One Gloucestershire
Transforming Care, Transforming Communities

PSYCHOLOGICAL SAFETY

Dr Julie Highfield and Dr Rachael McCarthy

Psychological Safety within and Across Teams

Safely putting our head above the parapet when advocating for the patient

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Chief Psychological Professions Officer GHFT

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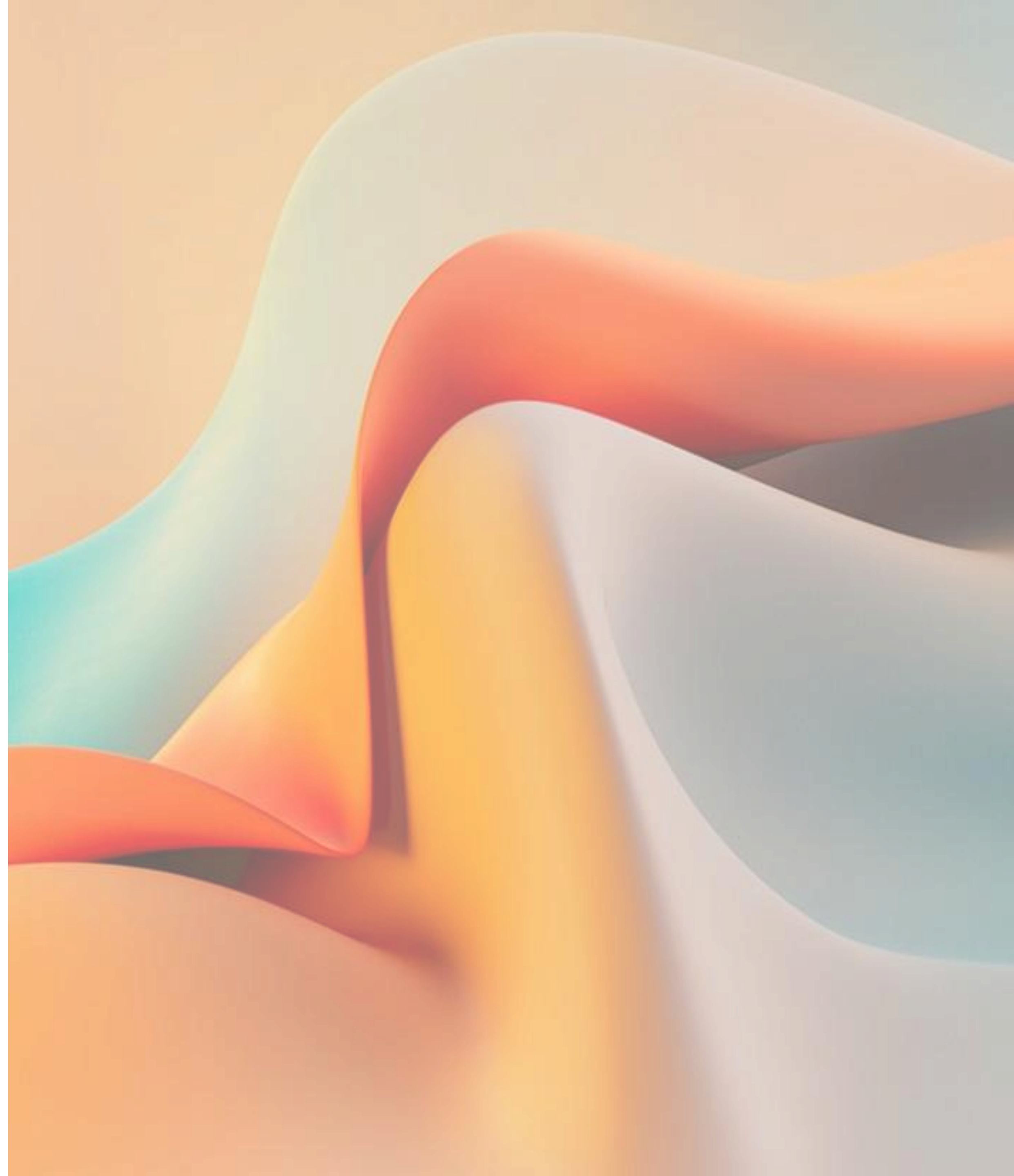
Principal Clinical Psychologist

Specialist Palliative Care Team



- What is Psychological Safety?
- Reflecting on what we bring to enable psychological safety.
- Cross team working and challenges in Palliative and End-of-Life Care
- Head above the parapet when the risk is being shot
- Can we improve Psychological Safety from team to team?

About us

Julie

Consultant Clinical Psychologist

CPPO for GHFT

Background in acute hospital settings: critical care, renal, cardiology, maternity etc

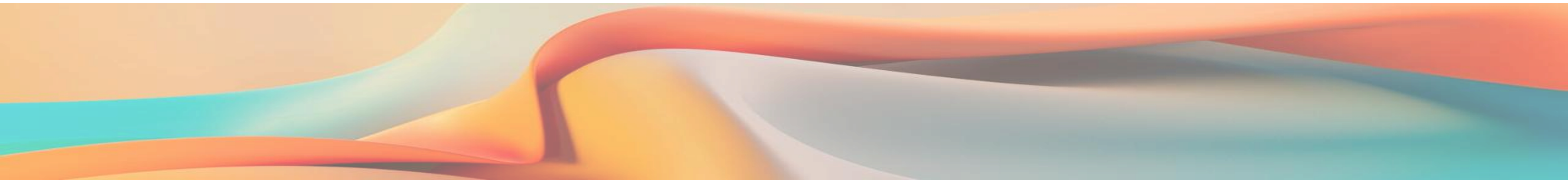
Special interest in staff wellbeing

Rachael

Principal Clinical Psychologist

Specialist Palliative Care Team – GRH and CGH inpatients

Previously part of the wider cancer and palliative care psychology service – outpatients



Understanding Psychological Safety in Healthcare Settings

the fearless organization

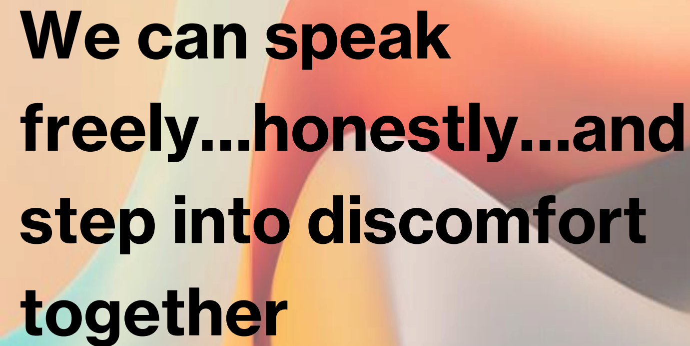
Creating Psychological Safety in the Workplace for Learning, Innovation, and Growth

From the research of Amy Edmonson

Psychological safety means a shared belief that the team is safe for interpersonal risk-taking and open communication.

Staff, patients, and families to express concerns without fear of humiliation or retaliation.

Promote learning behaviour and innovation



Why does it matter in health?

Psychological safety in healthcare fosters open communication essential for teamwork and patient safety.

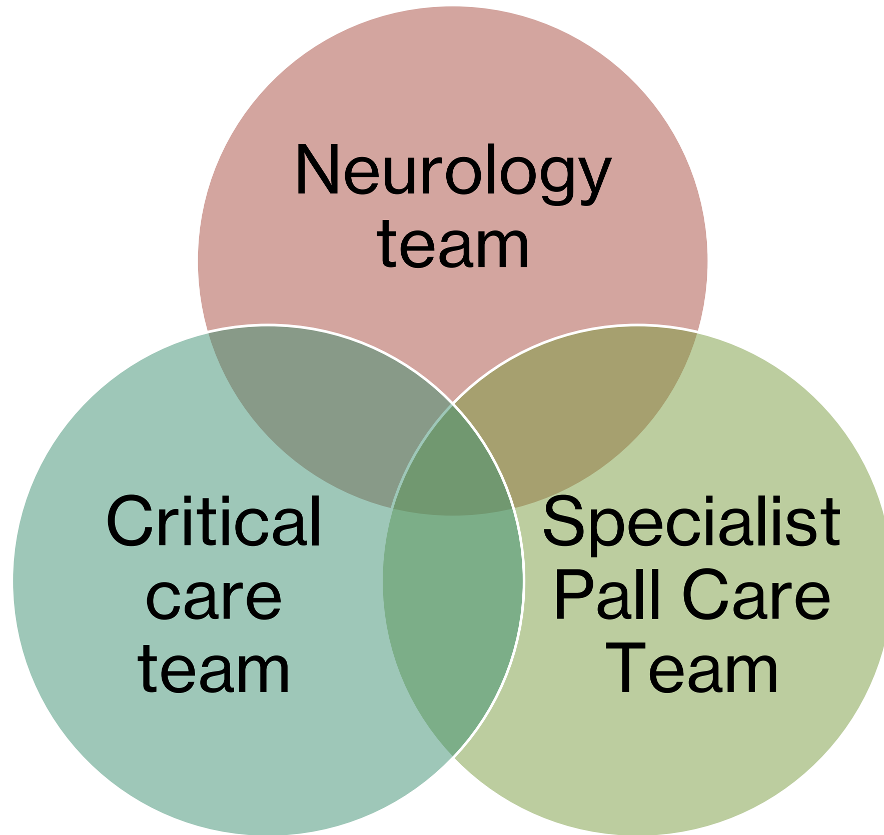
Teams with high psychological safety **report 30% fewer errors,** enhancing overall patient safety.

In areas like palliative care, psychological safety can support ethical and shared decision-making and emotional support.

Patients and families more likely to feel heard and considered

Care is co-produced

Engagement is higher


Neurology team
Critical care team
Specialist Pall Care Team

Reflections

Reflect on your position

You own personal history:

- What are the stories about voice in your family?

Your professional identity

- Where does your profession tend to position yourself

REFLECT ON YOUR TEAM:

How safe are we?

If you make a mistake on this team, it is not held against you.

Members of this team are able to bring up problems and tough issues.

People on this team never reject others for being different.

It is safe to take a risk on this team.

It is not difficult to ask other members of this team for help.

No one on this team would deliberately act in a way that undermines my efforts.

Working with members of this team, my unique skills and talents are valued and utilized.

When it's unsafe in teams

If you don't want to feel:-

DISCOMFORT	Keep quiet
STUPID	Don't ask questions
INCOMPETENT	Don't ask for feedback
NEGATIVE	Don't be doubtful or criticize
DISRUPTIVE	Don't suggest anything new or innovative

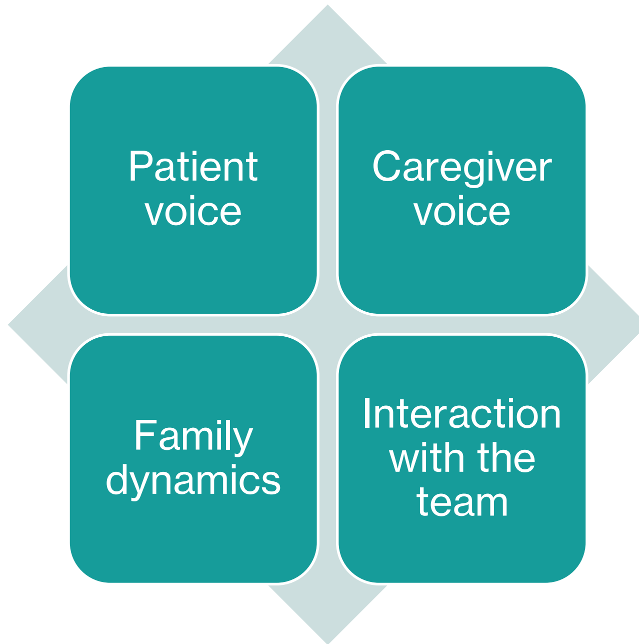
1. "I spotted that too, but I thought I didn't dare question a doctor"

2. "Everyone says '*That's just who she is*' so nobody challenges that"

3. "I sat there wondering 'what on earth is going on?' but I didn't want people to know I didn't know"

4. "I pointed out that the patient wasn't getting the right treatment but the nurse in charge said that's how we have always done it"

What do Patients and Families bring to the dynamic?



Fear and uncertainty, possibly avoidance

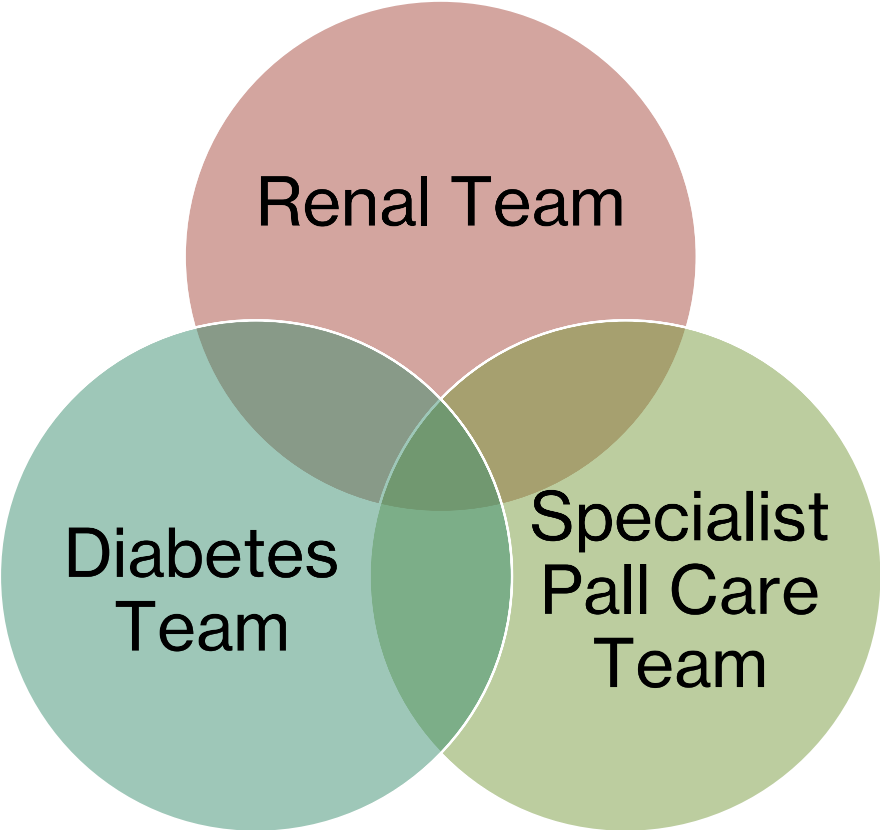
Hope – sometimes perceived as “in denial”

Family anticipatory grief – high emotions

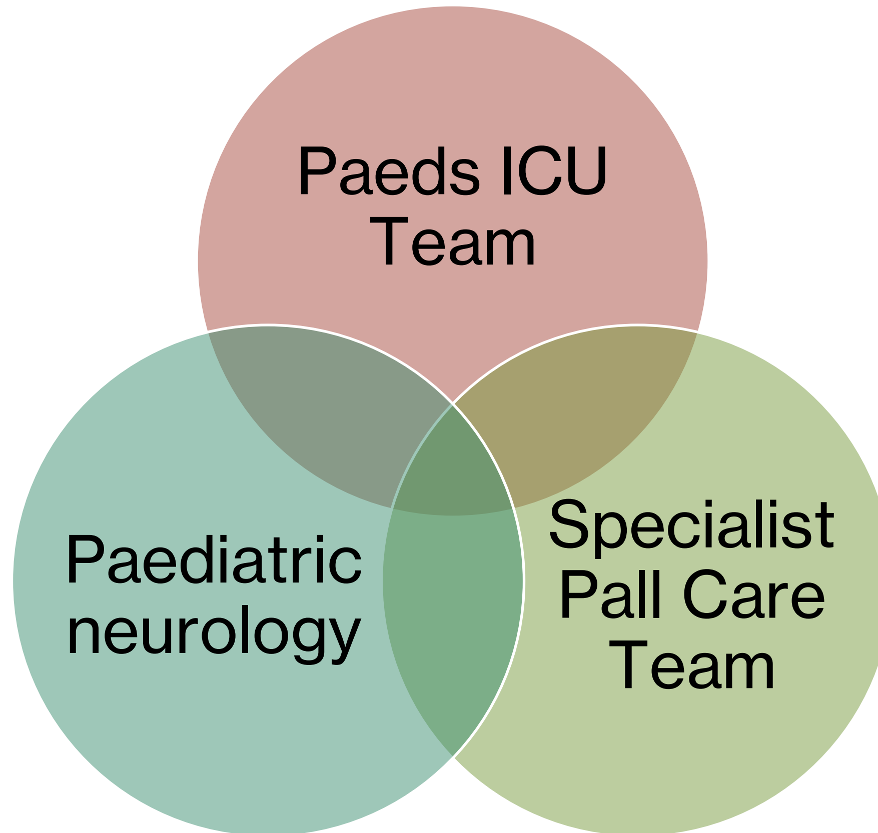
Family dynamics, background culture and beliefs

Wider communication: cognitive ability, language

Inter-Multidisciplinary Team Dynamics



Inter-Multidisciplinary Team Dynamics



Head above the parapet

The reality is, it does not always feel safe.

But it's important to step into the discomfort anyway.

What's your stuff, what's their stuff?

Afterwards return to the safety of your team.

When we are the barrier…

- We often have the skills to have these conversations, but it's not about lack of skills or not having the mechanisms, it's about lack of capacity to follow through when it feels uncomfortable

“

GET COMFORTABLE BEING UNCOMFORTABLE

”

cominguprosestheblog.com

- High intolerance of uncertainty often equals more ‘doing behaviours’ (scans, tests, treatments).
- ‘Doing’ – comfort zone
- Stopping treatment more of a grey area – what are the limits of my role? A move away from my role/treat/cure
- Worrying that a decision to stop is doing a disservice to the patient when in fact it is an active decision to consider other priorities
- Conversations evoke emotional responses on both sides. But an emotional response can be positive – the message has landed.
- We make assumptions – person not ready/too early/too young….may also hide behind these assumptions to avoid conversations?
- Something else? Need for self-reflection….
- The more we ‘do’, the more we close down the potential for conversations and this has consequences.

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Doctor – patient relationship and impact on prognosticating

- Research by Lesley Fallowfield:

- The better a doctor knows a patient (in time / intensity) the more likely they are to overestimate survival, + "doing something" behaviours instead of honest conversations

- Harder to be honest the better you know a patient

- Desirable benefits and acceptable costs often differ between patient and doctor

- Hard to maintain trust in doctor relationship if been overly optimistic - patients didn't see doctors as less compassionate if not overly optimistic, rather seen as trustworthy purveyors of information.

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What we think we say….

- What oncologists believe they said and what patients believe they heard (Jenkins 2011):

- Clinicians reported discussing prognosis in 50% cases
- Patients reported it in 6%
- Coders reported it in 20%

- Clinically, we see this….
  - Told by doctor: "you're not well enough for more chemo"
  - What the patient often hears: "I'm not well enough right now but when I'm a bit better, they'll give me more chemo"

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Impact of prognostic conversations

- Satisfaction with EOL care higher among patients who had discussed prognosis with doctor than those who had not

Open Med. 2009 Jun 16;3(2):e101–e110.

Discussing prognosis with patients and their families near the end of life: impact on satisfaction with end-of-life care

Daren K Heyland, Diane E Allan, Graeme Rocker, Peter Dodek, Deb Pichora, Amiram Gafni; Canadian Researchers at the End-of-Life Network (CARENET)

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Giving permission to explore the alternative

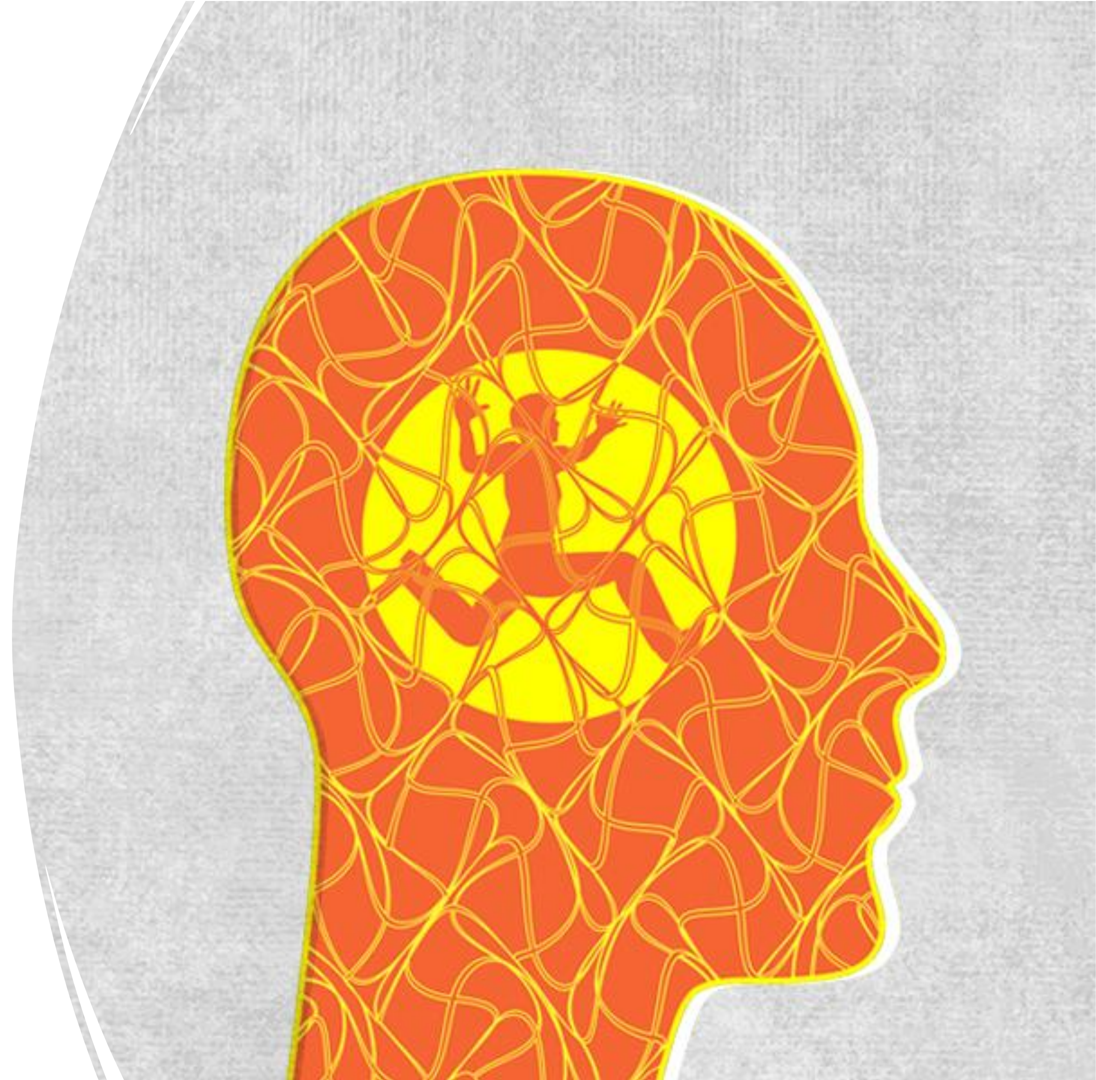
- **The catalyst for a patient to speak about uncertainty and dying is the practitioner’s permission to explore**
- Developing a language for discussions about uncertainty
- Conversations open up the possibility of uncertainty with patients – encourages growth and opportunities rather than conversations feeling frightening or crushing
- We can talk about uncertainty and emotive stuff whilst holding the hope

Discussion- your examples

Discuss on tables times when it has felt safe to speak up and it has worked out well and times when there have been barriers

Teams Under Threat

When your brain is planning for war, it doesn't need to attend to prosocial behaviour



Can we improve Psychological Safety?

Improve Relationships

Participation & belonging within teams “teaming”:

1. Value all voices & contributions
2. Space together: Team days, meetings, social events
3. Supportive and reflective discussions rather than just task orientated
4. Be considerate of when things feel scrutinising or blaming
5. 80:20 rule Trust in team to use discretion when to break some of the rules & to take positive risk- control & autonomy

Relationships across teams:

1. Grab opportunities, reach out where you can
2. Build empathy for each other’s positions
3. Any time together, more co-working
4. Make personal connections and get to know colleagues as individuals
5. Case discussion/ reflection/ M&M across teams

Cross MDT/ Flattened hierarchy

Leadership

Be a role model — share a mistake and learning, be willing to be vulnerable

Remove the fear — set the stage and remind staff at every opportunity that it is okay to make mistakes and we want to learn

Stop blaming — change systems of review from “who is responsible for this?” to “what can we learn from this?”

Be inclusive — Invite all voices, always

Making it safe: the effects of leader inclusiveness and professional status on psychological safety and improvement efforts in health care teams

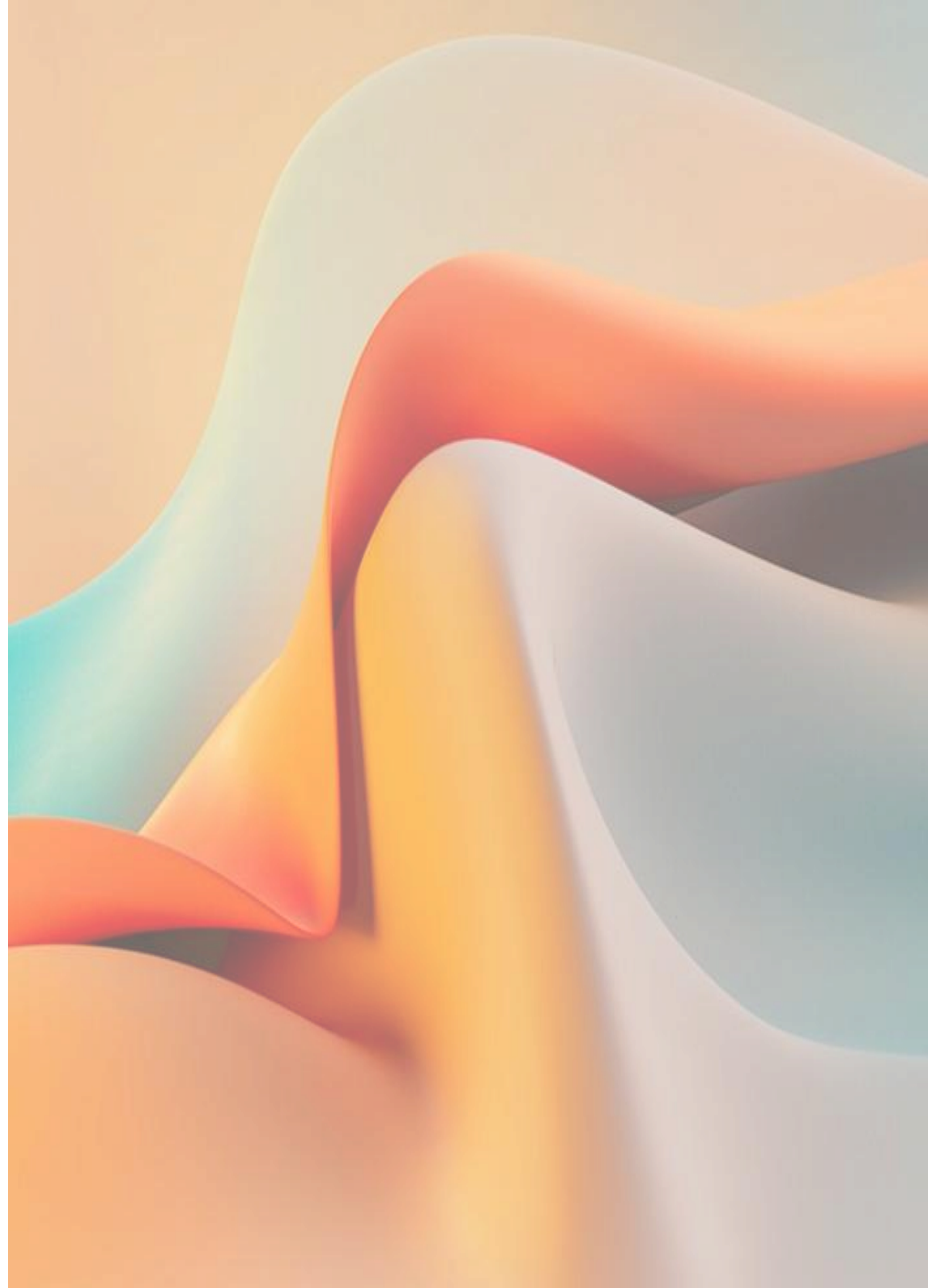
Ingrid M. Nembhard, Amy C. Edmondson

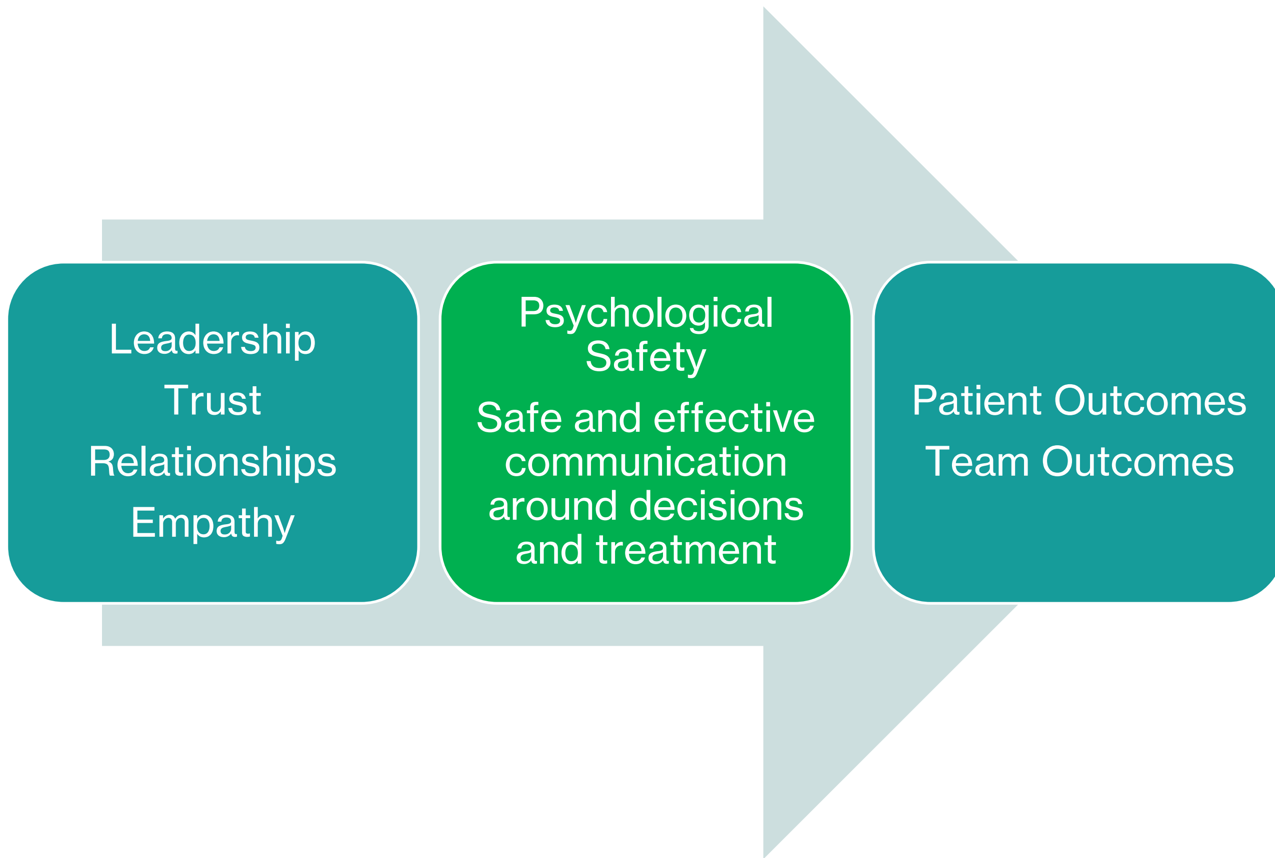
First published: 21 September 2006 | https://doi.org/10.1002/job.413 | Cited by: 563

Reflection

- What can you take to your team from tomorrow?

- What can you take with you?




Leadership
Trust
Relationships
Empathy
Psychological Safety
Safe and effective communication around decisions and treatment
Patient Outcomes
Team Outcomes