

# Measures to improve nurses' working environment often target individuals

Nurses' psychosocial challenges are transformed into something private and personal instead of being solved at an overarching level in the organisation.

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## Keywords

Psychosocial working environment

Hospital

Occupational health

Focus groups

Sykepleien Forskning 2018 13(71109)(e-71109)

DOI: <https://doi.org/10.4220/Sykepleienf.2018.71109>

## ABSTRACT

**Background:** Earlier research calls for an increased focus on organisational factors that affect nurses' psychosocial working environment. The disciplinary tradition of health promotion is based on the notion that individuals and their surroundings impact on each other and that working environment measures must be appropriate for the setting and not just target individuals.

**Objective:** To examine nurses' experiences of their psychosocial working environment, and to discuss obstacles and opportunities for a more coherent, settings-based approach.

**Method:** The study has a qualitative design using focus groups. We interviewed the nurses in three wards at a university hospital in Norway. We analysed the data using critical hermeneutic meaning analysis.

**Results:** The findings show that a number of central mechanisms related to psychosocial working environment challenges largely individualise nurses' challenges in this area. This is revealed through the informants' experiences of clinical incident reporting, quantitative assessment, HSE measures and managers' follow-up of personnel. Both individually and in combination, these experiences have the effect of turning the psychosocial working environment into something private and personal as opposed to an organisational challenge that can be resolved as part of a collective effort.

**Conclusion:** When working environment challenges are individualised, nurses must face them alone and must find their own solutions. Consequently, we need ways of working that focus more on the setting. This entails using working methods that take into consideration how the hospital's organisation affects the psychosocial environment of the nurses.

Psychosocial phenomena such as conflicting roles, poor leadership, high emotional demands, stress and exhaustion together with the problem of integrity represent major challenges for the working environment in the health and care professions (1, 2). A number of people claim that both research and practical measures aimed at the psychosocial working environment pay undue attention to approaches targeting the individual (1, 3). Consequently, it is argued that psychosocial working environment challenges must increasingly be examined in light of the physical, social and organisational aspects of the working environment and dealt with accordingly (3, 4).

The practical implementation of efforts to improve the working environment mainly takes place in the field of health, safety and the environment (HSE) and human relations (HR) – or personnel management. Clinical incident reporting, quantitative assessments of the working environment and performance reviews are key instruments in mapping the working environment and introducing new measures.

In the health service, the clinical incident reporting system is part of the overall quality system in which clinical incidents involving patients, HSE incidents and other adverse events are reported electronically. In general, clinical incidents in the health service are defined as adverse events or breaches of quality requirements, procedures, guidelines and laws that are intended to safeguard patients and staff and ensure a good living and working environment (5, p. 32).

## **HSE incidents**

However, in this article we discuss HSE incidents rather than incidents involving patients. HSE incidents are adverse events that relate to the working environment, and are underpinned by the internal control requirement of the regulations concerning management and quality enhancement in the health and care services (6). This is an important distinction because HSE incidents and incidents involving patients are often confused in practice.

In principle, clinical incident reports concern individual events with potentially negative consequences for the employee. This is also how we refer to a clinical incident in this article.

## **Assessments of the working environment**

Quantitative assessments are often conducted as measurements of employee satisfaction and are frequently based on the assessment requirement in the Regulations relating to Systematic Health, Environmental and Safety Activities in Enterprises (Internal Control Regulations) or the regulations concerning management and quality enhancement in the health and care services.

However, such assessments often have a more HR-based motivation that entails acquiring knowledge about management, organisation and development potential. With regard to performance reviews, these are carried out systematically in the form of discussions about personal and professional development between the staff member and manager, and are both an HSE and an HR initiative (7).



**«The questionnaire as a method individualises, since the prime focus is on individual experiences.»**

A number of people have pointed out that these systems do not sufficiently capture the complexity of the psychosocial working environment, and that working environment problems tend to be individualised through these systems (8–10). Clinical incident reporting is, by definition, about individual events – and has thus a tendency to trigger measures targeting the individual who reported the incident.

The questionnaire is criticised as a method because it individualises, since the prime focus is on individual experiences. The knowledge generated by the questionnaire is easily transferrable and applicable in terms of individual measures. Performance reviews with a line manager are often aimed at solving the particular challenges of the employee in question, and do not contribute to the development of the working environment as a whole.

### **The objective of the study**

In this article we wish to examine the challenges posed by the nurses' psychosocial working environment, and to critically reflect on systems related to this such as working environment measures, as opposed to a 'settings perspective'. The latter concept entails developing the working environment and health at the workplace by changing systemic and organisational factors.

In a settings perspective, assessment and a solution-oriented approach to working environment issues should primarily take into account the framework conditions at the workplace (3, 4). We wish to answer the following research questions:

- How do the nurses experience the hospital's efforts to deal with psychosocial working environment challenges?
- What opportunities do the nurses have to make their opinions heard about working environment challenges at the hospital?

## **Method**

The study builds on a qualitative design using focus group interviews. We chose focus groups because we wanted to find out more about informants' in-depth experiences of psychosocial working environment systems. It is reasonable to assume that such experiences will best be expressed through staff discussions, which foster the voicing of viewpoints and opinions.

The focus group interviews generate a different kind of data than individual interviews, for example (11). Focus group participants have the opportunity to ask each other and the researcher questions, thereby developing reasoning and new insights that they would not have gained from individual interviews (12).

The empirical data were collected and analysed in part in connection with the first author's master's degree thesis in health promotion (13). In this article, we analyse more specifically the empirical data that deal with the working environment, i.e. the staff's experiences of the incident reporting system, assessments and performance reviews.

## **Sample**

The informants consisted of nurses from a medical ward and two surgical wards at a university hospital in Norway. A clinical nurse educator or a clinical nurse manager selected the informants at random. The sample consisted of twelve nurses, with both sexes represented. Both recently qualified and experienced nurses were included in the study. Each group included a safety delegate or a clinical nurse educator.

## **Interview guide**

We devised an interview guide with five overarching questions. This functioned as a template for the focus group interviews. The focus group interviews adopted a funnel approach whereby the questions were open-ended at the start and became more rigidly structured towards the end (11). We conducted a pilot test of the interview guide in one focus group to test the questions and time required as well as to gain experience with the researcher role.

## **Data collection**

The first author conducted three focus group interviews in autumn 2014. The conversations began with an introduction of the topic, and lasted for 90 minutes. We used a dictation machine in all focus groups, and noted key words during and immediately after each focus group interview. Afterwards we played back the conversation.

## **Data analysis**

We analysed the data using a critical hermeneutic approach, applying a stepwise deductive-inductive analysis (14). This entailed first roughly coding the empirical data and then developing some general categories from the individual focus groups. Next, we wrote a so-called 'ethnographic summary' for each focus group (1, 12). An ethnographic summary is a summary of the key topics (categories) developed in the focus groups.

The summary was written in a coherent form that was as understandable as possible for the participants. We then submitted it to the participants to read through. After they had given their feedback, the summary was used in the further hermeneutic analysis process.

An important part of this process concerns clarification of one's own preconceptions. We attributed great importance to such clarification since the first author is a nurse. This entailed a general risk of bias when we interpreted the empirical material. We attempted to solve this challenge by working systematically with self-reflection in connection with the analysis. Specifically this meant interpreting the data in accordance with the double hermeneutic (15).

## **Ethical considerations**

We reported the study to the Norwegian Centre for Research Data and the data protection officer at the hospital. The nurses received an information letter about the project and signed a declaration giving consent to participation. No names are given in our material and we deleted the audio files at the end of the project. Confidentiality requirements have thus been complied with.

## **Results**

The results are synthesised under three topics:

- Clinical incident reporting
- Quantitative assessment and HSE measures
- Personal follow-up

### **Incident reporting**

The nurses said that they did not write many clinical incident reports, and that HSE incidents were seldom reported: 'I feel that submitting incident reports doesn't help. We send one after the other but nothing happens. We don't see any results from the incident report. We don't know what has been done.'

The lack of feedback was the most important reason for the informants writing few clinical incident reports. They found that there was little point in doing so: ‘Often you don’t have the time (to write an incident report). As a result, you probably have to work overtime to write the report. When you feel you don’t get any response anyway, it means that people don’t take the time.’



**«I feel that submitting incident reports doesn’t help. We send one after the other but nothing happens. We don’t see any results from the incident report.»**

Focus group participant

The nurses said that they had little faith in the clinical incident reporting system. They did not believe that submitting reports promoted learning and better handling of the challenges the reports might have pinpointed: ‘I feel when we don’t report, this is used against us ... Then management say: “You haven’t written any incident reports so everything must be fine.” But when we do, nothing happens anyway.’

‘When you talk to people about it, especially those who’ve worked in the field for a while, they say they can’t be bothered writing incident reports because nothing happens as a result. It’s such a shame that the system doesn’t work.’

Even though the nurses had little belief that writing incident reports helped, they nevertheless expressed a kind of bad conscience about not being ‘good enough’ at submitting incident reports: ‘Things are not done because we’re understaffed. We need more resources ... even though it doesn’t help, you should submit them.’

**Quantitative assessment and HSE measures**

The nurses had different experiences in relation to the annual employee survey at the hospital. The survey is a statistical mapping that includes the psychosocial working environment and assesses areas such as well-being, motivation and health.

In the focus groups, the nurses discussed whether the employee survey is a suitable tool for pinpointing working environment challenges. The informants thought that, in principle, such a survey had the potential to elicit important knowledge about the working environment. However, the nurses also claimed that no one had experienced improvements in the working environment as a result of the survey.

The groups had divergent experiences with regard to different kinds of health, safety and environment measures (HSE measures). The informants said that HSE measures were often directed at individuals. One example was how a specific working environment problem in one of the wards was handled. This was related to slander. The nurses wanted external help to solve the problem, which resulted in them receiving help from the occupational health service and the Norwegian Labour and Welfare Administration (NAV).

The measure implemented was mandatory discussion groups for the staff of the ward in question. The nurses in the focus group explained that the slander occurred because of a heavy workload over time: 'I think that the work pressure in the ward is so great sometimes that there's a tendency to complain about each other ... there can be a focus on what everyone else hasn't done.'

They also explained: 'People become uncertain, so that you start to feel unhappy at work ... You were frightened someone would complain about you, yes, frightened of being slandered.'

The nurses said that the occupational health service and NAV focused, however, on how the nurses should change their own behaviour. The nurses should become more aware of how they came across, and how that affected the ward's psychosocial working environment.

After participating in the discussion groups, one of the nurses remarked: 'You have to look inside yourself first: "What could I have done to improve things?" ... That seems to have helped ... Then maybe you fall back into old ways now and then when there's a lot of pressure and people are tired .... In a stressful everyday situation, I think it's important to think about how you come across.'

### **Personal follow-up**

The nurses described the various opportunities they had to express their opinions about the working environment. According to the nurses, the clinical nurse manager, who is their line manager, actually represents one of the most important channels when it comes to discussing issues related to the working environment.

It is the clinical nurse manager that they are in daily contact with and that they perceive as having practical responsibility for the working environment. For the most part, therefore, this is the person to whom they communicate their input, their concerns and suggestions. Some people stated that information and feedback often stop at this level: 'I feel that many people's attitude is that it's not worth saying anything, because nothing happens anyway. But it is important to speak up.'

Others felt that the line manager had limited room for action: 'She [the clinical nurse manager] can't always do much about it, but we know that she works on our behalf.'



## «Above all, the nurses felt the lack of a good dialogue with management and information about cases that concern them.»

The nurses said that management should be more adept at communicating their work processes and what action they have taken regarding the input from the nursing staff. The informants experienced that information was not always reported to the next level of the system after they had informed the clinical nurse manager.

In general, the nurses felt that they had few opportunities to express their opinions about their work situation, whether it concerned the imbalance between tasks and resources or reorganisations that have major impacts on the working environment. In the case of top-down changes, they said: ‘You must feel valued as an employee. That you do things the proper way ... and don’t make decisions over people’s heads and use people like pawns.’

Above all, the nurses felt the lack of a good dialogue with management and information about matters that concern them: ‘We can try to convey this, but we have no proper communication channels.’

## Discussion

Broadly speaking, a general picture emerges showing that working environment challenges are seldom handled as organisational issues through the tools we have examined here: clinical incident reporting, quantitative assessments and HSE measures in addition to personal follow-up.

### Clinical incident reporting

The nurses were of the opinion that the lack of feedback and the absence of perceived improvement after submitting clinical incident reports were the most important reasons for the underreporting of deviations. They appeared to have lost faith in the clinical incident reporting system. This finding agrees with research showing that nurses generally experience a lack of feedback after reporting adverse events, and that the feedback is not always in accordance with the nurses' view of the event (16–20).

The nurses found that the incident reports had little impact on future practice, nor did they contribute to constructive organisational learning processes (17, 18). When the Norwegian Journal of Clinical Nursing asked its readers about their clinical incident reporting, over half of the nurses replied that there was no point in writing incident reports because management remained silent (5).

Both Norwegian and international studies point to an underreporting of clinical incidents among nurses in hospitals (16, 17). Inspections following the God vakt (Good shift) action ascertained that there is an underreporting of HSE incidents in Norwegian hospitals. In particular, they emphasise that the imbalance between tasks and resources in the case of health personnel constitutes an area in which more deviation reports should be submitted (21, 22).

Lundberg et al. (23) also claim that the models used as analysis tools for incidents do not adequately capture the complexity underlying adverse events. The result is that the incidents are not sufficiently scrutinised in relation to systemic, underlying conditions, i.e. the real reasons behind many of the incidents.

The unintended consequences of treating incidents as individual events can lead to an individualisation of the challenges nurses meet in their everyday work. The general challenge in respect of adverse events is therefore not only that they are underreported. The handling of incidents should be analysed to a greater extent in an organisational and systemic perspective, thus enabling organisational learning (24).

We hold the view that it is vital to involve the staff following the reporting of clinical incidents so that they can take part in the necessary analyses of the deviations; partly because it is essential that they help to interpret the incidents (what do they 'really' mean?) and partly because it is important to establish a communication channel between staff and management in respect of clinical incidents.

In order to facilitate learning in the wake of adverse events, Aase and Wiig (24) recommend involving the staff, for example by face-to-face follow-up, and providing speedy feedback after incidents are reported. By being involved in this work, staff will be more inclined to feel that reporting incidents is worthwhile (16, 20, 24).

### **Quantitative assessment and HSE measures**

The informants did not find that they had experienced improvements in the working environment as a result of the annual employee survey. On a more general level, the results of the employee survey from 2012 to 2015 showed that psychosocial aspects such as opportunities to participate, perceived control and workload received the lowest scores when all employees at the university hospital evaluated their own working environment.

The results of the survey are intended to form a platform for improvement. The absence of improvements in connection with the three challenge areas at the hospital may have many explanations. Nevertheless, we are of the opinion that there are good reasons for scrutinising the assessment system itself. Hasle and Hvenegaard, who studied the psychosocial working environment in the big Danish research project on enterprises' efforts to improve the psychological working environment (the VIPS project), found that managers and staff did not perceive there to be any correlation between questionnaires and visible results and initiatives (25).

The employee survey at the university hospital is based on QPS Nordic (26), which according to Nordrik (8) is the most usual method of identifying working environment challenges in Norwegian companies. She claims that this type of quantitative measurement of the working environment is little suited to capturing the complexity of psychosocial working environment challenges (8).



**«We believe that the low scores on opportunities to participate, perceived control and workload are primarily dependent on organisational factors.»**

The reasons for this are that the questionnaires do not provide sufficient information about the underlying causes of the problems. Therefore, it is challenging to use them to accomplish specific improvement efforts. We believe that the low scores on opportunities to participate, perceived control and workload are primarily dependent on organisational factors.

In our opinion, in order to work with this kind of working environment challenge we need knowledge that tells us more about underlying reasons and that can thus identify some organisational solutions to the problems. The employee survey can serve as an aid in the working environment assessment because it provides an overview of the working environment in the various units and of the line manager

However, we lack methods that properly capture the experiences of staff and that have a strong focus on understanding how the organisation affects their working environment. Alternatively, we can use more democratic methods of pinpointing, understanding and working with psychosocial working environment issues (25, 27). The current design of the working environment assessment does not capture the complexity of psychosocial working environment challenges, which means that it is difficult to solve them. The nurses therefore face these challenges alone.

Measures initiated by the occupational health service and NAV in connection with slander problems are clearly characterised by an approach that targets individuals. One of the nurses said that the conversation groups had helped to some extent but that it was easy to backslide in periods of considerable stress. Measures that solely focus on individuals have limited impact if other factors are not also considered, for example framework conditions for the work (3, 4).

The Norwegian Labour Inspection Authority's (22) audits of six Norwegian hospitals in 2014 showed that the occupational health service has a much stronger focus on the individual level than on organisational factors. This thematic area can be viewed in light of a trend in contemporary working life to solve psychosocial working environment challenges by looking at the characteristics of individuals rather than solving these challenges at the executive level of the organisation (1, 8, 25). In our view, measures targeting the working environment that focus exclusively on changing behaviour also contribute to individualising nurses' working environment challenges.

### **Personal follow-up**

In their hectic working day, it is obvious that nurses direct many of their working environment challenges towards the clinical nurse manager. Therefore, in many ways the line manager appears to be the nurses' key spokesperson vis-a-vis the organisation.

Pettersen and Solstad (28), who carried out a study in five Norwegian hospitals, believe that clinical middle managers have to deal with different types of management logics which partly entail a large responsibility for budgets as well as for professionally responsible conduct. The researchers believe that it may be difficult for a middle manager to reconcile these two kinds of logic.

The Swedish working life researcher Rydén (29) has the view that it is essential that employees' views on their work situation should be heard. By this, she means that employees' input must be discussed and not simply brushed aside as of lesser importance when discussing financial considerations, for example. She believes that the perception of not being taken seriously in these work situations reinforces the staff's feeling of powerlessness in the encounter with the organisation (29).

The informants' perceptions of being heard by their line manager are twofold: some feel that there is a lack of information from management about what has happened as a result of the nursing staff's input, and they express powerlessness when it comes to having their views about their own working situation heard. Others are certain that the clinical nurse manager takes their descriptions of the working environment further up the management chain, while at the same time they are aware that decision-making powers rest with another service level in many cases.

The line manager can promote working environment-oriented efforts locally in the different hospital wards. However, strategic management must also be involved in order to change organisational factors (30). Continuing the research of Pettersen and Solstad (28), and Rydén (29), we can say that when staff are unable to express their opinions about their own working environment problems and the information is blocked in the system, this represents a serious failure.

## **Conclusion**

Through examining the clinical incident reporting, quantitative assessments and HSE measures as well as personal follow-up, we have seen that the working environment challenges facing nurses are inadequately handled at the organisational level. Health personnel have an independent responsibility to report such challenges.

Meanwhile it is important to keep in mind that clinical incident reports represent information that shall and should be used to develop the organisation of the work. Neither HSE or HR are meant to individualise working environment challenges. We believe it is opportune to point out that there is a danger of the systems we have described, which are of central importance to the psychosocial working environment, losing their support and legitimacy. When they do not actually pinpoint and deal with causes and problems, it is clear that staff will not make use of them.

There is a need for further research to elucidate nurses' psychosocial working environment challenges in a settings perspective. The specific areas we have dealt with do not appear to be able to tackle psychosocial working environment challenges as organisational issues.

At a time when nurses and other professional groups in hospitals are already subject to an unfortunate deluge of responsibility, it is regrettable if the responsibility for solving working environment challenges is also shifted to individuals.

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