

Title: "Health and social care professionals' experience of psychological safety within their occupational setting: a systematic thematic synthesis protocol"

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Abstract:

Background:

Psychological safety (PS) is commonly referred to within the organisational context. However, PS is also essential to mental health, wellbeing, and post-traumatic growth. Health and social care workers often work in stressful, challenging environments, and as a result, they may experience compounding stress, jeopardising their sense of safety. Consequently, individuals may experience burnout, which further impacts the care individuals receive, emphasising the importance of PS within the health and social care environments. This systematic review will identify and outline health and social care professional's experiences of psychological safety within the workplace. Consequently, emphasising the importance of PS for organisational and individual development to health and social care organisations.

Method and analysis:

The inclusion criteria include studies where health and/or social care professionals discuss their experience of individual or group psychological safety in their occupational setting. Related concepts, such as social engagement, will also be included. English-written studies of qualitative designs will be included.

The exclusion criteria are studies not including primary, qualitative data, and posters. Studies which have not been published in English; and studies published before the year 1995—participants who are not professionals within the health and social care occupation.

The following databases will be searched for qualitative studies from 1995 to 2023: CINAHL, PsychInfo and Web of Science.

A thematic synthesis of findings will be presented. Line-by-line coding of the primary research will occur; the organisation of the coding will be given descriptive themes, and analytical themes will be developed.

Introduction:

Psychological safety (PS) conceptualises the importance of mental health, wellbeing, and post-traumatic growth (Edmondson & Bransby, 2023; Porges, 2022; Sullivan et al., 2018; Morton et al., 2022). PS was first described by Schein and Bennis (1965) as an essential step in the "unfreezing" process necessary for successful organisational learning and development. PS is commonly used within the organisational context as Remtulla et al. (2021) described PS as the ability, to be honest, show initiative, and be prepared to admit to mistakes as an individual or within a team. Though, considering the growing interest in PS, there is relevance to PS within high-risk workplace environments- such as health and social care institutions (Fu et al, 2022; Hebles et al, 2022; Isobel & Thomas, 2021; O'Donovan, 2020; Zhao et al, 2020) While discussing the National Health Service (NHS) Patient Safety Strategy 2019, Harrison (2020) highlighted the approach taken by the NHS towards safety. The strategy focuses on going past an inherent fear of failure to learn from positive outcomes, discussing harm and establishing safer systems to deliver the proper care to patients. There is also an emphasis that it is imperative for the workplace setting to be psychologically safe, meaning the employees are free to hear, learn and act more to improve the overall quality of care (Harrison, 2020; Ito et al, 2022).

A comprehensive analysis of PS rooted in neurophysiology, psychology, and evolutionary theory is given by the Polyvagal Theory (PVT). Porges (2011; 2022) developed PVT, which discusses feeling safe by recognising how the body processes stress. He described the multiple states of the nervous system activation; Ventral Vagal (VV), sympathetic activation (SA) and Dorsal Vagal (DV). When stressed, individuals cannot remain in a state of SA or DV due to the amount of cortisol the body experiences, resulting in the activation of the body's 'fight or flight'. Health and social care professionals often work in highly stressful environments (Ding et al., 2014), which can neurologically alter their perception of reality, according to Porges (2011). As a result, they may have increased sensitivity to pain (Porges, 2011) and may experience burnout (Szwamel et al., 2022).

The Neuroception of Psychological Safety Scale (NPSS), established by Morton et al. (2022), utilises the PVT to assess PS by measuring how safe an individual feels. The scale contains 29 items and is separated into three sub-scales of *Social Engagement*, *Compassion* and *Bodily Sensations* (Morton et al., 2022). Being accepted, understood, and cared for, expressing oneself without being judged, and having someone to trust are attributes of the first subscale, *social engagement*. The items for this subscale assess how safe it is to engage in the social environment (Porges, 2011). The second subscale, *Compassion*, measured the ability to show empathy, feeling connected, caring, and wanting to lend a hand. According to Kirby et al. (2017), our ability to be compassionate regulates our autonomic nervous system, while regulating the following depends on our ability to express safety and soothe ourselves (Mok et al., 2019). The third subscale measures interior *Bodily Sensations* of calm, including a relaxed countenance and body, regular breathing and heartbeat, and a relaxed stomach. The regulatory function, particularly of the heart and bronchi, and the corresponding state of relaxation and restoration are linked to the activation and functioning of the SES (Porges, 2011). Thus, the NPSS uses these three subscales to assess PS psychometrically.

The wellbeing of professionals in health and social care settings is vital as it is critical to offering patients safe care (Cogan et al, 2022; Kessel et al., 2012; Lele et al, 2023). Health and social care professionals such as doctors and residential child support workers work in what can be considered a physically and mentally demanding setting (Isobel & Thomas, 2021; Purdy & Antle, 2021). Healthcare professionals must collaborate in a highly complex and dynamic work environment (Kessel et al., 2012), highlighting the importance of PS in healthcare settings. Despite its significance, PS is frequently neglected in healthcare teams. Healthcare staff are hesitant to speak up about problems for fear of retribution, not being heard, or causing trouble (Moore & McAuliffe, 2010). Several studies suggested that a focus on patient safety, including enablers such as safety culture, continuous improvement culture, familiarity across teams, leader behavioural integrity, professional responsibility, and change-oriented leadership, can support PS in healthcare settings (O'Donovan & McAuliffe, 2020). While a safety culture improves PS in healthcare teams, psychologically safe healthcare professionals become more engaged in behaviours that improve safety cultures. This further highlight that having a safety priority can cultivate a safe patient environment and high psychological safety among staff in health and social care (Nembhard & Edmonson, 2006).

Objectives/Research Questions:

What are health and social care professionals' experiences of psychological safety within the workplace?

Methods:

This review will adhere to the ENTREQ statement (2012) and utilise thematic synthesis per Thomas and Harden's (2008) methodology.

Eligibility Criteria:

Studies will be included if the participants are health- or social-care professionals, discussing their experience of individual or group PS in their occupational setting. The definition of PS will be based on Morton et al.'s (2022) definition of PS, using the three subcomponents they identified: *social engagement, compassion, and bodily sensations*. *Social engagement* will be defined as feeling understood, feeling safe to be honest and admit to mistakes, and expressing yourself without judgement. *Compassion* will be defined as showing empathy, feeling connected, and wanting to help others. *Bodily sensations* are internal bodily sensations of calm, such as a relaxed heartbeat and breathing (Morton et al., 2022).

Studies of qualitative method designs will be included. Studies included must be written in English and published between 1995 and present date.

The exclusion criteria are studies that do not include primary qualitative data, such as systematic reviews, quantitative studies, and posters; studies which have not been published in English; and studies published before 1995—participants who are not professionals within the health and social care occupation.

Information Sources:

The following databases will be searched for qualitative studies: CINAHL, PsychInfo and Web of Science. Databases will be searched from 1995 to the present.

Search Strategy:

The SPIDER tool will be utilised as the source for the search strategy and inclusion criteria. The tool allows for systematic and clarity in research by outlining important significant characteristics of the research question (Cooke et al., 2012).

The following search strategy will be employed:

S: "health care worker*" or "Healthcare worker*" OR Physician* OR Nurs* OR Doctor* OR Medic or Medics OR "Social worker*" OR "Care worker*" OR "Support worker*" OR "occupational therapist*" OR Psychologist* OR "health and social care" OR midwi*

PI: "Psychological Safety" or "Interpersonal Risk*" OR Team* OR "Polyvagal Theory" OR "Occupational wellbeing" or "Occupational well being" OR "Occupational wellbeing" OR "Workplace wellbeing" OR "workplace wellbeing" OR "workplace wellbeing" OR "workplace well being" OR "Workplace wellbeing" OR "workplace well being" OR "workplace Mental health" Or "workplace mental-health" OR "workplace mental health" OR "workplace mental-health" OR "Occupational mental health" OR "Occupational mental-health" OR Trauma* OR "Work culture" OR "Workplace culture" OR "Physical pain" OR "Workplace safety" OR "work place safety" OR "Moral distress"

D: interview* OR "focus group*" OR obser* OR ethnography OR "thematic analysis" OR qualitative

E: experience* OR opinion* OR outcome* OR satisfaction

R:

Note: Obser* will be removed from the search for Web of Science.

Data Extraction Process:

Data will be extracted, duplicates will be removed, and titles and abstracts will be screened. Papers which meet the inclusion criteria will be retained for full-text screening by four independent reviewers who will each screen 50% of the papers. If an abstract did not provide sufficient

exclusion information, the article was obtained for full-text screening. Two independent reviewers will screen full papers using the inclusion and exclusion criteria, and any uncertainty will be resolved through discussion. Data from articles included from will be charted using a data extraction table (Khali et al, 2021). The data extraction table will include author, publication year, title, participant information, results section, potential themes, and type of analysis used. Rayyan will be used to store references (Ouzzani et al., 2016).

Risk of Bias:

The Critical Appraisal Skills Programme (CASP) checklist for qualitative research is a validated tool for quality assessing qualitative research, and it is endorsed by Cochrane and the World Health Organisation (Long et al., 2020). The checklist is widely used, and recommended for novice researchers, and is known to be succinct and effective (Nadelson & Nadelson, 2014). Furthermore, the checklist was developed for use in health-related research (Long et al., 2020). The CASP checklist tool allows the researchers to systematically evaluate published papers by looking at the reliability, relevance and conclusions drawn. The quality of included papers will be assessed using the tool conducted by four reviewers, with each reviewer assessing 50% of the included studies. Any disagreements will be resolved through discussion. Any discrepancies will be discussed until a consensus has been met.

Data Synthesis:

A thematic synthesis of qualitative data based on the method described by Thomas & Harden (2008) will be utilised to synthesise and manage the data extracted, and themes emphasising key issues and messages will be created. In line with Thomas and Harden's method (2008), the first step of data synthesis will involve line-by-line coding of primary research. These codes will then be re-examined to identify similarities- a process termed "axial-coding" in grounded theory. The codes will be re-assessed to ensure they capture the data accurately. Following this, the codes will be organised into logical groups to develop descriptive themes. Reviewers will then make inferences about the experiences captured by the descriptive themes to generate analytical themes. This final step will be conducted independently.

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