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FACTORS AFFECTING THE PRESENCE OF A BLAME CULTURE IN NURSES' PATIENT SAFETY INCIDENT REPORTS: A LITERATURE REVIEW

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ABSTRACT

Background: Patient safety is crucial in delivering high-quality healthcare services, and incident reporting is one of the primary mechanisms for improving patient safety systems. However, the blame culture within hospitals hinders healthcare workers, especially nurses, from reporting incidents. Blame culture stems from the fear of punishment and the potential negative impact on professional careers, obstructing transparency and learning from mistakes. This study aims to analyze the factors that influence blame culture in incident reporting related to patient safety by nurses. **Methods:** A total of 20 relevant studies published between 2015 and 2024 were systematically reviewed using PRISMA guidelines. These studies were analyzed for themes including organizational support, fear of punishment, leadership style, communication, and psychological safety. **Results:** It was found that the main contributors to blame culture include fear of punishment, high workload, lack of managerial support, unsupportive organizational culture, negative perceptions of the reporting system, and social and local cultural influences.
On the other hand, mitigation strategies such as implementing a Just Culture, strengthening supportive leadership, patient safety training based on the Knowledge-Attitude-Practice (KAP) approach, open communication, and simplifying the reporting system have proven effective in reducing resistance to incident reporting. **Conclusion:** Blame culture is a systemic phenomenon that requires changes at various organizational levels. Institutional commitment is needed to build a patient safety culture based on learning rather than punishment. Further research is recommended to explore non-punitive policies' long-term effectiveness and examine the role of technology and psychological factors in patient safety incident reporting.

Keywords: Blame Culture, Incident Reporting, Just Culture, Nurses, Organizational Culture

Introduction

Patient safety is a fundamental aspect of high-quality healthcare services. One of the key components of the patient safety system is incident reporting, which serves as a mechanism to identify and prevent events that may harm patients. Through an effective reporting system, healthcare institutions can develop strategies to reduce the risk of recurring errors and improve overall service quality (Amarneh & Al Nobani, 2022). However, despite established regulations and systems, underreporting of patient safety incidents (PSIs) remains a persistent issue,

particularly among nurses. This reluctance to report is often linked to the prevalence of a blame culture, where mistakes are perceived as personal failures rather than opportunities for systemic learning (Afaya et al., 2021).

The existence of a blame culture within healthcare settings hinders transparency and obstructs the development of a safety-oriented culture. In punitive environments, healthcare workers tend to withhold incident reports due to fear of punishment, reputational damage, or peer stigmatization (Cooper et al., 2017; Elmontsri et al., 2017). These dynamics not only suppress opportunities for learning but also increase the likelihood of repeated adverse events.

This issue is not exclusive to developed countries with complex health systems. In developing countries such as Indonesia, hierarchical organizational structures, lack of managerial support, and limited implementation of non-punitive reporting mechanisms further aggravate underreporting (Dhamanti et al., 2019; Sinaga & Kusumaningsih, 2024). Additionally, a blame-based climate may induce psychological distress, including anxiety, burnout, and defensive clinical practices, which ultimately compromise both nurse well-being and quality of care (Boakye et al., 2024; Van Gerven et al., 2016).

Although several solutions have been proposed—such as the adoption of Just Culture frameworks, psychological safety approaches, and electronic reporting systems—studies evaluating the effectiveness of these strategies in various settings, particularly in low-resource contexts, remain scarce (Logroño et al., 2023; Ystaas et al., 2023). Most existing research focuses on describing the impacts of blame culture rather than systematically analyzing the root causes and contextual contributors, especially among nurses, who are frontline actors in patient safety.

Given this research gap, this study aims to systematically review the factors contributing to the persistence of blame culture in PSI reporting among nurses. By synthesizing findings from recent empirical studies, the review intends to offer insights into the structural, interpersonal, and psychological barriers that inhibit reporting behavior. The results are expected to support the design of evidence-based strategies and policies for creating a more just, learning-oriented culture that empowers nurses to engage actively in patient safety efforts..

Methods

This study employs a literature review method to identify, evaluate, and synthesize the factors influencing the blame culture among nurses in reporting patient safety incidents. This method was chosen because it allows for a comprehensive analysis of previous research to identify patterns of findings, research gaps, and recommendations for improving incident reporting systems (Afaya et al., 2021; Amarneh & Al Nobani, 2022). The literature review process follows the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines to ensure transparency and accuracy of the research.

Data was collected by searching for literature in the PubMed, Google Scholar, Scopus, Springer, and Science Direct databases. The keywords used were ("blame culture" OR "punitive culture") AND ("patient safety incident reporting" OR "adverse event reporting" OR "Incident Report") AND ("hospital environment" OR "organizational culture") AND ("nurses" OR "nursing staff"), ("blame culture" OR "fear of blame") AND ("psychological impact" OR "job satisfaction") AND ("nurses" OR "nursing staff"). Inclusion criteria comprised articles relevant to the blame culture affecting nurses in healthcare settings, published in indexed journals between 2014 and 2024, and employing empirical methods. Articles that were irrelevant, opinion-based, or lacking a transparent methodology were excluded.

The selection process followed three stages of PRISMA: identification, screening, and data extraction. Data were analyzed using thematic analysis through three stages: open, axial, and selective coding. The validity of the research was maintained through systematic search strategies, adherence to PRISMA guidelines, and triangulation of results.

Based on the scientific search conducted across five primary sources, namely the PubMed database (n = 79), Google Scholar (n = 121), Scopus (n = 4), Springer (n = 58), and Science Direct (n = 6), a total of 273 articles were identified for further review. After an initial screening, 10 duplicate articles were removed, 84 articles were marked as not meeting the criteria by automation tools, and no articles were excluded for other reasons. This resulted in 179 articles for the next selection stage.

In the title and abstract screening stage, 152 articles were excluded as they did not meet the established inclusion criteria. Finally, 27 articles proceeded to the full-text evaluation stage. Five articles were inaccessible, leaving 22 articles for eligibility assessment. The full-text evaluation process revealed that two articles were excluded as they did not involve nurses in the study. Therefore, A total of 20 studies met the inclusion criteria. Quality assessment was performed using the JBI critical appraisal checklist, and only studies with a quality score above 70% were included.

The flow of the literature search is clearly illustrated in Figure 1. PRISMA Flow Diagram.

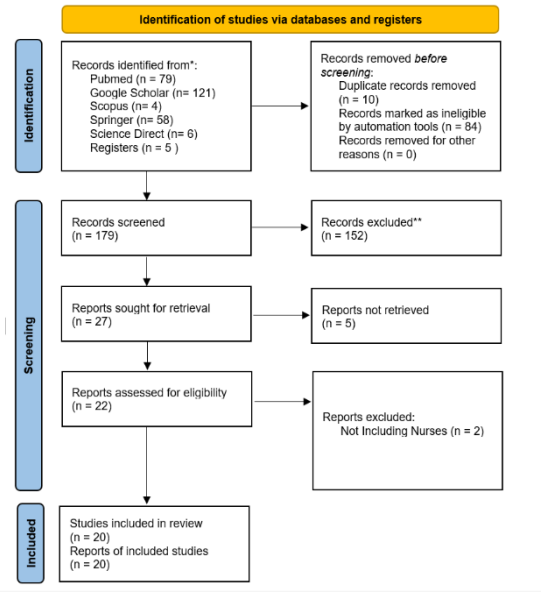

Figure 1. PRISMA Flowchart

Result

Table 1. Articles Analysis Results

NO	Research Title	Location	Research Findings	Factors Influencing Blame Towards Nurses	Research Discussion
1	Nurse perceptions of organizational culture and its association with the culture of error reporting (Jafree et al., 2015)	Pakistan	- A survey conducted among 309 nurses in Pakistan indicated that 72% of them felt uncomfortable reporting errors due to fear of negative consequences. A lack of resources and support from management were also identified as major barriers to developing a healthy reporting culture. - Ninety-five percent of medical errors remain undocumented in developing countries. - Nurses who work in a positive organizational culture are more likely to report errors. - Only 35% of patient safety incidents are officially reported, largely due to the lack of protection for reporters and the prevalence of a blame culture targeting individuals.	- Low levels of trust in the reporting system, the absence of protective policies, and excessive workloads. - A lack of support systems for nurses who report incidents. - Gender discrimination within the healthcare system that hinders the courage to report. - Fear of social and professional repercussions from incident reporting. - The absence of patient safety policies that promote transparent reporting.	Strengthening organizational culture can improve error reporting.
2	The reasons for Chinese nursing staff to report adverse events: a questionnaire survey	China	- A total of 58.03% of nurses in China did not report incidents due to fear of punishment or disciplinary action from management. - The main factors contributing to fear in reporting incidents are the fear of sanctions and the absence of guaranteed protection for nurses who report errors.	- The lack of a non-punitive reporting system, negative perceptions of incidents, and time constraints in completing reports. - Individual factors such as work experience and perceptions of patient safety influence incident reporting. - High work pressure among nurses.	Training and interventions are necessary to enhance understanding of the importance of incident reporting.

	(Hong & Li, 2017)			- Inadequate training on the incident reporting system. - Low levels of management support in fostering a safety culture.	
3	The practice of reporting adverse events in a teaching hospital (Siman et al., 2017)	Brazil	- Among 31 nurses, the majority reported fear of punishment and lack of managerial support as the primary reasons for not reporting incidents. - Between 5% to 17% of patients experience safety incidents, 60% of which are preventable. - The incident reporting rate is only 40%, with the main reasons being fear of sanctions and lack of clarity in the reporting system.	- Lack of clarity in the reporting system. - Insufficient knowledge and fear of punishment contribute to the under-reporting of incidents. - Fear of punishment from hospital leadership. - Absence of a feedback mechanism for incident reporters. - An organizational culture that prioritizes blaming individuals over improving the system.	Improvements in the reporting system and enhanced education for healthcare personnel are necessary.
4	Sociocultural Factors Influencing Incident Reporting Among Physicians and Nurses: Understanding Frames Underlying Self- and Peer-Reporting Practices (Hewitt et al., 2017)	Canada	- Doctors and nurses have differences in incident reporting: doctors are more likely to cover up mistakes, while nurses are more inclined to report but fear being considered a traitor by their colleagues. - Fear of mistakes and the "tattletale" stigma create barriers to incident reporting. - Fear of sanctions and stigma are major obstacles in incident reporting, despite the existence of non-punitive policies.	- Loyalty towards colleagues, the perception that reporting mistakes is a form of betrayal, and the stigma towards incident reporters. - Distrust in the reporting system is a major factor contributing to the low number of reported incidents. - Fear of negative impacts on professional reputation - Lack of support systems for healthcare workers who report incidents.	An inclusive approach is needed to reduce cultural barriers in patient safety incident reporting.
5	Nurses' perspectives on the impact of management	United States of America	- A blame culture has been found to have a negative impact on nurses' mental well-being, with 68% of respondents reporting	- Punitive managerial attitudes, lack of psychological support, and high work pressure. - Lack of psychological support systems for nurses.	Organizational and commitment-based approaches can reduce

	approaches on the blame culture in health-care organizations (Okpala, 2020)		anxiety due to fear of punishment. - A commitment-based approach in management can reduce blame culture and improve incident reporting. - Medical errors occur up to 69.5%, with 68% of errors being unintentional.	- Fear of legal actions or job loss. - Absence of protection for incident reporters (whistleblower protection). - Management focusing more on finding individual faults rather than system improvements.	the blame culture.
6	The impact of blame culture on paramedic practice: A qualitative study exploring English and Finnish paramedic perceptions (Kirk et al., 2018)	English and Finnish	- Blame culture leads to an increase in defensive practices, with 45% of paramedics in the UK and 38% in Finland preferring not to make high-risk clinical decisions due to fear of legal action. This indicates that blame culture can hinder innovation and efficiency in healthcare services. - 69.5% of healthcare workers avoid reporting errors due to fear of legal action. - In the UK, paramedics are more frequently involved in litigation compared to Finland, which has a system that better supports a reporting culture.	- Fear of legal litigation, pressure from patients and families. - Repressive management policies. - A pressuring work environment that demands perfect performance. - Lack of legal protection systems for healthcare workers. - Perception that incident reporting will negatively impact professional careers.	A more supportive approach is needed to reduce defensive practices.
7	Patient safety culture among nurses at a tertiary government hospital in the Philippines (Ramos & Calidgid, 2018)	Philippines	- Non-punitive responses to mistakes have the lowest score (17.65%) compared to other aspects. - 71.48% did not report incidents in the last 12 months.	- Lack of management support, a strong blame culture, and low incident reporting rates. - Distrust in the incident reporting system. - Lack of training related to patient safety. - Absence of guaranteed protection for incident reporters.	Focus on improving the safety culture and eliminating barriers to incident reporting.

8	Patient safety culture in intensive care units: perspective of health professionals (Souza et al., 2019)	Brazil	- Nurses and doctors acknowledge that mistakes in care often occur, but there is a tendency to blame individuals rather than evaluate the patient safety system. - The importance of a non-punitive approach to encourage incident reporting and system improvement. - Blame culture still exists in intensive care units. Many nurses do not report incidents for fear of punishment or being ostracized by colleagues. - Reporting is higher in hospitals that implement a non-punitive system.	- Lack of a supportive safety culture, pressure from management, and concerns about professional impact. - Hierarchical culture in hospitals. - Low trust in the reporting system. - Lack of support from hospital management. - Fear of negative evaluation from superiors.	The safety culture needs to be strengthened with a more effective reporting system.
9	Hospital safety climate from nurses' perspective in four European countries (Gurková et al., 2020a)	Europe (Croatia, Czech Republic, Poland, Slovakia)	- Patient safety perception is higher in environments with strong error feedback and non-punitive responses. - The high blame culture still hinders incident reporting. - The main factors are the lack of a transparent reporting system and the absence of feedback on mistakes.	- Lack of open communication, absence of a feedback culture, and high work pressure. - Individual factors such as work experience and patient safety perception influence reporting. - Lack of managerial support in creating an open reporting system. - Fear of sanctions from management and colleagues. - Low level of communication about medical errors.	There needs to be a focus on improving communication, organizational learning, and non-punitive responses to mistakes.
10	Patient safety culture: perception of nursing professionals in high complexity	Brazil	- In Brazil, only 30% of respondents provided positive feedback regarding transparency in patient safety incident reporting, indicating that the blame culture is still strong.	- Lack of transparency in the reporting system, pressure from colleagues and superiors, and a strong blame culture. - High under-reporting due to concerns about negative consequences.	A cultural change strategy is needed to improve reporting and patient safety.

	institutions (Sanchis et al., 2020)		- Less than 50% of healthcare workers feel safe to report mistakes. - 93.7% of 272,689 reported incidents had a negative impact on patients, but only a small portion was acknowledged as a result of systemic errors.	- Distrust among nurses towards the reporting system. - Lack of incentives for reporting mistakes.	
11	Assessment of patient safety challenges and electronic occurrence variance reporting (e-OVR) barriers (Albarrak et al., 2020)	Saudi Arabia	- Only 48% of healthcare workers feel confident enough to speak about patient safety incidents. - 31% of healthcare workers feel that incident reporting takes too much time. - 66% report having experienced violence in the workplace. - Only 25% of doctors and 52% of nurses are satisfied with the incident reporting system. - Many healthcare workers avoid reporting due to fear of sanctions.	- Lack of trust in the electronic reporting system. - Fear of negative consequences. - Complex and inefficient incident reporting system. - Uncertainty about how to access and use the reporting system. - Fear of professional impact due to reporting mistakes.	Further training and managerial support are needed to improve incident reporting in the emergency department.
12	Medical error reporting among doctors and nurses in a Nigerian hospital (Afolalu et al., 2021)	Nigeria	- 55% of nurses and 53% of doctors stated that they would never report medication errors due to fear of sanctions. - 51.4% of nurses and 32.2% of doctors were unaware of the incident reporting system in their hospital. - The main factors hindering reporting are the lack of protection from punishment and the negative stigma towards reporters. - 35.5% of nurses and 38.9% of doctors would not report blood transfusion errors.	- Lack of legal protection for reporters, social stigma, and the ineffectiveness of the reporting system. - Lack of a secure reporting system. - Fear of disciplinary action or legal sanctions. - Negative stigma towards nurses who report incidents. - Lack of training related to patient safety and incident reporting.	Further education and a non-punitive approach are needed to improve reporting.

			- The main factors are distrust in the reporting system and fear of sanctions.		
13	Comparison of Perceptions About Patient Safety Culture Between Physicians and Nurses in Public Hospitals in Vietnam (Tran et al., 2022)	Vietnamese	- In Vietnam, 71.7% of nurses did not report incidents in the last 12 months due to fear of negative consequences, compared to 62.8% of doctors. - The incident reporting rate is lower among doctors than nurses due to the blame culture. - Blame culture causes two-thirds of healthcare workers to be reluctant to report incidents. The main reasons: fear of punishment, work overload, and lack of information about patient safety.	- Fear of negative consequences, lack of trust in the reporting system, and lack of legal support for reporters. - High workload that reduces the opportunity to report incidents. - Differences in perception between doctors and nurses regarding the importance of patient safety. - The reporting system does not provide positive feedback to reporters.	Interventions are needed to improve the patient safety culture and reduce the blame culture.
14	Effect of Patient Safety Training Program of Nurses in Operating Room (Peijia et al., 2022)	China	- After safety training, there was a significant improvement in nurses' attitudes and knowledge towards incident reporting ($p < 0.001$). - Only 31% of nurses reported incidents before the training. - Blame culture reduces the willingness to report due to fear of professional impact.	- Negative attitudes towards error reporting, and high workload. - Lack of training on the incident reporting system. - Absence of safety policies that support reporting. - Negative perception towards nurses who report incidents.	There is a need to strengthen the safety culture through interprofessional training and better management systems.
15	Negative emotions experienced by healthcare staff following medication administration	England & Wales	- Analysis of 72,390 incident reports shows that fear, guilt, and anxiety are the most common emotions experienced by healthcare workers after medical errors. These factors contribute to the low incident reporting rate.	- Fear of punishment, anxiety, and lack of psychological support from colleagues and superiors are the main barriers to reporting. - Lack of post-incident support systems. - Social stigma against healthcare workers who make mistakes.	A more supportive approach and a fair system are needed in handling medical incidents.

	errors: a descriptive study (Mahat et al., 2022)		- Medication errors cause high emotional pressure on healthcare workers. - Fear of punishment and loss of patient trust are the main barriers to reporting.	- Absence of organizational policies that support incident reporting without punishment.	
16	Patient safety culture in nurses' clinical practice (Brás et al., 2023)	Portugal	- Surveys show that the non-punitive patient safety culture received a low score, with less than 40% of nurses reporting incidents. - The blame culture still dominates in healthcare organizations, leading to under-reporting.	- A strong punitive culture, low patient safety awareness, and lack of training in incident reporting. - Lack of training on incident reporting. - Minimal protection for nurses who report mistakes. - Ambiguity in the reporting system in hospitals.	Improvements in communication and increased management support for patient safety are needed.
17	Exploring the perception of safety culture among nurses in Saudi Arabia (Al Muharraq et al., 2024)	Saudi Arabia	- Blame culture and staff shortages are the main challenges in incident reporting, with 46.17% of nurses feeling that insufficient staff leads to more frequent errors. - Only 39.75% of nurses rate the response to errors in their hospital as positive, indicating the need for improvements in the reporting system. - The incident reporting rate remains low, with many nurses fearing the negative consequences of reporting. - Blame culture remains a major barrier to incident reporting.	- Weak leadership, a repressive work culture, and lack of protection policies for nurses. - A positive relationship between the frequency of incident reporting and open communication and management support. - High workload, making errors more likely to occur. - Lack of leadership that supports a safety culture. - Absence of policies that guarantee the safety of incident reporters.	Increasing awareness and organizational support can improve the patient safety culture.

18	Effects of a special continuous quality improvement in nursing on the management of adverse care events (Ouyang et al., 2024)	China	- After the implementation of the direct reporting system, the incident reporting rate increased from 6.7% to 8.1%, and the incident resolution time decreased from 56.87 hours to 31.87 hours ($p < 0.001$).	- Lack of transparency in the reporting system, uncertainty about consequences, and negative perceptions of incidents. - Absence of patient safety policies that protect reporters. - Lack of transparency in incident management. - High workload, which discourages healthcare workers from reporting.	A non-punitive approach increases the incident reporting rate. A direct reporting system enhances the safety culture and provides a quick response to incidents.
19	Shaping Safety: Unveiling the Dynamics of Incident Reporting and Safety Culture in Saudi Arabian Healthcare (Alsahli et al., 2024)	Saudi Arabia	- Blame culture remains the main barrier to incident reporting. - Only 39.75% of nurses feel safe reporting mistakes without the fear of being blamed. - Supportive management and open communication can increase the incident reporting rate. - Fear of negative backlash from superiors or colleagues leads to low patient safety incident reporting.	- The perception that incident reporting can negatively impact careers, blame culture within the organization, and lack of protection systems for reporters. - Lack of management support for incident reporting. - Stigma towards healthcare workers who report mistakes. - Absence of simple and easy-to-use reporting procedures.	Management support and a clear reporting system can improve incident reporting. Focusing on a safety culture can enhance transparency and the frequency of incident reporting.
20	A qualitative study of head nurses' experience in China: forced growth during patient	China	- Three main themes were found in this study: (1) Emotional experiences resulting from patient safety incidents, including anxiety, guilt, and stress; (2) Role dilemmas in patient safety management, including role confusion and burnout; (3) Barriers in incident management, including blame culture in hospitals, communication barriers, and	- Pressure from management, lack of support systems for head nurses. - Blame culture within the organization, and lack of managerial training for head nurses in handling patient safety incidents. - Blame culture hinders incident reporting, with many head nurses	A support system is needed for head nurses to help them adapt and manage patient safety incidents.

safety incidents (Zhang et al., 2024)	lack of accurate root cause analysis. - 45.26% of nurses experienced at least one patient safety incident with psychological stress. - 50% of them experienced psychological stress due to blame culture.	experiencing negative emotional impacts. - Lack of psychological support systems for nurses and head nurses. - Pressure from superiors to focus on individual mistakes rather than system improvements.

To systematically present the key contributors to blame culture identified across the reviewed literature, six dominant themes were extracted through thematic analysis. These themes—ranging from fear of punishment to low psychological safety—emerged consistently across multiple countries and healthcare settings. Presenting these factors in tabular form enables a clearer comparison of their prevalence and distribution across the 20 included studies. Table 2 provides a synthesis of these themes along with their frequency of occurrence and the specific studies in which they were identified. This summary highlights the recurring structural and psychological barriers that inhibit nurses from engaging in transparent incident reporting.

Table 2. Frequency of contributing Factor to Blame Culture

No.	Theme	Frequency (n/20)	Countries and Authors
1	Fear of Punishment	18	Nigeria (Afolalu), Brazil (Siman), Philippines (Caballar), Pakistan (Iqbal), China (Huang), Saudi Arabia (Alshammari, Alzahrani), Japan (Tanaka & Nakamura), UK (Mahat), South Korea (Park, Kim & Lee), Europe (Gurková), Hong Kong (Yau)

2	Lack of Organizational Support	16	Saudi Arabia (Alshammari, Alzahrani), Pakistan (Iqbal), Brazil (Siman), UK (Mahat), South Korea (Kim & Lee), China (Huang), Philippines (Caballar), Nigeria (Afolalu), Japan (Tanaka & Nakamura), Europe (Gurková)
3	Hierarchical Leadership	15	South Korea (Park, Kim & Lee), Saudi Arabia (Alshammari, Alzahrani), UK (Mahat), China (Huang), Pakistan (Iqbal), Europe (Gurková), Japan (Tanaka & Nakamura), Philippines (Caballar)
4	Inadequate Training & Awareness	13	China (Huang), Brazil (Siman), Philippines (Caballar), South Korea (Kim & Lee), Nigeria (Afolalu), Saudi Arabia (Alzahrani), Japan (Tanaka & Nakamura), UK (Mahat)
5	Peer Judgment	12	Europe (Gurková), South Korea (Kim & Lee), Pakistan (Iqbal), China (Huang), Brazil (Siman), Hong Kong (Yau), Saudi Arabia (Alshammari), Philippines (Caballar)
6	Low Psychological Safety	10	Japan (Tanaka & Nakamura), Hong Kong (Yau), South Korea (Park, Kim & Lee), Saudi Arabia (Alshammari), Brazil (Siman), Pakistan (Iqbal), UK (Mahat), Philippines (Caballar)

Discussion

The persistence of blame culture in healthcare organizations is a multifaceted issue rooted in the dynamic interaction between organizational systems, leadership structures, interpersonal relationships, and psychological safety (Boakye et al., 2024; Kirk et al., 2018). This review identified six interrelated themes contributing to nurses' reluctance to report patient safety incidents: fear of punishment, lack of organizational support, hierarchical leadership, inadequate training and awareness, peer judgment, and low psychological safety.

Fear of punishment emerged as the most dominant factor (Afolalu et al., 2021; Siman et al., 2017), but it does not operate in isolation. In environments where hierarchical leadership styles prevail, fear is amplified by authoritarian supervision, lack of open dialogue, and rigid chains of command (Alshammari et al., 2022). These structural dynamics cultivate a climate in which nurses are discouraged from voicing concerns or admitting mistakes, thereby reinforcing silence over transparency. Such environments are antithetical to the creation of a learning culture and align with Reason's Swiss Cheese Model, where latent organizational failures—such as poor communication and inadequate support

systems—serve as "holes" in the safety net that allow adverse events to slip through (Reason, 2000).

Simultaneously, the lack of organizational support and inadequate training exacerbate the issue (Abdelaliem & Alsenany, 2022; Arnell et al., 2021). When nurses are not empowered with clear protocols, constructive feedback, or psychological safety, their ability to engage with incident reporting mechanisms is significantly diminished. For instance, in settings where post-incident debriefings are absent and follow-up actions are unclear, the value of reporting becomes questionable. This reflects not merely a knowledge gap, but a systemic failure to embed patient safety as a shared responsibility (Elmontsri et al., 2017).

Peer judgment further complicates the cultural landscape. Fear of being blamed or ostracized by colleagues fosters a sense of isolation and discourages collective learning (Gurková et al., 2020b; Jeong & Jeong, 2021). This internalized stigma contributes to defensive practices, where nurses may avoid risk, conceal errors, or emotionally disengage from their roles. Over time, this leads to burnout, job dissatisfaction, and decreased retention, weakening the healthcare system's resilience and continuity of care (Brborović et al., 2019; Van Gerven et al., 2016).

The findings of this review also point to an underutilization of Just Culture principles. While Just Culture frameworks emphasize learning and shared accountability, their implementation remains limited, particularly in settings where managerial actions still lean toward punitive responses (Gorini et al., 2012; Tlili et al., 2020). This disconnect suggests a critical gap between institutional aspirations and operational realities. Bridging this gap requires leadership transformation—moving from command-and-control models to transformational leadership, where empathy, support, and open communication are valued (Alshammari et al., 2022; Ystaas et al., 2023).

In sum, the contributing factors to blame culture do not exist in silos. Rather, they function as interlinked systemic vulnerabilities that compromise the effectiveness of patient safety reporting. Addressing these issues requires a holistic strategy: revising policies to remove punitive elements, enhancing training and feedback systems, and cultivating psychological safety through leadership reform and team-based interventions.

Conclusion

This study identifies the main factors influencing blame culture in nurses' reporting of patient safety incidents. The main findings indicate that fear of punishment, high workload, lack of managerial support, and unsupportive organizational culture are the most significant factors in creating this culture. In addition, perceptions of ineffective reporting systems and social and cultural influences contribute to nurses' low incident reporting rates. This research provides deeper insight into how fear of sanctions, excessive workload, and lack of managerial support hinder patient safety incident reporting, which affects patient safety.

This study contributes to existing knowledge by highlighting the importance of implementing Just Culture policies and managerial support in reducing blame culture. Furthermore, the study underscores the importance of structured patient safety training and improvements in incident reporting systems to create a more

transparent and safe environment for healthcare workers.

Based on the findings of this review, several targeted strategies are proposed to address the persistence of blame culture in patient safety incident (PSI) reporting among nurses such as Enact Institutional Policies Supporting Just Culture, Establish Anonymous and Digital Incident Reporting Systems**,** Train Nurse Managers in Psychological Safety Leadership**,** Institutionalize Post-Incident Debriefings Integrate Patient Safety and Just Culture Modules into Continuous Education**,** Assign Patient Safety Champions**,** Include Blame Culture Indicators in Hospital Accreditation and Audit**.**

References

Abdelaliem, S. M. F., & Alsenany, S. A. (2022). Factors Affecting Patient Safety Culture from Nurses' Perspectives for Sustainable Nursing Practice. *Healthcare (Switzerland)*, *10*(10), 1889. https://doi.org/10.3390/healthcare10101889

Afaya, A., Konlan, K. D., & Kim Do, H. (2021). Improving patient safety through identifying barriers to reporting medication administration errors among nurses: an integrative review. *BMC Health Services Research*, *21*(1), 1156. https://doi.org/10.1186/s12913-021-07187-5

Afolalu, O. O., Jordan, S., & Kyriacos, U. (2021). Medical error reporting among doctors and nurses in a Nigerian hospital: A cross-sectional survey. *Journal of Nursing Management*, *29*(5), 1007–1015. https://doi.org/10.1111/jonm.13238

Al Muharraq, E. H., Abdali, F., Alfozan, A., Alallah, S., Sayed, B., & Makakam, A. (2024). Exploring the perception of safety culture among nurses in Saudi Arabia. *BMC Nursing*, *23*(1), 1–9. https://doi.org/10.1186/s12912-024-02077-7

Albarrak, A. I., Almansour, A. S., Alzahrani, A. A., Almalki, A. H., Alshehri, A. A., & Mohammed, R. (2020). Assessment of patient safety challenges and electronic occurrence variance reporting (e-OVR) barriers facing physicians and nurses in the emergency department: a cross sectional study. *BMC Emergency Medicine*, *20*(1), 98. https://doi.org/10.1186/s12873-020-00391-2

Alsahli, H., Al-Wathinani, A. M., Althobaiti, T. A., Abahussain, M. A., & Goniewicz, K. (2024). Shaping Safety: Unveiling the Dynamics of Incident Reporting and Safety Culture in Saudi Arabian Healthcare. *Journal of Multidisciplinary Healthcare*, *17*, 3775–3789. https://doi.org/10.2147/JMDH.S458718

Alshammari, T. M., Alenzi, K. A., Alatawi, Y., Almordi, A. S., & Altebainawi, A. F. (2022). Current Situation of Medication Errors in Saudi Arabia: A Nationwide Observational Study. *Journal of Patient Safety*, *18*(2), E448–E453. https://doi.org/10.1097/PTS.0000000000000839

Amarneh, B. H., & Al Nobani, F. (2022). The influence of physician-nurse collaboration on patient safety culture. *Heliyon*, *8*(9). https://doi.org/10.1016/j.heliyon.2022.e10649

Arnell, M., Demet, R., Vaclavik, L., Huang, X., Staggers, K. A., Cai, C. Y., & Horstman, M. J. (2021). Use of a Rubric to Improve the Quality of

Internal Medicine Resident Event Reporting. *MedEdPORTAL*, *17*, 11189. https://doi.org/10.15766/mep_2374-8265.11189

Boakye, D. S., Konadu, E., Boateng, E. A., Kumah, E., Dzakadzie, F., & Buabeng, K. O. (2024). Nurses' Refusal to Report Medication Administration Errors in a Ghanaian Municipality: Uncovering the Barriers with a Quantitative Approach. *Nursing Forum*, *2024*. https://doi.org/10.1155/2024/9664624

Brás, C. P. da C., Ferreira, M. M. C., de Figueiredo, M. D. C. A. B., & Duarte, J. C. (2023). Patient safety culture in nurses' clinical practice. *Revista Latino-Americana de Enfermagem*, *31*. https://doi.org/10.1590/1518-8345.6231.3837

Brborović, O., Brborović, H., Nola, I. A., & Milošević, M. (2019). Culture of blame—an ongoing burden for doctors and patient safety. *International Journal of Environmental Research and Public Health*, *16*(23). https://doi.org/10.3390/ijerph16234826

Cooper, J., Edwards, A., Williams, H., Sheikh, A., Parry, G., Hibbert, P., Butlin, A., Donaldson, L., & Carson-Stevens, A. (2017). Nature of blame in patient safety incident reports: Mixed methods analysis of a national database. *Annals of Family Medicine*, *15*(5), 455–461. https://doi.org/10.1370/afm.2123

Dhamanti, I., Leggat, S., Barraclough, S., & Tjahjono, B. (2019). Patient safety incident reporting in indonesia: An analysis using world health organization characteristics for successful reporting. *Risk Management and Healthcare Policy*, *12*, 331–338. https://doi.org/10.2147/RMHP.S222262

Elmontsri, M., Almashrafi, A., Banarsee, R., & Majeed, A. (2017). Status of patient safety culture in Arab countries: A systematic review. *BMJ Open*, *7*(2). https://doi.org/10.1136/bmjopen-2016-013487

Gorini, A., Miglioretti, M., & Pravettoni, G. (2012). A new perspective on blame culture: An experimental study. *Journal of Evaluation in Clinical Practice*, *18*(3), 671–675. https://doi.org/10.1111/j.1365-2753.2012.01831.x

Gurková, E., Zeleníková, R., Friganovic, A., Uchmanowicz, I., Jarošová, D., Papastavrou, E., & Žiaková, K. (2020a). Hospital safety climate from nurses' perspective in four European countries. *International Nursing Review*, *67*(2), 208–217. https://doi.org/10.1111/inr.12561

Gurková, E., Zeleníková, R., Friganovic, A., Uchmanowicz, I., Jarošová, D., Papastavrou, E., & Žiaková, K. (2020b). Hospital safety climate from nurses' perspective in four European countries. *International Nursing Review*, *67*(2), 208–217. https://doi.org/10.1111/inr.12561

Hewitt, T., Chreim, S., & Forster, A. (2017). Sociocultural factors influencing incident reporting among physicians and nurses: Understanding Frames underlying self-And peer-reporting practices. *Journal of Patient Safety*, *13*(3), 129–137. https://doi.org/10.1097/PTS.0000000000000130

Hong, S., & Li, Q. J. (2017). The reasons for Chinese nursing staff to report adverse events: a questionnaire survey. *Journal of Nursing Management*, *25*(3), 231–239. https://doi.org/10.1111/jonm.12461

Jafree, S. R., Zakar, R., Zakar, M. Z., & Fischer, F. (2015). Nurse perceptions of organizational culture and its association with the culture of error reporting: a case of public sector hospitals in Pakistan. *BMC Health Services Research*, *16*(1), 3. https://doi.org/10.1186/s12913-015-1252-y

Jeong, S., & Jeong, S. H. (2021). Effects of second victim experiences after patient safety incidents on nursing practice changes in Korean clinical nurses: The mediating effects of coping behaviors. *Journal of Korean Academy of Nursing*, *51*(4), 489–504. https://doi.org/10.4040/jkan.21089

Kirk, A., Armstrong, K., Nurkka, N., & Jinks, A. (2018). The impact of blame culture on paramedic practice: A qualitative study exploring English and Finnish paramedic perceptions. *International Journal of Emergency Services*, *7*(3), 214–227. https://doi.org/10.1108/IJES-10-2017-0052

Logroño, K. J., Al-Lenjawi, B. A., Singh, K., & Alomari, A. (2023). Assessment of nurse's perceived just culture: a cross-sectional study. *BMC Nursing*, *22*(1). https://doi.org/10.1186/s12912-023-01478-4

Mahat, S., Rafferty, A. M., Vehviläinen-Julkunen, K., & Härkänen, M. (2022). Negative emotions experienced by healthcare staff following medication administration errors: a descriptive study using text-mining and content analysis of incident data. *BMC Health Services Research*, *22*(1), 1–11. https://doi.org/10.1186/s12913-022-08818-1

Okpala, P. (2020). Nurses' perspectives on the impact of management approaches on the blame culture in health-care organizations. *International Journal of Healthcare Management*, *13*(S1), 199–205. https://doi.org/10.1080/20479700.2018.1492771

Ouyang, Q., Zhang, G., Xie, Y., Yuan, H., Cheng, F., & Huang, Q. (2024). Effects of a special continuous quality improvement in nursing on the management of adverse care events: a retrospective study. *BMC Health Services Research*, *24*(1), 1–7. https://doi.org/10.1186/s12913-024-10913-4

Peijia, Z., Xin, L., & Jie, L. (2022). Effect of Patient Safety Training Program of Nurses in Operating Room. *Journal of Korean Academy of Nursing*, *52*(4), 378–390. https://doi.org/10.4040/jkan.22017

Ramos, R. R., & Calidgid, C. C. (2018). Patient safety culture among nurses at a tertiary government hospital in the Philippines. *Applied Nursing Research*, *44*, 67–75. https://doi.org/10.1016/j.apnr.2018.09.007

Reason, J. (2000). Human error: Models and management. *British Medical Journal*, *320*(7237), 768–770. https://doi.org/10.1136/bmj.320.7237.768

Sanchis, D. Z., Haddad, M. D. C. F. L., Girotto, E., & Silva, A. M. R. (2020). Patient safety culture: perception of nursing professionals in high complexity institutions. *Revista Brasileira de Enfermagem*, *73*(5), 1–8. https://doi.org/10.1590/0034-7167-2019-0174

Siman, A. G., Cunha, S. G. S., & Brito, M. J. M. (2017). The practice of reporting adverse events in a teaching hospital. *Revista Da Escola de Enfermagem*, *51*, 1–8. https://doi.org/10.1590/S1980-220X2016045503243

Sinaga, R., & Kusumaningsih, I. (2024).

Persepsi Perawat Pelaksana Terkait Budaya Adil dengan Perspektif Leininger dalam Pelaporan Insiden: Literature Review. *Media Publikasi Promosi Kesehatan Indonesia (MPPKI)*, *7*(5), 1120–1133. https://doi.org/10.56338/mppki.v7i5.5067

Souza, C. S. de, Tomaschewski-Barlem, J. G., Rocha, L. P., Barlem, E. L. D., Silva, T. L., & Neutzling, B. R. da S. (2019). Patient safety culture in intensive care units: perspective of health professionals. *Revista Gaúcha de Enfermagem*, *40*(spe), 20180294. https://doi.org/10.1590/1983-1447.2019.20180294

Tlili, M. A., Aouicha, W., Dhiab, M. Ben, & Mallouli, M. (2020). Assessment of nurses' patient safety culture in 30 primary health-care centres in tunisia. *Eastern Mediterranean Health Journal*, *26*(11), 1347–1354. https://doi.org/10.26719/emhj.20.026

Tran, T. N. H., Pham, Q. T., Tran, L. H., Vu, T. A., Nguyen, M. T., Pham, H. T., Le, T. T., & Bui, T. T. H. (2022). Comparison of Perceptions About Patient Safety Culture Between Physicians and Nurses in Public Hospitals in Vietnam. *Risk Management and Healthcare Policy*, *15*, 1695–1704. https://doi.org/10.2147/RMHP.S373249

Van Gerven, E., Bruyneel, L., Panella, M., Euwema, M., Sermeus, W., & Vanhaecht, K. (2016). Psychological impact and recovery after involvement in a patient safety incident: A repeated measures analysis. *BMJ Open*, *6*(8). https://doi.org/10.1136/bmjopen-2016-011403

Ystaas, L. M. K., Nikitara, M., Ghobrial, S., Latzourakis, E., Polychronis, G., & Constantinou, C. S. (2023). The Impact of Transformational Leadership in the Nursing Work Environment and Patients' Outcomes: A Systematic Review. *Nursing Reports*, *13*(3), 1271–1290. https://doi.org/10.3390/nursrep13030108

Zhang, C., Yang, Z., Liang, Y., Feng, Y., & Zhang, X. (2024). A qualitative study of head nurses' experience in China: forced growth during patient safety incidents. *BMC Nursing*, *23*(1). https://doi.org/10.1186/s12912-024-02255-7