Exploring psychological safety as a component of facilitation within the Promoting Action Research in Health Services (PARIHS) framework.

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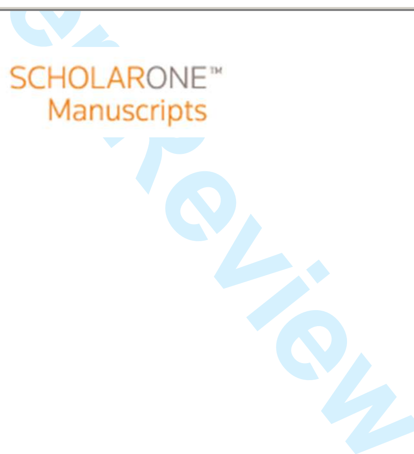

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ABSTRACT

Aims and objectives. To explore holistic facilitation as an approach to enable the healthcare team to critically analyse practice and enhance patient care.

Background. Globally the challenge of changing healthcare practices for enhanced patient care is the focus of much attention. Facilitation is emerging as an important approach to assist healthcare teams to explore and improve their practice. Within the Promoting Action on Research Implementation in Health Services (PARIHS) framework, which has been tested in an international arena, facilitation is a key element of operationalising collaborative changes in practice. This paper uses the framework to explore holistic facilitation and the concept of psychological safety.

Design. An Emancipatory Action Research approach was used.

Methods. Facilitated critical reflection was undertaken with the healthcare team working in an abdominal surgical unit. In addition, the lead researcher maintained a reflexive journal. Data were analysed using thematic analysis. Eighty-five percent (n = 48) of nursing staff and individual participants from other parts of the healthcare team (n = 3) participated in the two-year study.

Results. Data revealed fourteen sub- themes that impacted upon the culture of the unit. These were; support, leadership, oppressed behaviours, communication, interruptions, power imbalance, horizontal violence, threat, autonomy, distorted perceptions, vulnerability, value, trust and time. Psychological safety, leadership and oppressed behaviours emerged as three key themes in the practice context.

Conclusions. There is a need to create psychologically safe spaces in environments where insufficient support, weak leadership and oppressed behaviours are apparent. Psychological safety enables individuals to feel safe to engage in difficult conversations and consider changes to practice. In a

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theoretical contribution to the area of facilitation it is proposed that the additional element of psychological safety needs to be incorporated into facilitation models, in particular the PARIHS framework, to more accurately reflect the complexities of working with healthcare teams.

Key words. PARIHS framework, psychological safety, holistic facilitation, leadership, oppression, culture

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SUMMARY BOX

What does this paper deliver to the wider Global community?

Individuals and teams need assistance to explore their practice if they are to be enabled to enhance person-centred care. This can be achieved through the creation of psychologically safe spaces using holistic facilitation.

Using the PARIHS framework (Kitson *et al.* 1998) to focus and structure this Emancipatory Action Research project has identified the need:

- To examine more fully the importance of creating psychologically safe environments to promote changes in practice.
- To explore the way in which holistic facilitation impacts upon decision-making practices.
- To obtain further clarity about the important role of the facilitator in changing practice environments.

Furthermore

- There is potential to develop the facilitation component of the PARIHS (Kitson *et al.* 1998) and i-PARIHS framework (Harvey & Kitson 2015) to include the concept of psychological safety.

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INTRODUCTION

The challenges and complexity of changing culture and ensuring that the evidence generated is translated into practice for improved patient care has received increasing attention. International research has highlighted concerns with the quality of nursing care and its impact on patient safety (Dixon-Woods *et al*. 2013 Dubois *et al*. 2013; Heslop and Lu 2014). It is apparent that there are strong links between leadership, the motivation and well-being of practitioners and patient experience (Maben et al. 2012, Dixon-Woods *et al*. 2013, King's Fund 2014). Francis (2013) placed prominence on changing the culture within healthcare settings demanding that patients be treated as people, in a safe environment and with compassion and dignity. However, due to the complexities of practice environments, implementing change and improving the quality of patient care remains elusive. This paper seeks to outline how psychologically safe spaces can be created, through holistic facilitation, to enable more effective person-centred cultures.

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BACKGROUND

There is a the need to understand and develop effective cultures, if healthcare reforms are to be implemented and sustained for enhanced patient care (Powell & Davies 2012, Manley *et al*. 2011). This is important as failing to action the best available sources of empirical, clinical and patient evidence in healthcare is costly, time-consuming and can lead to health inequities (Ward *et al*. 2009). Culture concerns itself with social contexts that influence routines, behavioural norms and basic assumptions that shape the environment in which healthcare occurs. Often cultures which have existed alongside one another for a long time, such as doctors and nurses, can have differing perspectives making it challenging for them to work as an effective team (Edmondson 2012, Manias *et al*. 2014). This is problematic as contemporary healthcare requires collaborative working to ensure the patient is at the centre of care (McCance *et al*. 2011).

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To enhance effective team working and transform culture at a practical level requires individuals and teams to alter their mindsets and patterns of behaviour (Manley *et al*. 2011). Exploring issues of culture in acute care, Brown and McCormack (2011) unearthed that weak leadership, negative mindsets and adverse patterns of behaviour prevented the nursing team from delivering optimal patient care. Nursing staff working in a culture in which they considered their opinions invalid or not valued, seldom contributed positively to discussions or attempts to change the environment in which they worked. It is not that these individuals were disinterested in contributing, rather they were kept out of the conversation by the pervasive fear of what more powerful others may think of them (Edmondson 2012). Consequently, Brown and McCormack (2011) argued there was a need to create psychologically safe environments if practitioners were to be assisted to explore their practice and alter the culture and context in which they worked.

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Creating a psychologically safe environment, where people feel able to focus on the underlying issues without threat of loss of self-identity or integrity (Schein 2010), is essential to organisational learning (Carmeli *et al*. 2008, Huang *et al*. 2012). Furthermore, the concept of psychological safety connects changeable workplaces to the health, resilience and well-being of individuals and teams (Shian et al. 2012). Without the trust and respect found in psychologically safe places, individuals will minimise the risk to *self* by avoiding 'to act', unless they are certain of the outcome. Such a culture limits communication, authentic relationships, innovation and potentially creates performance and safety risks (Law *et al*. 2011, Edmondson 2012, Leung *et al*. 2015). However, to enable the development of a learning culture, individuals and teams are required to challenge the basic underlying assumptions of their practice. These are inclined to be non-confrontable and non-debatable matters that are extremely difficult to change (Schein 2010). Holistic facilitation encompasses working with practitioners to release their potential to explore improvements in practice and take action (Harvey & Kitson 2015). Therefore, it offers one way of creating a psychologically safe environment to enable practitioners to explore basic

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assumptions and alter their practice by problem solving and through providing support (Brown & McCormack 2011).

PARIHS FRAMEWORK

Cultural change requires effective leadership (Apekey *et al*. 2011, Dixon-Woods *et al*. 2013), learning in and from practice (Manley *et al*. 2009) and teamwork (Wilson *et al.* 2005). However, there is insufficient high quality information about what works, in which settings and with whom (Ward *et al*. 2009). The PARIHS conceptual framework (Kitson *et al.* 1998) is comprised of three key constructs (evidence, context, and facilitation). It is held that these key variables act as a map of the factors that need to be taken into account when implementing evidence into practice (Kitson *et al*. 1998). Originators of the PARIHS framework argue that successful implementation occurs when robust evidence matches professional consensus and patient needs (high evidence); the context is receptive to change with sympathetic cultures, effective leadership, and appropriate evaluative systems (high context); and when there is appropriate facilitation of change, with input from skilled external and internal facilitators (high facilitation; Kitson *et al*. 1998).

Since publication of the PARIHS framework, refinement, validation, and clarity of the key elements of evidence, context, and facilitation have been ongoing (McCormack *et al*. 2002, Harvey *et al*. 2002, Rycroft-Malone *et al.* 2004, Kitson *et al*. 2008). Internationally researchers have explored the use of the PARIHS framework as a practical and theoretical model to guide their research (for example, Stetler *et al.* 2011, Rycroft-Malone *et al.* 2013, Botti *et al*. 2014). Examining theoretical and practical challenges to its implementation, Kitson *et al*. (2008) propose ongoing refinement and international research are required in order to systematically collect and analyse experiences of using the framework.

Focusing on the facilitation aspect of the PARIHS framework, task and holistic facilitation are evolving and important concepts in evidence uptake in clinical practice (Dogherty *et al.* 2010). Facilitation is a

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deliberate, conscious and collaborative process that enables teams and individuals to engage in conversations about what is happening in practice. Though no singular facilitation approach has been found to be effective in enhancing evidence-based practice (Janes *et al*. 2009), facilitation, both task and holistic, are essential components in the operationalisation of the PARIHS framework. Qualitative critical synthesis of the literature on the PARIHS framework (Helfrich *et al*. 2010), led Stetler *et al*. (2011) to modify and provide a practical guide, based on task-orientated facilitation, to promote the PARIHS frameworks' evolution. While this guide is helpful for targeted evidence-based practice implementations that have a strong task-orientated focus (Stetler *et al*. 2011), further research is required to evaluate its effectiveness.

In a re-conceptualisation of the constructs of the PARIHS framework, Harvey and Kitson (2015) propose the integrated-PARIHS (i-PARIHS). The i-PARIHS places importance on the facilitator as the active component in guiding individuals and teams through complex contextual and change processes. The holistic facilitator needs to undertake an enabling and empowering role, as the skill of the facilitator determines the 'state of preparedness' of the team and individuals (Kitson *et al*. 2008). As teams and individuals are encouraged to step back and become more conscious of habitual ways of being (Senge *et al.* 2005), the holistic facilitator is required to demonstrate authentic, consistent, strong facilitative leadership (Brown & McCormack 2011). Finally, the holistic facilitator is required to assess, align and integrate the other constructs of the PARIHS framework to help individuals and team understand what is occurring (Harvey & Kitson 2015).

STUDY AIMS

To explore holistic facilitation as an approach to enable the healthcare team to critically analyse practice and consider ways to enhance patient care.

METHOD

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Design

The study was set within a qualitative Emancipatory Action Research approach (EAR), utilising the PARIHS framework (Kitson *et al*. 1998) as an overarching conceptual guide. In this study an EAR approach involved the facilitator/lead researcher (DB) working with participants, as co-researchers, to develop their practice. Using critical reflection the facilitator encouraged co-researchers to pinpoint the problems they experienced daily and explore the assumptions they made about their practice. With facilitator support individuals and teams then planned and implemented agreed actions. The facilitator and co-researchers evaluated actions taken through ongoing data collection and analysis. EAR requires researchers to be open to adapting to the unexpected. Therefore, the theoretical framework adopted must be flexible to allow for the complexity of an action research approach, while being sufficiently structured to guide the study's direction and aid the researchers understanding. This research study tested the PARiHS framework (Kitson et al. 1998) to ascertain if it met this criteria.

Sample

The study was undertaken in a regional abdominal surgical unit that consisted of two wards. Written consent was gained from: the lead nurse, medical team (n=3), ward managers (n = 2), deputy ward managers (n = 2) and forty-eight nursing staff, comprising of senior registered nurses (n=11), junior registered nurses (n=32) and healthcare support workers (n=5).

Prior to commencing work in the unit, one group discussion between the lead nurse, ward managers and the Medical Clinical Director of the unit was undertaken. At this meeting the findings from preliminary work involving 62 hours of non-participant observation of nursing practice and 8 taped semi-structured patient interviews to explore pain management practices with older people in the unit, were discussed. Having considered the findings it was agreed that the study reported here should primarily on nursing staff as there were concerns that nursing staff would be reluctant to openly explore practice issues in the presence of multidisciplinary team. Consequently, members of the

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medical team agreed to participate in three facilitated reflective sessions. In accordance with emancipatory ideals these findings were used to inform the development of the study reported here.

Data collection

To ensure this study adopted a systematic and rigorous approach there were multiple sources of data collection used in the overarching study (Brown & McCormack 2011). For the purposes of this paper data obtained through facilitated reflective sessions (RS) and the lead researchers' reflexive journal (RJ) will be drawn upon. Reflective sessions were periods of time set aside for a maximum of five members of the nursing team to critically reflect on issues they faced daily and consider ways to change their practice. Each reflective session was negotiated with ward managers and planned into the duty roster to allow the nursing staff an opportunity to consider participating. No period of reflection lasted for more than 1hour 30 minutes. The lead researcher maintained a reflexive journal systematically recording empirical events and difficulties or successes at the end of all facilitated sessions. Additionally, maintaining a reflexive journal helped the lead researcher/facilitator deal with the issues as they unfolded and consider their supportive role during challenging times.

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Having obtained ethical approval from the study authors' institutional review board, consenting participants where invited to critically reflect on and explore their practice. The study comprised of twenty-six formal facilitated reflective sessions and twenty-six ad hoc reflective sessions. Additionally, the lead nurse and ward managers undertook to work individually with the lead researcher/facilitator, using a model of 1:1 facilitation (27 sessions in total). Data were gathered using flip charts and consistently shared with the team to ensure collective understanding.

Ethical considerations

Working in groups to explore difficult issues meant participant anonymity was not possible. Nevertheless, action researchers must respect the privacy of research participants by ensuring

confidentiality is maintained and making it clear that people are free to decide what information they wish to share. To ensure ethical principles were adhered to overarching ground rules were negotiated and reinforced throughout the duration of the study. Additionally, participants agreed to avoid making explicit reference to members of the team. At the conclusion of all reflective sessions, participants were given the opportunity to review data and agree emergent themes. It was the broad themes that participants and the lead facilitator agreed could be discussed with the wider organisation.

The facilitation required for EAR moves towards the high end of the continuum, suggested in the i-PARIHS framework (Harvey & Kitson 2015). Therefore, the holistic facilitator must demonstrate effective leadership, self-discipline and level-headedness, if they are to maintain the trust and integrity required to undertake this type of research. The lead facilitator met with the Medical Clinical Director and Director of Nursing at regular intervals to ensure they were aware of how the study was progressing and to discuss if there were any issues that would impact on the organisation as a whole.

Analysis

Data were analysed using a thematic approach. Reading through the evidence, initial impressions and themes arising from the data were noted. Recurrent themes that formed the basis of repeated patterns across the data set were identified. Subsequently, the emerging themes were reviewed, defined and refined to identify the essence of each theme. At each stage data were returned to the nursing staff providing them with an opportunity to critique the data ensuring it was representative and trustworthy. Emerging themes were discussed with co-researchers and similarities between themes were merged. Subsequently findings were fed back to the wider team through interim reports. An audit trail of all data obtained was maintained by the lead facilitator/researcher.

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RESULTS

Data obtained through reflective sessions revealed 14 emergent sub-themes that impacted upon the culture and context of the unit. These were: insufficient support; weak leadership; oppressed behaviours; deficient communication; multiple interruptions; power imbalance; horizontal violence; threat; a lack of autonomy; distorted perceptions; vulnerability; value; trust and time constraints. Three key themes of psychological safety, leadership and oppressive behaviours emerged as influential themes in the practice context (figure 1).

Support

From the outset nursing staff clearly stated that failure to create an environment of high support and trust would leave them powerless to explore their practice and consider strategies to bring about effective change.

> We need to be supported. We have no influence on policy in here. It's all about doing what you are told. [Nurse 1]
>
> Challenge has to be appropriate, timely and sympathetically made, with no recriminations for sharing our thoughts. [Nurse 2]
>
> So a flat line. Everyone is equal. [Nurse 3]
>
> I can have a say I was wondering why it was ok for me to come. I was saying to the others are you sure the facilitator won't mind me being part of this as I'm only a care worker? But I wasn't going to say much, before I came, just in case it made life more difficult for me. [Healthcare support worker], [RS 1]

As support was fundamental to collaborative working much time was spent negotiating and re-emphasising ground-rules of how we would work together. For example, in the reflexive journal DB documented:

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> In the groups we debated issues of confidentiality, anonymity, vulnerability and the need for support. This has offered me a significant challenge. As facilitator I realise that I hold a key role in ensuring people are safe to participate in this work and I have spent much time working on this issue. The ground rules are in place and I am role modelling ways to be supportive and how to suspend hierarchical roles to enable nursing staff to explore their practice and consider actions to effect changes in patient care. [RJ4]

Working with the nursing team and role modelling ways they could support one another included being available to offer guidance when it was required, helping and encouraging the team to communicate with one another and ask explicitly for the help they needed (table 1). For example, one senior nurse commented:

> If I dress the central line for a junior nurse they should complete the patient observations. [Nurse]
>
> So, what gets in the way of this happening? [Facilitator]
>
> I guess I don't tell them that. I just expect them to know. That's not supportive I suppose. [Nurse], [RS 7]

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Presuming that junior nurses knew what they were required to do without offering clear direction strained nurse relationships. The nursing team began to realise how important communication was in improving team working.

Oppressed behaviours

The theme of oppressed behaviours was intertwined with the issue of support. Facilitated reflection highlighted that the nursing team considered their work was undervalued which in turn contributed to lowered self-esteem. For example:

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> Everyone else is self-interested in their own role and so we are under-valued. [Nurse 2]
>
> Our opinions are not sought when people want to change practice, even if that directly affects us. Do our needs ever matter? [Nurse 4]
>
> Some members of the multidisciplinary team just want their tasks done immediately with no consideration of our workload. [Nurse 2]
> And we do it. But they focus on our shortcomings rather than comment on the good things nurses do. [Nurse 3], [RS 10]

Working in a culture which the nursing team considered was based on 'blame and negativity' contributed towards nursing staff feeling unappreciated and powerless to change the context of nursing practice. They further identified that interruptions to nurses' work also impacted upon patient care leaving nursing staff frustrated and feeling under-valued. For example:

> Interruptions are about communication, but when they're untimely they devalued both patients and us. It's a lack of respect. [Nurse 1]
>
> It's like when the patient's embarrassed and we say we don't mind. Then someone comes in behind the screens and their dignity is gone again, [Nurse 3], [RS 24]

Nursing staff were discouraged by a culture that seemed to disregard the need for patient privacy and dignity. Furthermore, they felt powerless to 'prevent breeches of patient dignity occurring'. Nursing staff wished to advocate for the patients and 'deliver care in a person-centred and holistic way', but considered that issues of time, a lack of nursing autonomy and confidence to be assertive prevented them from preserving older people's personhood. For example:

> We tend to talk among ourselves, you know, moan about these things. [Nurse 1]
>
> You need to be careful not to step out of your role. [Healthcare support worker]

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Should we challenge people who peek behind the curtains? Nicely I mean. [Nurse 2], [RS 12]

Nursing staff aligned themselves with older people as a group who 'do not always speak up.' Despite nurses believing they should advocate for older people, through critical reflection they uncovered that their communication within the MDT was often insufficient. For example, in one reflective session they discussed the issue of patients not always understanding their analgesic options following surgery. Consequently some older people had to 'try and understand multiple pain relieving techniques which led to confusion.' Nursing staff uncovered that they had never addressed this issue with their medical colleagues directly and through reflection realised 'you know if I'm honest we don't always consult with doctors either.' [RS12]

Supporting the healthcare team through facilitated reflection they uncovered that their behaviours led to poor communication within the team and impacted upon patient care. For example:

When we make a decision you don't agree with you don't discuss it with us further. [Doctor]

This enabled them to consider how they might, as nurses and people, continue to be professional in their approach and discuss differences of opinion more openly (table 1). For example:

So we should say when we are not happy or don't understand the decision. [Nurse 2].

We should try to avoid saying I'm just the nurse, this just devalues ourselves. [Nurse 1], [RS22]

Leadership

Facilitated reflection with the ward leaders revealed that many nurses looked towards them as the person who had the responsibility for 'fixing everything,' 'finding solutions.' To a degree they were content to accept this role, as it made 'life easy for nurses.' Nevertheless, it exacerbated their stress as

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it meant that they could not do their own work. To be clinical, complete managerial tasks and 'be all things to all people,' was challenging. Daniel (charge nurse) and Sophie (ward sister), (pseudonyms), considered that they had a duty to support everyone, but accepted that they were not solely responsible for shaping initiatives within the unit. However, they initially struggled to relinquish their paternalistic approach to managing the ward environment stating:

> There are no other options, if I think it's a good idea then the nurses will agree. It's my responsibility to manage the ward. [RS2]

Their reticence was partly due to concerns that nurses exhibited signs of a lack of responsibility and accountability. Lucy (lead nurse) perceived that this was due to nurses lacking confidence in their abilities, at certain moments in patient care. Additionally, 'hierarchical medical attitudes made nurses adopt avoidance strategies' [RS3].

Reflection with the ward nursing and medical team highlighted that they considered that there was deficient leadership in the unit. I particular there was a lack of clarity around roles and boundaries, confusion about power and authority and a low regard for opinions shared. This was particularly evident when the nursing team, with the support of the ward managers, attempted to initiate an agreed changes practice.

> New changes to the morning routine have been abandoned, after only a few days, to pacify certain nurses. [Nurse 1]
>
> Everyone is unclear who really made the decision to abandon the new way of working. [Nurse 2]
>
> It's not supportive or encouraging. What's the point of agreeing things if it's only going to fail. [Nurse 3].

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> Things are really not good here in this ward at the moment. [Doctor], [RS18].

DB was also challenged by the lack of leadership shown at this time recording in the researcher's reflexive journal:

> Three times now I have met with ward managers to help them reflect on why and how they have failed to address this issue. Sophie in particular realises the nursing team are unhappy and has agreed on actions to resolve the issue. However, even offering to co-facilitate a meeting with the nursing team she seems unable to take the next step. Lucy has requested me to help her in an individual facilitated reflective session to find a way through this impasse. [RJ28]

For Peer Review

Lucy responded to the issue by reflecting with the facilitator to consider how she should approach this issue and develop a plan. Subsequently she met with the ward managers to discuss her 'concerns in relation to poor leadership and the junior staff being disillusioned.' Reflecting with the facilitator afterwards, Lucy considered that she had been 'initially directive and blunt' but had then been 'facilitative and supportive' as she sought ways to address the leadership issues in the unit and 'call people to account' [RS20]. This resulted in ward managers agreeing that the priority for the ward was to reinstate the change to the morning routine and challenge the behaviours of those who sought to undermine the initiative. This would 'reassure junior nurses that they were valued and supported.' In a reflective session with Sophie afterwards the facilitator encouraged her to critically reflect on her leadership role. Sophie identified:

I can see that some nurses are undermining my work and decisions. I have struggled to come to terms with the criticism being levelled at me and have been inconsistent in trying to please everyone. I've developed a deeper understanding of what's happening. That will help me find ways to deal with the problem and challenge these behaviours. Thinking things through with you has permitted a more

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appropriate response and resulted in a turning point allowing us to take action. I see it's imperative for me to be consistent and lead. [RS21]

Drawing the study to a close the healthcare team met for a final reflective session. Data obtained throughout the study was discussed and participants were invited to share their experience:

> I think things are generally better, more positive for patients. [Doctor]
>
> Working together things have changed and nursing staff seem more empowered to ask questions, talk things through and take responsibility. [Lead nurse]
>
> We discuss issues now. We include older patients. The senior nurses include us junior nurses too. [Nurse 1]
>
> We work better as a team, even with medics and this helps patient care. [Nurse 2]
>
> I've learnt the importance of delegating and supporting nurses to take on new initiatives. [Ward manager]
>
> It better now. I ensure new initiatives are seen through if patient care is to improve. We have come forward from a point of backwardness, I am proud to be part of so much learning. [Ward Manager], [RS26]

For Peer Review

DISCUSSION

This paper provides new knowledge about the importance of using holistic facilitation to create psychologically safe spaces to enable the nursing team to critically analyse practice and consider ways to enhance patient care. EAR offers a way to uncover new of understandings of practice, however it is not without its limitations. As the researcher works with co-researchers and adapts to specific events as they unfold, an EAR approach promotes understanding and change which is context specific (Cohen *et*

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al. 2011). This poses challenges for assessing the trustworthiness and transferability of data. Meyer *et al.* (2000) argue that findings from a single action research study more closely reflect reality. Therefore, if the findings resonate with the reader and potentially fit into other contexts, then the study meets the criterion of fittingness (Guba & Lincoln 1981). Furthermore, the close partnership requires the researcher/facilitator to have an awareness of how the 'self' affects all aspects of the research study. Thus the lead researcher maintained a reflexive journal and returned the data generated to co-researchers in a concerted effort to authenticate the data (Cohen *et al.* 2011).

For Peer Review

In nursing environments where weak leadership, oppressed behaviours and a lack of support are evident there is a need to create psychologically safe spaces to help change the context in which practitioners work. The PARIHS framework (Kitson et al 1998) that guided this study, proposes that context is a key determinant of the ability of an area to change (McCormack et al 2002). Leadership is the third sub-element of context and gives rise to clear roles, effective teamwork, and effective organisational structures (Kitson et al. 1998). Effective leadership is an essential component of a strong workplace culture and effective organisations (Kitson *et al*. 2008, Apekey *et al*. 2011, Dixon-woods *et al.* 2013). Leaders, particularly those who operate in the middle of an organisation, have a crucial role in ensuring optimal patient care and creating psychologically safe environments (Edmondson 2012). Their actions and reactions shape the team culture, thus it is essential that ward leaders understand that they required to establish and clarify boundaries for behaviour and action within the team. However, it was evident from initially working with ward leaders that they did not know how important their leadership role was in setting the culture in their unit. Challenged constantly to balance competing demands their leadership goals were not always consistent or clear. Critical reflection revealed that the boundaries for behaviour and action were primarily based on a paternalistic model, with ward leaders 'fixing things'. By their own admission this approach placed more stress upon them and encouraged a lack of accountability within the nursing team.

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To create psychologically safe spaces and open critically reflective discussion on their leadership role, the researcher/facilitator worked individually with the ward leaders. In this relationship ward leaders were challenged and supported to consider the impact their leadership style had on the ward environment. Holistic facilitation enabled carefully negotiated trusting partnerships to be built, permitting experiences and knowledge to be shared as a resource to help solve problems and take appropriate action. This was achieved by the facilitator role modelling supportive behaviours, being accessible, listening attentively, asking facilitative questions, being tenacious and encouraging participants to take action. These are the leadership behaviours that can actively cultivate the conditions for psychological safety (Edmondson 2012).

For Peer Review

As people internalise the cultures of which they are a part, altering mindsets and basic assumptions is not easy (Schein 2010). Ward leaders initially found it difficult to take the practical steps required to invite participation from the nursing team and see through initiatives. This was evidenced when the healthcare team expressed their dissatisfaction that agreed changes to practice were abandoned to pacify certain team members. Ward leaders were particularly challenged at this time as they were required to address their weak leadership behaviours. Holding the lead nurse in psychological safety, using holistic facilitation, assisted her to challenge negative behaviours. To support the ward managers further, the facilitator used holistic facilitation to help them develop insight into how important it was for them be a leader with clear, consistent direction and purpose (Dixon-Woods *et al*. 2013). These are essential elements of psychological safety (Edmondson 2012).

Dixon-Woods et al. (2013) propose that actively seeking uncomfortable and challenging information from staff is required if organisations are to strengthen and improve their communication, teamwork, personal skills and staff development. This requires the healthcare team to reflect on their environment and how their behaviours may impact upon patient care. Working with the nursing team, using holistic facilitation to create psychologically safe spaces, supported them to explore and learn

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about their oppressed behaviours. They acknowledged that they were challenged daily to deliver the high quality patient care they wished in an environment where frustration, feeling undervalued and lowered self-esteem were prevalent. Additionally, inadequate communication between themselves and all members of the multidisciplinary team hampered nurse decision-making and patient care (Manias *et al*. 2014). Initially nursing staff appeared reluctant to enter into meaningful conversations within the multidisciplinary team because their feelings of being undervalued made them uncertain of the outcome (Edmondson 2012, Leung *et al*. 2015). Furthermore, they perceived that this was how ward life was meant to be, they appeared accepting of their situation.

For Peer Review

These behaviours are not unusual in environments where psychological safety is absent (Law *et al*. 2011). Schepers *et al*. (2008) argue that individuals need to feel valued for their contribution by those senior to them and by their peers. Moreover, at a team level, psychological safety is important for triggering a synergetic ‘’we are in this together’’ mentality, which has been shown to enhance team innovativeness, adaptability, and learning (Edmondson 1999). Creating psychologically safe spaces, where nurses felt valued and supported to discuss ward issues, enabled them to explore how their actions, interactions and reactions affected patient care. Reflecting on these difficult issues they began to realise how important it was for them to value their own work, be more assertive, communicate well and work together if they were to ensure that older patients were at the centre of the care they delivered (McCance et al. 2011)

Supported by the facilitator and ward managers, the ward nurses focus shifted to considering actionable ways in which they could address the practice issues and deliver person-centred care in more positive ways. As social networks, communications, power and politics are all part of ward life and empirical evidence claims individual behaviour and characteristics impact upon practice environments (Kitson 2007), these are important aspects of ward life to reflect on. Fostering a psychologically safe climate in which individuals are encouraged to join the conversation without fearing what powerful

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others may think of them (Edmondson 2012), encouraged nurses to consider ways to enhance their practice. This in turn appeared to improve their confidence (Siemsen *et al.* 2007, Huang *et al*. 2012), help them to develop more authentic relationships and consider actioning ideas (Law *et al.* 2011, Leung *et al*. 2015).

Dogherty *et al*. (2010) assert that the holistic facilitator role encompasses supporting and enabling practitioners to improve practice and take action. Working as co-researchers the facilitator supported the healthcare team to explore their practice, review the data and agree themes and sub themes. While this enabled them to gain insight into what was occurring in the unit, often they did not like what they had uncovered. Creating psychologically safe spaces, using holistic facilitation, required strong leadership, maturity, resilience and an ability to work with the unfolding situation. These skills ensured that co-researchers did not become overwhelmed with the experience of working in an EAR approach and enabled them to consider and take action. This places holistic facilitation towards the high end of the continuum (suggested in the i-PARIHS framework), (Harvey & Kitson 2015). Thus findings from this study fit with the i-PARIHS (Harvey & Kitson 2015), ideals that maintain the holistic facilitator has an enabling and empowering role. The PARIHS framework (Kitson *et al*. 1998) offered a sufficient structure to guide this study's direction and aided the researchers understanding throughout. However, data obtained through this study is suggestive that creating a psychologically safe space is a fundamental element of holistic facilitation, which has received little attention in the nursing literature. This is potentially a missing component that needs to be incorporated into the PARIHS (Kitson *et al*. 1998) and i-PARIHS frameworks (Harvey & Kitson 2015) to more accurately reflect the complexities of working with practitioners in practice.

For Peer Review

CONCLUSION

In healthcare environments where weak leadership, oppressed behaviours and a lack of support are apparent there is a need for psychologically safety to help change culture. There are countless ways the

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unique elements of individual ward context, culture and leadership (sub elements of the PARIHS framework) impact upon the ever-changing practice environment. If individuals/teams are to be enabled to meet the demands of contemporary healthcare practices, creating psychologically safe spaces is of paramount importance. Through the creation of psychologically safe spaces practitioners can be enabled to engage in difficult conversations and take action, without loss of respect or threats to their identity. Furthermore, they can achieve learning and develop their leadership skills to affect a change in delivering person-centred practices. This paper argues that holistic facilitation can offer a medium for creating psychologically safe spaces. Furthermore, it has identified psychological safety as a missing component of the PARIHS and i-PARIHS framework, which may be crucial to transforming healthcare environments.

For Peer Review

RELEVANCE TO CLINICAL PRACTICE

The pressure on healthcare organisations and practice environments continues to increase. Healtcare teams need to be assisted to critically reflect on their practice and the culture in which they work if they are to be enabled to deliver safe and effective person-centred care. To achieve the necessary skills to lead and develop services, using the best available evidence, requires more than simply highlighting what is wrong with practice. Due to the complexities of practice environments, ward managers, in particular, and healthcare practitioners, in general, require support and assistance on how to try and put things right. Creating psychologically safe spaces, through holistic facilitation, enables individuals and teams to explore and alter the culture and context in which they work.

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DISCLOSURE

The authors have confirmed that all authors meet the ICMJE criteria for authorship credit (www.icmje.org/ethical_1author.html) as follows (1) substantial contributions to conception and design of, or acquisition of data or analysis and interpretation of data, (2) drafting the article or revising it critically for important intellectual content and (3) final approval of the version to be published.

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For Peer Review

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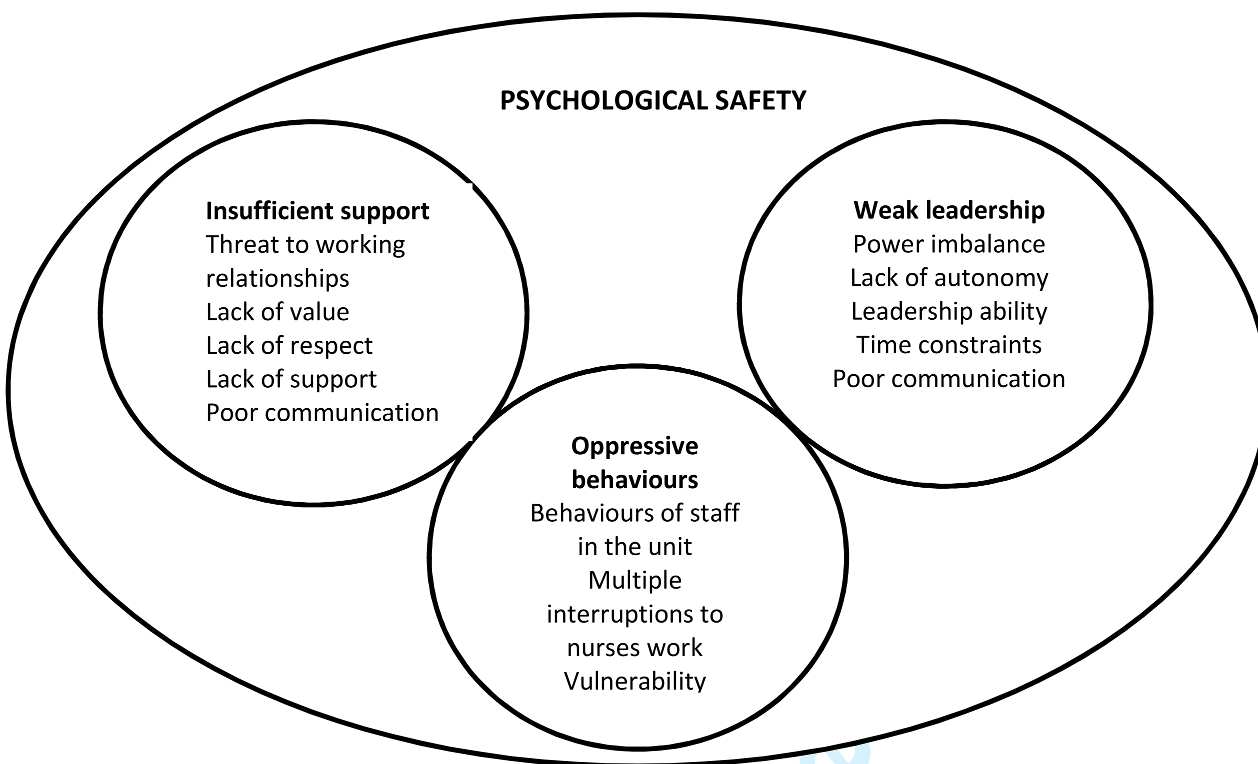

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Table 1: Examples of agree actions

Theme	Agreed Actions
Insufficient Support	Work within the overarching ground rules agreed by the nursing team. [RS2] Explicitly ask for help or guide others in how they can assist us. [RS7] Seek opinions and listen to what others have to say. This will display that we, as nursing staff, value others and their advice. [RS9] Improve communication with medical team by being available for ward rounds, being open about when we disagree with decisions while remaining respectful and professional. [RS8,11,22] Seek opportunities to discuss ongoing issues. [RS24] Care for and support one another to ensure good team working relationships. [RS1, 10, 18, 19 20, 21]
Oppressed behaviours	To be more positive about our role and contribution to the team. [RS12] Communicate with the MDT in a professional way to make sure we deliver better care to patients [RS12, 22] Prioritise patient needs over workload to enhance the care we give to patients. [RS 12, 24] Change current 'mindset' of self- imposed time frames.[RS15, 24] "Be realistic about what we can achieve". [RS6] Value ourselves - Avoid saying "I'm just the nurse." [RS22] "Challenge people who peek behind the curtains." Remaining professional [RS12]
Weak Leadership	Adopt a more consistent in leadership approach [RS21] Manage the behaviour of those who are not contributing effectively. [RS19, 20, 21]

For Peer Review

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	Nursing staff to actively seek information. Nursing staff volunteer to attend and actively communicating with members of the MDT during ward rounds, pathology meetings etc. [RS8, 11] Listening to the views of all staff. [RS1, 6, 24] "Working together things have changed and nursing staff seem more empowered to ask questions, talk things through and take responsibility." [RS26] Explore the issues and reformulate prevailing assumption of others. [RS26]

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