



Exploring psychological safety as a component of facilitation within the Promoting Action on Research Implementation in Health Services framework

Brown, D., & McCormack, B. (2016). Exploring psychological safety as a component of facilitation within the Promoting Action on Research Implementation in Health Services framework. *Journal of Clinical Nursing*, 25(19-20), 2921-2932. Advance online publication. <https://doi.org/10.1111/jocn.13348>

[Link to publication record in Ulster University Research Portal](#)

Published in:
Journal of Clinical Nursing

Publication Status:
Published (in print/issue): 31/10/2016

DOI:
[10.1111/jocn.13348](https://doi.org/10.1111/jocn.13348)

Document Version
Author Accepted version

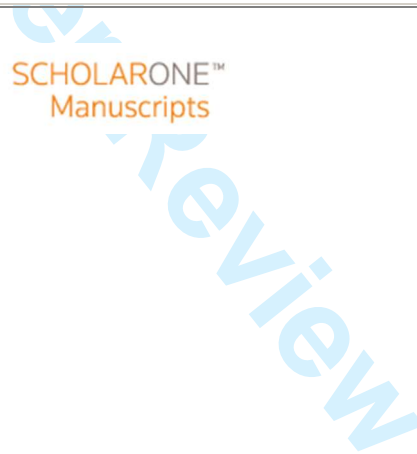
General rights
Copyright for the publications made accessible via Ulster University's Research Portal is retained by the author(s) and / or other copyright owners and it is a condition of accessing these publications that users recognise and abide by the legal requirements associated with these rights.

Take down policy
The Research Portal is Ulster University's institutional repository that provides access to Ulster's research outputs. Every effort has been made to ensure that content in the Research Portal does not infringe any person's rights, or applicable UK laws. If you discover content in the Research Portal that you believe breaches copyright or violates any law, please contact pure-support@ulster.ac.uk.



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

Journal:	<i>Journal of Clinical Nursing</i>
Manuscript ID	JCN-2016-0166.R1
Manuscript Type:	Original Article
Keywords:	Adult Nursing, Emancipatory Action Research, Facilitation, Evidence-Based Practice, Postoperative Nursing, Acute Care, Cultural Issues, Reflective Practice



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

1
2
3 theoretical contribution to the area of facilitation it is proposed that the additional element of
4
5 psychological safety needs to be incorporated into facilitation models, in particular the PARIHS
6
7 framework, to more accurately reflect the complexities of working with healthcare teams.
8
9

10
11 **Key words.** PARIHS framework, psychological safety, holistic facilitation, leadership, oppression, culture
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

For Peer Review

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.

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.

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).

1
2
3 To enhance effective team working and transform culture at a practical level requires individuals and
4
5 teams to alter their mindsets and patterns of behaviour (Manley *et al.* 2011). Exploring issues of culture
6
7 in acute care, Brown and McCormack (2011) unearthed that weak leadership, negative mindsets and
8
9 adverse patterns of behaviour prevented the nursing team from delivering optimal patient care.
10
11 Nursing staff working in a culture in which they considered their opinions invalid or not valued, seldom
12
13 contributed positively to discussions or attempts to change the environment in which they worked. It is
14
15 not that these individuals were disinterested in contributing, rather they were kept out of the
16
17 conversation by the pervasive fear of what more powerful others may think of them (Edmondson
18
19 2012). Consequently, Brown and McCormack (2011) argued there was a need to create psychologically
20
21 safe environments if practitioners were to be assisted to explore their practice and alter the culture and
22
23 context in which they worked.
24
25
26

27
28 Creating a psychologically safe environment, where people feel able to focus on the underlying issues
29
30 without threat of loss of self-identity or integrity (Schein 2010), is essential to organisational learning
31
32 (Carmeli *et al.* 2008, Huang *et al.* 2012). Furthermore, the concept of psychological safety connects
33
34 changeable workplaces to the health, resilience and well-being of individuals and teams (Shian *et al.*
35
36 2012). Without the trust and respect found in psychologically safe places, individuals will minimise the
37
38 risk to *self* by avoiding 'to act', unless they are certain of the outcome. Such a culture limits
39
40 communication, authentic relationships, innovation and potentially creates performance and safety
41
42 risks (Law *et al.* 2011, Edmondson 2012, Leung *et al.* 2015). However, to enable the development of a
43
44 learning culture, individuals and teams are required to challenge the basic underlying assumptions of
45
46 their practice. These are inclined to be non-confrontable and non-debatable matters that are extremely
47
48 difficult to change (Schein 2010). Holistic facilitation encompasses working with practitioners to release
49
50 their potential to explore improvements in practice and take action (Harvey & Kitson 2015). Therefore,
51
52 it offers one way of creating a psychologically safe environment to enable practitioners to explore basic
53
54
55
56
57
58
59
60

1
2
3 assumptions and alter their practice by problem solving and through providing support (Brown &
4
5 McCormack 2011).
6
7

9 **PARIHS FRAMEWORK**

10
11 Cultural change requires effective leadership (Apekey *et al.* 2011, Dixon-Woods *et al.* 2013), learning in
12 and from practice (Manley *et al.* 2009) and teamwork (Wilson *et al.* 2005). However, there is
13 insufficient high quality information about what works, in which settings and with whom (Ward *et al.*
14 2009). The PARIHS conceptual framework (Kitson *et al.* 1998) is comprised of three key constructs
15 (evidence, context, and facilitation). It is held that these key variables act as a map of the factors that
16 need to be taken into account when implementing evidence into practice (Kitson *et al.* 1998).
17
18 Originators of the PARIHS framework argue that successful implementation occurs when robust
19 evidence matches professional consensus and patient needs (high evidence); the context is receptive to
20 change with sympathetic cultures, effective leadership, and appropriate evaluative systems (high
21 context); and when there is appropriate facilitation of change, with input from skilled external and
22 internal facilitators (high facilitation; Kitson *et al.* 1998).
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54

55 Since publication of the PARIHS framework, refinement, validation, and clarity of the key elements of
56 evidence, context, and facilitation have been ongoing (McCormack *et al.* 2002, Harvey *et al.* 2002,
57 Rycroft-Malone *et al.* 2004, Kitson *et al.* 2008). Internationally researchers have explored the use of the
58 PARIHS framework as a practical and theoretical model to guide their research (for example, Stetler *et*
59 *al.* 2011, Rycroft-Malone *et al.* 2013, Botti *et al.* 2014). Examining theoretical and practical challenges to
60 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

1
2
3 deliberate, conscious and collaborative process that enables teams and individuals to engage in
4
5 conversations about what is happening in practice. Though no singular facilitation approach has been
6
7 found to be effective in enhancing evidence-based practice (Janes *et al.* 2009), facilitation, both task
8
9 and holistic, are essential components in the operationalisation of the PARIHS framework. Qualitative
10
11 critical synthesis of the literature on the PARIHS framework (Helfrich *et al.* 2010), led Stetler *et al.*
12
13 (2011) to modify and provide a practical guide, based on task-orientated facilitation, to promote the
14
15 PARIHS frameworks' evolution. While this guide is helpful for targeted evidence-based practice
16
17 implementations that have a strong task-orientated focus (Stetler *et al.* 2011), further research is
18
19 required to evaluate its effectiveness.
20
21
22
23

24
25 In a re-conceptualisation of the constructs of the PARIHS framework, Harvey and Kitson (2015) propose
26
27 the integrated-PARIHS (i-PARIHS). The i-PARIHS places importance on the facilitator as the active
28
29 component in guiding individuals and teams through complex contextual and change processes. The
30
31 holistic facilitator needs to undertake an enabling and empowering role, as the skill of the facilitator
32
33 determines the 'state of preparedness' of the team and individuals (Kitson *et al.* 2008). As teams and
34
35 individuals are encouraged to step back and become more conscious of habitual ways of being (Senge
36
37 *et al.* 2005), the holistic facilitator is required to demonstrate authentic, consistent, strong facilitative
38
39 leadership (Brown & McCormack 2011). Finally, the holistic facilitator is required to assess, align and
40
41 integrate the other constructs of the PARIHS framework to help individuals and team understand what
42
43 is occurring (Harvey & Kitson 2015).
44
45
46
47

48 **STUDY AIMS**

49
50 To explore holistic facilitation as an approach to enable the healthcare team to critically analyse
51
52 practice and consider ways to enhance patient care.
53
54

55 **METHOD**

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

1
2
3 medical team agreed to participate in three facilitated reflective sessions. In accordance with
4
5 emancipatory ideals these findings were used to inform the development of the study reported here.
6
7

8 9 **Data collection**

10
11 To ensure this study adopted a systematic and rigorous approach there were multiple sources of data
12
13 collection used in the overarching study (Brown & McCormack 2011). For the purposes of this paper
14
15 data obtained through facilitated reflective sessions (RS) and the lead researchers' reflexive journal (RJ)
16
17 will be drawn upon. Reflective sessions were periods of time set aside for a maximum of five members
18
19 of the nursing team to critically reflect on issues they faced daily and consider ways to change their
20
21 practice. Each reflective session was negotiated with ward managers and planned into the duty roster
22
23 to allow the nursing staff an opportunity to consider participating. No period of reflection lasted for
24
25 more than 1hour 30 minutes. The lead researcher maintained a reflexive journal systematically
26
27 recording empirical events and difficulties or successes at the end of all facilitated sessions.
28
29 Additionally, maintaining a reflexive journal helped the lead researcher/facilitator deal with the issues
30
31 as they unfolded and consider their supportive role during challenging times.
32
33
34
35
36

37
38 Having obtained ethical approval from the study authors' institutional review board, consenting
39
40 participants were invited to critically reflect on and explore their practice. The study comprised of
41
42 twenty-six formal facilitated reflective sessions and twenty-six ad hoc reflective sessions. Additionally,
43
44 the lead nurse and ward managers undertook to work individually with the lead researcher/facilitator,
45
46 using a model of 1:1 facilitation (27 sessions in total). Data were gathered using flip charts and
47
48 consistently shared with the team to ensure collective understanding.
49
50

51 52 **Ethical considerations**

53
54 Working in groups to explore difficult issues meant participant anonymity was not possible.
55
56 Nevertheless, action researchers must respect the privacy of research participants by ensuring
57
58
59
60

1
2
3 confidentiality is maintained and making it clear that people are free to decide what information they
4 wish to share. To ensure ethical principles were adhered to overarching ground rules were negotiated
5 and reinforced throughout the duration of the study. Additionally, participants agreed to avoid making
6 explicit reference to members of the team. At the conclusion of all reflective sessions, participants were
7 given the opportunity to review data and agree emergent themes. It was the broad themes that
8 participants and the lead facilitator agreed could be discussed with the wider organisation.
9
10
11
12
13
14
15
16
17

18 The facilitation required for EAR moves towards the high end of the continuum, suggested in the i-
19 PARIHS framework (Harvey & Kitson 2015). Therefore, the holistic facilitator must demonstrate
20 effective leadership, self-discipline and level-headedness, if they are to maintain the trust and integrity
21 required to undertake this type of research. The lead facilitator met with the Medical Clinical Director
22 and Director of Nursing at regular intervals to ensure they were aware of how the study was
23 progressing and to discuss if there were any issues that would impact on the organisation as a whole.
24
25
26
27
28
29
30
31

32 **Analysis**

33
34 Data were analysed using a thematic approach. Reading through the evidence, initial impressions and
35 themes arising from the data were noted. Recurrent themes that formed the basis of repeated patterns
36 across the data set were identified. Subsequently, the emerging themes were reviewed, defined and
37 refined to identify the essence of each theme. At each stage data were returned to the nursing staff
38 providing them with an opportunity to critique the data ensuring it was representative and trustworthy.
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

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.

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:

1
2
3 In the groups we debated issues of confidentiality, anonymity, vulnerability and the need for
4 support. This has offered me a significant challenge. As facilitator I realise that I hold a key role
5 in ensuring people are safe to participate in this work and I have spent much time working on
6 this issue. The ground rules are in place and I am role modelling ways to be supportive and
7 how to suspend hierarchical roles to enable nursing staff to explore their practice and consider
8 actions to effect changes in patient care. [RJ4]
9
10
11
12
13
14
15
16
17

18 Working with the nursing team and role modelling ways they could support one another included being
19 available to offer guidance when it was required, helping and encouraging the team to communicate
20 with one another and ask explicitly for the help they needed (table 1). For example, one senior nurse
21 commented:
22
23
24
25

26
27
28
29 If I dress the central line for a junior nurse they should complete the patient observations.

30 [Nurse]

31
32
33 So, what gets in the way of this happening? [Facilitator]

34
35 I guess I don't tell them that. I just expect them to know. That's not supportive I suppose.

36
37 [Nurse], [RS 7]
38
39
40
41

42 Presuming that junior nurses knew what they were required to do without offering clear direction
43 strained nurse relationships. The nursing team began to realise how important communication was in
44 improving team working.
45
46
47
48
49

50 **Oppressed behaviours**

51
52 The theme of oppressed behaviours was intertwined with the issue of support. Facilitated reflection
53 highlighted that the nursing team considered their work was undervalued which in turn contributed to
54 lowered self-esteem. For example:
55
56
57
58
59
60

1
2
3
4
5 Everyone else is self-interested in their own role and so we are under-valued. [Nurse 2]
6

7 Our opinions are not sought when people want to change practice, even if that directly affects
8
9 us. Do our needs ever matter? [Nurse 4]
10

11 Some members of the multidisciplinary team just want their tasks done immediately with no
12 consideration of our workload. [Nurse 2]
13

14 And we do it. But they focus on our shortcomings rather than comment on the good things
15 nurses do. [Nurse 3], [RS 10]
16
17

18
19 Working in a culture which the nursing team considered was based on 'blame and negativity'
20 contributed towards nursing staff feeling unappreciated and powerless to change the context of
21 nursing practice. They further identified that interruptions to nurses' work also impacted upon patient
22 care leaving nursing staff frustrated and feeling under-valued. For example:
23
24
25
26
27

28
29
30
31 Interruptions are about communication, but when they're untimely they devalued both
32 patients and us. It's a lack of respect. [Nurse 1]
33

34
35 It's like when the patient's embarrassed and we say we don't mind. Then someone comes in
36 behind the screens and their dignity is gone again, [Nurse 3], [RS 24]
37
38

39
40
41 Nursing staff were discouraged by a culture that seemed to disregard the need for patient privacy and
42 dignity. Furthermore, they felt powerless to 'prevent breaches of patient dignity occurring'. Nursing
43 staff wished to advocate for the patients and 'deliver care in a person-centred and holistic way', but
44 considered that issues of time, a lack of nursing autonomy and confidence to be assertive prevented
45 them from preserving older people's personhood. For example:
46
47
48
49
50

51
52
53
54 We tend to talk among ourselves, you know, moan about these things. [Nurse 1]
55

56 You need to be careful not to step out of your role. [Healthcare support worker]
57
58
59
60

1
2
3 Should we challenge people who peek behind the curtains? Nicely I mean. [Nurse 2], [RS 12]
4
5
6

7 Nursing staff aligned themselves with older people as a group who 'do not always speak up.' Despite
8 nurses believing they should advocate for older people, through critical reflection they uncovered that
9 their communication within the MDT was often insufficient. For example, in one reflective session they
10 discussed the issue of patients not always understanding their analgesic options following surgery.
11 Consequently some older people had to 'try and understand multiple pain relieving techniques which
12 led to confusion.' Nursing staff uncovered that they had never addressed this issue with their medical
13 colleagues directly and through reflection realised 'you know if I'm honest we don't always consult with
14 doctors either.' [RS12]
15
16
17
18
19
20
21
22
23
24

25 Supporting the healthcare team through facilitated reflection they uncovered that their behaviours led
26 to poor communication within the team and impacted upon patient care. For example:
27
28
29
30
31
32

33 When we make a decision you don't agree with you don't discuss it with us further. [Doctor]
34
35
36

37 This enabled them to consider how they might, as nurses and people, continue to be professional in
38 their approach and discuss differences of opinion more openly (table 1). For example:
39
40
41
42

43 So we should say when we are not happy or don't understand the decision. [Nurse 2].
44
45

46 We should try to avoid saying I'm just the nurse, this just devalues ourselves. [Nurse 1], [RS22]
47
48
49

50 Leadership

51
52 Facilitated reflection with the ward leaders revealed that many nurses looked towards them as the
53 person who had the responsibility for 'fixing everything,' 'finding solutions.' To a degree they were
54 content to accept this role, as it made 'life easy for nurses.' Nevertheless, it exacerbated their stress as
55
56
57
58
59
60

1
2
3 it meant that they could not do their own work. To be clinical, complete managerial tasks and 'be all
4 things to all people,' was challenging. Daniel (charge nurse) and Sophie (ward sister), (pseudonyms),
5
6 considered that they had a duty to support everyone, but accepted that they were not solely
7
8 responsible for shaping initiatives within the unit. However, they initially struggled to relinquish their
9
10 paternalistic approach to managing the ward environment stating:
11
12

13
14
15
16 There are no other options, if I think it's a good idea then the nurses will agree. It's my
17
18 responsibility to manage the ward. [RS2]
19

20
21
22 Their reticence was partly due to concerns that nurses exhibited signs of a lack of responsibility and
23
24 accountability. Lucy (lead nurse) perceived that this was due to nurses lacking confidence in their
25
26 abilities, at certain moments in patient care. Additionally, 'hierarchical medical attitudes made nurses
27
28 adopt avoidance strategies' [RS3].
29

30
31
32
33 Reflection with the ward nursing and medical team highlighted that they considered that there was
34
35 deficient leadership in the unit. In particular there was a lack of clarity around roles and boundaries,
36
37 confusion about power and authority and a low regard for opinions shared. This was particularly
38
39 evident when the nursing team, with the support of the ward managers, attempted to initiate an
40
41 agreed changes practice.
42
43

44
45
46 New changes to the morning routine have been abandoned, after only a few days, to pacify
47
48 certain nurses. [Nurse 1]
49

50
51 Everyone is unclear who really made the decision to abandon the new way of working. [Nurse
52
53 2]
54

55
56 It's not supportive or encouraging. What's the point of agreeing things if it's only going to fail.
57
58 [Nurse 3].
59
60

1
2
3 Things are really not good here in this ward at the moment. [Doctor], [RS18].
4
5
6

7 DB was also challenged by the lack of leadership shown at this time recording in the researcher's
8 reflexive journal:
9
10

11
12
13 Three times now I have met with ward managers to help them reflect on why and how they
14 have failed to address this issue. Sophie in particular realises the nursing team are unhappy and
15 has agreed on actions to resolve the issue. However, even offering to co-facilitate a meeting
16 with the nursing team she seems unable to take the next step. Lucy has requested me to help
17 her in an individual facilitated reflective session to find a way through this impasse. [RJ28]
18
19
20
21
22
23

24
25
26 Lucy responded to the issue by reflecting with the facilitator to consider how she should approach this
27 issue and develop a plan. Subsequently she met with the ward managers to discuss her 'concerns in
28 relation to poor leadership and the junior staff being disillusioned.' Reflecting with the facilitator
29 afterwards, Lucy considered that she had been 'initially directive and blunt' but had then been
30 'facilitative and supportive' as she sought ways to address the leadership issues in the unit and 'call
31 people to account' [RS20]. This resulted in ward managers agreeing that the priority for the ward was
32 to reinstate the change to the morning routine and challenge the behaviours of those who sought to
33 undermine the initiative. This would 'reassure junior nurses that they were valued and supported.' In a
34 reflective session with Sophie afterwards the facilitator encouraged her to critically reflect on her
35 leadership role. Sophie identified:
36
37
38
39
40
41
42
43
44
45
46
47
48
49

50 I can see that some nurses are undermining my work and decisions. I have struggled to come to terms
51 with the criticism being levelled at me and have been inconsistent in trying to please everyone. I've
52 developed a deeper understanding of what's happening. That will help me find ways to deal with the
53 problem and challenge these behaviours. Thinking things through with you has permitted a more
54
55
56
57
58
59
60

1
2
3 appropriate response and resulted in a turning point allowing us to take action. I see it's imperative for
4
5 me to be consistent and lead. [RS21]
6
7

8
9 Drawing the study to a close the healthcare team met for a final reflective session. Data obtained
10
11 throughout the study was discussed and participants were invited to share their experience:
12
13

14 I think things are generally better, more positive for patients. [Doctor]
15
16

17 Working together things have changed and nursing staff seem more empowered to ask
18
19 questions, talk things through and take responsibility. [Lead nurse]
20
21

22 We discuss issues now. We include older patients. The senior nurses include us junior nurses
23
24 too. [Nurse 1]
25
26

27 We work better as a team, even with medics and this helps patient care. [Nurse 2]
28
29

30 I've learnt the importance of delegating and supporting nurses to take on new initiatives. [Ward
31
32 manager]
33
34

35 It better now. I ensure new initiatives are seen through if patient care is to improve. We have
36
37 come forward from a point of backwardness, I am proud to be part of so much learning. [Ward
38
39 Manager], [RS26]
40
41
42
43
44

45 **DISCUSSION**

46
47 This paper provides new knowledge about the importance of using holistic facilitation to create
48
49 psychologically safe spaces to enable the nursing team to critically analyse practice and consider ways
50
51 to enhance patient care. EAR offers a way to uncover new of understandings of practice, however it is
52
53 not without its limitations. As the researcher works with co-researchers and adapts to specific events as
54
55 they unfold, an EAR approach promotes understanding and change which is context specific (Cohen et
56
57
58
59
60

1
2
3 *al.* 2011). This poses challenges for assessing the trustworthiness and transferability of data. Meyer *et*
4
5 *al.* (2000) argue that findings from a single action research study more closely reflect reality. Therefore,
6
7 if the findings resonate with the reader and potentially fit into other contexts, then the study meets the
8
9 criterion of fittingness (Guba & Lincoln 1981). Furthermore, the close partnership requires the
10
11 researcher/facilitator to have an awareness of how the 'self' affects all aspects of the research study.
12
13 Thus the lead researcher maintained a reflexive journal and returned the data generated to co-
14
15 researchers in a concerted effort to authenticate the data (Cohen *et al.* 2011).
16
17

18
19
20 In nursing environments where weak leadership, oppressed behaviours and a lack of support are
21
22 evident there is a need to create psychologically safe spaces to help change the context in which
23
24 practitioners work. The PARIHS framework (Kitson *et al.* 1998) that guided this study, proposes that
25
26 context is a key determinant of the ability of an area to change (McCormack *et al.* 2002). Leadership is
27
28 the third sub-element of context and gives rise to clear roles, effective teamwork, and effective
29
30 organisational structures (Kitson *et al.* 1998). Effective leadership is an essential component of a strong
31
32 workplace culture and effective organisations (Kitson *et al.* 2008, Apekey *et al.* 2011, Dixon-woods *et al.*
33
34 2013). Leaders, particularly those who operate in the middle of an organisation, have a crucial role in
35
36 ensuring optimal patient care and creating psychologically safe environments (Edmondson 2012). Their
37
38 actions and reactions shape the team culture, thus it is essential that ward leaders understand that they
39
40 required to establish and clarify boundaries for behaviour and action within the team. However, it was
41
42 evident from initially working with ward leaders that they did not know how important their leadership
43
44 role was in setting the culture in their unit. Challenged constantly to balance competing demands their
45
46 leadership goals were not always consistent or clear. Critical reflection revealed that the boundaries for
47
48 behaviour and action were primarily based on a paternalistic model, with ward leaders 'fixing things'.
49
50 By their own admission this approach placed more stress upon them and encouraged a lack of
51
52 accountability within the nursing team.
53
54
55
56
57
58
59
60

1
2
3 To create psychologically safe spaces and open critically reflective discussion on their leadership role,
4
5 the researcher/facilitator worked individually with the ward leaders. In this relationship ward leaders
6
7 were challenged and supported to consider the impact their leadership style had on the ward
8
9 environment. Holistic facilitation enabled carefully negotiated trusting partnerships to be built,
10
11 permitting experiences and knowledge to be shared as a resource to help solve problems and take
12
13 appropriate action. This was achieved by the facilitator role modelling supportive behaviours, being
14
15 accessible, listening attentively, asking facilitative questions, being tenacious and encouraging
16
17 participants to take action. These are the leadership behaviours that can actively cultivate the
18
19 conditions for psychological safety (Edmondson 2012).
20
21
22
23

24
25 As people internalise the cultures of which they are a part, altering mindsets and basic assumptions is
26
27 not easy (Schein 2010). Ward leaders initially found it difficult to take the practical steps required to
28
29 invite participation from the nursing team and see through initiatives. This was evidenced when the
30
31 healthcare team expressed their dissatisfaction that agreed changes to practice were abandoned to
32
33 pacify certain team members. Ward leaders were particularly challenged at this time as they were
34
35 required to address their weak leadership behaviours. Holding the lead nurse in psychological safety,
36
37 using holistic facilitation, assisted her to challenge negative behaviours. To support the ward managers
38
39 further, the facilitator used holistic facilitation to help them develop insight into how important it was
40
41 for them be a leader with clear, consistent direction and purpose (Dixon-Woods *et al.* 2013). These are
42
43 essential elements of psychological safety (Edmondson 2012).
44
45
46
47

48
49 Dixon-Woods *et al.* (2013) propose that actively seeking uncomfortable and challenging information
50
51 from staff is required if organisations are to strengthen and improve their communication, teamwork,
52
53 personal skills and staff development. This requires the healthcare team to reflect on their
54
55 environment and how their behaviours may impact upon patient care. Working with the nursing team,
56
57 using holistic facilitation to create psychologically safe spaces, supported them to explore and learn
58
59
60

1
2
3 about their oppressed behaviours. They acknowledged that they were challenged daily to deliver the
4
5 high quality patient care they wished in an environment where frustration, feeling undervalued and
6
7 lowered self-esteem were prevalent. Additionally, inadequate communication between themselves and
8
9 all members of the multidisciplinary team hampered nurse decision-making and patient care (Manias *et*
10
11 *al.* 2014). Initially nursing staff appeared reluctant to enter into meaningful conversations within the
12
13 multidisciplinary team because their feelings of being undervalued made them uncertain of the
14
15 outcome (Edmondson 2012, Leung *et al.* 2015). Furthermore, they perceived that this was how ward
16
17 life was meant to be, they appeared accepting of their situation.
18
19

20
21
22 These behaviours are not unusual in environments where psychological safety is absent (Law *et al.*
23
24 2011). Schepers *et al.* (2008) argue that individuals need to feel valued for their contribution by those
25
26 senior to them and by their peers. Moreover, at a team level, psychological safety is important for
27
28 triggering a synergetic “we are in this together” mentality, which has been shown to enhance team
29
30 innovativeness, adaptability, and learning (Edmondson 1999). Creating psychologically safe spaces,
31
32 where nurses felt valued and supported to discuss ward issues, enabled them to explore how their
33
34 actions, interactions and reactions affected patient care. Reflecting on these difficult issues they began
35
36 to realise how important it was for them to value their own work, be more assertive, communicate well
37
38 and work together if they were to ensure that older patients were at the centre of the care they
39
40 delivered (McCance *et al.* 2011)
41
42
43

44
45 Supported by the facilitator and ward managers, the ward nurses focus shifted to considering
46
47 actionable ways in which they could address the practice issues and deliver person-centred care in
48
49 more positive ways. As social networks, communications, power and politics are all part of ward life and
50
51 empirical evidence claims individual behaviour and characteristics impact upon practice environments
52
53 (Kitson 2007), these are important aspects of ward life to reflect on. Fostering a psychologically safe
54
55 climate in which individuals are encouraged to join the conversation without fearing what powerful
56
57
58
59
60

1
2
3 others may think of them (Edmondson 2012), encouraged nurses to consider ways to enhance their
4
5 practice. This in turn appeared to improve their confidence (Siemsen *et al.* 2007, Huang *et al.* 2012),
6
7 help them to develop more authentic relationships and consider actioning ideas (Law *et al.* 2011, Leung
8
9 *et al.* 2015).

10
11
12
13
14 Dogherty *et al.* (2010) assert that the holistic facilitator role encompasses supporting and enabling
15
16 practitioners to improve practice and take action. Working as co-researchers the facilitator supported
17
18 the healthcare team to explore their practice, review the data and agree themes and sub themes. While
19
20 this enabled them to gain insight into what was occurring in the unit, often they did not like what they
21
22 had uncovered. Creating psychologically safe spaces, using holistic facilitation, required strong
23
24 leadership, maturity, resilience and an ability to work with the unfolding situation. These skills ensured
25
26 that co-researchers did not become overwhelmed with the experience of working in an EAR approach
27
28 and enabled them to consider and take action. This places holistic facilitation towards the high end of
29
30 the continuum (suggested in the i-PARIHS framework), (Harvey & Kitson 2015). Thus findings from this
31
32 study fit with the i-PARIHS (Harvey & Kitson 2015), ideals that maintain the holistic facilitator has an
33
34 enabling and empowering role. The PARIHS framework (Kitson *et al.* 1998) offered a sufficient structure
35
36 to guide this study's direction and aided the researchers understanding throughout. However, data
37
38 obtained through this study is suggestive that creating a psychologically safe space is a fundamental
39
40 element of holistic facilitation, which has received little attention in the nursing literature. This is
41
42 potentially a missing component that needs to be incorporated into the PARIHS (Kitson *et al.* 1998) and
43
44 i-PARIHS frameworks (Harvey & Kitson 2015) to more accurately reflect the complexities of working
45
46 with practitioners in practice.
47
48
49
50

51 52 53 **CONCLUSION**

54
55 In healthcare environments where weak leadership, oppressed behaviours and a lack of support are
56
57 apparent there is a need for psychologically safety to help change culture. There are countless ways the
58
59
60

1
2
3 unique elements of individual ward context, culture and leadership (sub elements of the PARIHS
4 framework) impact upon the ever-changing practice environment. If individuals/teams are to be
5 enabled to meet the demands of contemporary healthcare practices, creating psychologically safe
6 spaces is of paramount importance. Through the creation of psychologically safe spaces practitioners
7 can be enabled to engage in difficult conversations and take action, without loss of respect or threats to
8 their identity. Furthermore, they can achieve learning and develop their leadership skills to affect a
9 change in delivering person-centred practices. This paper argues that holistic facilitation can offer a
10 medium for creating psychologically safe spaces. Furthermore, it has identified psychological safety as a
11 missing component of the PARIHS and i-PARIHS framework, which may be crucial to transforming
12 healthcare environments.
13
14
15
16
17
18
19
20
21
22
23

24 25 26 **RELEVANCE TO CLINICAL PRACTICE**

27
28 The pressure on healthcare organisations and practice environments continues to increase. Healthcare
29 teams need to be assisted to critically reflect on their practice and the culture in which they work if they
30 are to be enabled to deliver safe and effective person-centred care. To achieve the necessary skills to
31 lead and develop services, using the best available evidence, requires more than simply highlighting
32 what is wrong with practice. Due to the complexities of practice environments, ward managers, in
33 particular, and healthcare practitioners, in general, require support and assistance on how to try and
34 put things right. Creating psychologically safe spaces, through holistic facilitation, enables individuals
35 and teams to explore and alter the culture and context in which they work.
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

ACKNOWLEDGEMENTS

The authors are grateful to the Northern Ireland Department of Health, Social Services and Public Safety (DHSSPS) Doctoral Fellowship Scheme that enabled this work to be undertaken. A sincere word of thanks is extended to all the practitioners who participated in the project.

DISCLOSURE

The authors have confirmed that all authors meet the ICMJE criteria for authorship credit (www.icmje.org/ethical_lauthor.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.

REFERENCES

Apekey TA, McSorley G, Tilling M, & Siriwardena AN (2011) Room for improvement?

Leadership, innovation culture and uptake of quality improvement methods in general practice.

Journal of Evaluation in Clinical Practice **17**, 311–318.

Brown D & McCormack B (2011) Developing the practice context to enable more effective pain

management with older people: an action research approach. *Implementation Science* 6:9

[Doi:10.1186/1748-5908-6-9](https://doi.org/10.1186/1748-5908-6-9)

Botti M, Kent B, Bucknall T, Duke M, Johnstone MJ, Considine J, Redley B, Hunter S, de Steiger R,

Holcombe M, & Cohen E (2014) Development of a Management Algorithm for Post-operative Pain

(MAPP) after total knee or total hip replacement: Study rationale and design. *Implementation Science* 9:

110 Doi:10.1186/s13012-014-0110-3

Carmeli A, Brueller D & Dutton, JE (2008) Learning Behaviours in the Workplace:

The Role of High-quality Interpersonal Relationships and Psychological. *Safety Systems Research and*

Behavioural Science **26**, 81-98.

Cohen L, Manion L & Morrison K (2011) *Research Methods in Education*. 7th edn. Routledge, New York.

Dogherty EJ, Harrison NB & Graham ID (2010) Facilitation as a Role and Process in Achieving Evidence-

Based Practice in Nursing: A Focused Review of Concept and Meaning. *Worldviews on Evidence-Based*

Nursing **7**, 76–89.

1
2
3 Dubois C, D'Amour D, Pomey M, Girard F & Brault, I. (2013) Conceptualizing performance of nursing
4 care as a prerequisite for better measurement: a systematic and interpretive review. *BioMed Central*
5 *Nursing* 12:7 Doi: 10.1186/1472-6955-12-7
6
7
8

9
10
11 Dixon-Woods M, Baker R, Charles K, Dawson J, Jerzembek G, Martin G, McCarthy I, McKee L, Minion J,
12 Ozieranski P, Willars J, Wilkie P & West M. (2013) Culture and behaviour in the English National Health
13 Service: overview of lessons from a large multimethod study. *BMJ Quality and Safety* 0:1–10.
14
15
16 Doi:10.1136/bmjqs-2013-001947
17
18
19

20
21
22 Edmondson A. (2012) *Teaming: How Organisations learn, innovate and compete in the knowledge*
23 *economy*. Jossey Bass, San Francisco.
24
25
26

27
28
29 Edmondson A C (1999) Psychological safety and learning behaviour in work teams. *Administrative*
30 *Science Quarterly* **44**, 350–383.
31
32
33

34
35 Francis R.(2013) *Report of the Mid- Staffordshire NHS Foundation Trust Public Inquiry: Analysis of*
36 *evidence and lessons learned*. The Stationary Office, London.
37
38
39

40
41
42 Guba EG & Lincoln Y S (1981) *Effective evaluation: Improving the usefulness of evaluation results*
43 *through responsive and naturalistic approaches*. Jossey-Bass, San Francisco. CA.
44
45
46

47
48 Harvey J & Kitson, A (2015) *Implementing Evidence-Based Practice in Healthcare: A facilitation guide*.
49 Routledge, Oxon.
50
51
52

53
54
55 Harvey G, Loftus-Hills A, Rycroft-Malone J, Titchen A, Kitson A, McCormack B, & Seers K. (2002). Getting
56 evidence into practice: The role and function of facilitation. *Journal of Advanced Nursing* **37**, 577-588.
57
58
59
60

1
2
3
4
5 Huang C & Jiang P (2012) Exploring the psychological safety of R&D teams: An empirical analysis in
6
7 Taiwan. *Journal of Management & Organization* **18**, 175–192.
8
9

10
11 Helfrich CD, Damschroder LJ, Hagedorn HJ, Daggett GS, Sahay A, Ritchie M, Damush T, Guihan M,
12
13 Ullrich PM & Stetler CB (2010) A critical synthesis of literature on the promoting
14
15 action on research implementation in health services (PARIHS) framework. *Implementation Science* **2**,
16
17 5:82 [Doi:10.1186/1748-5908-5-82](https://doi.org/10.1186/1748-5908-5-82)
18
19

20
21
22 Heslop, L. and Lu, S. 2014. Nursing-sensitive indicators: a concept analysis. *Journal of Advanced Nursing*,
23
24 70 (11), 2469-2482.
25
26

27
28
29 Janes N, Fox M, Lowe M, McGilton K & Schindel-Martin L (2009) Facilitating best practice in aged care:
30
31 exploring influential factors through critical incident technique. *International Journal of Older People*
32
33 *Nursing* **4**, 166–176.
34
35

36
37
38 Kitson A, Rycroft-Malone J, Harvey G, McCormack B, Seers K & Titchen A (2008) Evaluating the
39
40 successful implementation of evidence into practice using the PARIHS framework: theoretical and
41
42 practical challenges *Implementation Science* **3**:1 Doi:10.1186/1748-5908-3-1
43
44

45
46
47 Kitson A. (2007) Guest Editorial: What influences the use of research in clinical practice. *Nursing*
48
49 *Research* **56**, S1-S3 (Supplement).
50
51

52
53
54 Kitson A, Harvey G, & McCormack B. (1998) Enabling the implementation of evidence based practice: A
55
56 conceptual framework. *Quality in Health Care* **7**, 149-158.
57
58
59
60

1
2
3 Law R, Dollard MF, Tuckey MR & Dormann C (2011) Psychological safety climate moderated
4 harassment and bullying behaviours and negative relationships between harassment and bullying and
5 engagement. *Accident Analysis and Prevention* **43**, 1782-1793.
6
7
8

9
10
11 Maben J, Adams M, Peccei M, Murrells T & Robert G. (2012) 'Poppets and parcels': the links between
12 staff experience of work and acutely ill older peoples' experience of hospital care. *International Journal*
13 *of Older People Nursing* **7**, 83–94 Doi:10.1111/j.1748-3743.2012.00326
14
15
16

17
18
19
20 Manias E, Gerdtz M, Williams A, & Dooley M (2014) Complexities of medicines safety: communicating
21 about managing medicines at transition points of care across emergency departments and medical
22 wards. *Journal of Clinical Nursing* **24**, 69–80.
23
24
25

26
27
28
29 Manley K, Sanders K, Cardiff S & Webster J (2011) Effective workplace culture: the attributes, enabling
30 factors and consequences of a new concept. *International Practice Development Journal* **1**, 1-29
31
32 Available at: <http://www.fons.org/library/journal.aspx>
33
34
35

36
37
38 Manley K, Titchen A & Hardy S. (2009) Work-based learning in the context of contemporary
39 health care education and practice: a concept analysis. *Practice Development in Health Care*
40
41 **8**, 87-127.
42
43
44

45
46 Meyer J, Spilsbury K & Prieto J. (2000) Comparison of findings from a single case in relation to those
47 from a systematic review of action research. *Nurse Researcher* **7**, 37-53.
48
49
50

51
52
53 McCance T, McCormack, B & Dewing J. (2011) An exploration of person-centredness in practice. The
54 *Online Journal of Issues in Nursing* **16**, Manuscript 1.
55
56
57
58
59
60

1
2
3 McCormack B, Kitson A, Harvey G, Rycroft-Malone J, Titchen A, & Seers K (2002) Getting evidence into
4
5 practice: The meaning of 'context.' *Journal of Advanced Nursing* **38**, 94-104.
6
7

8
9
10 Powell A & Davies H (2012) The struggle to improve patient care in the face of professional boundaries.
11
12 *Social Science and Medicine* **75**, 807- 814.
13

14
15
16 Rycroft-Malone J, Seers K, Chandler J, Hawkes CA, Crichton N, Allen C, Bullock I & Strunin L.= (2013) The
17
18 role of evidence, context, and facilitation in an implementation trial: implications for the development
19
20 of the PARIHS framework. *Implementation Science* 8:28 Doi:10.1186/1748-5908-8-28
21
22

23
24
25 Rycroft-Malone J, Harvey J, Kitson A, McCormack B, Seers K, & Titchen A (2002) Getting evidence into
26
27 practice: Ingredients for change. *Nursing Standard* **16**, 38-43.
28

29
30
31 Rycroft-Malone J, Seers K, Titchen A, Harvey G, Kitson A, & McCormack B. (2004). What counts as
32
33 evidence in evidence-based practice? *Journal of Advanced Nursing* **47**, 81-90.
34
35

36
37
38 Schein EH (2010) *Organisational Culture and Leadership*. 4th edn. Jossey Bass, San Francisco.
39

40
41
42 Schepers J, Jong A, Wetzels, M & Ruyter K (2008) Psychological safety and social support in groupware
43
44 adoption: A multi-level assessment in education. *Computers & Education* **51**, 757–775.
45

46
47
48 Siemsen E, Roth AV, Balasubramanian S & Anand G (2009) The Influence of Psychological Safety and
49
50 Confidence in Knowledge on Employee Knowledge Sharing. *Manufacturing and Service Operations*
51
52 *Management* **11**, 429–447.
53
54

1
2
3 Senge P, Scharmer CO, Jaworski J & Flowers BS (2005). *Presence: Exploring profound change in people,*
4
5 *organisations and society.* Nicholas Brealey Publishing, London.
6
7

8
9 Shian M, Arnold I & Germ, AK (2012) The Road to psychological safety: legal, scientific and social
10
11 functions for a Canadian National Standard on psychological safety in the workplace. *Bulletin of Science,*
12
13 *Technology and Society* **32**, 142-162.
14
15

16
17
18 Stetler CB, Damschroder LJ, Helfrich CD & Hagedorn HJ (2011) A Guide for applying a revised version of
19
20 the PARIHS framework for implementation. *Implementation Science* 6:99 Doi:10.1186/1748-5908-6-99.
21
22

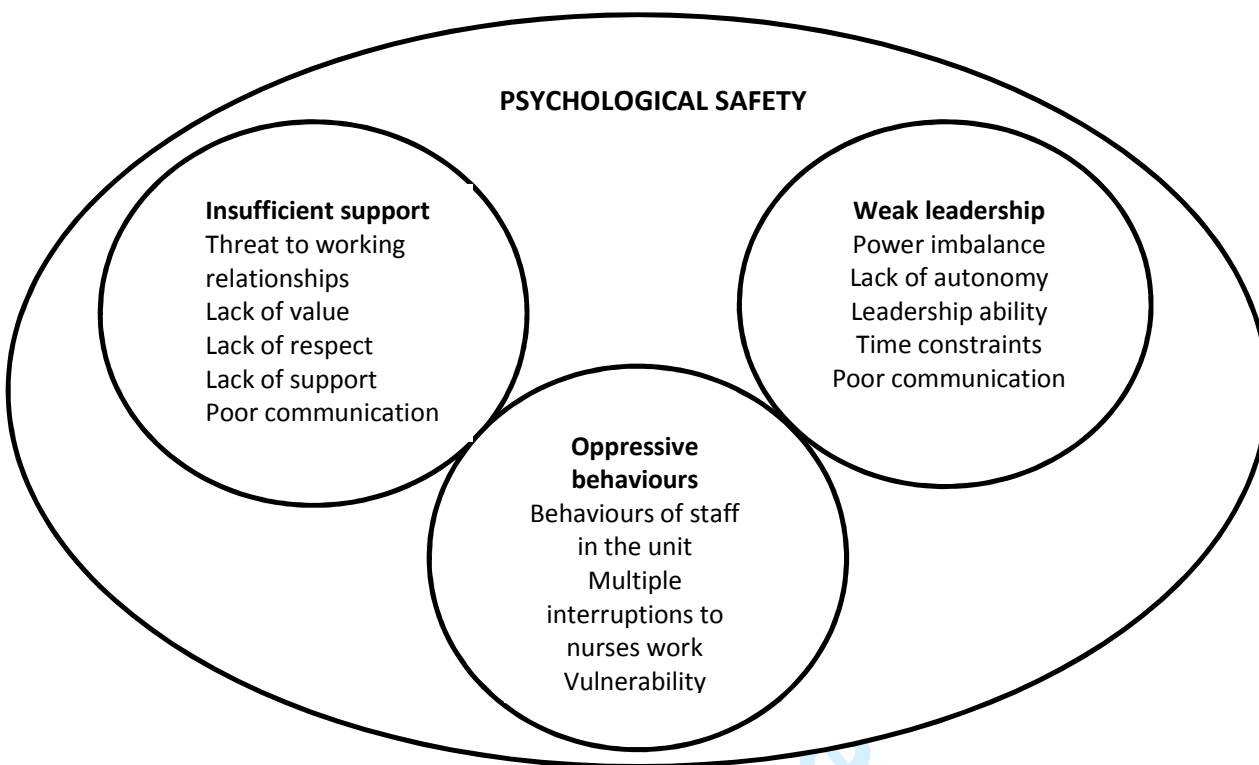
23
24
25 Ward V, House A & Hamer S. (2009) Developing a framework for transferring knowledge into action: a
26
27 thematic analysis of the literature. *Journal Health Service Research Policy* **14**, 156–164.
28
29

30
31 Weaver Moore L, Leahy C, Sublett C & Lanig H (2013) Understanding Nurse-to-Nurse
32
33 Relationships and Their Impact on Work Environments. *Medical Surgical Nursing* **22**, 172-179.
34
35

36
37
38 West M, Eckert R, Stewart K & Pasmore B. (2014) *Developing collective leadership for healthcare.* The
39
40 Kings Fund. London.
41
42

43
44
45 Wilson V, McCormack B, & Ives G.(2005) Understanding the workplace culture of a special care
46
47 nursery. *Journal of Advanced Nursing* **50**, 27-38.
48
49
50
51
52
53
54
55
56
57
58
59
60

Figure 1: Data analysis of themes and subthemes



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Table 1: Examples of agreed actions

Theme	Agreed Actions
<p data-bbox="233 317 423 388">Insufficient Support</p>	<p data-bbox="423 317 1325 388">Work within the overarching ground rules agreed by the nursing team. [RS2]</p> <p data-bbox="423 388 1325 459">Explicitly ask for help or guide others in how they can assist us. [RS7]</p> <p data-bbox="423 459 1325 558">Seek opinions and listen to what others have to say. This will display that we, as nursing staff, value others and their advice. [RS9]</p> <p data-bbox="423 558 1325 758">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]</p> <p data-bbox="423 758 1325 829">Seek opportunities to discuss ongoing issues. [RS24]</p> <p data-bbox="423 829 1325 989">Care for and support one another to ensure good team working relationships. [RS1, 10, 18, 19 20, 21]</p>
<p data-bbox="233 989 423 1087">Oppressed behaviours</p>	<p data-bbox="423 989 1325 1045">To be more positive about our role and contribution to the team. [RS12]</p> <p data-bbox="423 1045 1325 1157">Communicate with the MDT in a professional way to make sure we deliver better care to patients [RS12, 22]</p> <p data-bbox="423 1157 1325 1289">Prioritise patient needs over workload to enhance the care we give to patients. [RS 12, 24]</p> <p data-bbox="423 1289 1325 1346">Change current ‘mindset’ of self- imposed time frames.[RS15, 24]</p> <p data-bbox="423 1346 1325 1402">“Be realistic about what we can achieve”. [RS6]</p> <p data-bbox="423 1402 1325 1459">Value ourselves - Avoid saying “I’m just the nurse.” [RS22]</p> <p data-bbox="423 1459 1325 1656">“Challenge people who peek behind the curtains.” Remaining professional [RS12]</p>
<p data-bbox="233 1656 423 1728">Weak Leadership</p>	<p data-bbox="423 1656 1325 1713">Adopt a more consistent in leadership approach [RS21]</p> <p data-bbox="423 1713 1325 1856">Manage the behaviour of those who are not contributing effectively. [RS19, 20, 21]</p>

1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
21	
22	
23	
24	
25	
26	
27	
28	
29	
30	
31	
32	
33	
34	
35	
36	
37	
38	
39	
40	
41	
42	
43	
44	
45	
46	
47	
48	
49	
50	
51	
52	
53	
54	
55	
56	
57	
58	
59	
60	

	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]