Leadership Style, Blame Culture, and Perceived Organizational Support for Patient Safety Incident Reporting at RSIA at Jakarta

Meri Indriani, Rokiah Kusumapradja, and Rina Anindita

ABSTRACT

The hospital is an integral part of a social and health organization whose function is to provide comprehensive, curative and preventive services to the community. Patient safety is the right of the patient, the patient has the right to obtain his security and safety during the treatment period in the hospital. Based on data from patient visits at Private RSIA Type B at Jakarta, there were 50,842 outpatients and 2932 inpatients in 2020. In 2021 there was an increase for 54,794 outpatients and 3091 inpatients. The results of the incident reporting in 2020 contained 80 reports of patient safety incidents that occurred and there was a decrease to 74 reports in 2021. The incident report is a record of every event or situation that can result in or has potential to cause harm that should not have occurred. This study uses a quantitative approach with a causal design research design using a covariant-based Structural Equation Model (SEM), namely AMOS, aiming to analyze the effect that can increase Patient Safety Incident’s reporting, marked by creating improvements, and providing support for changing the blame culture to a just culture in order to increase staff awareness to work in an orderly administration and orderly Standard Operating Procedure.

Keywords: Blame Culture, Leadership Style, Perceived Organizational Support, Patient Safety Incident Reporting.

I. INTRODUCTION

The hospital is an integral part of a social and health organization whose function is to provide complete (comprehensive), disease healing (curative) and disease prevention (preventive) services to the community. Patient safety is the patient's right, the patient has the right to obtain his security and safety during the treatment period in the hospital. Hippocrates in 460-335 BC, first echoed the slogan Primum, Non-No Cere or First Do No Harm. Kohn et al. (2000) made a report with the title To Err Is Human: Building A Safer Health System which awakens us all to the importance of patient safety, something that is unacceptable when patients are injured by health services that should actually offer healing and convenience, a system that promises first do no harm, errors occur due to system failures, processes, and conditions that make people make mistakes or fail to prevent errors from occurring. There are no health workers who deliberately want to harm their patients.

Patient Safety Incident (IKP) is any event or situation that can result in or has the potential to cause harm (illness, injury, disability, death, etc.) that should not have occurred. In the theory of "the swiss cheese" it is explained that almost all unexpected incidents in patient safety incidents are a combination of defense system failures, officers, potential conditions and organizational and management failures.

Leadership plays dominant, crucial, and critical role in the overall effort to improve work performance, at the individual, group, organizational level, including security in the work environment. Leadership as a process of influencing a group of people so that they want to work earnestly to achieve the group's goals. Leadership style, basically contains an understanding as a manifestation of the behavior of a leader, which concerns his ability to lead. The leadership style is divided into two leadership styles, namely transformational as the ability to motivate others to achieve high standards and long-term goals. While transactional leadership as leadership that motivates followers by pointing to self-interest, as an effort to approach subordinates by exchanging things with work. Transactional leadership as an exchange of rewards for compliance.
In a safety culture, there is a culture to report errors or near-miss events. Incident reporting is used as a lesson for organizations on improving service systems. This culture can only develop in an atmosphere that does not corner or blame individuals so that sustainable organizational learning is created which is a proactive process that can create and transmit knowledge in organizational values. Blame culture is the tendency in an organization to not be open to mistakes, suggestions, and ideas, and tends to demand individual accountability for members of the organization.

The implementation of a safety culture cannot be separated from how management supports its employees in bridging every incident that occurs in the service as well as corrective steps it will not happen in the future. Perceived organizational support is the belief that the organization values the contributions of its employees through their works and shows concern for their well-being. Perceptions of organizational support are influenced by the experiences possessed by individuals, as well as observations about the daily life of the organization in treating someone.

Private RSIA Type B at Jakarta is a leading specialist health care institution for mothers and children. Based on data from patient visits at Private RSIA Type B at Jakarta, it was recorded that in 2020 there were 50,842 patients in outpatient care and 2932 patients in inpatient care. In 2021, there was an increase in the number of patient visits to hospitals for 54,794 outpatients and 3091 inpatients. Based on the number of patient safety incident reports per type of incident in 2020, the number of reports of unexpected events (KTD) was recorded for 16 cases, non-injury incidents (KTC) 28 cases, near-injury events (KNC) 27 cases and potential injury events (KPC) 9 cases or its total 80 patient safety incident reports that occurred at Private RSIA Type B at Jakarta during the period 2020. Based on the patient safety incident reporting figures per type of incident in 2021, the number of reports of unexpected events (KTD) was recorded as 17 cases, 25 cases of non-injury (KTC), 22 cases of near miss (KNC) and 10 cases of potential injury (KPC) or a total of 74 report patient safety incidents that occurred at Private RSIA Type B at Jakarta during the period 2021. The results showed incremental inpatient visits at X Jakarta proving a high enough interest in visiting, it's just that the number of reports of safety incidents that occurred in the hospital showed a derivation, giving rise to a perception of whether there is a decrease in the willingness of employees to report or a fear of being blamed (blame culture) if an incident occurs in the hospital X Jakarta

The results of a preliminary survey related to employee perceptions at Private RSIA Type B at Jakarta stated, as many as 50% answered that there was a blame culture when a patient safety incident occurred in the hospital where an incident occurred the main focus was to find out who was at fault not the causing incident, 40% stated that the employee have a sense of laziness to report in the event of a minor incident such as a potential injury, not infrequently a near-injury event occurs because of a fear of SP, 60% stated that the leadership style was considered quite good in directing employees to work by always prioritizing patient safety, 30% stated that employees did not feel that they had received lessons in the form of guidance related to the evaluation of every incident that occurred including how to make proper incident reports, 70% stated that the awareness of reporting in each unit was considered not good enough by employees.

Lilian et al. (2017) in their research stated that overall, there is a significant relationship between transformational leadership style and patient safety culture in hospitals. Wanda et al. (2020) stated in their research that leadership has a direct influence on reporting patient safety incidents (p = 0.021). Mashuri (2019) in his research states that the perception of the blame culture has a significant effect on the attitude of nurses in reporting incidents. The higher the perception of the blame culture, the more negative the attitude of nurses in reporting patient safety incidents. Hery and Yanuar (2019) in their research stated that leadership positively and significantly influences job satisfaction and is also mediated by perceived organizational support. Employees who are satisfied with their organization will directly impact how they work based on SOPs in maintaining safety which is the patient's right while in service at the hospital.

Based on this condition, the authors identified a decrease in reporting of patient safety incidents at Private RSIA Type B at Jakarta. Leadership Style, Blame Culture, and Perceived Organizational Support are used in this study as variables that can influence the behavior of hospital staff's desire to report patient safety incidents.

II. RELATIONSHIP BETWEEN VARIABLES

A. The Influence of Leadership Style and Blame Culture on Patient Safety Incident Reporting Through Perceived Organizational Support

A patient safety incident is an event or situation that can result in or has the potential to cause harm (illness, injury, disability, death, etc.) that should not have occurred (National Safety and Quality Health Service (NSQHS) Standards, 2022). Leadership style is a conducive situation, where a leader tries, at certain times, to influence the behavior of others in order to follow his will in order to achieve common goals (Hersey & Blanchard, 1994).

Blame culture is the tendency in an organization to not be open to mistakes, suggestions, and ideas and tend to demand individual accountability for members of the organization. (Khatri et al., 2009). Perceived organizational support is the belief that the organization values the contributions of its employees through their work and shows concern for their welfare (Rhoades & Eisenberger, 2002).

Lilian et al. (2017) stated that overall, there is a significant relationship between leadership style and patient safety culture. Wanda et al. (2020) stated that leadership has an influence on reporting patient safety incidents (p = 0.021). Mashuri (2019) in his research revealed that the higher the perception of the blame culture, the more negative the attitude of nurses in reporting patient safety incidents. The advice given to RSIS A. Yani and RSIS Jemursari is that the patient safety committee should carry out proactive activities to explore blame culture issues in reporting patient safety incidents. And Jungbauer et al. (2018) in their research stated that management support for patient safety moderates the relationship between leader member exchange and reporting on trust.
Leadership Style (X1) and Blame Culture (X2) as independent variables affect the reporting of patient safety incidents as the dependent variable, perceived organizational support as the intervening variable. Based on the description above, the following hypothesis is obtained:

**H1: Leadership style and blame culture have a significant effect on reporting patient safety incidents through perceived organizational support.**

### B. Effect of Leadership Style on Patient Safety Incident Reporting

Prevention of incidents (adverse event) is a systemic factor, meaning that it does not only come from the performance of a nurse, doctor, or other health worker. The report also draws attention to the human community factors involved in health care issues. Patient safety incidents result from the interaction of several factors that are necessary and for some factors that are not appropriate. The report has an impact on the movement to carry out patient safety programs in every hospital around the world to address the problem of patient safety incidents that often occur in hospitals around the world. Most of the factors that cause incidents to occur are organization, manager leadership and patient safety culture.

The management function that has been implemented in an organization will not work without a leader. However, the existence of a leader also does not guarantee that organizational goals are achieved effectively and efficiently. In order for organizational goals to be achieved effectively and efficiently, a leader needs to apply leadership properly and correctly. Leadership plays dominant, crucial, and critical role in the overall efforts to improve work performance, both at the individual, group and organizational levels.

The results of the research Hexanini et al. (2021) Analysis of the Effect of the Leadership Role of the Head Nurse and the Implementation of Effective Communication on the Patient Safety Culture, the results obtained. Based on the data obtained and from the results of the research in the thesis, it was found that patient safety culture in hospitals. Rahmawati (2018) in her research stated that the results showed that the leadership style had a load factor value of 0.552 and a T-count value of 4.778 (T-count 1.96), which means that there is a significant influence on patient safety culture. Then the hypothesis is obtained as follows:

**H2: Leadership style has a significant positive effect on reporting patient safety incidents.**

### C. Effect of Blame Culture on Patient Safety Incident Reporting

The organizational culture factor that may influence the unwillingness of employees to report IKP or patient safety incidents is blame culture. In a blame culture, employees fear of being blamed for mistakes and therefore remained silent. Fear is mostly a consequence a person will suffer, from misreporting an incident. When an employee believes he or she caused the incident, this fear is even more Substantial. The feared negative consequences, for example, endanger the employee's reputation, social exclusion, disciplinary action, limited career opportunities and responsibilities. This consequence makes employees feel afraid in making reports.

Handriyanto (2020) in his research that supports the development of the Komen (2016) model, shows statistical results that blame culture has an effect of \( p=0.001; \beta=-0.264 \) on IKP reporting. The results of this study indicated that the blame culture has an influence on the willingness of employees to report the IKP. Blame culture still needs to be lowered in order to increase the willingness of employees to report IKP in X, Y, and Z Government Hospitals.

Mashuri (2019) in his research stated that the perception of the blame culture had a significant effect on nurses' attitudes in reporting incidents. The higher the perception of the blame culture, the more negative the attitude of nurses in reporting patient safety incidents. Then the hypothesis is obtained as follows:

**H3: Blame culture has a significant negative effect on patient safety incident reporting.**

### D. The Effect of Leadership Style on Perceived Organizational Support

Leaders manage relationships in groups, tend to make standard patterns in channeling communication, and regulate how a task is carried out. Leaders with a high tendency for initiating structures focus on targets and results. If the employee assesses the task-oriented leadership style used by a leader is high enough where the leader only pays attention on achieving the company's targets, while the hard work and presence of employees from the company is not paid attention to, the employee will judge that the company's support for them is very lacking or it can be said that perceived organizational support is valuable. negative, and vice versa if employees judge that the task-oriented leadership style used by a low leader where the leader pays enough attention to the hard work and presence of employees, employees will judge that the company's support for them is quite good or it can be said that perceived organizational support is positive. Hery and Yanuar (2019) in their research stated that leadership can have a positive and significant influence on job satisfaction which is also mediated by perceived organizational support. Then the hypothesis is obtained as follows:

**H4: Leadership style has a significant positive effect on perceived organizational support.**

### E. The Effect of Blame Culture on Perceived Organizational Support

Management has the authority to extend contracts, fire employees, or manage employees. This means that management behavior can have an influence on employee attitudes and behavior. Management support is the behavior of an authorized person within the hospital organization that shows encouraging or supportive behavior towards patient safety reporting. This form of support can take the form of a good feedback response in the process of evaluating an incident. Perceived organizational support is that employees believe that the organization values the contributions of its employees through their work and shows concern for their welfare. This level of trust arises because management sets an example by actively participating in efforts to improve patient safety by providing positive feedback, otherwise negative feedback will strengthen the blame culture so that employees are increasingly unwilling to report incidents they know correctly.

Vellyana and Rahmawati, (2016) in their research state that management support is less than optimal to increase awareness of health workers in implementing a patient safety

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culture, lack of awareness to report incidents that occur in units/sections due to fear of sanctions for mistakes is still positively proven in reporting incidents. This proves that perceived organizational support or the belief that employees believe that the organization appreciates the contributions of its employees through their work and shows concern for welfare has not been fully felt by employees. Then the hypothesis is obtained as follows:

H5: Blame culture has a significant negative effect on perceived organizational support.

F. Effect of Perceived Organizational Support on Patient Safety Incident Reporting

The high number of Patient Safety Incidents (IKP) in some countries makes risk identification very important. One way that can be used to identify risks is through the development of a reporting and analysis system. This is done as a means of monitoring efforts to prevent errors from occurring so that further investigations can be carried out. In addition, with patient safety reporting, it can reduce the same mistakes from happening again. Without reporting on patient safety incidents, it causes more burdens that are received by individuals, families, and society socially and economically due to death and the inability to prevent incidents (Mauti & Githae, 2019).

Jungbauer et al. (2018) in their research stated that management support for patient safety moderates the relationship between leader member exchange and reporting on trust. The trust that employees believe that the organization values the contributions of its employees through their work and shows concern for their welfare has not been fully felt by employees. By knowing the inhibiting factors or causes of low patient safety incident reporting in hospitals, it is hoped that it can help increase patient safety rates, reduce the occurrence of errors and provide an overview to stakeholders in formulating and establishing policies for reporting patient safety incidents in hospitals. as follows:

H6: Perceived organizational support has a significant positive effect on patient safety incident reporting.

III. CONCEPTUAL FRAMEWORK

H1: There is a significant influence of leadership style and blame culture on patient safety incident reporting at Private RSIA Type B at Jakarta through perceived organizational support.

H2: There is a significant positive effect of leadership style on patient safety incident reporting at Private RSIA Type B at Jakarta.

H3: There is a significant negative influence of blame culture on patient safety incident reporting at Private RSIA Type B at Jakarta.

H4: There is a significant influence of leadership style on perceived organizational support at Private RSIA Type B at Jakarta.

H5: There is a significant negative effect of blame culture on perceived organizational support at Private RSIA Type B at Jakarta.

H6: There is a significant positive effect of perceived organizational support on patient safety incident reporting at Private RSIA Type B at Jakarta.

IV. RESEARCH METHODS

The design of this study used a quantitative approach, and the design of this study was a causal design. Causal research is used to analyze the relationship between one variable and another. Based on the research objectives, this study aims to identify factors related to patient safety incident reporting and determine steps to improve and improve patient safety incident reporting at Private RSIA Type B at Jakarta. The results of data processing will then be used as a basis for analysis and answer the proposed hypothesis. The analysis used in this study uses structural equation modeling (SEM) with the help of AMOS software. In this study, the number of question indicator items was 74 items used to measure 4 variables, and the number of samples used in this study was a saturated sample of 143 respondents, with the inclusion criteria of respondents being all service medical staff at Private RSIA Type B at Jakarta.

V. RESULT AND DISCUSSION

A. Characteristics of Respondents

Based on the results of the questionnaire distributed by the researchers, the demographic data of the respondents from 143 people studied showed that based on gender, women dominated in this study as many as 131 people (91.61%), while the smallest number of respondents' gender was 12 people (8.39%). Characteristics based on the education of the respondents, most of them have the latest diploma education as many as 78 people (54.55%), while the smallest number have the last education high school/equivalent as many as 14 people (9.79%). Characteristics based on majors, most of them have pharmacist majors as many as 21 people (14.69%), while the smallest number has education majors, English, communication science, information management and language and literature education each as many as 1 person (0.70%). Characteristics based on years of service, most of the respondents had a working period of 6-10 years as many as 47 people (32.87%), while the smallest number had a service period of <1 year as many as 6 people (4.20%).

B. Data Analysis

Based on the results of the measurement model, the validity test in Structural Equation Modeling (SEM), namely the confirmatory analysis test, shows that in 11 dimensions including 28 exogenous variable questions that have been measured, the exogenous variable leadership style is formed by 2 dimensions because the loading factor results have value > 0.5, while the blame culture variable is formed by 5 dimensions, this is because the loading factor results have a value > 0.5 while the remaining 4 other dimensions need to be eliminated because the loading factor results have a value <0.05. Meanwhile, the 7 dimensions which include 46 questions on the measured endogenous variables have a loading factor value of > 0.5 (Table I). So that it can be stated that all dimensions of each leadership style variable, perceived organizational support, and patient safety incidents are the forming factors of the latent variable, while for the blame culture variable of the 9 forming dimensions, only 5 are the forming factors of the latent variable.

The results of the reliability test, based on the results of
data processing, obtained the results of the construct reliability (CR) and average variance extracted (AVE) in Table I. From Table I, it can be seen that all variables have construct reliability and average variance extracted values >0.7 and >0.5. So, this shows that the variable construct can be declared to have good data reliability (reliable).

### TABLE I. DATA ANALYSIS

<table>
<thead>
<tr>
<th>Variable</th>
<th>Estimate Standard Loading</th>
<th>CR</th>
<th>AVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership Style</td>
<td>0.775-1.027</td>
<td>0.704</td>
<td>0.548</td>
</tr>
<tr>
<td>Blame Culture</td>
<td>0.325-0.968</td>
<td>0.977</td>
<td>0.841</td>
</tr>
<tr>
<td>Perceived</td>
<td>0.905-0.969</td>
<td>0.940</td>
<td>0.840</td>
</tr>
<tr>
<td>Organizational Support</td>
<td>0.850-0.990</td>
<td>0.919</td>
<td>0.740</td>
</tr>
<tr>
<td>Patient Safety</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incident Reporting</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

C. Three Box Method Analysis

Descriptive analysis in this study uses the Three Box Method of index number analysis. To get the tendency of respondents’ answers to each variable, it will be categorized into a range of scores based on the calculation of the three-box method. The resulting index number is 143, while the scale range for each criterion is 35.75.

Based on the results of the study, the variables of leadership style and perceived organizational support have a high response value, indicating that the leadership style and perceived organizational support of Private RSIA Type B at Jakarta are considered good. While the patient safety incident reporting variable and blame culture have a moderate value response which can be interpreted quite meaningfully, there is still a need for supervision on the PMKP program and there is still a need to change the behavior of the mindset towards reporting patient safety incidents.

D. Structural Model Fit Test

Based on the calculation results, it is known that all indicators in this study have their critical ratio values below ± 2.58, which means the data is normally distributed. AMOS output results in this study also indicate that there are no data outliers shown from the results of the mahalanobies d-squared, the largest value in this study is 112.879 and the chi-square value is 171.901. Due to the value of 112.879 <171.901, it can be stated that in this study there were no data outliers.

Based on the results of the goodness of fit test in Table II, it is obtained that most of the test results are in the good fit criteria, namely: probability, cmindf/chi-square, GFI, RMSEA, TLI, NFI, IFI, RFI while the rest are in the marginal fit category, namely AGFI, PNFI, and PGFI.

Hair et al. (2019) explained that if the results are close to the recommended value, then the model is still feasible to continue. In an empirical study, a researcher is not required to fulfill all the goodness of fit criteria, but depends on the judgment of each researcher. From some of these assumption criteria, the results of the structural model in this study are shown in Fig. 2.

### TABLE II: GOODNESS OF FIT CRITERIA

<table>
<thead>
<tr>
<th>Category Fit</th>
<th>Fit Measure</th>
<th>Cut-off value</th>
<th>Result</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absolute fit measure</td>
<td>Probability</td>
<td>p &gt; 0.05</td>
<td>0.061</td>
<td>Good Fit</td>
</tr>
<tr>
<td></td>
<td>Cmndf</td>
<td>&lt; 2</td>
<td>1.077</td>
<td>Good Fit</td>
</tr>
<tr>
<td></td>
<td>GFI</td>
<td>≥0.90</td>
<td>0.931</td>
<td>Good Fit</td>
</tr>
<tr>
<td></td>
<td>RMSEA</td>
<td>≤0.08</td>
<td>0.075</td>
<td>Good Fit</td>
</tr>
<tr>
<td></td>
<td>AGFI</td>
<td>≥0.90</td>
<td>0.838</td>
<td>Marginal Fit</td>
</tr>
<tr>
<td></td>
<td>TLI</td>
<td>≥0.90</td>
<td>0.979</td>
<td>Good Fit</td>
</tr>
<tr>
<td>Incremental fit measure</td>
<td>NFI</td>
<td>≥0.90</td>
<td>0.977</td>
<td>Good Fit</td>
</tr>
<tr>
<td></td>
<td>IFI</td>
<td>≥0.90</td>
<td>0.990</td>
<td>Good Fit</td>
</tr>
<tr>
<td></td>
<td>RFI</td>
<td>≥0.90</td>
<td>0.953</td>
<td>Good Fit</td>
</tr>
<tr>
<td>Parsimonious fit measures</td>
<td>PNFI</td>
<td>≥0.90</td>
<td>0.483</td>
<td>Marginal Fit</td>
</tr>
<tr>
<td></td>
<td>PGFI</td>
<td>≥0.90</td>
<td>0.399</td>
<td>Marginal Fit</td>
</tr>
</tbody>
</table>

E. Coefficients of Determination Test (R²)

Structural model evaluation is done by looking at the Coefficient of Determination. The coefficient of determination aims to measure how far the model's ability to explain the variance of the dependent variable is. The value of the coefficient of determination is between 0 and 1. The value of the coefficient of determination (R²) is close to the value of 1. The value of R² explains how much the independent variable hypothesized in the equation is able to explain the dependent variable. Sugiyono (2016) explains the criteria for limiting the value of R² into three classifications, namely the value of R² = 0.67, 0.33, and 0.19 as substantial,
moderate, and weak. Based on the results of the analysis, the results of the largest R2 value on the Perceived Organizational Support variable are shown in Table III.

<table>
<thead>
<tr>
<th>TABLE III: REGRESSION WEIGHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Squared Multiple Correlations: (Group number 1 - Default model)</td>
</tr>
<tr>
<td>Variable</td>
</tr>
<tr>
<td>Perceived Organizational Support</td>
</tr>
<tr>
<td>Patient Safety Incident Reporting</td>
</tr>
</tbody>
</table>

F. Hypothesis Testing

Hypothesis testing in this study was carried out partially, the t-test basically shows how far the influence of one independent variable individually in explaining the variation of the dependent variable. The test is carried out using a significance level of 0.05 (α=5%), ttable is obtained from the probability results of 5% (0.05) and n=143-1=142, then the table results are 1.977. Based on the results of data processing, the results of hypothesis testing (regression weight) are obtained. Direct effect and Indirect Effect are shown in Table IV and Table V.

<table>
<thead>
<tr>
<th>TABLE IV: TESTING THE DIRECT EFFECT HYPOTHESIS (REGRESSION WEIGHT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structural</td>
</tr>
<tr>
<td>IKP ќ GK</td>
</tr>
<tr>
<td>IKP ќ BC</td>
</tr>
<tr>
<td>POS ќ GK</td>
</tr>
<tr>
<td>POS ќ BC</td>
</tr>
<tr>
<td>IKP ќ POS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TABEL V: SOBEL TEST</th>
</tr>
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<tbody>
<tr>
<td>Strukural</td>
</tr>
<tr>
<td>EWOM ќ KP ќ NPU</td>
</tr>
<tr>
<td>CM ќ KP ќ NPU</td>
</tr>
</tbody>
</table>

I. Influence of leadership style and blame culture on patient safety incident reporting through perceived organizational support

The test results have a probability value (significance) of 0.061 (>0.05) and an R2 value of 0.914. It can be concluded that leadership style and blame culture have a significant effect on patient safety incident reporting through perceived organizational support. Perceived organizational support variable is an intervening variable that can mediate the influence of leadership style and blame culture variables on patient safety incident reporting.

The leader is defined as the direct supervisor of the implementing staff, in other words, the head of the room/supervisor. Transactional leadership as an exchange of rewards to get compliance, while transformational leadership as the ability to motivate others to achieve high standards and long-term goals. In building a patient safety culture, two leadership models are needed at the same time. In terms of patient safety, transactional leadership can be used to encourage staff to report incidents while transformational leadership is used to learn from events and redesign programs for patient safety.

Culture in a health organization is important because culture plays a role in how errors can be detected and handled. Culture is the most important foundation in improving patient safety in health facilities, it consists of attitudes, values, beliefs, and behaviors that are packaged into one in implementing. Building and changing a patient safety culture is one way to build a comprehensive patient safety program. If the focus of improvement is on a patient safety culture, then the output will be better than if it focuses on the program alone. Blame culture, which we know as blame culture, requires individuals to perform perfect performances and take full responsibility for their performance. In order to make changes, an understanding of the existing culture is needed, as well as in changing the perception of nurses or staff who were initially reluctant to report to be able to consciously and voluntarily report errors, it needs to be based on cultural changes. A positive work safety culture provides confidence for nurses/staff that patient safety is an important priority for the organization and the organization supports any efforts to develop hospital patient safety.

The results of this study are in line with previous research conducted by Mashuri (2019) in his research which revealed that the higher the perception of the blame culture, the more negative the attitude of nurses in reporting patient safety incidents. The advice given to RSIS A. Yani and RSIS Jemursari is that the patient safety committee should carry out proactive activities to explore blame culture issues in patient safety incident reporting and research (Castel et al., 2015) that the Blame culture was formed due to a lack of management support in facilitating resolution. every incident. Perceived organizational support is the belief that the organization values the contributions of its employees through their work and shows concern for their well-being.

2. Effect of leadership style on patient safety incident reporting

Based on the results of hypothesis testing, it was found that there was a significant positive effect of leadership style on reporting patient safety incidents at X Jakarta, meaning that the better the leadership style was applied based on conditions in the field, the more staff compliance would be to report any patient safety incidents that occurred due to the influence of leadership to encourage staff to report incidents, as a process of learning from incidents and redesigning programs for patient safety.

Leaders must have effective leadership competencies in accordance with developments and task demands to improve patient safety. Implementing managers or supervisors must use modern management methods to address challenges encountered in maintenance systems and safety culture. Efforts to improve patient safety are a dynamic process that continues to change, and it depends on the state and the development of science and technology related to patient safety, which is supported by a leadership style that is suitable for these conditions. Leadership style and tendencies, which must be considered is how a manager/supervisor must be able to have the initiative, be able to develop and understand the changes that occur, which are directly or indirectly related to improving patient safety (Farokhzadian et al., 2018).

Changes in leadership patterns occur because of conditions.

3. Effect of Blame Culture on Patient Safety Incident Reporting

Based on the results of hypothesis testing, it was found that there was a significant negative influence of blame culture on
Blame culture is a tendency in an organization not to be open to mistakes, suggestions, ideas, and tends to demand individual accountability for members of the organization. Reason (2000) as one of the first to describe the blame culture, argues that the high level of individual autonomy in western culture contributes to the development of the blame culture. When things go wrong, westerners are taught to be individually responsible. This has resulted in the habit of looking for culprits to blame when incidents occur. Guilt culture requires individuals to appear fully and fully responsible for its implementation. Individuals who make mistakes focus on their weaknesses, which have a negative impact on work comfort, miss opportunities to learn and implement changes, and reduce the number of incident reports for both individuals and teams (Sproll, 2018).

Cooper et al. (2017) stated that health care professionals reported patient safety incidents that were attributed to blaming someone in 36% of 975 cases, those who reported incidents attributed the blame to others, while 2% of those who reported admitted personal responsibility. Errors are generally related to the incident for which the complaint was anticipated. This high frequency of errors in safety incidents reflects a health care culture that leads to mistakes and retaliation, rather than identifying areas for learning and improvement, a failure to appreciate contributing to behavior. The results of this study are in line with the research conducted by Handriyanto (2020) and Mashuri (2019) that blame culture has a significant negative effect on the reporting of Patient Safety Incident Reports.

4. The Influence of Leadership Style on Perceived Organizational Support

Based on the results of hypothesis testing, it was found that there was a significant positive effect of leadership style on perceived organizational support at Private RSIA Type B at Jakarta, meaning that the better the leadership style used, the more employees’ opinions about the extent to which the company values contributions and cares about employee welfare. Perceived organizational support or perceived organizational support is an employee's belief in the organization where they work, which in turn will support the employee's perception that the organization values employee contributions and pays attention to employee welfare. Perceptions of organizational support can elicit attention, approval, and respect for the organization. Organizational support can take many forms, such as opportunities for training and career development programs, the extent to which the organization rewards contributions through wages and other forms of compensation.

Servant leadership style can create an environment where individuals can develop which leads to increased confidence in the individual, so that when the company undergoes changes, employees remain committed to their work and are able to adapt and have readiness to change (Mahessa & Frieda, 2016).

A leader who has a high degree of task-oriented leadership style will reduce the degree of leadership style value, so that employees will rate the organizational support provided by the company as negative. Everything a leader says, does and feels will be observed by employees who have influence on the organization. Leaders inherit the responsibility to set an example of the desired behavior not only to benefit the organization, but also benefits employees. The presence of employees from the company is not paid attention to, employees will judge that the company's support for them is very lacking or it can be said that perceived organizational support is negative, and vice versa if employees judge that the task-oriented leadership style used by a low leader is where the leader pays enough attention to hard work and existence. Employees, employees will judge that the company's support for them is quite good or it is said that perceived organizational support is positive. The results of this study are in line with previous research conducted by Hery and Yanuar (2019) that leadership can have a positive and significant influence on perceived organizational support.

5. The Influence of Blame Culture on Perceived Organizational Support

Based on the results of hypothesis testing, it was found that there was a significant negative effect of blame culture on perceived organizational support at Private RSIA Type B at Jakarta, meaning that the higher the blame culture, the lower the employee's opinion about the extent to which the company values contributions and cares about employee welfare. On the other hand, the lower the blame culture, the higher the employee's opinion about the extent to which the company values contributions and cares about employee welfare. Management support is the behavior of an authorized person within the hospital organization that shows encouraging or supportive behavior towards patient safety reporting. This form of support can take the form of a good feedback response in the process of evaluating an incident. Perceived organizational support is the belief that employees believe that the organization values the contributions of its employees through their work and shows concern for their welfare. This level of trust arises because management sets an example by actively participating in efforts to improve patient safety with positive feedback, otherwise negative feedback will strengthen the blame culture so that employees are increasingly unwilling to report incidents they know correctly (Derickson et al., 2015).

The results of this study are in line with research conducted by Vellyana and Rahmawati, (2016) in their research stating that management support is less than optimal to increase awareness of health workers in implementing a patient safety culture, lack of awareness to report incidents that occur in units/sections due to fear. against sanctions for wrongdoing is still positively proven in reporting incidents.

6. The Effect of Perceived Organizational Support on Patient Safety Incident Reporting

Based on the results of hypothesis testing, there is a significant positive effect of perceived organizational support on patient safety incident reporting at Private RSIA Type B at Jakarta, meaning that the higher the employee's opinion regarding the extent to which the company values contributions and cares about employee welfare, the more reporting of patient safety incidents in the hospital. at Private RSIA Type B at Jakarta. Patient safety is something that is far
more important than just service efficiency. The patient safety component consists of a safety management system, safety behavior and safety culture. Safety culture is a value that is shared by members of the organization about how important it is, how they believe in something, how they operate something within the organization and how the interactions between each member of the organization and systems can form norms of safety behavior in the organizational environment. Safety culture and patient safety incident reporting are solely aimed at providing safety and support for patient recovery. Carrying out a safety culture and reporting patient safety incidents requires a caring attitude from officers to be honest and responsible for patient safety.

The results of this study are in line with previous research conducted by Junghauer et al. (2018) in their research stating that management support for patient safety moderates the relationship between leader member exchange and reporting on trust. The trust that employees believe that the organization values the contributions of its employees through their work and shows concern for their welfare has not been fully felt by employees. By knowing the inhibiting factors or causes of low patient safety incident reporting in hospitals, it is hoped that it can help increase patient safety rates, reduce the occurrence of errors and provide an overview to stakeholders in formulating and establishing patient safety incident reporting policies in hospitals.

VI. RESEARCH FINDINGS

This study found that perceived organizational support is an intervening variable that can influence leadership style and blame culture on patient safety incident reporting. The results of the measurement of determination of R2 and hypothesis testing show that the influence of the intervening variable perceived organizational support on the dependent variable of reporting patient safety incidents has the largest contribution from the influence structure of other variables.

VII. CONCLUSIONS, IMPLICATIONS, AND SUGGESTIONS

A. Conclusion

The results of hypothesis testing in research with regression weight, probability value, and determination of R2 prove that the perceived organizational support variable is an intervening variable that can influence leadership style and blame culture on patient safety incident reporting. The results of hypothesis testing indicate that the effect of the perceived organizational support on the dependent variable on reporting patient safety incidents has the largest contribution from the influence structure of other variables. Based on the results of the study, it shows that the more positive or better the role of leadership style and the more negative the blame culture in the intervention, the higher perceived organizational support can make the reporting of patient safety incidents increase.

B. Implications

The results of the study indicate that there is a significant influence of leadership style and blame culture on reporting patient safety incidents through perceived organizational support at Private RSIA Type B at Jakarta. This study proves that the influence of the perceived organizational support intervening variable on patient safety incident reporting at Private RSIA Type B at Jakarta has the largest contribution value when compared to the coefficient of influence between other variables.

The results showed that the decreased reporting of patient safety incidents occurred due to the Quality Improvement and Patient Safety Program which still required supervision. The need to improve a series of planning, methods, evaluation and monitoring in it, in order to create a good Safety Culture, and free from Blame Culture that can affect the reporting of Patient Safety Incidents.

The role of the appropriate leadership style in each work unit in the hospital, which can create a good and dynamic work climate in its implementation. It is hoped that the leaders will apply the discussion method and their team involvement in various programs in hospitals that are currently running or being developed.

The organization as the biggest supporter for employees at work is to seek compensation in accordance with the provisions that refer to the financial and non-financial needs of life, namely in the form of salaries, benefits, awards, social security and job satisfaction in order to increase the good perception of the staff towards the organization where they work.

C. Suggestions

Based on the results of the research that has been done, here are some suggestions that researchers can give, namely:

Management is advised to further improve and evaluate the level of employee work involvement, to make it even better. Encouraging employees to have more attachment between employees and their work, among others by providing motivation from superiors so that they can foster an attitude that work is important for self-esteem, a reward system for officers or units that have good patient safety incident reporting documentation records and their handling, and helping employees to find meaning and purpose in their work.

The leaders of RS X are advised to always innovate by developing strategies/methods used in current work. The need to conduct a competency assessment or training in order to produce reliable leaders, so that it can be seen how well someone is in their position or how worthy a person is to be promoted.

Management is advised to improve the attitude of a blame culture in every performance, trying to complete the work together working with a team, the need for positive feedback from management that every incident that occurs must be traced and corrected where the error is such as re-evaluating the SOP and the system used when This is not just blaming the officers for making mistakes, such as SP sanctions, dismissals, pay cuts, etc.

Management is advised to immediately improve services regarding policies related to health insurance, especially family members of workers, because this will affect performance in the form of a sense of security in working employees in hospitals. Future research is expected to be able to carry out further research with different research designs such as mixed methods to improve the assessment of research results and explore other variables such as loyalty, knowledge, workload, etc.
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