

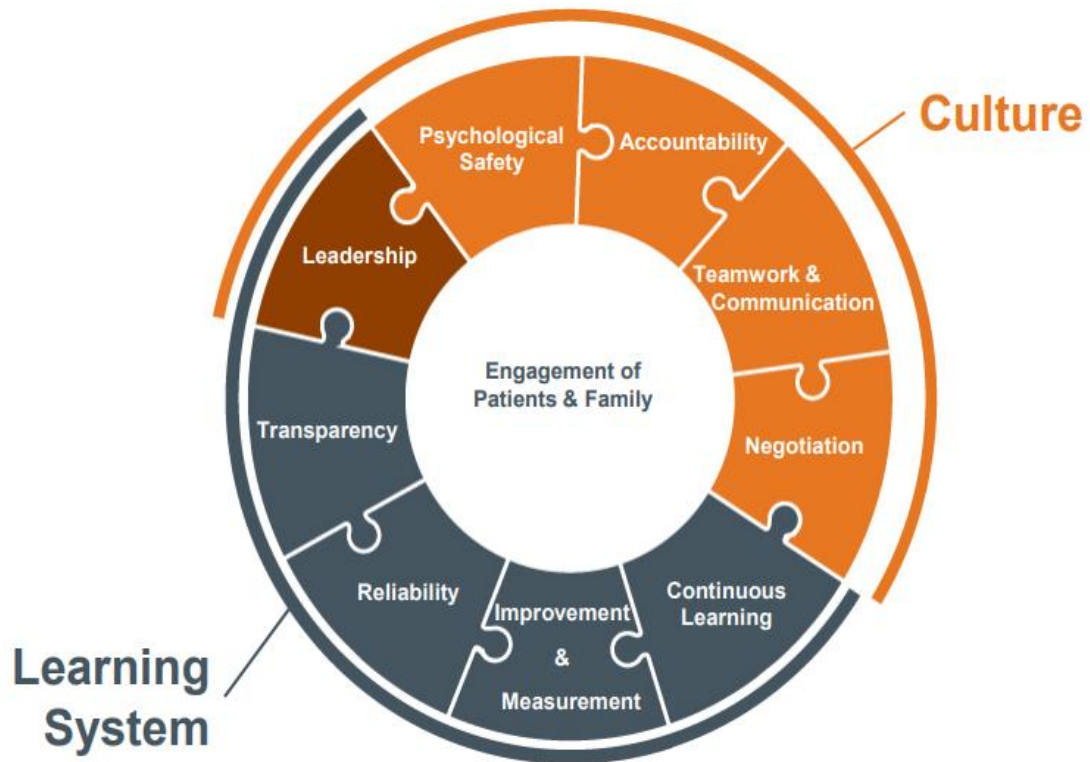
Improvement Cymru Academy Toolkit Guide



Psychological Safety

Introduction

Psychological safety is feeling safe within your workplace to openly express your ideas, admit mistakes and to respectfully question or challenge your colleagues, without fear of any retaliation or detrimental effects to you. Developing, promoting, and operating a psychologically safe culture in your health care team is a crucial part of providing safe patient care (1).



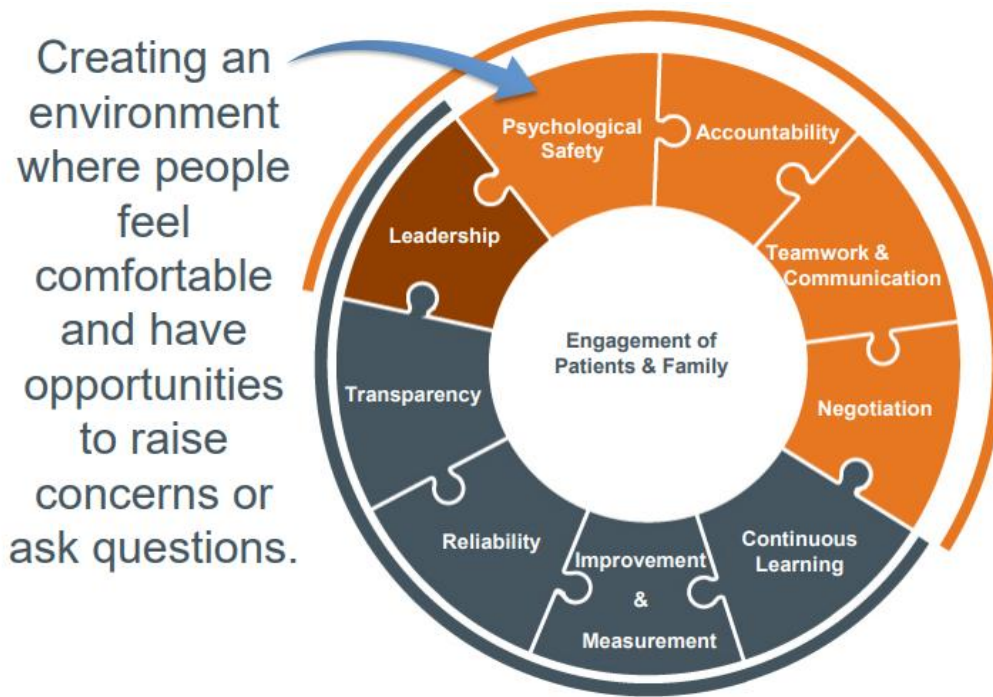
Frankel A, Haraden C, Federico F, Lenoci-Edwards J. *A Framework for Safe, Reliable, and Effective Care*. White Paper. Boston, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare; 2017. ihi.org/PtSafetyWhitePaper



Figure 1: [Framework for Safe, Reliable and Effective Care](#) (SREC).

Source: Institute for Healthcare Improvement and Safe & Reliable Healthcare (2)

The Institute for Healthcare Improvement (IHI) (2) describe a framework for Safe, Reliable and Effective Care (SREC), highlighting culture as one of two interconnected foundational domains (see figure 1), vital for creating safe systems of care. Whilst all the framework components are interrelated and vital for continuous learning, and improvement, psychological safety is identified as one of the fundamental factors crucial in creating a culture of safety (see figure 2) and will be the focus of this toolkit guide.



Frankel A, Haraden C, Federico F, Lenoci-Edwards J. *A Framework for Safe, Reliable, and Effective Care*. White Paper. Boston, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare; 2017. ihi.org/PtSafetyWhitePaper



Figure 2: Psychological Safety within the Culture domain (SREC)

Source: Institute for Healthcare Improvement and Safe & Reliable Healthcare (2)

Rationale

Psychological safety promotes a positive, supportive, and productive working environment allowing open communication, trust, and innovation to thrive, essential for safe, reliable, and effective patient care.

Creating a psychologically safe environment is key to developing a culture of safety within healthcare to reduce harm to patients, learn from errors and continuously improve care. When healthcare staff communicate well, feel able to raise concerns, discuss errors and suggest changes, learning from error/failure is facilitated, improvements are possible within teams and organisations, with staff morale and wellbeing improved.

Inclusive participation supports diversity, as groups who might feel marginalised can engage freely and contribute securely, promoting a diverse, creative organisational culture.

The Speaking up Safely framework (3) is an initiative to support NHS Wales employees to identify and report concerns, to empower staff to suggest changes. The aim is to encourage team and organisational improvements and reduce risks to patients. NHS organisations and leaders are responsible for creating the right conditions for psychological safety to thrive in support of this framework.

VIDEO: Please watch this brief video detailing the importance of and [critical outcomes of psychological safety in healthcare](#) ¹

Background

James Reason (4) is often credited as the originator of the concept of psychological safety, but its origins could be rooted even further back. In 1954, psychologist and psychotherapist Carl Rogers (5) discussed establishing the right conditions for creativity to thrive by nurturing the psychological environment, so individuals feel safe to take risks, free from criticism and fear of judgement.

More recently, Amy Edmonson (6), a leading authority on the subject of psychological safety, shared research demonstrating that when individuals work in a psychologically safe environment, they are empowered to speak up openly and safely about errors in healthcare, thus increasing honesty about mistakes, promoting learning from error and directly improving patient safety (7). The concept is commonly misunderstood as simply being nice to one another and avoiding conflict. According to Edmonson, it is creating a climate where individuals and teams can speak up without fear, which is critical to foster learning, innovation, and collaboration.

When to use

The SREC framework (2) clearly states that creating and supporting psychological safety is an expectation of you and everyone within your organisation as part of your job. It encourages a conscious and ongoing commitment to demonstrate behaviours towards your colleagues that will facilitate speaking up, to practise effective communication, to speak up about your concerns and to suggest ideas for improvements.

¹ Please note that subtitles are available, and playback speed is adjustable within the video settings icon, should these be required

The SREC framework is intended to provide you with a 'roadmap' of the principles to apply to improving healthcare systems. Psychological safety is a fundamentally important part of the SREC framework and pivotal in ensuring the effectiveness of other elements in promoting safe reliable and effective care.

VIDEO: Please watch the video by clicking the link. [Amy Edmonson](#) describes the importance and role of psychological safety in healthcare delivery.

How to use

The SREC framework (2) can help guide you and your organisation on the essential elements required to build and organise systems of safe, reliable care; creating psychological safety as part of this takes time, skill and dedication but some suggestions to promote psychological safety in your workplace are:

- A flat hierarchy and a robust learning system to create an environment where you and your colleagues can ask questions without judgement, ask for feedback, question approaches and make suggestions for alternatives.
- Leaders need to be role models for applying learning, listening without judgement, supporting staff, and admitting own failures and mistakes.
- Coaching and feedback skills are essential for leaders to encourage and expect questions and to provide effective feedback, so staff feel concerns are heard and acted upon.
- Regular but short one-to-one meetings with your staff or your manager to support all the above and to enable any issues or concerns to be raised that might be harder to raise in the context of a group meeting.
- Regular, brief 'huddles', which is a group meeting, in addition to one to ones, where information is shared in a focused, task specific way. Participants have the opportunity to discuss, provide and receive feedback and all team members feel they have input.

VIDEO: Please watch the short video by clicking the link that follows as Amy Edmonson provides some tips on [how you can help to create psychological safety](#) in your workplace and team.

What next?

Begin by assessing your current performance concerning psychological safety by using a diagnostic tool (see figure 3 below). The IHI diagnostic tool helps you to identify current behaviours, systems, processes, and communications, from the lists in the columns below. This tool helps you determine whether you are just beginning, making progress, making a significant impact, or demonstrating exemplary efforts to create a psychologically safe environment. It might also help you to consider where you need to focus your efforts and guide team discussion for improvements.

Diagnostic Tool: A Framework for Safe, Reliable, and Effective Care

1. Psychological Safety			
Creating an environment where people feel comfortable and have opportunities to ask questions, ask for feedback, be respectfully critical, and suggest ideas.			
<ul style="list-style-type: none"> • Policies may state that staff should feel psychologically safe but leaders and managers do little to actively practice or encourage this. • Staff are reluctant to speak up for fear of ridicule or negative reactions from fellow staff, even when there is imminent danger to the patient. • Feedback is only provided through formal process such as appraisal and this feels like a superficial exercise to most staff. • Staff rarely receive feedback after reporting an adverse event. 	<ul style="list-style-type: none"> • Some leaders and middle managers model the behaviors associated with psychological safety but this is not standardized across the organization. • Many staff don't feel comfortable speaking up although they may be likely to in cases of imminent danger to a patient. • Staff are not generally forthcoming with innovations or suggestions as they feel they won't be taken seriously. • Staff usually receive superficial feedback after reporting an adverse event. 	<ul style="list-style-type: none"> • All leaders and middle managers encourage staff to speak up, address behaviors that do not support psychological safety, and are transparent with communications and data. • The hierarchy is not flat but there are many examples of learning from feedback or appropriate criticism. • Innovations that staff suggest are regularly tested and implemented after successful tests. • All staff receive detailed feedback and thanks for reporting an adverse event. 	<ul style="list-style-type: none"> • All staff feel comfortable to ask questions, ask for feedback, be appropriately critical, and suggest innovations. • All staff are actively encouraged to do the above; it is expected at all levels of the organization. • There is a flat hierarchy that supports this behavior and a learning system that is responsive to the information. • Leaders clearly demonstrate these activities and behaviors. • Learning from adverse events is routinely and effectively shared across the organization.
Just beginning	Making progress	Significant impact	Exemplary
Please provide a brief description of the type of data or other evidence you used to inform your choice:			

Figure 3: Assessing Psychological Safety. Diagnostic Tool: Framework for Safe Reliable and Effective Care.

Source: Institute for Healthcare Improvement and Safe & Reliable Healthcare (2)

You could go on to utilise further diagnostic tools within the SREC framework to assess and compare your performance in all the different components of the two foundational domains.

Helpful tips

- Start by considering psychological safety in your organisation; using a diagnostic tool as illustrated earlier can help you assess this and plan a focus for change and improvement.
- Expect resistance to change and plan how to manage key stakeholders (please see [Involving Others Toolkit Guide](#))
- Lead by example! Create the conditions to listen to your colleagues, role model openness, admit your mistakes and acknowledge learning, invite feedback, provide feedback, encourage/recognise ideas and creativity, and celebrate achievements.
- Arrange/attend regular brief one to one meetings with staff you manage or with your manager to foster trust, communication, and collaboration.
- Arrange/attend huddles with your team and provide input and feedback.
- Ensure inclusivity – diversity of skills and experience should be embraced.
- Provide clear guidance on expectations e.g. for contribution and signpost your staff/colleagues to appropriate policies, wellbeing support and/or training as required.
- Speak up if have any concerns about your patient’s safety or about psychological safety in your workplace – highlight problems and make suggestions for improvement.
- Remember, it is everyone’s responsibility to create the right environment to ensure safe, reliable effective patient care.



Additional resources

If you are interested in learning more about how improvement practices can benefit your workplace, we offer a range of training courses. Visit [Improvement Cymru Academy website](#) for more information or email us at improvementcymruacademy@wales.nhs.uk to find about the improvement courses we offer.

Further reading

1. NHS England. The NHS Patient Safety Strategy Safer culture, safer systems, safer patients NHS England and NHS Improvement [Internet]. NHS England. 2019 Jul. Available from: https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf (accessed on 03/06/25).
2. Frankel A., Haraden C., Federico F., Lenoci-Edwards J. A Framework for Safe, Reliable, and Effective Care | Institute for Healthcare Improvement [Internet]. www.ihl.org. 2017. Available at: <https://www.ihl.org/resources/white-papers/framework-safe-reliable-and-effective-care> (accessed on 03/06/25).
3. Speaking up Safely: A Framework for the NHS in Wales Supporting people to speak up safely and with confidence Contents [Internet]. 2023. Available from: https://www.gov.wales/sites/default/files/publications/2023-10/speaking-up-safely_0.pdf (accessed on 03/06/25).
4. Reason J. Managing the Risks of Organizational Accidents. Routledge; 1997.
5. Rogers, C.R. Toward a theory of creativity. ETC: A Review of General Semantics. 1954: 11(4):249-60.
6. Edmondson A.C. Teaming: How organizations learn, innovate, and compete in the knowledge economy. San Francisco, CA: Jossey-Bass; 2012.
7. Edmondson A.C. The Fearless Organization. John Wiley & Sons; 2019.