

Review Article

A systematic review of factors that enable psychological safety in healthcare teams

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Abstract

Purpose: The current systematic review will identify enablers of psychological safety within the literature in order to produce a comprehensive list of factors that enable psychological safety specific to healthcare teams.

Data sources: A keyword search strategy was developed and used to search the following electronic databases PsycINFO, ABI/INFORM, Academic search complete and PubMed and grey literature databases OpenGrey, OCLC WorldCAT and Espace.

Study selection: Peer-reviewed studies relevant to enablers of psychological safety in healthcare setting that were published between 1999 and 2019 were eligible for inclusion. Covidence, an online specialized systematic review website, was used to screen records. Data extraction, quality appraisal and narrative synthesis were conducted on identified papers.

Data extraction: Thirty-six relevant studies were identified for full review and data extraction. A data extraction template was developed and included sections for the study methodology and the specific enablers identified within each study.

Results of data synthesis: Identified studies were reviewed using a narrative synthesis. Within the 36 articles reviewed, 13 enablers from across organizational, team and individual levels were identified. These enablers were grouped according to five broader themes: priority for patient safety, improvement or learning orientation, support, familiarity with colleagues, status, hierarchy and inclusiveness and individual differences.

Conclusion: This systematic review of psychological safety literature identifies a list of enablers of psychological safety within healthcare teams. This list can be used as a first step in developing observational measures and interventions to improve psychological safety in healthcare teams.

Key words: Psychological safety, Enablers, Healthcare teams

Introduction

When teams are psychologically safe, they have a shared belief that they can take interpersonal risks, such as speaking up, asking questions and sharing ideas [1]. Psychological safety is associated with improved team learning [1, 2], workplace creativity [3, 4] and team performance [5–7]. These outcomes make psychological safety particularly important within high stakes work environments, such as healthcare organizations. Healthcare professionals must work interdependently, within a highly complex and dynamic work

environment, to provide safe care for patients [3, 8]. This makes psychological safety particularly vital within healthcare settings.

Despite the importance of psychological safety in healthcare teams, it is often lacking. Healthcare professionals are reluctant to speak up about concerns due to fear of retribution, not being listened to or not wanting to cause trouble [9–12]. There is an absence of interventions to improve psychological safety within healthcare teams and a lack of clear objective measures to understand when psychological safety is low and to track changes over time [13]. Previous research

Table 1 Search strategies used

Database	Search string
PsychInfo and ABI/INFORM	AB,TI("Psychological* safe*" OR "speak* up" OR voic* OR silen*)
PubMed	((("Psychological* safe*"[Title/Abstract] OR "speak* up"[Title/Abstract]
	OR voic*[Title/Abstract] OR silen*[Title/Abstract])) AND
	("1999/01/01"[PDat]: "2018/12/31"[PDat]))
Academic search complete search string	AB "Psychological* safe*" OR "speak* up" OR voic* OR silen*

has established the benefits of improving psychological safety in healthcare teams, and it is now time to shift our focus to building interventions to do so. Identifying practical enablers of psychological safety within healthcare teams is an important first step in developing interventions to improve and maintain psychological safety.

Previous research has established that inclusive leadership behaviours, good interpersonal relationships and supportive organizational practices can promote psychological safety [5, 6, 14, 15]. Previous systematic reviews have explored antecedents of psychological safety in a variety of workplace contexts [6, 7]. Most recently, Newman and colleagues [5] examined antecedents of psychological safety, including, supportive leadership, organizational practices, relationship networks, team characteristics and individual differences. However, only 6 (13%) of these studies were conducted in a healthcare environment [2, 8, 16–19]. Aranzamendez et al. [15] identified leaders' behaviour as a major antecedent to psychological safety in healthcare settings. While leadership plays an important role in psychological safety, it is but one dimension of a complex system of organizational-, team- and individual-level factors that may influence an individual's sense of psychological safety. This study seeks to advance our understanding of the concept of psychological safety by taking a systems approach to identify the practical enablers of psychological safety in the healthcare environment. This list of practical enablers can inform the development of observational measures of psychological safety and interventions to improve psychological safety, which are tailored for use within healthcare teams.

Methodology

The protocol for this review has been published on PROSPERO (registration number: CRD42018107650).

Inclusion and exclusion criteria

Peer-reviewed studies that identified enablers of psychological safety, speaking up or voice behaviour, within healthcare teams were included in this review. Included studies were experimental or observational research from any country carried between 1999 and 2019. The relevant studies were extracted from systematic literature reviews, and the reviews were excluded to avoid duplication of data. Studies were excluded if they were not available in English or if they were not conducted within a healthcare setting.

Search strategy

Keywords were identified through a scoping review of the literature and were grouped together using the OR Boolean term. The search strategy was reviewed by a researcher with extensive systematic review experience. The final search is presented in Table 1.

Information sources

Electronic databases were searched between 19 March 2018 and 8 June 2018 and were then updated between 10 July 2019 and 19 August 2019. The electronic databases searched were PsycINFO, ABI/INFORM, Academic search complete and PubMed. The grey literature databases searched were OpenGrey, OCLC WorldCAT and Espace (Curtin's institutional repository). The authors also handsearched the reference lists of included studies and contacted experts in the field to identify any further eligible studies.

Study screening

Covidence, an online specialized systematic review website, was used to screen studies. One reviewer screened record titles and abstracts based on the eligibility criteria. Two reviewers then independently reviewed the identified full-text studies. If there was any disagreement or ambiguity, a third reviewer assessed the relevant records, and consensus was reached on eligibility through discussion.

Data extraction process

A data extraction template was developed based on the guidelines produced by the Cochrane Public Health Group (see Table 2).

Quality assessment

Depending on the study design, the Critical Appraisal Skills Programme (CASP) Qualitative Checklist, the CASP Cohort Study Checklist, the Joanna Briggs Institute Critical Appraisal Checklist for Analytical Cross-Sectional Studies or the Mixed Methods Appraisal Tool was used to assess the quality of included studies.

Study synthesis

Identified studies were reviewed using a narrative synthesis [20]. The iterative steps outlined in Popay *et al.* [20] were followed: familiarization with studies and organizing then into logical categories, comparing and synthesizing studies, exploring relationships within and between the studies and synthesizing data under the relevant themes.

Results

Thirty-six relevant studies were included for full review and data extraction. The PRISMA diagram included in Fig. 1 illustrates the full screening process. A summary of each article can be found in Table 3. Table 4 presents the 13 enablers identified.

The key themes identified in the literature are reported below.

Table 2 Data extraction template

Review title or ID	
Author(s)	
Date published	
Date extraction completed	
Publication type	
Notes	

Methods

	Descriptio	ons as stated in re	port/paper	Location in text
Aim of study				
Design				
Participants				
Data collection				
Variables of interest				
Key findings				
Ethical approval needed/obtained for study	□ Yes	□ No	□ Unclear	

Notes:

Enabler 1

	Description	Location in text
Description/definition		
Relationship to other enablers		
Other evidence		
Notes:		

Priority for patient safety

Thirteen studies suggested that a priority for patient safety can support psychological safety.

Safety culture. At the organizational level, studies identified safety culture as an enabler of psychological safety. Nurses' with higher perceptions of safety climate also had higher psychological safety [21]. When hospitals have a safety culture, staff can speak up and discuss concerns openly [22–24]. Cultivating a safety culture among all healthcare professionals can help to make safe public spaces which can encourage newly graduated registered nurses to speak up [25].

Leader behavioural integrity for safety. Behavioural integrity is when leaders' words and deeds relating to safety are in alignment. This signals to team members that their concern for safety is genuine and that it is safe to report errors. Leroy *et al.* [17] found that team psychological safety moderated the indirect relationship between leader behavioural integrity for safety and reported treatment error.

Professional responsibility. When healthcare professionals know that speaking up will result in meaningful change to patient safety, they are more likely to speak up [26]. Nursing staff have reported that their sense of responsibility and accountability for their patients



Figure 1 PRISMA flow diagram illustrating the inclusion and exclusion of identified studies.

motivated them to speak up to protect them, even when doing so was difficult or uncomfortable [10, 24, 27–31].

Improvement or learning orientation

Four studies highlighted the positive impact of a learning orientation on psychological safety.

A culture of continuous improvement. Care providers who reported greater continuous quality improvement environments also reported greater psychological safety [2]. Halbesleben and Rathert [19] found that psychological safety mediated the relationship between a climate for continuous quality improvement and staff engaging in experimentation and suggesting improvements to work processes.

Change-orientated leadership. Leaders play an important role in encouraging continuous quality improvement and psychological safety [19, 32]. Change-oriented leaders enable psychological safety by encouraging innovative thinking, envisioning change, taking personal risks and facilitating open discussion of errors and solutions [19].

Support

Seventeen studies explored the role of support in creating psychological safety.

Organizational support. Supportive healthcare environments have an open and respectful culture; raising concerns is a professional duty that is received positively and supported by administration and policies [10, 27, 28, 33]. This promotes speaking up and assertive

communication [24, 27]. Healthcare professionals, who believe that their organization values their contribution and cares about their wellbeing, experience a higher level of psychological safety [34].

Support from leader. Predicted level of support from manager influences nurses' decisions to raise concerns [10]. Transformational and commitment-based leaders, who are positive role models and prioritize patient safety, facilitate psychological safety and assertiveness [24, 35, 36]. Laissez-faire leadership encourages psychological safety by giving team members shared authority to make decisions and resolve problems [35]. However, more directive leadership, such as coaching, also facilitates psychological safety [37, 38]. Leaders, who listen and provide feedback, facilitate open communication across healthcare organizations [28, 32, 39]. To foster psychological safety, leaders can use more advocacy statements and less negative evaluative statement [40] and recognize the impact they have on psychological safety within their team [41].

Support from peers. In psychologically safe teams, shared coworker norms and values about speaking up influence team members' willingness to speak up [39]. Having positive relationships, effective role models [24] and higher teamwork climates [23, 26] can encourage assertive communication and speaking up for safety. Stronger workgroup identification reduces silence in nursing teams, once the procedural justice climate, the perception of organisational authorities as making fair decisions, was high [42].

Familiarity with colleagues

Familiarity with colleagues as an enabler of psychological safety was mentioned by six studies.

Author	Aims	Participants	Setting	Enablers identified	Methods of Evaluation
Edmondson (2003)	Explore the impact of leader behaviours on speaking up within teams	16 operating room teams	Hospital	Boundary spanning coaching leadership	Interviews: qualitative and quantitative data
Atwal and Caldwell (2005)	Record interactions of the team members using the Bales' interaction process analysis	Healthcare professionals in two older persons multidisciplinary team meetings	Large acute NHS Trust	Hierarchy/status	Observations of meetings
Maxfield <i>et al.</i> (2005)	Exploring concerns about communication that may contribute to avoidable errors and other problems in healthcare	1700 nurses, physicians, clinical care and administrative staff	Urban, suburban and rural hospitals in the USA	Culture of safety	Focus groups, interviews, workplace observations and survey
Nembhard and Edmondson (2006)	Examine the relationship between status and psychological safety	1440 healthcare professionals (physicians, nurses, respiratory therapists, social workers, dieticians)	23 neonatal intensive care units in the USA and Canada	Status Leader inclusiveness	Survey
Attree (2007)	Explore factors influencing nurses' decisions to raise concerns	142 nurses	Acute National Health Service (NHS) Trust in England	Professional responsibility Positive leadership	Survey
Dufresne (2007)	Explore the relationship between debriefing leaders, psychological safety and learning behaviours after critical incidents	40 teams (227 resident anaesthesiologists)	Center for Medical Simulation in Cambridge	Positive leadership behaviours	Videotaped team debriefing
Halbesleben and Rathert (2008)	Examine continuous quality improvement and psychological safety in workarounds	83 cancer registrars	Acute care hospitals in the USA	Continuous improvement	Survey
Tangirala and Ramanujam (2008)	Examine the cross-level effects of procedural justice climate on silence	606 frontline hospital nurses from 30 workgroups	A large Midwestern hospital	Personal control	Survey
Carmeli and Zisu (2009)	Examine a three-pronged model of organizational trust, perceived organizational support and psychological safety	Employees who work in medical clinics and provide daily medical services	Large healthcare organization in Israel	Perceived organizational support	Survey
Rathert (2009)	Explore model linking the work environment to work engagement, organizational commitment, patient safety and psychological safety	252 respondents: nurses (87%), allied health professionals (7%) and healthcare support personnel (6%)	Large metropolitan acute care hospital	Quality improvement and patient centred climate	Survey

Table 3 Summary of reviewed studies, sorted by year of publication

Table 3 Continued

Author	Aims	Participants	Setting	Enablers identified	Methods of Evaluation
Churchman and Doherty (2010)	Explore the extent to which nurses are willing to challenge doctors' practice	12 nurses	Acute NHS hospital in England	Supportive organization Status and hierarchy	Interviews
Adelman (2012)	Understanding CEO behaviours and actions that promote employee voice and upward communication in healthcare organizations	In each hospital, interviews took place with: the CEO, the Baldridge lead, a director and supervisor of a clinical service area and a frontline nurse	Four healthcare organizations who had received a performance award in the past 7 years	Leader: visibility, approachability, focus on continuous improvement, communication strategies	Document review and semi-structured interviews
Garon (2012)	Explore nurses' perceptions of their own ability to speak up and be heard in the workplace	Staff registered nurses and managers	Magnet and non-magnet hospitals in California, USA	Experience and education organizational administration	Focus groups
Hirak <i>et al.</i> (2012)	Investigate relationship between leader inclusiveness and psychological safety	55 work unit leaders and a total of 224 unit members	Clinical units in a large hospital in Israel	Leader inclusiveness	Survey
Leroy <i>et al.</i> (2012)	Explore how behavioural integrity for safety helps followers speak up	54 nursing departments. An average of 11 nurses per department	Four Belgian hospitals	Leader behavioural integrity	Survey
Lyndon <i>et al.</i> (2012)	Explore factors effecting whether clinicians to speak up about safety concerns	125 obstetricians and registered nurses	Two moderately sized US labour and delivery units	Professional responsibility	Survey
Sayre <i>et al.</i> (2012)	Evaluate intervention to develop speaking up behaviours among nurses	58 (53 post-test) registered nurses in the intervention 87 (51 at post-test) in control group	Two acute care hospitals	Familiarity with leader	Survey list of individual nurse behaviours
Raes <i>et al.</i> (2013)	Investigates when and how team engage in team learning behaviours	28 divisional nursing teams	University hospital in Belgium	Transformational and laissez-faire leadership	Questionnaire
Ortega <i>et al.</i> (2014)	Examine role of change-oriented leadership in learning process	107 nursing teams ($n = 689$) from different hospital areas	37 public hospitals in Spain	Change-oriented leadership	Survey
Schwappach and Gehring (2014)	Explore factors influencing voice or silence in oncology staff	32 doctors and nurses from 7 oncology units	Six Swedish hospitals (seven oncology departments)	Professional responsibility Hierarchy/status	Interviews
Sundqvist and Carlsson (2014)	Describe advocacy in anaesthesia care during the perioperative phase	112 registered nurse anaesthetists	Two hospitals in Sweden	Professional responsibility Experience	Interviews
Yanchus <i>et al</i> . (2014)	Explore perceptions of communication in psychologically safe and unsafe environments	Clinical providers	USA veterans' Health Administration	Communication Hierarchy/status Speaking up culture	Interviews and survey

Continued

Table 3 Continued

Author	Aims	Participants	Setting	Enablers identified	Methods of Evaluation
Law and Chan (2015)	To explore the process of learning to speak up	Newly graduated registered nurses	Public hospital in Hong Kong	Speaking up training Mentoring Safety culture	Interviews Email conversation
Aydon <i>et al.</i> (2016)	Identify factors influencing nurse's decisions to question medication administration	103 nurses	Neonatal care units in two public hospitals in Western Australia	Organizational support Professional responsibility Knowledge	Interviews
Jain <i>et al.</i> (2016)	Examine psychological safety through a patient case study	Single case study and discussion	Cancer care teams	Hierarchy/status Familiarity Boundary spanning Inclusive leadership	Case study
O'Leary (2016)	Examine effective communication, shared decision-making and knowledge sharing	Teams of care providers ($n = 24$) and one client	Two private facilities for older people in Ireland	Leadership behaviour	Field notes Interviews Group discussion
Reese <i>et al.</i> (2016)	Understand barriers facilitating factors of assertion	6 focus group with 36 nurses, residents and attending physicians	373 beds in academic children's hospital	Hierarchy Familiarity	Focus group
Etchegaray <i>et al.</i> (2017)	Examine association between willingness to speak up and perception teamwork and safety organizational cultures	Healthcare professionals with direct patient care responsibility	Large healthcare system in the USA	Leadership and cultural enablers	Survey: qualitative and quantitative
Martinez <i>et al.</i> (2017)	Compare factors related to interns' and residents' speaking up about traditional versus professionalism safety threats	1800 medical and surgical interns and residents (47% responded)	Across 6 US academic medical centres	Professional responsibility Leadership behaviour Peer support	Survey
Munn (2016)	Examine effect of safety climate, leader inclusiveness and psychological safety on nurses' error	Nurses $(n = 814)$ Nurse manager (n = 43)	Large academic medical centre in the USA	Leadership Safety climate	Self-administrated surveys
Ng et al. (2017)	Explore perceptions of communication openness communication issues	80 ICU staff members	Large public hospital in Hong Kong	Familiarity Hierarchy/status	Questionnaire and interviews
Weiss <i>et al.</i> (2017)	Test the effects of inclusive leader language on voice	40 anaesthesia nurses, 16 recovery room nurses, 52 resident anaesthesiologists and 18 attending anaesthesiologists (n = 126)	Hospital setting	Leader inclusiveness	Participants completed simulation exercise and questionnaire Behavioural coding and leader language analyses
Farh & Chen (2018)	Assess effect of leader behaviours and familiarity on voice	118 surgical team performance episodes (or cases) randomly sampled	Five hospitals within a large hospital system	Coaching leadership Familiarity	Observer ratings Survey data

Continued

Table 3 Continued

Author	Aims	Participants	Setting	Enablers identified	Methods of Evaluation
Omura <i>et al.</i> (2018)	Explore nurses' perceptions of assertive communication and identify facilitating or impeding factors	23 Japanese registered nurses	Workplace or university in Japan	Supportive environment Positive relationships Effective role models Experience and knowledge Professional responsibility	Interviews
Albritton <i>et al.</i> (2019)	Explore effectiveness of new quality improvement (QI) teams	122 hospital-based QI teams	Hospitals in Ghana	Team leadership	Survey observer-rated measures
Alingh <i>et al</i> . (2019)	Explore relationships between control-based and commitment-based safety management, safety climate, psychological safety and speaking up	302 nurse managers and 2627 nurses from 334 clinical wards in Dutch hospitals	84 Dutch hospitals	Leadership behaviour: commitment-based management	Survey

Table 4 Enablers identified across levels of healthcare organizations

Organizational	Team	Individual
Safety culture	Leader behavioural integrity	Professional responsibility
Continuous improvement culture	Status, hierarchy and inclusiveness	Individual differences
Organizational support	Change-oriented leadership	
Familiarity across teams	Leader support	
	Peer support	
	Familiarity leader	
	Familiarity team members	

Familiarity between team members. Familiarity and face-to-face communication between team members facilitates psychological safety [43]. To leverage the expertise of specialists who work in different areas, geographically dispersed teams are often required in healthcare. This reduces the direct communication needed to develop psychological safety [44]. Similarly, when new members are constantly joining the team, building and maintaining psychological safety becomes challenging [45]. Having a stable core team membership facilitates the development of trusting interpersonal relations and team psychological safety [45].

Familiarity across teams. Due to the complex and interdependent nature of healthcare teams, there is a growing need to communicate and collaborate across different teams. Boundary spanners are members of the team who integrate the work of other teams in order to facilitate communication and information sharing [38]. Both Edmondson [38] and Jain *et al.* [44] found a positive association between boundary spanning and team psychological safety.

Familiarity with team leaders. Hospital leaders who are visible and present on a regular basis promote employee voice [32]. This visibility creates familiarity between employees and their leader allowing trusting relationships to develop. Sayre *et al.* [46] created more leader visibility in order to improve speaking up behaviours among registered nurses.

Status, hierarchy and inclusiveness

Healthcare professionals find it easier to challenge those who have less experience than them [24, 27, 29, 33, 47, 31]. Those with higher status report higher levels of psychological safety [29, 43, 44, 48], while those lower in the hierarchy perceive a knowledge gap between themselves and their superiors and are less likely to assert themselves [29, 43, 48].

Inclusive leadership behaviours help to overcome the negative effects of low status on psychological safety by flattening hierarchical differences [8, 16, 21, 32, 23, 45, 49]. Inclusive leadership is when leaders' words and deeds invite and appreciate their contributions and feedback from all team members [8]. In interventions to improve psychological safety, implicit inclusive leader language, such as 'we', 'us' or 'our', improved voice behaviour [49] and inclusive leadership behaviours helped to develop team psychological safety [45].

Individual differences. Individual differences can also enable psychological safety in healthcare teams. Three studies found that gender influences psychological safety. Females have a lower rate per minute of asking and giving opinions [48], while males are more likely to speak up about professionalism safety issues [26]. Personality also influences healthcare professionals' likelihood of speaking up. Registered nurses and obstetricians were more inclined to speak up when they had higher bravery and assertiveness scores [30]. Courage was associated with speaking up among medical and surgical interns and residents [26]. Similarly, nurses perceive speaking up as a behaviour requiring bravery and courage [25, 29].

Tangirala and Ramanujam [42] found that personal control positively affected the speaking up behaviour of nurses. This relationship was U-shaped meaning that when personal control was either high or low, there were higher levels of voice behaviour. This relationship was moderated by organisational identification, with those who had high levels of personal control and stronger identification having higher use of voice.

Discussion

This review identified 13 enablers of psychological safety within healthcare contexts. Four were at the organizational level, seven were at the team level and two were at the individual level (see Table 4). These findings concur with previous research [5, 6, 14, 15]. While this review has not identified any novel enablers of psychological safety, it adds value to previous research by adopting a systems lens to identify a comprehensive list of factors at organization, team and individual levels that enable psychological safety within healthcare teams. The review was driven by a desire to shift the focus from understanding the antecedents of psychological safety, to thinking more about how to enable and improve psychological safety in teams. We grouped our findings into five broad categories: priority for patient safety, improvement or learning orientation, support, familiarity with colleagues and status, hierarchy and inclusiveness and individual differences.

The category 'priority for patient safety' reflects this reviews' specific focus on the healthcare environment. There is an important bidirectional relationship between psychological safety and safety culture, while a safety culture improves psychological safety in healthcare teams, psychologically safe healthcare professionals also become more engaged in behaviours that improve safety cultures [6, 8, 14]. Leader's behavioural integrity for safety promotes psychological safety culture within these teams [2, 8]. These findings highlight that having a priority for safety can cultivate both a safe environment for patients and high psychological safety among staff.

When healthcare organizations have a climate of continuous improvement, it supports the development of psychological safety and encourages staff to become more engaged in improving team or organizational practices. At the team level, change-oriented leaders play a key role in enabling psychological safety by role modelling innovative thinking, taking interpersonal risks and discussing errors.

Support from organizations, leaders and peers all encourage psychological safety within healthcare settings. This can also be seen outside of the healthcare context [5, 50]. Leader visibility can promote familiarity with their team members and is also an opportunity for leaders to role model supportive behaviours which cultivate psychological safety. While the familiarity that results from face-to-face contact and stable team membership facilitates psychological safety, creating these circumstances can be challenging within a complex and rapidly changing healthcare environment [3, 8, 44]. Healthcare teams need to engage in the active process of 'teaming', which occurs when diverse employees are brought together as needs demand and are then disbanded once the need has been addressed [51]. While teaming allows organizations to adapt to chaotic environments, it reduces the time teams have to develop familiarity and psychological safety. It is necessary to develop psychological safety alongside teaming in order

for healthcare professionals to adapt to the demands of increasingly complex patient care [52]. The other enablers of psychological safety identified in this review, such as priority for safety, may be used in order to compensate for any lack of familiarity within and across healthcare teams.

Similar to the aviation industry [53], team members with high status, and more knowledge and experience, are more likely to feel psychologically safe. When staff are less experienced and have a lower status, inclusive leadership can support them to feel more psychologically safe. Although, psychological safety has been defined as a group level phenomenon [1], it is influenced by healthcare professionals' individual differences such as gender, personality traits and individuals' perceptions of personal control.

Strengths and limitations

This systematic review presents factors which enable psychological safety within healthcare teams. While the enablers identified are not novel, this review takes a systems approach to develop a comprehensive list of practical enablers of psychological safety in the healthcare environment. This list can be applied to the development of more objective measures of psychological safety and interventions targeted at improving psychological safety in healthcare teams. To minimize the risk of publication bias, searches were conducted on academic and grey literature databases as well as through contacting experts.

Practical implications and future research

The list of practical enablers presented in this review aid the future development of objective measures of psychological safety and interventions to improve psychological safety within healthcare teams. Despite the important role played by psychologically safe healthcare teams, a culture of fear still exists [11, 12, 14, 38]. There is a lack of guidance on how healthcare teams can improve and maintain psychological safety and, therefore, a need to develop and implement interventions to improve psychological safety within these teams [13]. The enablers of psychological safety presented in this review are a useful starting point for developing the necessary components of these interventions. It is recommended that future research draw on the enablers outlined by this review in order to develop effective interventions to improve psychological safety. Ensuring that future interventions focus on developing a priority for safety may be of particular importance to improving psychological safety in healthcare organizations. By incorporating intervention components that target the development of enablers of psychological safety, future interventions are more likely to be successful.

In order to understand whether an intervention is successful in improving psychological safety, there is a need for objective outcome measures. To date, most studies have relied on self-report survey measures which can be limited by self-report bias and response fatigue [5, 54]. Therefore, there is a need for reliable objective measures of psychological safety, such as observational measures, which can offer a more holistic understanding of changes in psychological safety over time [5, 13]. Understanding the enablers of psychological safety is necessary in order to develop these observational measures. Future research is needed in order to incorporate enablers of psychological safety into objective measures of psychological safety. By building on this review, future research can identify observable behaviours associated with the enablers of psychological safety in healthcare teams and include them as part of an observational measure of psychological safety.

Conclusion

The current systematic review identifies a list of enablers of psychological safety within healthcare teams. These findings provide a starting point for future research to develop objective measures and interventions to improve psychological safety within healthcare teams.

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