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Research Article

The Influence of Clinical Leadership and Reporting Intensity on Patient Safety Culture: The Mediating Role of Blaming Culture in Hospitals

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Abstract : Background: Patient safety culture forms the cornerstone of safe and high-quality healthcare delivery. However, its implementation often encounters barriers, particularly the persistence of a blaming culture that discourages staff from reporting patient safety incidents. Clinical leadership and the intensity of incident reporting are believed to play a pivotal role in shaping and sustaining a positive patient safety culture.**Objective:** This study aims to examine the influence of clinical leadership and patient safety incident reporting intensity on patient safety culture, with blaming culture serving as an intervening variable at Sentra Medika Cikarang Hospital.**Methods:** A quantitative research approach with an explanatory design was applied. The study involved 147 nurses selected through stratified random sampling. Data were collected using structured questionnaires and analyzed using Structural Equation Modeling (SEM) with the Partial Least Squares (PLS) method to test the direct and indirect relationships among variables.**Results:** The findings revealed that both clinical leadership and incident reporting intensity significantly influence patient safety culture, both directly and indirectly, through the mediation of blaming culture. Strong clinical leadership and a high level of incident reporting were associated with a more positive patient safety culture, while a high blaming culture weakened this relationship.**Conclusion:** The study underscores the importance of fostering supportive clinical leadership and cultivating a non-punitive reporting environment to strengthen patient safety culture. Hospital management should focus on leadership development and the creation of open, blame-free communication systems to enhance safety outcomes.

Keywords: Blaming Culture; Clinical Leadership; Patient Safety; Report Intensity; Safety Culture.

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1. Introduction

Patient safety culture has become a key pillar in the delivery of quality healthcare. Global healthcare organizations emphasize the importance of safety culture as the foundation in creating safe, effective, and patient-oriented care (WHO, 2019). This culture reflects values, attitudes, perceptions and behaviors that support risk reduction and learning from incidents. However, in practice, the implementation of patient safety culture is still faced with major challenges, one of which is the blaming culture, which causes health workers to be reluctant to report incidents for fear of being punished or blamed (Kohn & Medicine, 2000).

Clinical leadership plays an important role in the establishment of a patient safety culture. Leaders who are able to create an open and supportive work environment will increase incident reporting and reduce the impact of a blame culture (Stanley, 2017). On the other hand, the intensity of patient safety incident

reporting reflects the level of openness and awareness of staff towards the importance of patient injury prevention. High incident reporting correlates with a mature safety culture (Vincent, 2010), while low reporting rates are often associated with a still strong blame culture (Dekker, 2012).

Many previous studies have highlighted the influence of leadership and reporting on patient safety culture. However, studies that simultaneously analyze the role of blaming culture as a mediating variable are still limited, especially in private hospitals in Indonesia. Therefore, this study aims to analyze the effect of clinical leadership and intensity of patient safety incident reporting on patient safety culture with blaming culture as an intervening variable.

RS SM Cikarang, as one of the growing private hospitals in Cikarang, faces challenges in strengthening patient safety culture. The results of a preliminary survey conducted in December 2024 showed that 60% of nurses were reluctant to report incidents due to fear of sanctions, while 70% felt that the blame culture was still dominant. In addition, only half of the respondents felt leadership support for incident reporting. This data indicates the need to improve leadership and reporting systems to establish a positive and non-punitive safety culture

This study is expected to contribute to enriching the literature on patient safety and serve as a practical reference for hospital management in designing leadership-based interventions and supportive reporting systems. By understanding the interaction between clinical leadership, incident reporting, and blaming culture, healthcare institutions can build a stronger and more sustainable patient safety culture.

2. Preliminaries or Related Work or Literature Review

Patient safety culture is an important cornerstone of a safe healthcare system. It reflects shared values, beliefs and norms that support risk reduction and improved patient safety. Organizations such as WHO, AHRQ, and IOM emphasize the importance of a safety culture that is built on commitment, open communication, learning from mistakes, and managerial support. In this study, patient safety culture was measured using four dimensions from AHRQ (2019), namely clinical leader support for patient safety, teamwork, information exchange in handover, and organizational learning and continuous improvement.

Blaming culture is a major barrier to safety incident reporting. This culture is characterized by a tendency to blame individuals for mistakes without looking at systemic factors. Fear of punishment causes staff to be reluctant to report incidents, which in turn hinders system improvements. Dekker's blaming culture theory (2012) was used in this study, with dimensions including individual accountability, safe reporting environment, and procedural justice.

Clinical leadership emphasizes the role of health workers in leading and directing clinical practice to improve service quality. Clinical leaders are not only administratively tasked, but also play a strategic role in driving innovation, team collaboration, and patient safety. This study used the Clinical Leadership Competency Framework (CLCF) from the NHS Leadership Academy (2011), which includes personal qualities, teamwork, service management, and continuous improvement.

Patient safety incident reporting intensity indicates the extent to which staff are involved in reporting events that put patients at risk. Frequency of reporting, ease of the system, organizational support, and perceived importance of reporting are key indicators in measuring such intensity. This concept was adopted from Bowie et al. (2020), which emphasizes the importance of a non-punitive and learning-based system to create a safe and transparent work environment.

3. Proposed Method

This study uses a quantitative approach with the type of explanatory research that aims to explain the causal relationship between the variables studied, namely clinical leadership, intensity of patient safety incident reporting, blaming culture, and patient safety culture. The research location is Sentra Medika Cikarang Hospital, which was conducted in January 2025.

The population in this study were all functional health workers consisting of nurses and midwives with a total of 204 people. Sample determination was carried out by considering the inclusion and exclusion criteria, and using the sample size calculation formula for the correlation test. Based on these calculations, a sample size of 147 respondents was obtained which was considered to have met the adequacy requirements for further analysis.

Data collection was carried out by distributing closed questionnaires using a four-point Likert scale. The instruments in this study consisted of several questionnaires that have been standardized and used in previous studies, such as questionnaires from AHRQ's Hospital Survey on Patient Safety Culture (HSOPSC 2.0) to measure patient safety culture and blaming culture, and instruments developed from the Clinical Leadership Competency Framework (CLCF) by the NHS Leadership Academy to measure clinical leadership. All instruments underwent validity and reliability testing before being used in data collection.

The collected data were analyzed through two stages. The first stage was descriptive analysis using the three box method and index calculation to describe the distribution of respondents' answers to each indicator. The second stage is inferential analysis using Structural Equation Modeling - Partial Least Squares (SEM-PLS) technique through the help of SmartPLS 3.0 software. The outer model test is conducted to assess the validity and reliability of the construct, while the inner model test is used to test the relationship between variables and test the effect of mediation through path analysis.

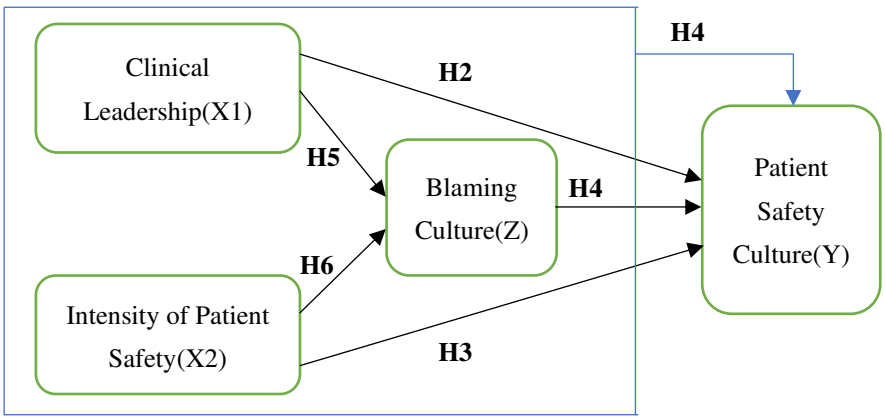


Figure 1. Conceptual

4. Results and Discussion

Results

Respondens Characteristics

The study involved 147 respondents, the majority of whom were female (61.0%) and aged over 45 years (28.6%), followed by those in the 25–30-year age group (25.1%). Most participants held a Diploma in Nursing (D3) (63.3%) and had between 1–3 years of work experience (36.7%). These findings indicate that the nursing workforce at Sentra Medika Cikarang Hospital is predominantly composed of mature, female nurses with vocational-level education who are in the early to mid stages of their professional careersHipotesis Test

Hypothesis Test

Simultaneous Hypothesis Test (F Test)

$$F = \frac{R^2/k}{(1 - R^2)/(n - k - 1)}$$

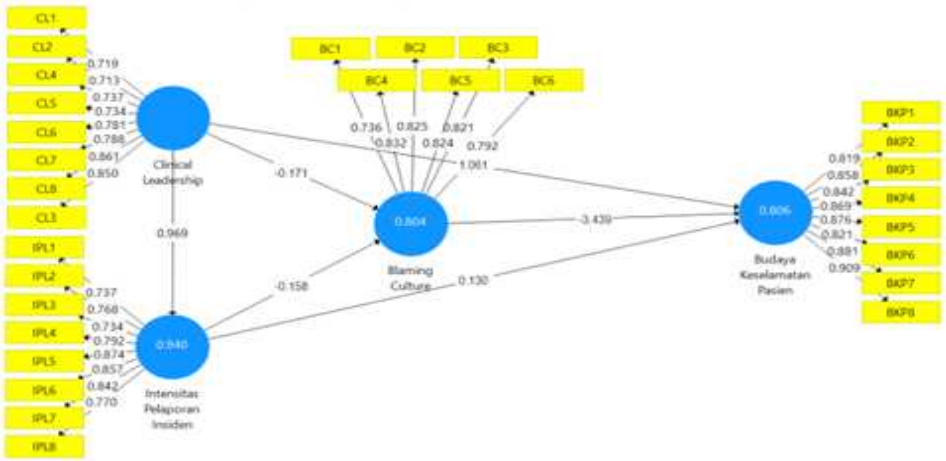
$$= \frac{\mathbf{0,806/3}}{\mathbf{(1 - 0,806)/(147 - 3 - 1)}}$$

$$= \frac{0,268}{(0,194)/(143)} = (\frac{0,268}{0,00135})$$

= 197,54

Description:
F = F test value
Rsquare = Multiple correlation coefficient (0.806).
k = Number of independent variables (3)
n = Number of sample members (147)

The Fcount value (197.54) is greater than the Ftable value (2.67), it can be concluded that clinical leadership, intensity of patient safety incident reporting, blaming culture simultaneously have a significant effect on patient safety culture. Thus, the first hypothesis which states that "There is a simultaneous and significant effect of clinical leadership, intensity of reporting patient safety incidents, blaming culture simultaneously has a significant effect on patient safety culture" can be accepted.



Source: Results of data processing with Smart PLS 3.2 (2025)

Figure 2. Outer Model SEM-PLS

. **In structural model analysis, hypotheses can be tested using t-statistics. The test results can be seen in the structural model output, indicating the significance of the factor loadings that explain the influence between constructs. In this case, data processing was performed using SmartPLS v3.0 software.**

Tabel 2. Direct Hypothesis Test Results

	Path Coefficient	P Value	Hypotesis
CL(X1) -> PSC (Y)	**1.061**	**0,000**	**Accepted**
IPS(X2) -> PSC(Y)	**1,130**	**0,001**	**Accepted**
BC (Z) -> PSC (Y)	**-3,439**	**0,002**	**Accepted**
CL(X1) -> BC (Z)	**-0,171**	**0,004**	**Accepted**
IPS(X2) -> BC (Z)	**-0,158**	**0,000**	**Accepted**

Based on the tabel above, all direct relationships between variables show t-statistic values exceeding the t-table value, and p-values below the 5% significance level. Therefore, it can be concluded that all direct influences tested in this model are statistically significant, and therefore the hypotheses proposed in the direct influence model are accepted.

This finding indicates that each independent variable has a significant direct contribution to both the dependent and intervening variables in the research model, as indicated by the direction and magnitude of the influence coefficients obtained from the analysis.

Tabel 3. Indirect Hypotesis Test Result

	Path Coefficient	P value	Hypotesis
CL(X1-> BC (Z) -> PSC(Y)	**0,588**	**0,000**	**Accepted**
IPS (X2) -> BC (Z) -> PSC (Y)	**0,546**	**0,004**	**Accepted**

Based on the table above, the results of the study indicate that digital marketing strategy acts as a moderating variable that strengthens the relationship between digital literacy, website quality, and ease of access to brand image. This is evidenced by the t-statistic value of each interaction being greater than the t-table value and a significance level below 0.05. The positive coefficients in all three relationships confirm that blaming culture plays a strong mediating role in the relationship between clinical instructors and the intensity of patient safety reporting on patient safety culture.

Discussion

Simultaneous and Significant Influence of Clinical leadership, Intensity of Patient Safety Incident Reporting and Blaming culture in Patient Safety Culture

The results showed that the value of $F_{(count)}$ (197.54) is greater than the value of $F_{(table)}$ (2.67), it can be concluded that clinical leadership, intensity of reporting patient safety incidents, blaming culture simultaneously have a significant effect on patient safety

culture. This finding reinforces the concept that the formation of a safety culture does not stand alone, but is the result of the dynamic interaction of various elements in the health care system.

Clinical leadership, as described by Stanley (2011), serves as the main driving force in the formation of a patient safety culture. Effective clinical leaders not only direct teams in the implementation of evidence-based safety practices, but also create a conducive psychological climate through open communication, staff empowerment, and supportive leadership approaches (West et al., 2014) . In this context, good leadership becomes the initial foundation that drives other positive behaviors such as increased incident reporting and reduced blaming culture.

Furthermore, the intensity of patient safety incident reporting reflects a culture of openness to risk and error. Kirk et al. (2007) emphasized that organizations that have a high level of incident reporting tend to show a greater readiness to learn from mistakes and improve systems. When reporting is done actively without fear, health systems have a greater chance of preventing similar incidents in the future (Singer et al., 2009) .

However, the success of reporting is greatly influenced by blaming culture. As stated by Khatri et al. (2009), a blaming culture creates fear among health workers, making them reluctant to report patient safety events. This suggests that even if clinical leadership and reporting intensity are high, if there is still a strong blaming culture, the impact on safety culture will be reduced.

This study reinforces the understanding that blaming culture can act as a disturbing variable that inhibits the positive effects of clinical leadership and reporting intensity on patient safety culture. On the other hand, strong clinical leadership can also suppress blaming culture, as suggested by Firth- Cozens & Mowbray (2001), through the creation of a psychologically safe and sanction-free work environment for whistleblowers.

Edmondson (2004) also emphasizes the importance of psychological safety in healthcare organizations. In a non-punitive system, reporting is higher, and patient safety can be significantly improved. This is in line with the research findings that when clinical leadership and reporting systems are strengthened while reducing the culture of blame, the culture of patient safety can develop optimally.

In other words, the simultaneous relationship between the three variables, clinical leadership, incident reporting intensity, and blaming culture, is synergistic. Effective clinical leadership can strengthen incident reporting and simultaneously suppress the blaming culture. When this happens, patient safety culture becomes not just a concept, but internalized in the daily practice of health workers.

Hospitals therefore need to formulate a systemic and integrative approach to building a patient safety culture. Such efforts should include strengthening clinical leadership, facilitating safe and transparent incident reporting, and transforming organizational culture to abandon the practice of blaming individuals. By managing all three elements simultaneously, the establishment of an effective and sustainable patient safety culture will be easier to achieve.

The effect of clinical leadership on patient safety culture

The second hypothesis test was conducted by looking at the coefficient estimate value (original sample estimate) of the effect of clinical leadership on patient safety culture, which is 1.061 (positive) with a t-count value of 4.888> t-table 1.96, and a significance value of 0.000 <0.05, it can be concluded that the effect is statistically significant. This shows that patient safety culture can be directly improved through the implementation of effective clinical leadership.

This positive coefficient indicates that the higher the role of clinical leadership demonstrated by medical personnel, especially in the ability to lead teams, make clinical decisions, guide colleagues, and maintain effective communication and a culture of professionalism, the higher the patient safety culture formed in the hospital. Strong clinical leadership is able to create a safe, coordinated work environment and focus on incident prevention efforts, thus encouraging the realization of a consistent safety culture in various medical service lines.

Patient safety culture is a central element in efforts to improve the quality of service in hospitals. This culture not only reflects the formal policies and procedures implemented by the organization, but also describes the values, attitudes, and daily behaviors of health workers in identifying, reporting, and preventing risks that endanger patient safety.

One of the crucial factors that influence the formation of this culture is clinical leadership. According to Stanley (2011), clinical leadership is defined as the ability of leaders in the clinical environment to direct, guide, and motivate health workers in implementing patient safety-based practices. This leadership creates strategic direction, models safety behaviors, and ensures that every clinical decision supports patient protection efforts.

The results showed that there was a significant direct effect between clinical leadership and patient safety culture, which showed a very strong and statistically significant effect. This finding corroborates the theory of West et al. (2014) which states that effective clinical leaders are able to shape a psychologically safe work environment, support incident reporting, and drive behavior change towards a culture of safety.

Supportive clinical leaders will encourage open communication between fellow health workers and between staff and management. As stated by Edmondson (2004), open communication is the foundation of psychological safety, where health workers feel safe to report mistakes without fear of punishment. This plays an important role in strengthening the culture of patient safety, as incident reporting is one of the key indicators in organizational learning systems.

Furthermore, Firth-Cozens & Mowbray (2001) emphasized that clinical leaders who are active in providing training, developing staff competencies, and enforcing safety standards are able to create an overall cultural change. In other words, clinical leadership not only acts as a director, but also as a change agent that normalizes safety practices as part of the organizational culture.

However, on the other hand, the results of this study must also be understood in the context of interactions with other variables. Because in the dynamics in the field, the influence of clinical leadership can be influenced by other conditions such as the existence of a blaming culture or the low intensity of incident reporting. The study of Khatri et al. (2009) showed that in environments with weak leadership, a blaming culture develops, which can inhibit incident reporting and worsen safety culture.

Therefore, these findings emphasize that strengthening clinical leadership is a strategic first step in establishing a patient safety culture. Strong leadership will have a direct influence on staff behavior and perceptions of patient safety, while reducing psychological barriers such as fear and passivity in dealing with clinical incidents.

Overall, these results support theory and previous empirical evidence that clinical leadership has a significant influence in creating, shaping and sustaining a positive and sustainable patient safety culture. On the basis of these findings, the second hypothesis in this study which reads "There is an influence between clinical leadership on patient safety culture" is accepted.

The influence between the intensity of patient safety incident reporting on patient safety culture

The third hypothesis testing was conducted to determine the effect of patient safety incident reporting intensity on patient safety culture. Based on the results of data processing, the path coefficient value (original sample) is 0.130 with a calculated t-value of 2.281, which is greater than the t-table of 1.96, and a p-value of 0.001 <0.05, so this effect is statistically significant.

This positive coefficient indicates that the higher the intensity of reporting patient safety incidents, both incidents that cause and do not cause injury, the higher the level of patient safety culture in the hospital. This reflects that a culture of reporting incidents without fear or blame contributes greatly to strengthening safety culture, as it allows institutions to learn from mistakes and improve the system on an ongoing basis.

Patient safety culture is an important foundation of an effective healthcare system. One important indicator of this culture is the intensity of patient safety incident reporting, which is the extent to which health workers actively and routinely report events that have the potential to harm patients. Incident reporting is not only a tool to identify and analyze risks, but also a reflection of a work environment that is open to continuous improvement and learning (Kirk et al., 2007).

Based on the results of the study, it was found that the intensity of patient safety incident reporting has a direct effect on patient safety culture, which shows a positive and statistically significant relationship. This finding reinforces Edmondson's (2004) theory that incident reporting is an indicator of psychological safety among health workers. When staff feel safe to report errors, they are more likely to engage in learning and collaboration to prevent similar events in the future.

Furthermore, consistent incident reporting provides valuable data for hospitals to analyze root causes and develop evidence-based interventions. Singer et al. (2009) asserted that organizations that encourage incident reporting without negative consequences for the reporter tend to have a better safety culture, as it allows for learning from reported incidents.

However, high reporting rates not only reflect concern for patient safety, but also indicate the presence of a supportive organizational structure. Firth-Cozens & Mowbray (2001) mention that an effective reporting system must be accompanied by leadership that encourages transparency and a non-punitive approach. Without this kind of support, health workers will be reluctant to report incidents for fear of sanctions, social pressure, or a bad reputation.

In this context, research by Khatri et al. (2009) showed that a blaming culture is often a major barrier to incident reporting. When health workers feel that their reports may lead to personal sanctions, reporting will be low, and learning systems will be hampered. Therefore, increasing the intensity of incident reporting should be accompanied by systemic efforts to reduce the blaming culture, as well as encouraging collective learning approaches.

Overall, these findings support the view that patient safety incident reporting is not just an administrative process, but an integral part of strengthening safety culture. When reporting is intensive, supported by an open and non-punitive system, healthcare organizations are better able to identify potential risks, prevent recurrences, and build a strong and sustainable patient safety culture.

The effect of clinical leadership on blaming culture

The fifth hypothesis test was carried out by looking at the estimated coefficient value of the effect of clinical leadership on blaming culture, which is -0.171 (negative) with a t-count value of 4.734> t-table 1.96, and a p-value of 0.004 <0.05, it can be concluded that the effect is statistically significant.

This negative coefficient indicates that the higher the quality of clinical leadership applied, the lower the level of blaming culture in the hospital. This means that strong and supportive clinical leadership is able to reduce the tendency of blaming culture among staff by creating a safe, open, and supportive environment for learning from mistakes. This indicates that the stronger and more effective the role of clinical leadership in a healthcare organization, the lower the tendency of blaming culture in the work environment. This finding supports the theory that effective clinical leaders play an important role in promoting a culture of patient safety by removing the fear of punishment and replacing it with a systemic and solution-based approach. Leaders who demonstrate empathy, openness and support for incident reporting tend to build more collaborative and reflective teams.

This finding is consistent with the theory proposed by Khatri et al. (2009), who highlighted that blaming culture is one of the main barriers to reporting patient safety incidents. When health workers feel that mistakes will be treated as individual errors, they become reluctant to report incidents that should be the subject of system evaluation and improvement. In this context, the role of clinical leadership becomes very crucial to change this mindset.

As explained by Stanley (2011), clinical leadership includes the leader's ability to create an environment that supports patient safety, not only by implementing formal policies, but also by providing role models and emotional support. Leaders who are able to guide staff with a solution-oriented approach to system improvement will build trust among health workers so that they are no longer afraid to be open to mistakes.

This approach is also in line with Edmondson's (2004) view of psychological safety, which is the feeling of psychological safety within the team to express ideas, concerns, or mistakes without fear of being shamed or punished. In organizations with effective clinical leaders, this kind of climate will be more easily realized, which ultimately suppresses blaming culture and replaces it with a learning culture.

In addition, Singer et al. (2009) and Firth-Cozens & Mowbray (2001) underline that transformational leaders who are able to encourage open communication, provide support, and manage patient safety incidents constructively, will strengthen the culture of safety and reduce the culture of blame. These findings are in line with the results of the current study which showed a negative influence between clinical leadership and blaming culture.

Overall, the results of this study reinforce the strategic role of clinical leadership in shaping a safe organizational culture that supports patient safety. Clinical leaders who demonstrate empathy, provide space to share experiences without fear of punishment, and focus on learning from mistakes, will create a collaborative, transparent, and continuous improvement-oriented work environment.

The influence between the intensity of patient safety incident reporting on blaming culture

The sixth hypothesis testing aims to assess whether the intensity of patient safety incident reporting (IPL) affects blaming culture (BC). Based on the results of the analysis, the path coefficient value (original sample) was -0.158, with a t-statistic of 3.160, which

is greater than the t table of 1.96, and a p-value of 0.002 <0.05, so the relationship is statistically significant.

This negative coefficient indicates that the higher the intensity of patient safety incident reporting, the lower the level of blame culture in the hospital environment. In other words, active incident reporting reflects an open culture and trust between teams, which indirectly reduces the tendency to blame individuals for mistakes that occur. Reporting supported by a non-punitive system will strengthen organizational learning and improve the system, rather than looking for who is at fault.

The results of testing the sixth hypothesis show that the intensity of patient safety incident reporting (IPL) has a significant negative effect on blaming culture (BC), statistically indicating that the higher the level of patient safety incident reporting in an organization, the lower the level of blame culture in the organization.

This finding is consistent with the theory proposed by Khatri et al. (2009) which states that blaming culture often arises when organizations focus more on finding individual faults rather than improving the system. In situations like this, health workers tend to refrain from reporting incidents for fear of punishment or negative stigma. Therefore, when the intensity of incident reporting increases, which usually occurs in an environment that supports openness and psychological safety, blaming culture tends to decrease.

The decrease in blaming culture through increased incident reporting is also in line with the concept of psychological safety described by Edmondson (2004). A psychologically safe work environment allows individuals to admit mistakes or risks without fear of blame, which in turn strengthens the culture of reporting and collective learning.

Singer et al. (2009) emphasized that the high intensity of reporting reflects the existence of an organizational culture that supports patient safety, where reporting is seen as part of the system improvement process, not as an attempt to blame individuals. Such organizations focus more on root cause analysis rather than looking for scapegoats.

This is also reinforced by the findings of Waring (2005), who states that low incident reporting is a strong indicator of the presence of a blame culture. When reporting increases, it indicates trust in the organization's systems and leaders, as well as the belief that the reports will be used for improvement rather than punishment.

Thus, the results of this study empirically support the theoretical assumption that the intensity of patient safety incident reporting is one important indicator of a healthy safety culture. Increased incident reporting not only reflects success in identifying and addressing potential hazards, but also plays a direct role in suppressing a blame culture by encouraging a systemic and collaborative approach to addressing incidents.

The influence between blaming culture on patient safety culture

The seventh hypothesis testing aims to determine whether blaming culture (BC) affects patient safety culture (PSC). Based on the results of the analysis, the path coefficient (original sample) value of -3.439 was obtained, with a t-statistic of 6.878, which is much greater than the t table of 1.96, and a p-value of 0.000 <0.05. This shows that the effect is highly statistically significant.

This sizable negative coefficient value indicates that the higher the blame culture in the hospital environment, the lower the level of patient safety culture. A blaming culture can inhibit incident reporting, decrease trust among staff, and hinder the process of learning from mistakes. In contrast, when blaming culture is suppressed, staff will feel safer to report incidents, have open discussions and engage in system improvements, all

of which are essential elements of a strong safety culture. This finding reinforces previous literature which suggests that healthcare organizations with high levels of blaming culture will struggle to build a strong patient safety culture (AHRQ, 2022; Reason, 2000). Therefore, eliminating blaming culture is an important step in strengthening safety systems in hospitals.

This finding is consistent with the theory presented by Khatri et al. (2009), which explains that a blaming culture inhibits incident reporting and encourages health workers to be defensive rather than reflective. In such an environment, patient safety incidents are rarely reported, resulting in missed opportunities for system improvement and prevention of similar events in the future.

Furthermore, Edmondson (2004) also supports these findings, where a sense of psychological safety is an important prerequisite for the establishment of a patient safety culture. In a work environment dominated by a blaming culture, health workers are afraid to speak up or report mistakes for fear of being penalized or negatively stigmatized. This fear limits their involvement in improvement efforts and organizational learning.

Singer et al. (2009) also found that hospitals with low blaming culture had better reporting systems, more open communication, and more systematic incident investigation processes. All of these contribute directly to strengthening the culture of patient safety. Similarly, Firth-Cozens & Mowbray (2001) showed that health workers working in a non-punitive environment felt safer and more involved in the incident reporting and evaluation process, which ultimately improved quality of care and patient safety.

This finding is also in line with AHRQ (2022), which asserts that removing blaming culture is one of the main pillars in the transformation of patient safety systems in various health facilities.

Thus, the results of this analysis not only reinforce previous theories and literature, but also show that reducing blaming culture is a strategic step in building a strong patient safety culture. Hospitals that want to improve service quality and safety need to instill the principles of transparency, learning from mistakes, and support for incident reporting as part of a sustainable organizational culture.

The influence between clinical leadership on patient safety culture mediated by blaming culture

The eighth hypothesis test was conducted to test the effect of clinical leadership on patient safety culture through the mediation of blaming culture. Based on the results of data processing, a coefficient value of 0.588 (positive) was obtained, with a t-count of 3.638> t-table 1.96, and a p-value of 0.000 <0.05, so it can be concluded that the indirect effect is statistically significant.

The positive coefficient indicates that clinical leadership can indirectly improve patient safety culture by first reducing the level of blaming culture. This means that strong clinical leadership, demonstrated through role modeling, open communication, and support for staff, can create a work environment that minimizes blame. This environment ultimately encourages the creation of a stronger patient safety culture, based on transparency and learning from mistakes.

This finding is highly relevant to the theory proposed by Stanley (2011) and Cook (2014) who explained that clinical leadership is not just a matter of technical or administrative ability, but also a matter of influence on values, culture, and collective behavior in clinical organizations. Effective clinical leaders shape a work environment that supports openness, reflection on mistakes, and continuous learning, all of which are core to a culture of patient safety.

However, as described by Khatri et al. (2009), the existence of a blaming culture can be a barrier for clinical leadership in building a strong safety culture. When organizations are still stuck in a culture of blaming individuals for mistakes, then leaders' initiatives to encourage reporting and system improvements will be difficult for staff to accept and carry out, as they feel psychologically insecure.

The results of this mediation also support Edmondson's (2004) view of the importance of psychological safety in the context of work teams. Clinical leadership that is able to create a work climate that is emotionally safe and free from the threat of punishment will reduce blaming culture, open up space for open discussion about incidents, and ultimately strengthen the culture of patient safety.

Furthermore, the transformational leadership model as described by Singer et al. (2009) suggests that leaders who are able to inspire, provide emotional support and promote the collective values of the organization will be more successful in influencing work culture. In this context, clinical leadership does not work directly, but rather through improving the organizational culture, in this case, through eliminating the culture of blame, so that a culture of patient safety can be established in a more robust and sustainable manner.

The influence between the intensity of patient safety incident reporting on patient safety culture mediated by blaming culture

The ninth hypothesis test was conducted to determine the indirect effect of patient safety incident reporting intensity on patient safety culture through the mediation of blaming culture. Based on the results of data processing, a coefficient value of 0.546 (positive) was obtained, with a t-count of 3.860> t-table 1.96, and a p-value of 0.004 <0.05. This shows that the effect is statistically significant.

This positive coefficient indicates that the higher the intensity of incident reporting, the more patient safety culture tends to increase through a decrease in blaming culture. In this context, active and continuous incident reporting can erode the culture of blame and encourage the formation of an environment that is more open, reflective, and oriented towards system improvement rather than individual punishment.

Thus, blaming culture acts as a mediator in the relationship between incident reporting intensity and patient safety culture. This finding supports the view that an effective incident reporting system must be accompanied by an organizational climate that supports learning and is free from fear of reporting. Therefore, building a strong reporting culture must be accompanied by explicit strategies to eliminate the blame culture as a prerequisite for creating an effective safety culture.

This result supports the previously discussed theory that high incident reporting intensity not only reflects the existence of an open and psychologically safe culture, but can also actively reduce the culture of blame. As described by Edmondson (2004) and Khatri et al. (2009), a high reporting culture allows organizations to shift from a punitive to a systemic and solution-focused approach in dealing with patient safety incidents.

In a work environment that supports fearless incident reporting, staff feel valued for their contribution to system improvement, rather than blamed for making mistakes. This directly erodes the blaming culture, which is a major obstacle to building a patient safety culture. Waring (2005) asserts that when organizations fail to eliminate the blaming culture, existing reporting systems will not be optimally utilized because fear and distrust still dominate.

This finding is also in line with the thoughts of Singer et al. (2009), which suggests that high incident reporting in a non-punitive environment can create a more open, collaborative and learning-focused organizational climate. With a decreased blaming

culture, health workers will more actively participate in the process of risk identification and system improvement, resulting in a stronger and more sustainable patient safety culture

Conclusions

Based on the findings of the study conducted at Sentra Medika Hospital Cikarang, it can be concluded that the patient safety culture is significantly influenced by the synergy between clinical leadership, incident reporting intensity, and blaming culture. Effective clinical leadership plays a crucial role in creating a safe, open, and supportive work environment that encourages active incident reporting. Clinical leaders who are able to guide, set an example, and foster transparent two-way communication can strengthen healthcare workers' awareness and commitment to patient safety. Thus, clinical leadership serves as one of the main pillars in building a sustainable patient safety culture.

Furthermore, the intensity of patient safety incident reporting has a significant positive impact on enhancing the patient safety culture. Active incident reporting reflects trust and openness within the organization and demonstrates a collective awareness of the importance of learning from every mistake. A non-punitive reporting culture encourages healthcare professionals to actively participate in identifying, reporting, and addressing potential safety risks, thereby creating a safer and higher-quality healthcare system.

Meanwhile, the blaming culture has been shown to be a major barrier to the development of a strong patient safety culture. This culture can be reduced through clinical leadership that emphasizes system-based learning and a collaborative approach to error management. When clinical leaders successfully create an atmosphere of trust and psychological safety, healthcare workers become more open to reporting incidents and engaging in continuous improvement efforts. Therefore, blaming culture acts as an important mediating variable, where reducing the tendency to blame enhances the positive influence of clinical leadership and incident reporting on the establishment of a robust, learning-oriented patient safety culture.

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