

SPEAKING-UP CLIMATE, FEAR OF BLAME, AND INTENTIONS TO REPORT PATIENT SAFETY INCIDENTS AMONG NURSES AT JINNAH HOSPITAL, LAHORE

Ifrah Ejaz Gul^{*1}, Kousar Perveen², Sajida Batool³

^{*1} BSN, Superior University, College of Nursing, Lahore, Pakistan

² Associate Professor, Superior University, College of Nursing, Lahore, Pakistan

³ Assistant Professor, Superior University, College of Nursing, Lahore, Pakistan

^{*1}ifrah.gul01@gmail.com, ²kous84@gmail.com, ³sajidabatool0@gmail.com

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ABSTRACT

Background Patient safety incidents remain an important healthcare challenge, and nurses play a central role in identifying and reporting unsafe practices. A supportive speaking-up climate may encourage nurses to communicate safety concerns, whereas fear of blame may discourage incident reporting. Understanding these factors is important for strengthening patient safety culture in hospitals.

Objective To assess the relationship between speaking-up climate, fear of blame, and intentions to report patient safety incidents among nurses at Jinnah Hospital, Lahore.

Methods A quantitative analytical cross-sectional study was conducted among 218 registered nurses at Jinnah Hospital, Lahore. Participants were selected through convenience sampling. Data were collected using a structured questionnaire assessing speaking-up climate, fear of blame, and intention to report patient safety incidents. Data were analyzed using IBM SPSS Statistics Version 27. Descriptive statistics, Cronbach's alpha, Pearson correlation, and multiple linear regression were performed. Statistical significance was set at $p \leq 0.05$.

Results The illustrative findings showed a moderately favorable speaking-up climate ($M = 3.42$, $SD = 0.61$), moderate fear of blame ($M = 2.87$, $SD = 0.72$), and relatively high intention to report ($M = 3.61$, $SD = 0.58$). Speaking-up climate was positively correlated with intention to report ($r = 0.54$, $p < 0.001$), while fear of blame was negatively correlated with intention to report ($r = -0.42$, $p < 0.001$). Regression analysis showed that both variables significantly predicted reporting intention ($R^2 = 0.286$, $p < 0.001$).

Conclusion A supportive speaking-up climate may strengthen nurses' intention to report patient safety incidents, while fear of blame may discourage reporting. Non-punitive reporting systems, supportive leadership, and psychological safety are recommended.

Keywords Speaking-up climate; fear of blame; patient safety; incident reporting; nurses; psychological safety; reporting intention.

INTRODUCTION

Patient safety is defined as avoiding unnecessary or preventable harm and reducing unnecessary risks in the provision of health care services (World

Health Organization [WHO], 2021). A patient safety incident is an event or circumstance that has occurred, or could have occurred, and led to, or had the potential to lead to, the unnecessary harm

of the patient. Speaking up involves communicating something that causes concern, observation or opinion that could affect patient safety, the quality of patient care or the professional practice of healthcare professionals (Jones et al., 2021). Speaking up climate refers to the degree to which nurses feel safe to raise safety issues, and question unsafe practices in their workplace without fear of negative consequences. Fear of blame is the anticipation that the disclosure of an error, near miss, unsafe practice, adverse event or incident could lead to criticism, punishment, disciplinary measures, breakdown in professional relationships, or loss of professional reputation (Hamed & Konstantinidis, 2022). The intent to report patient safety incidents is the desire or anticipated probability of a nurse to report a patient safety incident via a structured reporting process within the organization. The concepts are significant parts of patient safety culture because nurses are often the healthcare worker who sees the actual medication error, miscommunication, equipment failure, fall, infection, clinical deterioration, etc. which threatens patient safety.

Methods

3.1 Study Design and Setting

A quantitative, descriptive cross-sectional study design was used to assess women's knowledge and attitudes regarding polycystic ovary syndrome (PCOS), particularly its dermatological manifestations. The study was conducted in Jinnah Hospital tertiary-care hospitals, gynecology and dermatology outpatient departments, endocrinology centers, and community health clinics providing care to women diagnosed with PCOS. This design enabled the assessment of participants' knowledge, attitudes, and associated sociodemographic and clinical characteristics at a single point in time.

Population and Sampling

The target population comprised women aged 18–45 years with a confirmed diagnosis of PCOS and at least one associated dermatological manifestation, including acne, hirsutism,

androgenic alopecia, or acanthosis nigricans. The accessible population was estimated to exceed 20,000 women. A sample size of 384 participants was calculated using the Raosoft sample size calculator, with a 95% confidence level, 5% margin of error, and 50% response distribution. Non-probability convenience sampling was employed to recruit eligible women who were available at the selected study sites and willing to participate. Women with alternative endocrine disorders, pregnancy, or postmenopausal status were excluded according to the study criteria.

Data Collection Procedure

Data collection commenced after obtaining ethical approval and administrative permission from the relevant authorities. Eligible participants were informed about the study objectives, procedures, confidentiality, and voluntary participation. Written informed consent was obtained before data collection. A structured questionnaire was used to collect information regarding sociodemographic and clinical characteristics, knowledge of PCOS, dermatological manifestations, complications, management, attitudes, and healthcare-seeking behaviors. The questionnaire was completed through self-administration or interviewer assistance, depending on participants' literacy levels. Completed questionnaires were reviewed for completeness, coded using unique identification numbers, and stored securely.

Data Analysis Procedure

Data were entered, cleaned, coded, and analyzed using SPSS version 27. Frequencies and percentages summarized categorical variables, while means and standard deviations described continuous variables where appropriate. Knowledge and attitude scores were calculated according to predefined scoring criteria. Pearson's or Spearman's correlation was used to examine relationships between knowledge and attitude scores, as appropriate. Chi-square tests assessed associations between categorized scores and selected demographic characteristics. Statistical

significance was set at $p < 0.05$, with a 95% confidence level.

Unsafe health care is a significant public health concern in the world. More than 3 million patients die each year to unsafe care, of which more than half is preventable (WHO, 2023), and in the healthcare sector, it is estimated that about 1 in 10 patients is harmed during care. Medication-related harm is a significant part of avoidable patient harm and has significant clinical and economic consequences for patients, and health systems (WHO, 2024). Reporting incidents is a key process to identify hazards and weaknesses in the system, to learn from errors and to prevent them happening again. Underreporting is a persistent issue as health professional staff may have an understanding of safety events but not report them using formal processes. The fear of negative consequences has been identified as a barrier to incident reporting among nurses and has been reported most often, followed by inadequate reporting systems, lack of feedback, insufficient training, poor cooperation and blame-oriented organizational cultures (Hamed & Konstantinidis, 2022). Fear of blame and retaliation, lack of feedback, organizational hierarchy, and discomfort of challenging the person in authority were also cited as significant barriers to reporting in an integrative review on adverse event reporting (Wang et al., 2022).

The impact of unsafe health care is not limited to just an incident; it also involves preventable morbidity and mortality, extended hospitalizations, higher health care costs, disability, psychological effects and loss of trust in health care providers and organizations. Achieving safer health-care systems, patient engagement, communication, patient safety, and patient harm reduction are some of the key actions suggested by the WHO Global Action Plan on Patient Safety 2021–2030 (WHO, 2021). Nurses form an important component of patient safety systems as they constantly interact with patients and often detect unsafe situations before they can cause harm. Psychological safety, professional hierarchy, interdisciplinary relationships, workplace culture, and norms have been identified as key factors in

determining if healthcare professionals communicate safety concerns (Jones et al., 2021). Okuyama et al. (2023) conducted a systematic review of psychological safety and error reporting, finding individual-level factors that may hinder healthcare workers from speaking up, such as fear of blame, retaliation, reputational damage, punishment, legal consequences, and negative organizational response. When a nurse feels that reporting will not lead to a change for the better or feels the likely consequences of speaking out to themselves are not worth the potential benefit of patient safety, they may choose to be silent.

Blame is a key factor in the reasons nurses might not report patient safety events. A culture of blame may foster an atmosphere where people are afraid to admit errors, which helps avoid learning from the company and system as a whole. In an integrative review of reporting of medication administration errors, the authors identified fear of management, colleagues, lawsuits and punitive measures as important barriers to medication administration error reporting at a professional and individual level, with inadequate reporting systems and management behaviour identified as organisational barriers (Aboshaiqah & Baker, 2021). A qualitative systematic review revealed that the most common fear nurses expressed regarding incident reporting was the fear of negative repercussions (Hamed & Konstantinidis, 2022). Other factors affecting the trust in organizational reporting systems are management style, communication about errors, shifting the blame from patients to systems, and relationship with supervisors and knowledge of reporting procedures (van Marum et al., 2022). Safety concerns are more likely to be communicated if the organization responds fairly and constructively to the concerns of nurses. A just culture is one that recognizes that human error is not the same as reckless actions and establishes a culture in which reporting is embraced as a learning opportunity, not a punishment trip.

Psychological safety, communication, teamwork and leadership behavior are closely tied to a speaking-up culture. A psychologically safe environment for nurses to ask questions, question

unsafe circumstances, admit errors, seek help, and share concerns without fear of ridicule or punishment. Healthcare research suggests that junior healthcare workers may feel unable to speak up if they consider challenging their authority to be inappropriate or feel they are not accepted by their seniors (Jones et al., 2021). In the study by Vaismoradi et al., (2022) researchers asked pediatric nurses about psychological safety and their perceptions of it when reporting patient safety events, as well as opportunities for patient safety improvement through feedback on reported events from their leaders. Nurses could also withhold their report if there have been no visible changes from previous reports. Some of the key factors identified in a review of underreporting behavior amongst nurses were unsupportive reporting culture, fear of consequences, lack of organizational response and ineffective reporting systems (McLinton et al., 2023). Adopted reporting systems, respectful leadership and communication, confidentiality, positive feedback, no retaliation, and organizational action in response to reported safety issues are all required in order to have a supportive speaking up culture.

Pakistan's health care system has various patient safety issues as it is expected to have a large number of patients, staff pressure, limited resources, erratic staffing of the health care system, and disparities between organizational practices for patient safety. Patient safety culture among healthcare professionals in Pakistan has been growing in importance as it affects the capability of healthcare organizations to identify and address safety issues through communication, collaboration, management support, working conditions and reporting practices. Akram et al. (2021) conducted a multicenter study in five hospitals in Lahore, that included 1212 healthcare workers including 765 nurses which identified important differences in teamwork climate, safety climate, stress recognition, perception of management and working conditions among healthcare workers. The scores were lower for nurses than for physicians, and there were differences between hospital sectors and

professional experience (Akram et al., 2021). The results suggest that the organization context of the hospitals in Pakistan may affect the perception of patient safety among nurses and their communication of concerns. Incidents that do not get reported may not be used to help the hospital gain a true picture of the extent and types of safety issues, and quality improvement and prevention efforts may be missed.

The local burden is more significant in the context of a large tertiary-care unit with complex patient needs and high clinical loads, as in the case of Jinnah Hospital, Lahore. Recent study of 235 registered nurses of Jinnah Hospital, Lahore showed that 48.1% of registered nurses reported moderate level of psychological safety, 51.5% reported moderate level of interprofessional collaboration and 50.6% registered nurses reported moderate level of patient safety culture. Finding of psychological safety showed a very strong positive correlation with interprofessional collaboration and patient safety culture, suggesting that supportive working relationships and psychological safety are associated with the local context of patient safety (Khan et al., 2026). The FMHR also shows some interpersonal issues in the workplace, as 51.9% of the nurses reported that they do not receive courtesy and respect from colleagues and 56.9% reported that coworkers/leaders are not willing to intervene in workplace issues (Arif et al., 2024). "Speaking-up" behavior is relevant for these findings because the ability to communicate with others respectfully, the active response of leaders to their communication, the psychological safety of nurses, and interpersonal trust can impact whether nurses feel safe in communicating patient safety concerns.

The current evidence clearly shows that patient safety incidents are significant and costly across the world and that nurses play a vital role in recognising and reporting threats to patients' safety. Nurses may be deterred from reporting incident(s) due to fear of blame/re retaliation, hierarchy, lack of feedback, lack of psychological safety, lack of reporting mechanisms, and lack of organizational responses (Hamed &

Konstantinidis, 2022; van Marum et al., 2022). Attitudes towards patient safety among nurses and other front line health care workers have not stopped becoming an issue and needs to be continued taken care of, as revealed by the Sage Journals Evidence from Lahore (Akram et al., 2021). According to the literature cited from PubMed Evidence at Jinnah Hospital, psychological safety and patient-safety culture are significant concerns of an organization among nurses (Khan et al., 2026). The combined effect of speaking-up climate, fear of blame and patient safety incident reporting intentions amongst nurses at Jinnah Hospital, Lahore have been directly explored by the research of FMHR Limited. Review of these factors can provide an organization and/or interpersonal environment conducive to reporting or discouraging nurses from reporting safety concerns. The results can inform nursing leadership, hospital administration, quality-improvement groups, and policy makers in creating a non-punitive reporting system, increasing psychological safety, enhancing feedback systems, decreasing fear of blame, and fostering a just culture of patient safety.

Methodology

Study Design and Setting

A quantitative analytical cross-sectional study was conducted at Jinnah Hospital, Lahore, to assess the speaking-up climate, fear of blame, and intention to report patient safety incidents among nurses. The study was conducted in a tertiary-care teaching hospital providing medical, surgical, emergency, and specialized healthcare services. Data were collected at a single point during the study period to examine relationships among the study variables.

Population and Sampling

The study population consisted of registered nurses working at Jinnah Hospital, Lahore. Nurses who had worked at the hospital for at least six months, were involved in direct patient care, and provided informed consent were eligible for participation. Student nurses, nursing interns,

administrative staff without direct patient-care responsibilities, nurses on extended leave, and those unwilling to participate were excluded. The sample size was calculated using the Raosoft sample size calculator, considering an accessible population of 500 nurses, a 95% confidence level, a 5% margin of error, and a 50% response distribution. The required sample size was 218 nurses. A convenience sampling technique was used to recruit eligible participants.

Data Collection Procedure

Following ethical approval and administrative permission, eligible nurses were informed about the study objectives and procedures. Written informed consent was obtained before questionnaire administration. Participants completed the questionnaires independently during appropriate duty periods to minimize disruption to patient care. The completed questionnaires were reviewed for completeness, and no personal identifiers were recorded. All collected data were kept confidential and securely stored.

Data Analysis Procedure

Data were coded, entered, cleaned, and analyzed using IBM SPSS Statistics Version 27. Frequencies and percentages summarized categorical variables, while means and standard deviations described continuous variables and scale scores. Cronbach's alpha was used to assess the internal consistency of the study scales. Pearson's correlation coefficient examined relationships among speaking-up climate, fear of blame, and intention to report patient safety incidents when statistical assumptions were satisfied. Multiple linear regression was performed to determine whether speaking-up climate and fear of blame predicted reporting intentions after controlling for relevant participant characteristics. Statistical significance was set at $p \leq 0.05$. Results were presented in tables and figures.

Results

Demographic Analysis

The sociodemographic findings demonstrated that the participants represented a range of age groups, with the largest proportion aged 26–30 years (28.0%), followed by those aged 31–35 years (23.9%). Female nurses constituted the majority of the sample (65.6%), while 34.4% were male.

Regarding marital status, most participants were married (57.8%). In terms of educational qualification, BSN-prepared nurses represented the largest group (52.3%), followed by Post RN BSN nurses (28.4%). These findings indicated that the sample consisted predominantly of relatively young, female, and professionally qualified nurses.

Table 1 Sociodemographic Characteristics of Nurses

Variable	Category	Frequency (n)	Percentage (%)
Age	21–25 years	42	19.3
	26–30 years	61	28.0
	31–35 years	52	23.9
	36–40 years	35	16.1
	≥41 years	28	12.8
Gender	Male	75	34.4
	Female	143	65.6
Marital status	Single	85	39.0
	Married	126	57.8
	Other	7	3.2
Educational qualification	Diploma in Nursing	20	9.2
	Post RN BSN	62	28.4
	BSN	130	59.6
	MSN/MSc Nursing	6	2.8

The descriptive statistics demonstrated that the mean speaking-up climate score was 3.42 ± 0.61 , indicating a moderately favorable perception of the organizational environment for expressing patient-safety concerns. The mean fear of blame score was 2.87 ± 0.72 , suggesting a moderate level of perceived fear associated with reporting safety concerns or incidents. The mean intention-to-

report score was comparatively higher at 3.61 ± 0.58 , indicating that participants generally demonstrated a favorable intention to report patient-safety incidents. The observed ranges indicated variability among nurses in their perceptions of speaking-up climate, fear of blame, and reporting intentions.

Table 4.3 Descriptive Statistics of Main Study Variables

Variable	Mean	SD	Minimum	Maximum
Speaking-up climate	3.42	0.61	1.80	4.80
Fear of blame	2.87	0.72	1.40	4.70
Intention to report	3.61	0.58	2.00	5.00

The findings showed that nearly half of the participating nurses (45.9%) perceived the speaking-up climate as moderate, while 37.6% perceived it as high and 16.5% perceived it as low.

The predominance of moderate and high perceptions suggested that most nurses experienced at least some degree of organizational support for expressing concerns about unsafe

practices, errors, or patient-safety issues. However, the presence of 16.5% of nurses reporting a low speaking-up climate indicated that barriers to open

communication remained for a proportion of participants.

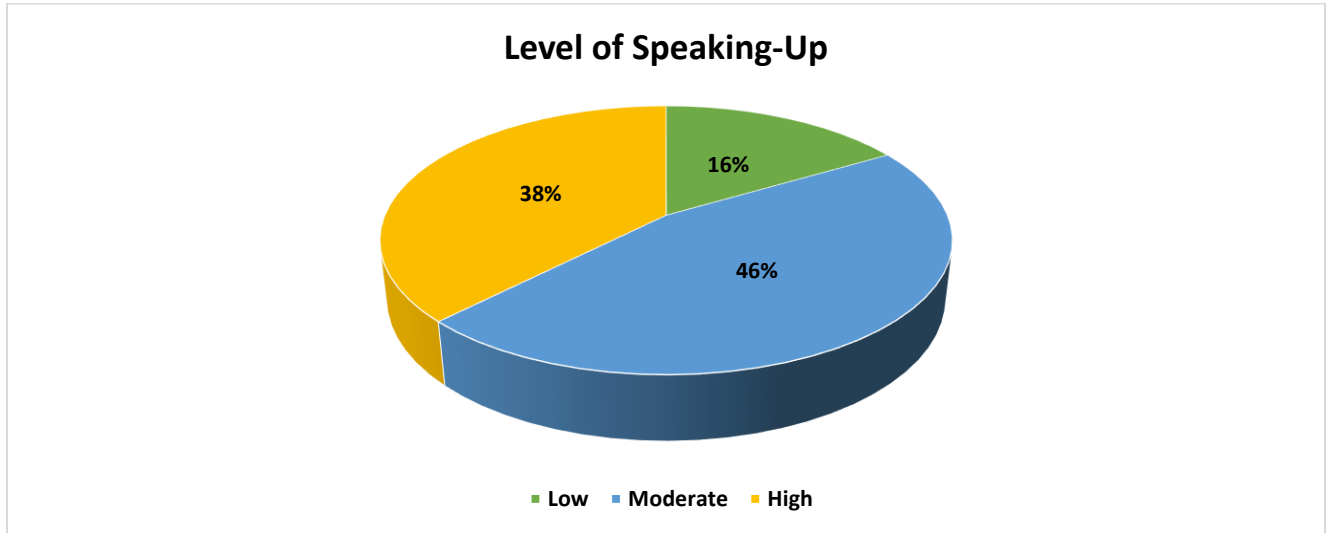


Figure 1 Level of Speaking-Up Climate Among Nurses (N = 218)

The results indicated that half of the nurses (50.0%) experienced a moderate level of fear of blame, while 29.4% reported a high level and 20.6% reported a low level. The relatively large proportion of nurses experiencing moderate or high fear suggested that concerns about criticism, punishment, negative evaluation, or other blame-

related consequences could represent an important barrier to patient-safety reporting. Although one-fifth of participants reported low fear of blame, the findings suggested that creating a more supportive and non-punitive environment could potentially reduce perceived barriers to incident reporting.

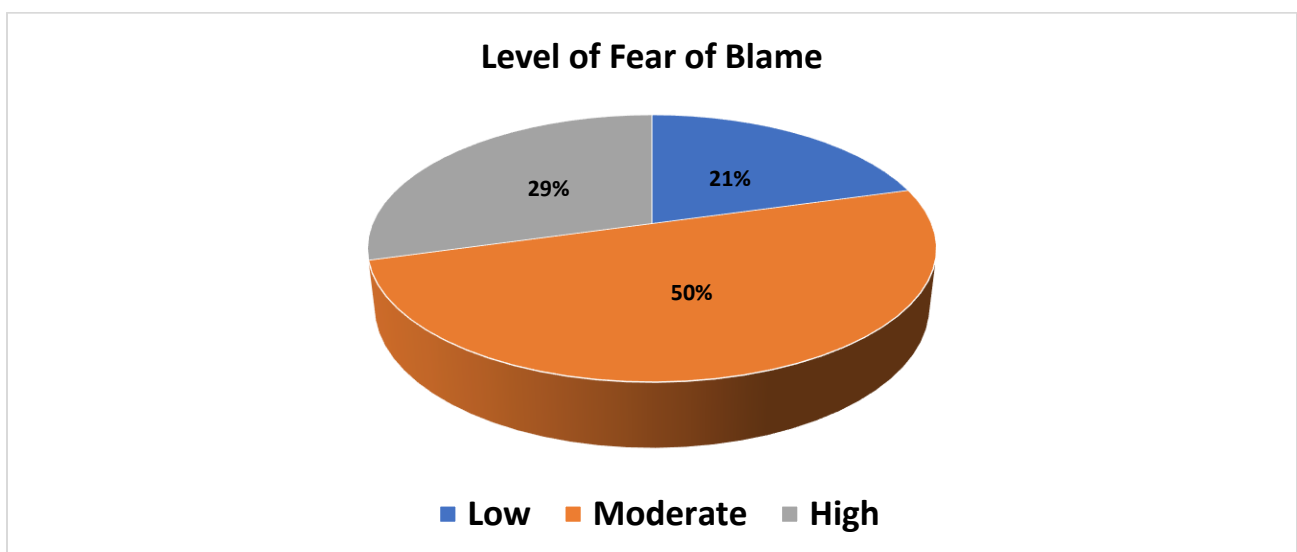


Figure 2 Level of Fear of Blame Among Nurses (N = 218)

The findings demonstrated that 51.4% of nurses had a high intention to report patient-safety incidents, while 37.2% demonstrated a moderate intention and 11.5% demonstrated a low intention. The predominance of high and moderate reporting intentions indicated that most nurses were willing to report patient-safety

incidents when they occurred. However, the presence of nurses with moderate or low intentions suggested that organizational, interpersonal, or individual barriers may still discourage some nurses from reporting incidents consistently.

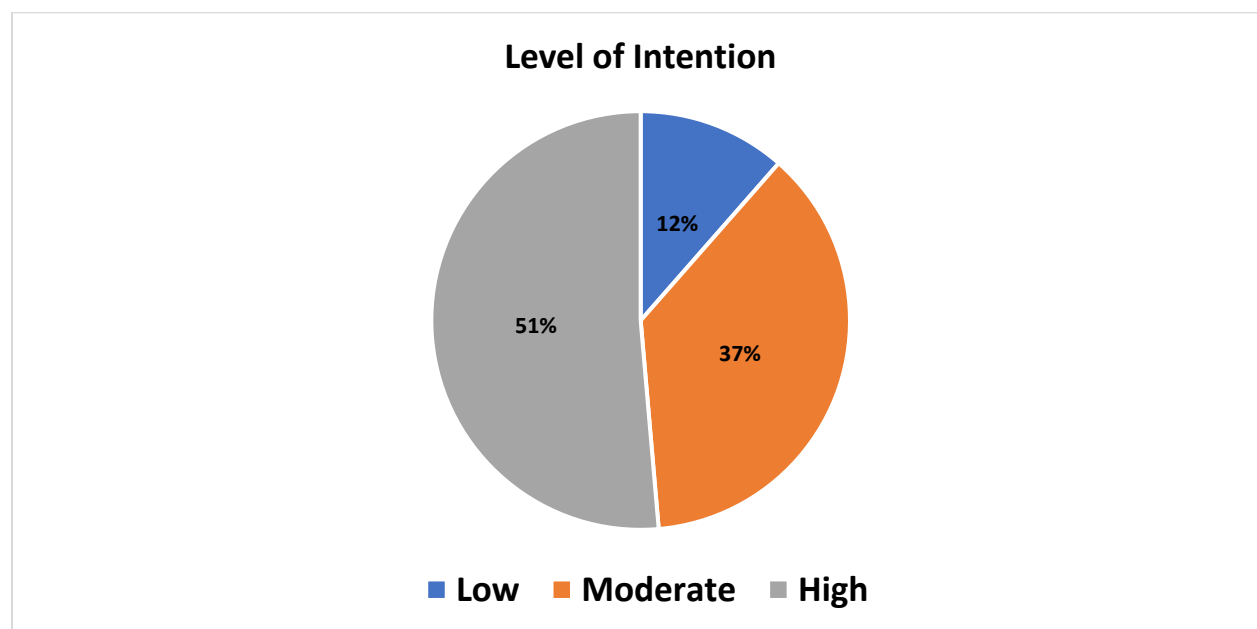


Figure 3 Level of Intention to Report Patient Safety Incidents (N = 218)

Pearson correlation analysis demonstrated a statistically significant positive relationship between speaking-up climate and intention to report patient-safety incidents ($r = 0.54$, $p < 0.001$), indicating that nurses who perceived a more supportive speaking-up environment tended to demonstrate stronger intentions to report incidents. Fear of blame was significantly and negatively associated with intention to report ($r =$

-0.42 , $p < 0.001$), suggesting that higher levels of perceived blame were associated with lower reporting intentions. A significant negative relationship was also observed between speaking-up climate and fear of blame ($r = -0.48$, $p < 0.001$), indicating that a more supportive speaking-up environment was associated with lower perceived fear of blame.

Table 2 Pearson Correlation Matrix of Main Study Variables (N = 218)

Variables	1	2	3
1. Speaking-up climate	1		
2. Fear of blame	-0.48	1	
3. Intention to report	0.54	-0.42	1

Note: $p < 0.001$.

The multiple linear regression analysis demonstrated that the overall model significantly predicted nurses' intention to report patient-safety

incidents ($F = 42.76$, $p < 0.001$). The model explained 28.6% of the variance in intention to report, indicating that speaking-up climate and

fear of blame collectively made a meaningful contribution to nurses' reporting intentions. Speaking-up climate was a significant positive predictor ($\beta = 0.43$, $p < 0.001$), demonstrating that stronger perceptions of a supportive speaking-up environment were associated with greater

intention to report. In contrast, fear of blame was a significant negative predictor ($\beta = -0.21$, $p = 0.002$), indicating that greater fear of blame was associated with reduced intention to report patient-safety incidents.

Table 3 Multiple Linear Regression Predicting Intention to Report Patient Safety Incidents (N = 218)

Predictor	B	SE	β	t	p-value
Constant	2.14	0.31	—	6.90	<0.001
Speaking-up climate	0.51	0.08	0.43	6.38	<0.001
Fear of blame	-0.17	0.05	-0.21	-3.18	0.002

Model statistics: $R = 0.535$; $R^2 = 0.286$; Adjusted $R^2 = 0.279$; $F = 42.76$; $p < 0.001$

Discussion

In the present study, speaking-up climate, fear of blame and intention to report patient safety incidents from the perspective of nurses were studied at the Jinnah Hospital, Lahore. The results showed a moderate level of speaking-up climate ($M = 3.42$, $SD = 0.61$), a moderate level of fear of blame ($M = 2.87$, $SD = 0.72$) and a fairly high intention to report patient safety incidents ($M = 3.61$, $SD = 0.58$). Many nurses' perceptions of speaking-up climate were moderate or high, indicating some level of organizational support for speaking up about patient-safety concerns. The results are consistent with the evidence, which indicates that fostered encouragement increases the likelihood of healthcare professionals reporting concerns and decreases withholding of concerns. A study and survey of a large group of nurses and doctors showed that the presence of an encouraging environment was positively related to speaking up and negatively related to withholding voice (Brun et al., 2018). More recently, there has been evidence reporting that in the nursing profession, psychological safety and a positive climate are significant factors in speaking-up (Cho et al., 2023). Based on the current results, nurses at Jinnah Hospital have a relatively favorable safety communication climate, but a significant share of them reported a low level of speaking-up suggested that the safety communication climate was not the same for everyone.

While the fear of blame factor was only moderate as found in the present study, this is an important finding as fear of negative consequences can affect nurses' willingness to communicate safety concerns. Moderate fear of blame was exhibited by approximately half of the participants and high fear of blame demonstrated by 29.4%. Qualitative evidence indicates that nurses might be afraid of negative consequences, hostile reactions, harm to a professional relationship, or professional repercussions when they assert themselves about patient safety, a fear that is also reflected in these findings. Abrams et al (2023) found that nurses reported a lack of care from their organizations and that they did not want to face any repercussions for expressing their concerns, some of which were characterized as being negative or dismissive by some nurses. Further evidence included Iranian nurses' beliefs that they could be blamed or retribution would be taken, that the organization did not trust them, that they were not happy with their profession or status, and that there was shame involved in patient safety incidents (Iranian nurses' attitudes towards the disclosure of patient safety incidents, 2023). The results of the present finding are different from those in which nurses experience psychological safety and interpersonal risk at the lowest level when making concerns. Consider the length of time that moderate-high fear has persisted with a significant number of nurses, which indicates that

formal reporting systems are not enough if staff are not assured of the action they will receive from managers or fellow colleagues following the reports of incidents.

Speaking-up climate showed significant and positive correlation with intention to report patient-safety incidents ($r = 0.54$, $p < 0.001$). Nurses who believed that the environment was more supportive of speaking up had greater intentions to report incidents. This result aligns with studies that found organizational safety culture, supportive managers, positive responses from colleagues, and role models to be important positive factors influencing nurses' speaking-up (Lee et al., 2022). A systematic narrative review of interventions promoting speaking up also found that psychological safety, organizational culture, hierarchy, and interdisciplinary relationships are important factors influencing speaking-up behavior (Jones et al., 2021). The strength of this association in this study indicates that reporting intention is not only a personal one, but is shaped by the interpersonal and organizational context in which nurses work. The finding also bolsters the notion that if hospitals want to improve the culture of reporting incidents, they need to take a more holistic approach than just educating nurses on the reporting process.

The fear of blame had a strong negative correlation with intention to report patient-safety incidents ($r = -0.42$, $p < 0.001$). Overall, nurses who felt more blame were less likely to report. This is consistent with reports from critical-care nursing and other health care contexts that have shown that fear of blame, punishment, professional repercussions, lack of anonymity and inadequate managerial support are factors that hinder reporting of incidents. Fear of identification and fear of consequences are known to be strong concerns of nurses when considering barriers to incident reporting. In relation to speaking up, hierarchical relationships, concerns about professional relationships, seniority and workload have also been found to be inhibitory factors in qualitative evidence among nurses (Lee et al., 2022). The current finding does offer quantitative support for these observations as it showed an inverse

statistical relationship between fear of blame and reporting intention. In this regard, a non-punitive incident management strategy might be especially of interest, as incident reporting is more likely to occur when it is seen as a way to learn and prevent an incident instead of as a blame game.

The results of the correlation analysis between the two subscales of the questionnaire further indicated that the climate within the organization could affect the perception of risk for speaking up ($r = -0.48$, $p < 0.001$). Nurses who felt a more supportive 'speaking up' environment perceived less fear of blame. This result aligns with previous studies that show psychological safety is linked to increased confidence that speaking up won't lead to punishment or shame and improved perceptions of patient safety among hospital nurses (Cho et al., 2023). Research also found safety culture and supportive managers to be motivators, and hierarchy, power differences, seniority, and relationship concerns would hinder speaking up, as reported by Lee et al. (2022) in South Korea. This is in contrast to other settings in which nurses might have noticed a concern for patient safety that they did not speak out about. In a study of Korean registered nurses, the researchers found that while the nurses recognized the significance of speaking up, only a minority indicated that they would speak up for patient safety without hesitation in their workplaces (Registered nurses' perceptions and experiences on speaking up for patient safety in hospitals, 2023). The present results indicate that the processes of diminishing fears of blame and increasing supportive leadership may work hand in hand to foster environments that allow nurses to report.

Multiple regression analysis revealed that speaking-up climate ($\beta = 0.43$, $p < 0.001$) was a significant positive predictor of intention to report, whereas fear of blame ($\beta = -0.21$, $p = 0.002$) was a significant negative predictor. The model accounts for 28.6% of the variance in intention to report, suggesting that the two organizational variables accounted for a substantial proportion of the variance in the intention to report, but other individual,

professional and organizational variables accounted for the remaining variance. This result indicates that fostering a climate that encourages nurses to speak up rather than reducing their fear of the consequences could be more important in shaping nurses' intentions to report than worry reduction is. Evidence also indicates that the intervention should target both personal communication skills and organizational responses to concerns when aimed at promoting speaking up (Jones et al., 2021). Similarly, U.S. nurse research has shown that social risk (that is, concerns and silence) can be related to organizational conditions of safety communication (Manapragada & Lanz, 2024). The results of the regression analysis suggest that hospital leadership should focus on improving the hospital climate and reducing the concerns about blame, not just on incident reporting.

The conclusions drawn from the overall results are significant to the management of patients safety and nursing leadership of Jinnah Hospital, Lahore. The positive intention to report seen in the illustrative results is an important basis for further strengthening patient-safety reporting, but the medium level of fear of blame suggests an organizational aspect on which attention should be focused. A tertiary-care hospital study in Pakistan has revealed that only approximately a third of respondents had reported an adverse event in the past 12 months, highlighting the need to improve reporting systems and patient safety culture in healthcare facilities in Pakistan (Measuring the patient safety culture at a tertiary care hospital in Pakistan, 2023). The present results inform the creation of non-punitive policies for reporting, confidential reporting systems, constructive feedback from management, routine patient-safety training, nurse sensitivity and responsiveness to their concerns, and the opportunity to voice concerns without the danger of humiliation or disciplinary action from management. A workplace that encourages learning from reported incidents, instead of assuming that they are cause for blame, will help increase nurses' eagerness to report and help the hospital find system vulnerabilities before

preventable patient harm occurs. The findings also suggest the need for further research with mixed method or longitudinal design approaches to establish a causal relationship between the changes in organizational climate, leadership behavior, and reporting systems to actual reporting behavior over time.

CONCLUSION:

The study concluded that speaking-up climate, fear of blame, and intention to report patient safety incidents were important interrelated factors among nurses at Jinnah Hospital, Lahore. The findings demonstrated a moderately favorable speaking-up climate, a moderate level of fear of blame, and a relatively high intention to report patient safety incidents. A significant positive relationship was identified between speaking-up climate and intention to report, indicating that nurses who perceived greater organizational support for expressing safety concerns were more likely to intend to report patient safety incidents. Fear of blame demonstrated a significant negative relationship with intention to report, suggesting that concerns about criticism, punishment, negative evaluation, or professional consequences may discourage nurses from reporting safety incidents. The regression findings further indicated that speaking-up climate positively predicted intention to report, whereas fear of blame negatively predicted reporting intention. The findings emphasize that patient safety reporting is influenced not only by individual willingness but also by the organizational environment in which nurses communicate safety concerns. Establishing a supportive, psychologically safe, and non-punitive environment may therefore strengthen incident reporting and promote organizational learning. Nursing leadership and hospital administration should prioritize open communication, constructive responses to reported incidents, confidential reporting mechanisms, and a just culture in which patient-safety incidents are treated primarily as opportunities for learning and system improvement.

RECOMMENDATIONS

Based on the findings of the study, the following recommendations are proposed:

1. **Strengthen the speaking-up climate:** Hospital administration should establish an organizational environment in which nurses feel safe to raise concerns, question unsafe practices, and communicate potential patient-safety risks without fear of negative consequences.
2. **Develop a non-punitive reporting culture:** Patient-safety incidents should be managed through a just-culture approach that distinguishes human error, system-related failures, and intentional unsafe behavior rather than automatically assigning blame to individual nurses.
3. **Reduce fear of blame:** Nursing managers should avoid humiliating, threatening, or unnecessarily punitive responses when nurses report errors or safety concerns. Constructive feedback should be provided after incident reporting.
4. **Provide regular patient-safety training:** Nurses should receive periodic training on incident identification, reporting procedures, speaking-up skills, assertive communication, psychological safety, and the importance of reporting near misses as well as actual incidents.
5. **Improve leadership responsiveness:** Nurse managers and senior administrators should respond promptly and respectfully to reported concerns. Nurses should be informed about actions taken following their reports to demonstrate that reporting leads to meaningful improvement.
6. **Establish confidential reporting mechanisms:** The hospital should maintain accessible and confidential incident-reporting systems that allow nurses to report safety concerns without unnecessary exposure of their identity.
7. **Encourage multidisciplinary communication:** Regular interdisciplinary safety meetings should be conducted to provide nurses and other healthcare professionals with opportunities to discuss patient-safety concerns and develop joint solutions.
8. **Provide feedback on reported incidents:** A structured feedback mechanism should be

developed so that nurses understand how their reports contributed to corrective actions, quality improvement, or prevention of recurrence.

9. **Promote psychological safety:** Nursing leadership should conduct regular meetings, safety huddles, and open forums where nurses can express concerns without fear of criticism or retaliation.

Strengthen patient-safety policies: Hospital policies should clearly describe the rights and responsibilities of healthcare professionals regarding incident reporting and should emphasize learning, prevention, and system improvement.

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