Psychological Safety - ensuring a safe environment for learning in the Danish healthcare system (Introductory brief)

The current situation in healthcare

We are becoming increasingly aware of the impact that the 'work environment' can have on the provision of safe, reliable and effective healthcare.

*"The establishment of a **psychologically safe work environment**, i.e., one in which employees feel safe to voice ideas, willingly seek feedback, provide help, collaborate, take risks and experiment, is one way to overcome threats to individual and organizational learning"*

Prof Amy Edmondson, Harvard Business School.

*"Patient harm imparts a **high financial cost**. Overall … 15% of hospital expenditure and activity in OECD countries can be attributed to treating safety failures".*
*"Developing a **culture conducive to safety** is seen as critical … reducing harm effectively and efficiently."*

OECD (2017) The Economics of Patient Safety.

What we know

- The provision of safe, reliable and effective healthcare is reliant on high levels of psychological safety
- Health care teams engage in, and benefit from, improvement efforts more successfully in cultures with high levels of psychological safety

Three questions for you

1. Do you have a clear understanding of what psychological safety is & how it effects the work in your organisation?
2. Are you able to measure psychological safety in your organisation to understand areas of strength or weakness?
3. What evidence-based interventions can you implement to build psychological safety in your organisation?

At PS! we have been working on these kinds of issues and developing expertise in a range of health and social care settings. If you would like to know more, please contact us at:

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Psychological Safety – a model of learning

At PS! we use a 'model of learning' developed by Professor Amy Edmondson (Harvard Business School) which proposes a number of antecedents and consequences of psychological safety in work teams. Most empirical work on psychological safety has treated the construct as a mediating mechanism that explains how positive leadership behavior, organizational practices, relational networks, and individual and/or team differences can facilitate positive organizational outcomes.

Model of antecedents & consequences of team Psychological Safety

(Edmondson, 2004; Psychological Safety, Trust, and Learning in Organizations: A Group-Level Lens).

PS! – how we have worked so far…

Over the last two years PS! has been raising awareness of these important issues. We have primarily engaged in workshops and presentations to achieve this, alongside the use of social media, e.g. Twitter or LinkedIn. However, we have also undertaken a number of projects which have informed our knowledge and practice, as well as made beneficial changes to the organisations we have worked with, for example:

- **Improvement work at Herlev Akutmodetagelse** – Using a model of learning which posits psychological safety as a critical moderator in the development of learning behaviours, we (in partnership with colleagues from CAMES and the quality department at Herlev) worked alongside clinicians in the department to understand better what team-based factors contribute to successful improvement work

- **Education program at Rigshospitalet** – The Human Resources department commissioned PS! to help develop an Introductory Guide to Psychological safety for all staff. The guide included simple team-level activities to understand and improve their work environments to promote the kinds of learning behaviours associated with psychologically safety.

- **Leadership development with Dansk Sygeplejeråd** – In collaboration with the leadership team, PS! developed a one-day workshop program for the regional leaders from Dansk Sygeplejeråd to introduce the key concepts, understand how to measure psychological safety in their teams and to develop actions to improve the psychological safety for their colleagues.

Next step…

We believe a safe and high-quality health system requires a culture which is focused on learning. Learning which can be derived from good practice, bad practice and everyday delivery of care. A culture where people feel safe to speak up, to ask for help, to ask for feedback, to collaborate with people outside their 'silo' and to test new ways of working, to try and yes, to fail. But to learn from that failure.

If you are interested in this subject and would like to know more, please contact us directly.