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Evaluation of Disciplinary and Grievance Handling Policies in Hospitals: A Comparative Analysis with CBAHI Accreditation Standards

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Abstract: ***Disciplinary and grievance handling mechanisms are important components of hospital human-resource management because they influence fairness, transparency, accountability, trust and workplace stability. This paper examines disciplinary and grievance handling policies in Thuriban General Hospital (TGH), a 50-bed hospital in Saudi Arabia, with particular emphasis on their alignment with Central Board for Accreditation of Healthcare Institutions (CBAHI) requirements. The study adopts a mixed-methods, descriptive and comparative framework incorporating staff perceptions, semi-structured interviews and document analysis. The study identifies inconsistent application of policies, inadequate staff awareness and training, procedural delays, barriers to grievance reporting and challenges associated with hierarchical and cultural factors as key areas requiring attention. The proposed improvement approach includes standardized training, accessible grievance-reporting channels, digital tracking, defined resolution timelines, periodic policy audits, staff feedback mechanisms and safeguards against retaliation. The paper presents the study's documented observations and proposed analytical framework rather than statistical test results, and situates them within a review of the peer-reviewed and institutional literature on grievance management, disciplinary due process and accreditation-linked human-resource governance in healthcare settings. The paper highlights the importance of transparent, consistently implemented and accreditation-aligned employee grievance systems in supporting staff morale and organizational effectiveness in hospital settings.***

Keywords: disciplinary procedures; grievance handling; hospital human-resource management; CBAHI; staff morale; policy implementation; healthcare accreditation; Saudi Arabia

1. Introduction

Healthcare organizations are complex socio-technical systems in which human-resource practices influence operational efficiency, workforce stability and quality of patient care. Disciplinary and grievance handling policies provide formal mechanisms for responding to employee misconduct, workplace concerns, disputes and perceived unfair treatment. When these mechanisms are clearly defined and consistently applied, they can promote fairness, transparency and accountability.

The study is set in the Saudi healthcare context and focuses on Thuriban General Hospital (TGH), a 50-bed CBAHI-accredited hospital. It identifies inconsistent policy application, inadequate training and procedural delays as important implementation concerns. It also considers hierarchy and cultural factors that may influence willingness to report grievances. The study therefore examines the relationship between internal policy implementation, staff perceptions and accreditation expectations.

Effective grievance mechanisms are particularly relevant in hospitals because unresolved workplace concerns may affect morale, trust, staff stability and day-to-day operations. Hospitals differ from many other organizational settings in that disciplinary and grievance outcomes can indirectly touch patient safety: a nurse who feels unable to raise a legitimate concern about staffing, supervision or workload may be less likely to escalate a safety-relevant observation through other channels. The literature on healthcare human resources increasingly frames grievance and disciplinary systems not purely as administrative processes but as part of the wider safety and quality culture of an institution. The study further proposes that technology can support more accessible reporting, transparent tracking and timely escalation of grievances.

The significance of this study lies in its attempt to connect two areas of hospital management that are often examined separately: internal human-resource process design and external accreditation compliance. Much of the existing literature on hospital accreditation, discussed further in the literature review below, focuses on clinical quality and patient-safety outcomes rather than on staff-facing HR processes such as discipline and grievance handling. Conversely, much of the existing literature on grievance management is drawn from general organizational or industrial settings rather than from accredited healthcare institutions specifically. By examining TGH's disciplinary and grievance practices explicitly against CBAHI's accreditation framework, this study contributes to a comparatively underexamined intersection between these two literatures, with practical relevance for any hospital pursuing or maintaining CBAHI accreditation in Saudi Arabia or a comparable regulatory environment. This paper situates the study's observations within a broader body of published research on grievance management, disciplinary due process and accreditation standards, and develops the discussion, methodological justification and recommendations in depth.

2. Literature Review

2.1 Grievance Management as an Organizational Process

Grievance handling has long been studied as a structured organizational process rather than a purely reactive administrative task. Gulzar, Rehman and Radouch (2023)

examined the grievance management process in a healthcare organization from the employee's perspective and found that constructs such as acceptance of the grievance by supervisors, supervisors' attitudes toward the grievant, and the level of trust between employees and supervisors were strongly associated with how effectively a grievance was resolved. Their review of related work also pointed to workplace equity, communication quality and consistent procedural application as recurring themes across multiple studies of grievance systems. This body of work supports the view, echoed in the TGH study, that a grievance policy's effectiveness cannot be assessed solely from its written content; it depends heavily on how supervisors and managers actually apply it in practice.

Similar themes appear in studies conducted within hospital settings specifically. An analytical study of grievance handling mechanisms in a cooperative hospital setting reported that, while employees expressed general satisfaction with the existence of a grievance system, specific concerns remained around workload-related grievances, the timeliness of responses to complaints, and the quality of record-keeping throughout the grievance lifecycle. These findings are relevant to TGH because they suggest that even where a policy framework exists on paper, gaps in responsiveness and documentation can undermine staff confidence in the system. A separate assessment of employee knowledge of grievance procedures at a hospital-based medical college similarly found that awareness of the grievance process was uneven across staff groups, reinforcing the study's observation that inadequate training and awareness constrain how effectively a policy is used.

2.2 Disciplinary Processes and Procedural Fairness

Procedural fairness is a central theme in the literature on workplace discipline. Verhoef, Weenink, Winters, Robben and Westert (2015) conducted a qualitative interview study examining the impact of disciplinary processes and imposed measures on healthcare professionals in the Netherlands. Their findings indicated that the experience of being subject to a disciplinary process could have a significant personal and professional impact on the individual involved, regardless of the eventual outcome, and that the perceived fairness of the process itself shaped how professionals viewed the legitimacy of the disciplinary body. This underscores why the study's concern with consistent application of disciplinary procedures across departments is not a peripheral administrative detail: perceived inconsistency can affect how legitimate the entire system appears to staff, independent of any single case outcome.

More recently, Cooper, Neal, Windsor, Lewis, Bansal and Yarker (2025) proposed an integrated framework for disciplinary processes and the conduct of employee investigations, arguing that investigatory quality, clarity of roles and structured documentation are central to defensible and fair disciplinary outcomes. Their framework is broadly consistent with the improvement measures proposed in this study, particularly the emphasis on standardized procedures, defined escalation levels and documentation requirements. Read together, these two studies suggest that disciplinary fairness is best understood as a function of process design (how clearly roles, timelines and investigatory steps are defined) rather than of the severity of any individual sanction.

2.3 Accreditation and Human-Resource Governance

Accreditation frameworks are widely used internationally as a mechanism for standardizing hospital governance, including human-resource practices. Hussein, Pavlova, Ghalwash and Groot (2021) conducted a systematic literature review of the impact of hospital accreditation on the quality of healthcare and reported that accreditation was generally associated with improved compliance with structural and process standards, although the strength of the relationship with clinical outcomes varied across studies and settings. This is relevant to the TGH study because it suggests that accreditation compliance, including compliance with human-resource-related standards, should be treated as a proxy for structured governance rather than as an automatic guarantee of on-the-ground staff experience.

The CBAHI framework itself, applicable to TGH as a Saudi Arabian hospital, organizes its accreditation requirements into standards addressing governance, leadership and human resources, patient care and quality management, medication management, facility safety, patient rights, and information management, among other domains. Within the Leadership and Human Resources component, CBAHI's published framework and associated training materials emphasize structured governance, staff support mechanisms, and continuous quality improvement as core expectations for accredited institutions. Because CBAHI, like related bodies such as the Joint Commission International (JCI), positions human-resource governance as integral to overall accreditation rather than as a stand-alone administrative concern, a hospital's disciplinary and grievance systems can reasonably be treated as one of the areas a CBAHI survey would expect to see functioning consistently, even where the standards do not spell out a single prescriptive grievance procedure.

2.4 Cultural and Contextual Factors in Grievance Reporting

Nurse and Devonish (2007) examined the relationship between grievance management and perceptions of workplace justice in a survey of 660 employees across the public and private sectors, and found that the procedural justice employees perceived in grievance procedures influenced their perceptions of distributive justice. Their findings suggest that how a grievance procedure is experienced shapes employees' broader judgments of fairness at work, and not only their view of the procedure itself. Perceptions of this kind are particularly relevant in hierarchical, high-power-distance workplace cultures, where employees may be more hesitant to formally challenge a supervisor's decision through official channels. The study's attention to hierarchy, fear of retaliation and cultural norms as barriers to reporting reflects this concern with perceived fairness: such barriers are not unique to Saudi Arabia, but the specific hierarchical and cultural dynamics of a given healthcare labor market can shape how strongly they are felt and how they should be addressed.

2.5 Documentation, Record-Keeping and Grievance-System Credibility

A recurring but sometimes underemphasized theme across the hospital-grievance literature is the role of documentation quality in shaping how credible a grievance system appears to staff, independent of the outcome of any individual case. The Vadakara Co-operative Hospital study noted specific concerns about record-keeping practices even where overall staff satisfaction with the grievance mechanism was reported as reasonably positive, suggesting that documentation gaps can persist as a source of dissatisfaction even in an otherwise functioning system. This is a useful caution for TGH: the study's proposal for a digital tracking mechanism should be understood not merely as a convenience feature but as a direct response to a documented failure mode observed in comparable settings, where inconsistent record-keeping undermined confidence in an otherwise adequate process.

Institutional grievance policies published by individual hospitals reinforce this emphasis on procedural clarity. Publicly available hospital grievance policy documents, such as those maintained by accredited hospitals operating under formal HR governance structures, typically specify defined filing windows, a named grievance committee or equivalent body responsible for hearing concerns, and explicit non-retaliation and confidentiality provisions. The presence of these structural elements in institutional practice supports the study's recommendation that TGH formalize similar features, including defined escalation levels, a documented time limit for filing a grievance, and explicit safeguards protecting employees who raise concerns from retaliation.

2.6 Synthesis and Gaps in the Existing Literature

Reviewing this literature alongside the TGH study also highlights a gap that this study was designed to help address: much of the published hospital-grievance literature is either broadly descriptive (documenting staff satisfaction levels or general awareness) or focused on disciplinary due process in isolation, without directly connecting grievance-system design to a specific external accreditation framework such as CBAHI. Studies examining the relationship between hospital accreditation and quality of care, such as Hussein et al. (2021), tend to focus on clinical and structural outcomes rather than on employee-facing HR processes specifically. The study's explicit framing of disciplinary and grievance policy against CBAHI requirements therefore addresses a comparatively underexamined intersection in the literature: how an accreditation framework's general governance and human-resource expectations translate into specific, staff-facing grievance and disciplinary practice at the level of an individual hospital. This positions the present paper's contribution as bridging two literatures that are more often treated separately: the grievance-management and organizational-justice literature on one hand, and the hospital-accreditation literature on the other.

2.7 Digital Grievance Management Systems

RQ5 asks what role technology can play in streamlining grievance procedures, and the recommendations in Section 9 propose a secure digital grievance-reporting and tracking mechanism for TGH. While this study does not include a technology-vendor evaluation, documented case examples from other organizations that have digitized employee-relations and grievance workflows offer a useful, non-vendor-specific illustration of what such a system typically changes in practice. One published implementation case describes a manufacturing employer that digitized its grievance and disciplinary-action intake using an employee-relations case-management platform; the reported result was a reduction in average case-handling time from a range of six to nine months down to an average of around fifteen days, alongside electronic record-keeping that supported auditing and reduced manual administrative effort. While this example comes from a non-healthcare, unionized manufacturing setting and its specific figures should not be assumed to transfer directly to TGH, it illustrates the general mechanism by which digitization is expected to improve grievance handling: standardized intake reduces case-routing ambiguity, automated timeline reminders reduce the kind of drift that produces the procedural delays the TGH study already documents, and centralized electronic records address the record-keeping weaknesses identified in comparable hospital-grievance studies discussed in Section 2.5.

Published grievance-intake workflow templates used across sectors including healthcare typically emphasize several structural features that would be directly relevant to TGH's proposed digital mechanism: a consistent single intake path regardless of how a complaint first arrives (in person, by phone, or in writing); confidentiality controls that restrict who can view sensitive case details; automatic acknowledgement to the employee within a defined timeframe; and case routing to a designated investigator or employee-relations owner rather than leaving assignment informal. These features map directly onto the study's own recommendations for a secure, trackable system with acknowledgement and escalation controls, and can be treated as a practical checklist against which any digital solution TGH ultimately selects could be evaluated, independent of which specific vendor or platform is chosen.

Taken together, the reviewed literature supports four propositions that inform the remainder of this paper: first, that grievance system effectiveness depends on consistent application and supervisory behavior rather than policy wording alone; second, that disciplinary fairness is a matter of process design and documentation quality; third, that accreditation frameworks such as CBAHI provide an external governance benchmark against which internal HR practices can be compared even without prescribing a single procedure; and fourth, that cultural and hierarchical context meaningfully shapes reporting behavior and therefore needs to be addressed directly rather than treated as an unavoidable background condition.

3. Objectives of the Study

1) To assess the effectiveness of current disciplinary and grievance handling policies at TGH.
2) To compare TGH practices with applicable CBAHI accreditation requirements.
3) To evaluate staff awareness and perceptions of disciplinary and grievance procedures.

4) To analyze the perceived impact of policy implementation on staff morale, productivity and hospital operations.
5) To provide recommendations for improving implementation and alignment with CBAHI requirements.

4. Research Questions and Hypotheses

RQ1: What are the primary barriers to implementing effective disciplinary and grievance policies at TGH?
RQ2: How do staff perceptions of fairness and transparency influence policy outcomes?
RQ3: What strategies can enhance alignment with CBAHI standards?
RQ4: How do cultural factors in Saudi Arabia affect policy implementation?
RQ5: What role can technology play in streamlining grievance procedures?

Three hypotheses guide the analysis. H1 proposes that effective disciplinary and grievance policies positively impact staff morale; this is consistent with the procedural-fairness literature reviewed above, which links perceived fairness of process to broader employee attitudes. H2 proposes that compliance with CBAHI standards improves policy effectiveness, reflecting the view that external accreditation benchmarks provide structure that internal policies alone may not enforce. H3 proposes that cultural factors negatively moderate the relationship between policy effectiveness and staff morale, meaning that even a well-designed policy may deliver a weaker morale benefit in a context where hierarchy or fear of retaliation discourages open use of the system. These hypotheses are presented as the analytical framework for empirical testing against the staff questionnaire and interview data described in the methodology below, and are not reported here as tested claims.

5. Methodology

The study uses a mixed-methods, descriptive and comparative design. This design was selected because the research questions span both measurable staff perceptions (suited to a quantitative questionnaire) and contextual, process-level detail that quantitative measures alone would not adequately capture (suited to qualitative interviews and document review). Quantitative information is intended to be obtained through a structured staff questionnaire, while qualitative information is intended to be obtained through semi-structured interviews and document analysis. This combination is designed to examine both staff perceptions and organizational evidence available in policies and records, and to allow triangulation between what staff report experiencing and what the hospital's own documentation specifies.

5.1 Study Setting and Population

The setting is Thuriban General Hospital (TGH), a 50-bed hospital in Saudi Arabia. The study population includes staff from nursing, administrative and support-service departments, reflecting the range of roles most likely to interact with disciplinary or grievance procedures in day-to-day operations. The sample comprises 30 staff members. A sample of this size is appropriate for a descriptive, exploratory study of a single 50-bed facility and for generating qualitative and thematic insight, though it constrains the extent to which any future inferential statistics could be generalized beyond TGH itself.

5.2 Instruments

The questionnaire covers fairness, transparency, efficiency, grievance effectiveness, accessibility, training and cultural influences. Each of these constructs corresponds to a theme identified in the literature review: fairness and transparency draw on the procedural-fairness and organizational-justice literature; efficiency and grievance effectiveness draw on the grievance-process literature; accessibility and cultural influences draw on the reporting-barriers literature; and training draws on the recurring finding that awareness gaps limit how staff use even well-designed systems.

The interview guide addresses disciplinary processes, grievance effectiveness, organizational and cultural barriers, CBAHI compliance, technology and improvement opportunities. Semi-structured interviews allow follow-up probing on sensitive topics, such as fear of retaliation, that a fixed-response questionnaire item might not fully capture. The document checklist covers the code of conduct, grievance procedures, training materials, accreditation reports, staff feedback forms, employee handbooks, performance records and incident reports. Document analysis serves as a validity check against staff-reported perceptions: for example, a written escalation timeline can be compared against staff reports of how quickly grievances are typically resolved in practice.

5.3 Planned Analysis

The proposed analysis includes descriptive statistics and appropriate inferential analysis where supported by the final sample and data quality, together with thematic analysis of qualitative responses. Thematic analysis of interview transcripts and open-ended questionnaire responses would be used to identify recurring categories such as those already documented in Section 6 (inconsistent application, training gaps, procedural delays, reporting barriers and digitalization opportunities), and to examine whether these categories cluster differently across departments or staff roles. No p-values, effect sizes or other statistical outputs are reported in this paper; the findings presented in Section 6 are documented observations.

5.4 Triangulation and Validity Considerations

The mixed-methods design is intended to support triangulation across three distinct sources: the structured questionnaire, the semi-structured interviews, and the document checklist. Triangulation of this kind is a standard approach for improving the credibility of descriptive organizational research, since agreement across independently collected sources reduces the risk that a finding reflects an artifact of a single instrument or respondent group. For example, if document analysis of TGH's written grievance procedure shows a defined resolution timeline, but staff questionnaire responses and interview accounts

consistently describe experiencing much longer resolution periods in practice, this divergence would itself be a meaningful finding, indicating a gap between documented policy and lived staff experience of the kind the study's core concerns already anticipate.

A related validity consideration concerns the risk of social-desirability bias in staff responses, particularly given the hierarchical and retaliation-related barriers identified in Section 2.4. Staff may understate dissatisfaction with disciplinary or grievance handling if they are concerned that critical responses could be traced back to them, even where anonymity is assured. Semi-structured interviews, conducted with appropriate assurances of confidentiality and, where feasible, by an interviewer without direct authority over the respondent's department, can partially mitigate this risk relative to a purely self-administered questionnaire, though it cannot be eliminated entirely. This is a limitation inherent to studying sensitive workplace topics in a hierarchical organizational setting, rather than a specific flaw in the study design, and is acknowledged here alongside the sample-size limitation noted in Section 5.1.

5.5 Ethical Considerations

Given that grievance and disciplinary topics can touch on sensitive workplace experiences, the study design anticipates the need for informed consent, voluntary participation, and confidentiality of individual responses, particularly given the hierarchical concerns identified in the literature review. Interview and questionnaire data would be expected to be anonymized prior to analysis so that no individual respondent's views on supervisors or specific incidents could be identified from the reported findings.

6. Documented Findings and Observations

The study identifies several recurring implementation concerns. First, disciplinary and grievance policies may not be applied consistently across departments, creating perceptions of unequal treatment. Second, inadequate staff awareness and training may limit understanding of reporting channels, procedural rights and responsibilities. Third, procedural delays are identified as an operational concern, particularly when grievance escalation and resolution are not governed by clear timelines.

A further issue concerns accessibility and willingness to report. The study identifies hierarchy, fear of retaliation and cultural considerations as potential barriers to open reporting. These factors are important in a hospital environment because employees may depend on supervisors for daily operational decisions and may therefore hesitate to raise concerns through conventional channels. This observation aligns closely with the organizational-justice literature discussed in Section 2.4, which links grievance management to broader perceptions of fairness rather than treating the grievance mechanism in isolation.

The study also identifies an opportunity for digital grievance management. A secure electronic mechanism could provide standardized submission, status tracking, escalation and documentation. Regular audits and staff feedback could then be used to evaluate whether the system is functioning as intended and whether policies remain aligned with accreditation requirements. This proposal is consistent with the record-keeping concerns documented in comparable hospital-based grievance studies, where inconsistent documentation was identified as a limiting factor even when overall staff satisfaction with the system was reasonably positive.

7. Comparative Positioning Against CBAHI Requirements

CBAHI accreditation standards are organized around a set of chapters covering governance and leadership, human resources, patient care and quality management, medication management, facility safety, patient and family rights, infection prevention and control, and management of information, among other domains. The Leadership and Human Resources component is the chapter most directly relevant to disciplinary and grievance practice, since it addresses how a hospital structures its governance and supports its workforce.

CBAHI's published guidance also categorizes its standards into three broad types: structural standards, covering infrastructure, staffing levels and facility design; procedural standards, covering clinical and operational processes; and outcome standards, covering measurable performance indicators such as patient safety and infection-control results. Disciplinary and grievance handling sits most naturally within the procedural category, since what CBAHI would typically expect to see is not a specific staffing level or infrastructure requirement, but evidence of a defined, consistently followed process for handling employee concerns and misconduct. This categorization is useful for TGH because it clarifies that the appropriate evidence of compliance is process-level documentation and demonstrated consistency of application, of the kind proposed in this paper's recommendations, rather than a structural metric such as headcount or facility layout.

Positioning the study's observations against this framework, three points of comparison stand out. First, CBAHI's general expectation of documented, consistently applied policies is echoed directly in the study's concern about inconsistent application of disciplinary and grievance procedures across departments; a hospital preparing for or maintaining CBAHI accreditation would be expected to demonstrate not just the existence of a policy but evidence of its uniform use. Second, CBAHI's emphasis on staff support and continuous quality improvement corresponds to the study's recommendation of structured training and periodic policy audits: training and audit cycles are the practical mechanisms through which a written policy is kept aligned with actual practice over time. Third, CBAHI's broader information-management expectations, concerning accurate and accessible record-keeping, correspond to the study's proposal for a digital grievance-tracking mechanism, since a system that produces an auditable record of grievance submission, escalation and resolution would support the kind of documentation an accreditation survey would expect to review.

These points of comparison also carry practical implications for how TGH's leadership might prepare for an accreditation survey or renewal cycle. Rather than treating disciplinary and grievance documentation as a compliance artifact assembled shortly before a survey, the literature reviewed above suggests that surveyors using a tracer-style methodology of the kind JCI describes (CBAHI surveys similarly rely on structured on-site evaluation) are likely to test whether staff can describe the actual operation of these processes from memory and experience, not only whether the correct documents exist in a file. Embedding the recommendations in Section 9 into ordinary staff onboarding and periodic refresher training, rather than treating them as a one-time documentation exercise, would therefore better position TGH to demonstrate genuine, lived compliance rather than paper compliance alone.

Clause-level compliance with the CBAHI Hospital Accreditation Standards edition applicable to TGH is not assessed here. The comparison is made at the level of general standard domains and publicly described accreditation expectations, and specific clause references should be verified against the applicable official CBAHI edition.

7.1 Positioning Against the Joint Commission International (JCI) Framework

Although the relevant accreditation framework for TGH is CBAHI's, it is useful to briefly compare CBAHI's structure with that of the Joint Commission International (JCI), a widely used international accreditation body, because JCI's published standards articulate human-resource-related expectations in well-documented terms and help clarify what an accreditation body typically expects in this domain. JCI organizes its standards into two broad groups: standards relating directly to patient care, such as patient assessment, medication management and patient and family rights; and standards relating to hospital management and governance, which include staff qualification and education, governance and leadership, and management of information. Human-resource-related expectations therefore sit within the hospital-management group in both frameworks, alongside governance, information management and facility safety, rather than being treated as a narrow personnel-department concern.

JCI's survey methodology also relies on what it describes as a tracer approach, in which surveyors follow how care is actually delivered to patients and how staff describe their own processes, rather than reviewing written policy alone. This is instructive for TGH's disciplinary and grievance context: an accreditation survey grounded in this kind of methodology would be expected to probe staff experience directly (for example, whether staff can describe how they would raise a concern and what happens next) rather than accepting a written grievance policy at face value. This reinforces the study's central premise that policy existence and policy effectiveness are analytically distinct, and that staff-level awareness, of the kind the TGH questionnaire and interviews were designed to measure, is itself a meaningful accreditation-relevant indicator, not only an internal HR metric.

This comparison is offered for contextual purposes only. It does not imply that TGH is or should be pursuing JCI accreditation, and it does not substitute for direct reference to the applicable CBAHI standard text, which remains the correct benchmark for TGH's own compliance assessment.

7.2 A Standard Multi-Stage Model as a Reference Point

Beyond the accreditation-specific comparison offered above, it is useful to situate TGH's proposed standardization effort against the generic multi-stage grievance-procedure model widely used across employment settings, since this model is not specific to any one country's labor law and offers a practical structural reference point independent of the CBAHI or JCI text. In general HR practice, a grievance procedure typically proceeds through an informal resolution stage, in which the employee first raises the concern with an immediate supervisor; a formal complaint stage, in which the employee submits the concern in writing if informal resolution is unsuccessful or inappropriate given the nature of the complaint; an investigation stage, in which relevant facts are gathered and involved parties are consulted; a decision or hearing stage, in which the employer communicates a formal outcome; and, in many models, an appeal stage, allowing the employee to seek review if dissatisfied with the outcome. Each stage is typically governed by a defined response timeline, and written documentation is expected at the formal stage onward.

This generic structure maps closely onto the study's own recommendations. The study's call for defined internal timelines for acknowledgement, investigation, decision and closure corresponds to the timeline expectations built into each stage of the generic model above. Its call for more than one reporting channel corresponds to the common practice of directing employees to escalate beyond their immediate supervisor, whether to an HR director, a designated grievance committee, or an equivalent body, when the immediate supervisor is themselves the subject of the complaint or when informal resolution has failed. Adopting an explicit, named multi-stage structure of this kind, rather than leaving escalation implicit or ad hoc, would give TGH staff a clear, predictable path to follow and would give hospital management a structure against which delays or inconsistencies could be more easily identified and corrected.

It is worth noting that TGH's context does not necessarily require replicating every element of the generic model exactly; for instance, formal union representation, common in some grievance-procedure templates from unionized workplaces, may not be directly applicable at TGH depending on its workforce structure. The relevant transferable elements are the underlying principles: a clear informal-to-formal escalation path, written documentation from the formal stage onward, defined response timelines at each stage, and an appeal or secondary-review option, all of which are compatible with the study's own recommendations and with CBAHI's general expectation of documented, consistently applied procedures.

8. Discussion

The documented observations indicate that the effectiveness of a disciplinary or grievance policy depends not only on the existence of a written procedure but also on how consistently it is implemented. A policy that is difficult to understand, inaccessible to employees or inconsistently applied may not achieve its intended organizational purpose. Fairness and transparency are therefore central to the credibility of the system. This is consistent with Verhoef et al. (2015), who found that the perceived fairness of a disciplinary process shaped how legitimate healthcare professionals considered the process to be, independent of the specific outcome reached.

The observations also support the conceptual framework proposed in the study, in which policy effectiveness is linked with trust, accreditation compliance and staff morale. Employees are more likely to view a system positively when procedures are understandable, consistently applied and allow concerns to be heard. In an accredited hospital, the additional requirement is to ensure that internal processes are demonstrably aligned with applicable accreditation expectations. Hussein et al.'s (2021) systematic review finding, that accreditation is more reliably associated with structural and process compliance than with uniform clinical-outcome improvement, suggests a useful caution here: accreditation status alone should not be read as proof that staff-level grievance experience is positive, and internal staff-perception data (of the kind the TGH study sought to collect) remains necessary to assess that separately.

Cultural and hierarchical influences require careful handling. The objective should not be to attribute reporting behavior to culture alone, but to identify practical organizational barriers and create channels through which employees can raise concerns safely and confidentially. Training for managers and staff can support this approach by clarifying non-retaliation expectations, escalation pathways and responsibilities. Nurse and Devonish's (2007) findings on the link between procedural justice in grievance management and broader justice perceptions suggest a practical implication: interventions aimed only at the mechanics of the grievance process (for example, a new reporting form or an intranet portal) are unlikely to overcome reporting reluctance on their own if staff do not also perceive the process as fair. Improvement measures at TGH would therefore need to combine procedural changes with visible, consistent follow-through on past cases in order to build the trust that is likely to be a precondition for open reporting.

A further point for discussion concerns the relationship between disciplinary fairness and grievance-system trust. Where staff perceive that disciplinary outcomes have been applied inconsistently, as the study suggests may be occurring at TGH, this can plausibly reduce confidence in the grievance system as well, since both processes are typically administered through overlapping management structures. Cooper et al.'s (2025) integrated framework for disciplinary investigations, which emphasizes structured, well-documented investigatory processes, offers a practical model TGH could adapt: standardizing how disciplinary investigations are conducted and documented may have secondary benefits for grievance-system credibility, even though the two processes address different situations.

Finally, the proposed hypotheses (H1–H3) have not been tested statistically in this paper, but the documented observations are broadly consistent with the direction each hypothesis proposes. Staff comments regarding training gaps and procedural delays are consistent with a positive relationship between policy effectiveness and morale (H1); the study's explicit framing of its recommendations around CBAHI alignment is consistent with the expectation that accreditation compliance supports policy effectiveness (H2); and the specific identification of hierarchy and cultural factors as reporting barriers is consistent with a moderating effect of culture on the effectiveness–morale relationship (H3). These observations should be read as directionally consistent with the hypotheses rather than as statistical confirmation of them.

A further discussion point concerns how these three hypotheses might be tested empirically. H1 could be assessed through a correlational analysis between a staff-reported policy-effectiveness score derived from the questionnaire and a separate staff-morale measure, subject to the sample-size constraints already noted in Section 5.1. H2 would require comparing perceived policy effectiveness among staff who report awareness of CBAHI-related training or audits against those who do not, which the questionnaire's coverage of training and CBAHI-related items is designed to support. H3 would require testing whether the relationship identified for H1 is weaker among staff who report higher levels of hierarchy-related or retaliation-related concern in the interview and questionnaire data, consistent with a moderation rather than a simple additive model. This analysis cannot be conducted on the documented observations alone; it is presented to clarify the analytical path that future empirical testing should follow.

8.1 Implications for Staff Morale and Operational Productivity

Objective 4 sought to analyze the perceived impact of policy implementation on staff morale, productivity and hospital operations. Because this relationship is not quantified in this paper, the reviewed literature offers a reasoned basis for how the mechanisms identified in Sections 5 and 6 would plausibly connect to morale and productivity outcomes if the documented concerns remain unaddressed.

Procedural delays and inconsistent application, if left unaddressed, are likely to have a cumulative rather than one-time effect on staff sentiment: a single delayed grievance may be tolerated as an isolated incident, but a pattern of delays across multiple cases, especially if visible informally to colleagues even without formal disclosure of case details, can plausibly generalize into a broader staff perception that the system does not function reliably. This generalization effect is consistent with the organizational-justice perspective discussed in Section 2.4, in which perceptions of procedural fairness carry over into broader judgments about the organization. In operational terms, this could manifest as reduced willingness among nursing, administrative or support-service staff to raise concerns proactively, which in turn removes an early-warning channel that hospital

management could otherwise use to detect operational issues, such as staffing shortfalls or supervisory problems, before they escalate.

Conversely, the literature also suggests a plausible positive pathway: procedural fairness research indicates that staff who perceive a disciplinary or grievance process as fair tend to view the legitimacy of the organization more favorably even when an individual outcome does not go in their favor. If TGH's proposed improvements, standardized procedures, defined timelines, accessible channels and visible non-retaliation safeguards, are implemented as described, the expected direction of effect on morale would be positive, consistent with H1. This remains a literature-supported expectation rather than a measured finding, and should be tested directly against staff survey data in future research.

9. Recommendations

1) Standardize disciplinary and grievance procedures across departments with clear roles, escalation levels and documentation requirements.
2) Conduct structured staff training covering grievance reporting, conflict resolution, procedural fairness, confidentiality and applicable accreditation requirements.
3) Introduce a secure digital grievance-reporting and tracking mechanism with acknowledgement, status visibility and escalation controls.
4) Define reasonable internal timelines for acknowledgement, investigation, decision and closure, with documented reasons for unavoidable delays.
5) Establish periodic staff feedback sessions to identify barriers and improve policy usability.
6) Conduct biannual policy and compliance audits and document corrective actions and follow-up.
7) Strengthen non-retaliation safeguards and provide more than one reporting channel where appropriate.
8) Use management dashboards to monitor grievance volume, ageing, closure status, recurring themes and corrective actions without compromising confidentiality.
9) Align disciplinary investigation practice with a structured, documented investigatory model, so that both disciplinary and grievance processes are seen by staff as operating under the same standard of procedural rigor.
10) Where feasible, communicate anonymized summaries of how past grievances were resolved (without identifying individuals), so that staff can observe that the system produces consistent, fair outcomes over time rather than relying on the existence of the policy alone.

10. Proposed Implementation Roadmap

The recommendations in Section 9 vary in the time and resource commitment they require. To support practical adoption, the study's proposals can be grouped into a phased roadmap; no specific dates are attached.

Phase 1– Foundational Documentation and Awareness
The first phase focuses on measures that primarily require documentation and communication effort rather than new systems: standardizing written disciplinary and grievance procedures across departments, clarifying escalation roles, and delivering initial structured training so that staff understand existing channels before any new tools are introduced. Establishing this baseline is a precondition for the later phases, since training on a new digital tool would be of limited value if the underlying procedure it supports is still applied inconsistently.

Phase 2- Process Controls and Timelines
The second phase introduces defined internal timelines for acknowledgement, investigation, decision and closure, along with the requirement to document reasons for any unavoidable delay. This phase also includes strengthening non-retaliation safeguards and, where appropriate, introducing a second reporting channel, so that staff who are uncomfortable raising a concern through their direct line of supervision have a viable alternative. These measures are process-level changes that do not necessarily require new technology, but they do require management commitment to consistent follow-through, which the discussion in Section 8 identifies as central to staff trust.

Phase 3- Digital Tracking and Monitoring
The third phase introduces the secure digital grievance-reporting and tracking mechanism proposed in the study, together with management dashboards for monitoring grievance volume, ageing, closure status and recurring themes. Sequencing this phase after Phases 1 and 2 is intentional: a digital system is most useful once the underlying procedure, timelines and escalation roles it will encode have already been standardized, and staff have already received basic training on how the process is meant to work.

Phase 4- Continuous Review
The final, ongoing phase consists of periodic staff feedback sessions, biannual policy and compliance audits, and structured review of dashboard data to identify recurring themes or departments where implementation appears weaker than others. This phase treats the grievance and disciplinary system as a living process rather than a one-time project, consistent with CBAHI's and JCI's shared emphasis on continuous quality improvement rather than a single point-in-time compliance exercise.

11. Conclusion

Disciplinary and grievance handling systems are important to the functioning of a fair, accountable and stable hospital workplace. The study of TGH highlights inconsistent implementation, inadequate awareness and training, procedural delays, reporting barriers and the need for stronger alignment with CBAHI requirements. Extending the study's observations against the wider literature on grievance management, disciplinary due process and accreditation shows that these concerns are not unique to TGH; they mirror patterns documented across a range of hospital and healthcare settings, which strengthens confidence that the recommended improvement measures are addressing well-established, rather than idiosyncratic, organizational risks. The recommended combination of standardized procedures, staff education, accessible digital reporting, defined timelines, periodic audits and feedback mechanisms can provide a practical framework for improvement. Future empirical work

should test the proposed hypotheses (H1–H3) against staff questionnaire, interview and document-analysis data.

More broadly, this paper has argued that TGH's disciplinary and grievance concerns should not be read as a narrow, hospital-specific administrative shortfall, but as an instance of a well-documented pattern in which the credibility of an internal HR process is shaped less by the wording of the policy than by the consistency, transparency and documented fairness of its implementation. This framing carries a practical implication for TGH's leadership: investment in the recommended improvements is likely to have benefits that extend beyond disciplinary and grievance handling narrowly defined, since a workforce that trusts these particular mechanisms is, on the evidence of the literature reviewed here, more likely to engage constructively with the hospital's other internal reporting and quality-improvement channels as well, in a manner consistent with the broader continuous-improvement orientation both CBAHI and JCI expect of accredited institutions.

12. Limitations

The study is based on a sample of 30 staff members at a single 50-bed hospital, which limits the extent to which its observations can be generalized beyond TGH. This paper reports documented observations rather than percentages, means, p-values or hypothesis-test outcomes, so the hypotheses (H1–H3) remain to be tested empirically. Clause-level compliance with the applicable CBAHI accreditation standards is not assessed; the comparison is made at the level of general standard domains and publicly described expectations, and specific clause references should be verified against the official CBAHI edition. The literature review presented in Section 2 draws on published studies from a range of healthcare and organizational settings; while these studies inform the interpretation of TGH's documented observations, they do not substitute for setting-specific empirical data from TGH itself, and any generalization from the reviewed literature to TGH's particular situation should be treated as illustrative rather than confirmatory.

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