledge scores, the ability to correctly identify all six near-miss and adverse-event scenarios remained low (Table 5). This pattern suggests that while the training improved theoretical understanding, it did not fully translate into the abstract clinical judgement required to recognize near misses in practice. Stakeholder consultations with senior clinicians reinforced this interpretation, highlighting that scenario recognition depends on clinical experience, contextual awareness, and a workplace culture that encourages open discussion of errors. Without repeated exposure to real cases, reflective dialogue, and ongoing feedback, staff may retain definitions but hesitate to apply them reliably in busy clinical environments.

The slight change in self-reported reporting behaviour, despite improved knowledge and perceptions, reveals a persistent gap between awareness and action (Table 6). Participants continued to report near misses infrequently, and no one indicated that they “always” reported such events. This phenomenon signals stakeholder feedback that fear of blame, hierarchical pressures, and uncertainty about whether reports lead to meaningful change remain powerful barriers. These findings imply that educational interventions must be accompanied by visible, system-level responses to reports if behaviour is to shift sustainably.

To support this interpretation, insights from stakeholder consultations and implementation experiences were incorporated for a better understanding of the persistent barriers influencing reporting behaviour. Senior clinicians and nursing leaders frequently described how hierarchical structures, fear of blame, and doubts about whether reports lead to meaningful changes discourage routine reporting, even when knowledge improves. Staff also highlighted the practical difficulty of recognizing near-miss scenarios during busy clinical shifts, noting that confidence in identifying and reporting such events develops gradually through repeated exposure, discussion, and feedback. These qualitative inputs help explain why improvements in knowledge and perceptions did not translate into proportional changes in reporting behaviour, and they provide essential context for interpreting the quantitative findings.

The Sri Lankan project findings were different from the study finding in Saudi Arabia, where 94% of the participants had claimed that they knew the difference between a near miss and a medical incident (Elkhider & Savage, 2020). This was similar to the study findings in New York in 2017, where 94.3% of resident physicians were able to correctly identify a near miss, and 73.9% and 79.6% of respondents were able to correctly identify an adverse event or a sentinel event, respectively (Singal et al., 2018). These contrasts likely reflect greater exposure to patient safety programmes and routine safety event reporting in those settings, compared with Sri Lanka, where such initiatives are still emerging. The USA researchers concluded that the lack of knowledge seems to be the most important barrier to safety event reporting (Singal et al., 2018).

4.2: Comparison with International Near-Miss Reporting Systems

Although the newly designed Sri Lankan near-miss reporting system is in pace with international models in its core functions like coverage, categorization, analysis and dissemination, it remains in an early maturity phase. The decision to begin with paper forms and later transition to electronic reporting reflects stepwise approaches described in global guidance and country experiences (World Health Organization, 2005; Reed *et al.*, 2014). Sri Lanka’s two-phased analytics (national and hospital levels) are somewhat similar to Japan’s blend of national and local learning systems than to Finland’s predominantly local model, positioning the country to generate both national and institution -specific preventive measures. (Kodate *et al.*, 2022; Reed *et al.*, 2014).

In contrast to Sweden system, in which adverse events are emphasized, the Sri Lankan system explicitly prioritizes near-misses, highlighting the value of earlier detection of system vulnerabilities before harm occurs (Reed *et al.*, 2014). Feedback mechanisms are another differentiating factor where Switzerland’s CIRNET demonstrates the quantitative value of timely, visible alerts (‘Quick-Alerts’) to spread learning rapidly, whereas the pilot in Sri Lanka relied mainly on verbal feedback to unit leaders; scaling

up to routine bulletins and digital updates should increase timely feedback to the grassroots level healthcare workers (Reed *et al.*, 2014; Fujita *et al.*, 2021).

Another key feature of the Sri Lankan system was the lack of public involvement in reporting. This decision was taken after discussions with stakeholders of the initial consultative meetings to provide psychological safety and manage cultural resistance. This approach differs from some Australian implementations but is consistent with early-phase designs in other settings (World Health Organization, 2005). As reporting normalizes, stepwise introduction of additional channels can be reconsidered.

4.3 Level of Reporting and Under-Reporting

During the three-month intervention, eight near-misses were reported at the pilot hospital. Among these, most were related to radiology/laboratory investigations and to the patient monitoring process (Table 7). Although the number is small, it reflects early activation of the system within a short implementation window. International evidence shows that patterns of near-miss types vary widely across settings; for example, a South Korean study reported higher volumes in areas such as drug dispensing and patient protection (Park *et al.*, 2016), highlighting how reporting behaviour is shaped by local workflows and system maturity rather than event frequency alone.

Self-reported behaviour showed only moderate improvement, with fewer staff indicating that they “never” reported near misses, but no participant reported that they “always” did so (Table 6). This level of under-reporting is consistent with early-phase experiences in other countries, where reporting tends to remain low unless supported by rapid feedback mechanisms and a strong just culture (Evans *et al.*, 2007; Crane *et al.*, 2015). These findings suggest that while the intervention-initiated reporting activity, sustained behavioural change will require visible system responses and continued reinforcement.

Cross-study comparisons reinforce the point: in South Korea, 43.9% of respondents did not report near-misses they experienced, despite a functioning system (Park *et al.*, 2016). European surveys similarly highlight variability across national systems and the importance of feedback and standardization to increase reporting behaviour (Reed *et al.*, 2014).

4.4: Reasons for Continued Under-Reporting

This study highlighted several underlying determinants of under-reporting that are likely to operate across multiple contexts, including limitations of one-off training, persistent cultural barriers, and weak feedback mechanisms. This aligns with previous research elucidating that one-off training rarely builds the nuanced clinical judgement required for accurate incident recognition, and that continuous, case-based refreshers are essential for sustained improvement (Pham *et al.*, 2013; Mitchell *et al.*, 2016).

Although perceptions improved, this did not translate into staff reporting near misses “always”, keeping in line with the U.S. and European findings that positive attitudes alone are insufficient when process complexity and fear of blame persist (Evans *et al.*, 2007; Crane *et al.*, 2015). Stakeholders in this study described how trust in the system and perceived value of reporting are closely linked with the speed and visibility of feedback. International experience suggests that quick-alert style summaries, unit-level dashboards (“you said—we did”), and routine dissemination cycles are associated with higher engagement, as they demonstrate that reports lead to tangible change (Reed *et al.*, 2014; Fujita *et al.*, 2021).

Financial incentives have been shown to increase reporting in the early stages of system implementation in some high-income settings (Crane et al., 2015; Crane et al., 2017). However, subsequent analyses have raised concerns that incentives may distort reporting quality, create dependency, and be difficult to withdraw without undermining system sustainability, particularly in resource-constrained environments (Auciello, 2016). Reflecting these considerations and given the financial constraints of the Sri Lankan health system, this pilot deliberately avoided monetary incentives and instead focused on building intrinsic motivation through training, leadership engagement, and feedback. This approach is consistent with other successful near-miss reporting systems that rely on non-financial drivers of behaviour change (Kostopoulou et al., 2007).

In summary, these factors help explain why reporting behaviour remained limited despite improvements in knowledge and perceptions, and emphasize that durable change will require cultural shifts, stronger feedback mechanisms, and sustained institutional commitment rather than training alone.

4:5 Limitations

This study has several limitations that should be considered when interpreting the findings. As a single-site pilot conducted over a short three-month period, the results may not be generalizable to all Sri Lankan hospitals, particularly larger tertiary institutions or facilities with different organizational cultures. The sample size was relatively small, especially for medical officers, which limits statistical power and the precision of subgroup comparisons.

The pre-post design without a control group restricts causal inference, as improvements in knowledge and perceptions may have been influenced by external factors not captured in the study. In addition, the scenario-based knowledge assessment may not fully reflect real-world clinical judgement, which is shaped by contextual cues, team interactions, and accumulated experience.

Reporting behaviour was self-reported rather than objectively measured, introducing the possibility of social desirability bias. Finally, the pilot relied on a paper-based reporting system with limited feedback mechanisms, which may have constrained staff engagement and underestimates the potential performance of a more mature, digitally supported system.

5. Conclusion

This pilot study demonstrates that a structured near-miss reporting system can be introduced successfully within a resource-constrained public hospital, leading to meaningful improvements in staff knowledge and perceptions. However, reporting behaviour remained limited, underscoring the need for stronger feedback mechanisms, continuous case-based learning, and a supportive organizational culture that encourages open discussion of errors.

The findings provide an important foundation for national scale-up, but further refinement is required to ensure sustained behavioural change. Multi-site implementation, longer follow-up periods, and integration of digital feedback tools will be essential to strengthen system responsiveness and staff engagement. With these improvements, a near-miss reporting system has the potential to contribute significantly to patient safety improvement across the Sri Lankan health system.

Future research should extend beyond single-site pilots to include longitudinal studies that examine how near-miss reporting systems evolve over time and how sustained use influences organizational culture, learning processes, and patient outcomes. In addition, further exploration of the organizational, behavioural, and system-level factors that contribute to continued under-reporting despite improvements in knowledge and awareness is needed. Such work could investigate how hierarchical norms, workload pressures, feedback practices, and perceptions of psychological safety shape reporting behaviour in routine clinical settings. Together, these initiatives would provide a broader understanding of the long-term effectiveness, sustainability, and system-level impact of near-miss reporting within the Sri Lankan health system.

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Declaration of Interest Statement

The authors declare that they have no conflicts of interest.

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