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Head Nurse Leadership and Blame Culture Among Nurses: A Cross-Sectional Study in a Public Hospital

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Abstract

Head nurse leadership plays an important role in shaping organizational culture and influencing nurses' perceptions of psychological safety in hospital settings. Ineffective leadership may contribute to fear-based work environments, reduced psychological safety, and the emergence of a blame culture among nurses, which can hinder open communication and learning from clinical errors. This study aimed to examine the relationship between head nurse leadership and blame culture among nurses in a public hospital. A quantitative analytic study with a cross-sectional design was conducted involving 220 nurses recruited from inpatient, intensive care, emergency, and outpatient units of a public hospital. Data were collected using structured questionnaires measuring perceived overall head nurse leadership and blame culture in clinical practice. Data were analyzed using descriptive statistics and Pearson correlation analysis using SPSS version 26. The results showed that overall head nurse leadership was perceived at a moderately high level (3.62 ± 0.54), while blame culture was categorized as moderate (3.41 ± 0.63). Pearson correlation analysis demonstrated a significant moderate negative relationship between head nurse leadership and blame culture ($r = -0.528$, $p = 0.001$), indicating that higher perceived leadership was associated with lower levels of blame culture among nurses. These findings highlight the importance of strengthening effective and supportive leadership practices among head nurses to promote a psychologically safe and learning-oriented organizational culture in hospital settings.

INTRODUCTION

Patient safety remains a global priority in healthcare systems. Organizational response to clinical errors is strongly influenced by workplace culture and leadership behavior. According to the Agency for Healthcare Research and Quality (AHRQ), underreporting of safety incidents remains a critical issue, with only about 10% of events formally reported (Agency for Healthcare Research and Quality, 2020). This condition reflects deeper organizational problems related to psychological safety and fear of consequences. Similarly, the World Health Organization reports that a significant proportion of patients experience preventable harm during healthcare delivery (Cummings et al., 2020). These findings highlight that beyond procedural systems, cultural and leadership factors play a central role in shaping patient safety outcomes. Therefore, understanding how leadership influences blame culture becomes essential in improving healthcare quality.

In Indonesia, patient safety policies emphasize structured incident reporting systems regulated by the Ministry of Health Regulation No. 11 of 2017. However, the implementation of patient safety programs is often influenced by organizational culture and leadership practices rather than regulations alone (Zalukhu, 2020). Hospitals are required to develop a non-punitive environment to support

openness in reporting clinical errors. Despite these regulations, many healthcare facilities still demonstrate hierarchical and blame-oriented work environments. This suggests that policy implementation alone is insufficient without supportive leadership that promotes psychological safety and a just culture. Preliminary data from RSUD Kota Kediri indicate the presence of patient safety incidents, yet nurses report hesitation in disclosing errors. Observations suggest that fear of negative evaluation from supervisors and potential blame may influence reporting behavior. Such conditions reflect underlying organizational culture issues, particularly the presence of blame-oriented responses in clinical settings. Although reporting systems are available, psychological safety remains a concern. These findings indicate the need to explore how leadership practices may contribute to the formation of blame culture among nurses.

One of the key determinants of incident reporting behavior is individual awareness and perception of patient safety (Rahmanida & Bachtiar, 2022; Rehder et al., 2020). Studies suggest that healthcare professionals often fail to report incidents due to lack of knowledge, fear of consequences, or uncertainty about reporting procedures (Linnik et al., 2023). Patient safety incident reporting is inherently voluntary and requires self-awareness, defined as the ability to align actions with professional standards and ethical values (Maghfiroh, 2023). However, awareness alone is insufficient if not supported by a conducive work environment In particular, a culture that discourages blame and promotes open communication is essential to encourage reporting behavior. Organizational culture, particularly blame culture, plays a crucial role in shaping nurses' behavior in reporting and managing clinical errors (Cooper et al., 2017).

Leadership, especially at the unit level, is widely recognized as a critical factor influencing organizational culture and staff behavior. Effective nurse managers can significantly improve patient safety outcomes, workforce stability, and organizational performance. Empirical evidence shows that units led by highly competent nurse managers report fewer medication errors, lower turnover rates, and shorter lengths of stay compared to those under less effective leadership (da Silva Lessa & da Silva, 2024; Kwisoon et al., 2022; Linnik et al., 2023). Leadership styles such as transformational leadership are associated with open communication, trust, and empowerment, which encourage staff to report incidents without fear (Alanazi et al., 2022; Draghici et al., 2022). Conversely, authoritarian or punitive leadership styles may suppress reporting and foster a culture of silence. This indicates that leadership plays a fundamental role in shaping blame culture within healthcare teams.

A critical issue emerging in healthcare organizations is the persistence of blame culture, characterized by fear of punishment, shame, and reluctance to disclose errors (Brborovic et al., 2019). Blame culture is defined as an organizational environment in which individuals are held primarily responsible for errors, leading to fear, shame, and reluctance to report mistakes. This culture is often contrasted with a just culture, which emphasizes system improvement rather than individual punishment. This culture is often reinforced by toxic leadership behaviors, including harsh criticism, lack of support, and punitive responses to mistakes (Baarle et al., 2022; Wu & Kachalia, 2023). Studies indicate that nurses working under supportive leadership are significantly more likely to report incidents, whereas those experiencing negative leadership may reduce reporting rates by up to 50% (Labrague et al., 2020). Fear of blame has been identified as a major barrier to reporting, particularly in hierarchical healthcare systems. As a result, blame culture not only inhibits transparency but also undermines patient safety by preventing organizational learning from errors (Baarle et al., 2022). Therefore, examining how leadership contributes specifically to the development of blame culture becomes essential.

Despite extensive literature on patient safety and leadership, limited studies have specifically examined the relationship between head nurse leadership and blame culture among nurses, particularly in Indonesian hospital settings. Most previous research has focused on incident reporting or patient safety culture in general, with less attention to blame culture as a distinct construct. Therefore, this study

aims to examine the relationship between head nurse leadership and blame culture among nurses in a public hospital setting.

METHODS

This study employed an analytical cross-sectional design to examine the relationship between head nurse leadership and blame culture among nurses. This design was selected to identify associations between variables within a real clinical setting without implementing any intervention. The study was conducted at RSUD Kota Kediri, a public referral hospital in East Java, Indonesia, which provides comprehensive healthcare services across various units, including medical-surgical wards, intensive care units, emergency services, and outpatient departments. As a public hospital, RSUD Kota Kediri is required to implement patient safety programs, including incident reporting systems, in accordance with national regulations. Although incident reporting exists as part of the system context, this study focuses specifically on leadership and blame culture.

The study population consisted of all registered nurses working at RSUD Kota Kediri during the study period. A proportionate stratified random sampling technique was used to ensure representation across different hospital units. The sample size was determined using statistical power analysis with a confidence level of 95% and power of 80%, resulting in a minimum sample of approximately 200 respondents, with an additional 10% added, resulting in a final sample of 220 nurses. Inclusion criteria included nurses with at least six months of working experience and willingness to participate, while those on leave or in administrative positions were excluded.

Data were collected using structured and validated questionnaires. Leadership style was measured using the Multifactor Leadership Questionnaire (MLQ Form 5X), which assesses transformational and transactional leadership dimensions (Foguet et al., 2021). Blame culture was measured using an adapted version of the Hospital Survey on Patient Safety Culture (HSOPSC), focusing on the non-punitive response to error dimension, along with additional items assessing fear of blame (Westat, Rockville et al., 2018). Each questionnaire item was scored using a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). After data collection, all responses were checked for completeness, coded numerically, and entered into SPSS version 26 for analysis. The scores of each respondent were summed to obtain overall scores for head nurse leadership and blame culture variables. Mean scores were categorized into five levels: low (1.00–1.80), moderately low (1.81–2.60), moderate (2.61–3.40), moderately high (3.41–4.20), and high (4.21–5.00). The category of overall head nurse leadership represented the combined score of all leadership dimensions measured in the MLQ Form 5X rather than each individual dimension separately. Similarly, the category of blame culture represented the combined score of all blame culture items.

Data collection was conducted over a four-week period from January to February 2026 after obtaining ethical approval from the Faculty of Health Sciences Ethics Committee with approval number 1073/FIK/EP/I/2026. Descriptive statistical analysis was performed to calculate frequencies, percentages, means, and standard deviations (SD) for respondent characteristics and study variables. The validity of the instruments was supported by previous studies and expert review, while reliability testing using Cronbach's alpha demonstrated acceptable internal consistency values above 0.70. Before conducting bivariate analysis, data normality was assessed using the Kolmogorov–Smirnov test, which showed that the data were normally distributed ($p > 0.05$). Pearson correlation analysis was subsequently conducted to examine the relationship between overall head nurse leadership and blame culture among nurses.

RESULTS

The distribution of respondent characteristics in Table 1 shows that the majority of participants were female (78.2%), while male respondents accounted for 21.8%. In terms of educational

background, most nurses held a Bachelor degree with professional certification (Ners) (61.8%), whereas 38.2% had a diploma-level education. Based on work experience, more than half of the respondents (56.8%) had ≥5 years of experience, indicating that the sample was predominantly composed of relatively experienced nursing staff. In terms of work units, most respondents were from outpatient departments, representing 138 nurses (62.7%). The remaining respondents worked in medical-surgical wards (14.5%), intensive care units (11.4%), and emergency services (11.4%). These findings indicate that the respondents were predominantly experienced female nurses with professional nursing qualifications. The distribution of respondents across different clinical units also reflects the involvement of nurses from diverse healthcare service settings within the hospital.

Table 1
Frequency Distribution of Respondent Characteristics (n=220)

Characteristics	F	%
Gender		
Male	48	21.8
Female	172	78.2
Education Level		
Diploma(D3 nursing)	84	38.2
Bachelors + Registered Nurse (Ners)	136	61.8
Years of Experience		
< 5 Years	95	43.2
≥ 5 Years	125	56.8
Work Unit		
Medical Surgical Wards	32	14.5
Intensive Care Unit	25	11.4
Emergency Services	25	11.4
Outpatient Departments	138	62.7

Table 2
Frequency Distribution of Research Variables

Characteristics	Mean	SD	Category
Head Nurse Leadership	3.62	0.54	Moderately High
Blame Culture	3.41	0.63	Moderate

Table 2 presents the descriptive statistics of the study variables. The mean score for overall head nurse leadership was 3.62 (SD = 0.54), which was categorized as moderately high. This finding indicates that nurses generally perceived head nurse leadership positively within the hospital setting. Meanwhile, the mean score for blame culture was 3.41 (SD = 0.63), categorized as moderate, suggesting that blame-oriented attitudes and responses were still present among nurses. The categories reflected the overall combined scores of each variable rather than all individual dimensions or items being in the same category.

Table 3
Correlation Matrix Between Study Variables

Variable	*Mean*	SD	*r*	*p-value*
Overall Head Nurse Leadership	3.62	0.54	-0.528	0.001
Blame Culture	3.41	0.63		

The relationship between overall head nurse leadership and blame culture is presented in Table 3. Pearson correlation analysis showed a statistically significant moderate negative correlation between the two variables (r = -0.528, p = 0.001). This finding indicates that higher perceived leadership among head nurses was associated with lower levels of blame culture among nurses in the hospital setting.

The findings showed that nurses perceived overall head nurse leadership at a moderately high level, with a mean score of 3.62 ± 0.54. Meanwhile, blame culture among nurses was categorized as moderate, with a mean score of 3.41 ± 0.63. Pearson correlation analysis demonstrated a significant moderate negative relationship between overall head nurse leadership and blame culture (r = -0.528, p = 0.001). This finding indicates that higher perceived leadership among head nurses was associated with lower levels of blame culture among nurses in the hospital setting.

DISCUSSION

The findings of this study demonstrate a significant negative relationship between head nurse leadership and blame culture among nurses. In the context of public hospitals in Indonesia, which often have a strong hierarchical structure, the head nurse's role in the "directing" function is crucial. Leadership approaches that emphasize support, communication, and fairness may help reduce the psychological burden on staff. Furthermore, the high percentage of nurses with Ners professional degrees and over five years of experience in this study suggests that even a competent workforce requires a non-punitive environment to thrive. A leadership style that promotes safety over silence encourages nurses to report errors without fear of immediate retribution, which is essential for organizational learning.

The correlation analysis revealed that better leadership is associated with lower levels of blame culture in clinical settings. This suggests that leadership plays an essential role in shaping organizational behavior and emotional climate within hospital units. The result indicates that nurses who perceive stronger leadership tend to experience a safer and more supportive work environment. Consequently, the tendency toward blame-oriented responses is reduced when leadership is perceived as effective. The findings emphasize that leadership is a key determinant of blame culture rather than merely influencing reporting behavior. Therefore, leadership is not only managerial but also cultural in its influence on nursing practice.

The findings are consistent with leadership theories suggesting that positive leadership practices, including transformational leadership, contribute to supportive organizational outcomes. Bass (1990; 1999) explains that transformational leadership enhances trust, motivation, and shared goals among employees. In nursing contexts, such leadership fosters openness and reduces fear of negative consequences when errors occur. Cummings et al (2020) also emphasize that nursing leadership is essential in shaping safe work environments and improving organizational performance. Ethical leadership contributes to improved communication and reduced defensive behaviors in clinical practice. da Silva Lessa & da Silva, (2024) further support this by showing that ethical leadership is associated with constructive conflict management strategies. These findings strengthen the argument that leadership directly influences workplace culture, including blame-oriented behaviors.

Blame culture in healthcare settings remains a significant barrier to patient safety and organizational learning (Alanazi et al., 2022). It is characterized by fear of punishment, avoidance of accountability, and reluctance to report errors. In such environments, mistakes are often attributed to individuals rather than systemic weaknesses (Draghici et al., 2022). The presence of blame culture can inhibit transparency and reduce opportunities for improvement. This condition aligns with the findings of this study, where stronger leadership is associated with reduced blame culture. Leadership appears to function as a protective factor against punitive organizational norms. Therefore, improving leadership quality is essential in transforming blame-oriented environments into learning-oriented systems (Saleh et al., 2024).

From a theoretical perspective, ethical leadership provides a strong explanation for the observed relationship. Ethical leaders demonstrate fairness, integrity, and supportive behavior toward their subordinates. (Poikkeus & Leino-kilpi, 2014) found that organizational and individual support are closely linked to nurses' ethical competence and safety perceptions. This suggests that leadership directly influences psychological safety in the workplace (Wei et al., 2018). When nurses feel supported by leadership, they are more likely to engage in open communication and less likely to fear blame. Khaghanizadeh et al (2023) further emphasize that ethical competence in nursing practice is shaped by the organizational environment. Thus, blame culture can be understood as a reflection of leadership quality within healthcare institutions.

The relationship between leadership and moral competence is also supported by recent literature. da Silva Lessa & da Silva (2024) argue that moral competence serves as an antecedent to transformational leadership. This indicates that leadership effectiveness is deeply rooted in ethical awareness and professional values. Nurses who operate under ethically competent leaders tend to exhibit higher levels of responsibility and reflective practice. This contributes to a reduction in fear-based behavior and blame-oriented responses.Boamah et al (2018) also found that transformational leadership and supportive organizational culture improve nurses' willingness to remain in their jobs. These findings suggest that leadership not only shapes culture but also influences workforce stability. Therefore, leadership development is critical for sustaining a healthy organizational environment.

Ethical leadership has also been strongly associated with patient safety culture in previous studies. Yu et al (2024) found that ethical leadership is significantly related to organizational commitment and perception of patient safety culture. This supports the idea that leadership plays a central role in reducing punitive responses to clinical errors. Taskiran & Turk (2023) further highlight that perceived ethical leadership is negatively associated with missed nursing care. This indicates that better leadership reduces neglectful behaviors and improves clinical accountability. In the context of this study, reduced blame culture may encourage more transparent reporting and communication. Therefore, leadership acts as a foundational element in promoting safe and accountable nursing practice.

The findings of this study are particularly relevant in hospital settings where hierarchical structures may influence communication patterns. In such environments, head nurses occupy a strategic position in shaping team dynamics and cultural norms (Wei et al., 2018). The negative correlation found in this confirms that leadership significantly influences blame culture. This implies that strengthening leadership competencies can reduce fear-based organizational behavior. It also suggests that promoting effective and supportive leadership practices may help establish a just culture in healthcare institutions. Therefore, leadership development programs should be prioritized in hospital management strategies. Ultimately, improving head nurse leadership is essential for reducing blame culture and enhancing overall patient safety culture.

This study was conducted in a public hospital setting using a cross-sectional approach; therefore, the findings should be interpreted within the context of the study setting and period. The study focused on the overall relationship between head nurse leadership and blame culture among nurses. Nevertheless, the findings provide important insights into the role of nursing leadership in shaping organizational culture and patient safety practices. Future studies involving broader healthcare settings and additional organizational variables are recommended to strengthen and expand the current findings.

CONCLUSION

Head nurse leadership was significantly associated with blame culture among nurses in a public hospital. The findings showed that leadership practices play an important role in creating a supportive and safe working environment for nurses. Effective leadership from head nurses may reduce blame-oriented responses and encourage more open incident reporting. Therefore, hospitals should strengthen head nurses' leadership competencies through management training and supportive supervision. Head

nurses are also encouraged to promote open communication, fairness in responding to errors, and constructive feedback. These leadership behaviors may help reduce blame culture and improve psychological safety among nurses. In addition, involving nurses in decision-making and promoting a learning-oriented approach to clinical errors may further strengthen patient safety culture in hospitals.

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