

# ISMP Canada Safety Bulletin

Volume 24 • Issue 3 • March 26, 2024

## Safe Spaces: Psychological Safety for Patients

Psychological safety describes the situation of feeling safe to speak up and share ideas, questions, or mistakes, without fear of negative consequences or reactions. It is defined as a “shared belief held by members of a team that the team is safe for interpersonal risk taking.”<sup>1</sup> Patients are part of their own health care team and the creation of a **safe and inclusive space for patients** is needed to allow them to be active members. This bulletin provides evidence-informed recommendations for nurturing psychological safety among patients and their care providers, to ensure patient safety, including safety related to medications.

### INCIDENT EXAMPLE

A patient presented to hospital for a scheduled skin biopsy. The hospital had tried to cancel the appointment because the patient’s physician was providing care to a trauma patient. The patient had travelled a long distance from home, so the physician decided to proceed with the biopsy, despite the additional demands of the trauma case.

In preparation for the biopsy, the physician gave the patient a subcutaneous injection from an unlabelled syringe with what the physician believed was a local anaesthetic. Within a few minutes, the patient experienced difficulty moving and breathing and called out for help. The person was unable to speak for several minutes and later reported having experienced complete loss of muscle control, although they remained conscious throughout the event. Oxygen was administered until the symptoms subsided. The patient was stabilized, and the biopsy proceeded.

The physician disclosed the error immediately following the incident, telling the patient they had inadvertently selected a syringe containing midazolam, a benzodiazepine that is used for procedural sedation or anesthesia, rather than the intended local anesthetic.

During the follow-up appointment, the patient (who happened to be a retired health care provider) tried to share questions and concerns about what had happened the day of the procedure, including questions about whether a paralyzing drug (neuromuscular-blocking agent) had been inadvertently administered. Unfortunately, from the patient’s perspective, despite the physician’s initial disclosure, they were left feeling unheard and dismissed.

### BACKGROUND

Although the concept of psychological safety has been examined in health care teams for years, it has yet to be applied purposefully in engagement with patients. Patients and care partners are integral members of their care team, and can provide valuable insights to their experiences, but only if they have a sense of psychological safety in doing so.

In clinical environments where psychological safety is absent, providers are less likely to question, share ideas, report, and learn from incidents. As well, disrespectful behaviours such as intimidation, conflict, microaggressions, and lapses in professionalism are more prevalent<sup>2,3</sup> than is the case in safer settings. Work environments with a culture of openness are considered to facilitate psychological

safety<sup>4</sup> and are associated with lower patient mortality rates.<sup>5</sup> As such, psychological safety is a recognized concept that continues to gain attention in health care.<sup>3,6,7</sup> Incidents are more likely to be reported in settings where psychological safety exists for health care providers.<sup>4</sup> In such an environment, continuous quality improvement can occur through learning from reported incidents.

Creating an atmosphere that permits listening attentively, sharing information and focusing on the concerns and questions of patients and care partners are key aspects of an environment of psychological safety. Failure to do so may result in the perception that information is being withheld by their health care team, and result in patients' feeling anxious, fearful, and angry.<sup>8</sup>

Several barriers to patients' psychological safety in health care settings have been identified:

- An inherent power imbalance between the patient and health care providers may lead care providers to dismiss questions or concerns, leaving the patient with a sense of doubt, a feeling of invalidation,<sup>9</sup> and a reluctance to question further.
- A reluctance on the part of the patient to speak up due to a fear of losing access to care, or a fear of being "labelled" a problem patient, might affect the provision of care during future encounters. Additionally, a patient may hesitate to express their concerns for fear of prompting disciplinary action for the providers involved.
- A lack of psychological safety among members of the health care team may lead to lack of psychological safety for the patient.

**Medical invalidation, whereby health care providers dismiss, minimize or otherwise do not take patient concerns seriously, can lead to feelings of distrust and reluctance of patients to seek health care.<sup>9</sup>**

## DISCUSSION

In the reported incident, the patient's perspective was shared through ISMP Canada's consumer reporting program MedError.ca. Providing a confidential mechanism for consumer reporting, which enables shared learning, is a key component of the Canadian Medication Incident Reporting and Prevention System. For patients and families who are experiencing a lack of psychological safety within their care team, this reporting mechanism represents an opportunity for their voice to be heard.

Following a review of the recent literature and consultation with experts, ISMP Canada offers the following recommendations for strengthening psychological safety in patient care teams, in all health care settings.

## RECOMMENDATIONS

### **For Health Care Organizations:** *Creating Psychological Safe Spaces Within the Workplace*

- Ensure a culture of safety, including psychological safety, for patients, care partners, and health care providers.<sup>10</sup> This entails:
  - Incorporating education about psychological safety into health care provider orientation sessions and continuous quality improvement programs.
  - Encouraging open dialogue<sup>11</sup> among leaders that will allow team members to speak with candor. Supporting team members to openly question, engage in inquiry, and call attention to uncertainties as they arise can lead to important learning moments.<sup>12</sup>
  - Inviting patients and/or care partners directly affected by an error to be part of the ensuing quality improvement process and listening attentively to their feedback. Doing so gives patients and families an actionable way to ensure an opportunity for learning from their experience, and contributes to initiatives to prevent similar occurrences for other patients.<sup>13</sup>
  - Considering how to increase engagement of patients and/or care partners, for example by creating a patient and family ombudsman role in

patient relations processes, developing patient and family advisory committees, and/or encouraging participation in continuous quality improvement initiatives.

**For Health Care Providers:** *Creating Psychological Safe Spaces for Patients*

- Seek out education and training in the principles of psychological safety that can be embedded into daily practice.
- Acknowledge the power imbalance inherent in relationships with patients. Create a safe, inclusive, and open atmosphere centred around patients and their care partners.
- Invite patients and their care partners to ask questions. Patients who are encouraged to speak up, ask questions, and seek clarification will feel included in their care team. This approach fosters the creation of a safe and respectful space.<sup>8</sup>
- When an incident occurs, and there is disclosure, apologize to the patient.<sup>14</sup> If the patient has questions arising from the apology, respond with empathy. This approach can improve relationships between patients and health care providers/ organizations, which can in turn support patients to feel respected and validated; it is also a requisite to restoring trust.<sup>8</sup>

## CONCLUSIONS

Opportunities exist to establish and nurture psychological safety for patients so that they feel empowered to take action, question unsafe practices, identify risky situations, and report errors and near misses, with the aim of improving safety.

Health care team members who are unafraid to question decisions and are encouraged to share concerns can contribute to a higher-functioning, medically safer team.<sup>12</sup>

Establishing psychologically safe environments that purposefully include patients and care partners within their care teams, will advance patient safety including medication safety.

## USEFUL RESOURCES

1. Creating a Safe Space – Healthcare Worker Support Toolkit  
[https://www.healthcareexcellence.ca/media/zamhlhcq/5\\_creating-a-safe-space-toolkit\\_en-final-ua.pdf](https://www.healthcareexcellence.ca/media/zamhlhcq/5_creating-a-safe-space-toolkit_en-final-ua.pdf)
2. Psychological Safety  
<https://www.cmpa-acpm.ca/en/education-events/good-practices/physician-team/psychological-safety>
3. Mismanagement of Client and Family Complaints  
<https://www.hiroc.com/resources/risk-reference-sheets/mismanagement-client-and-family-complaints>
4. Rethinking Patient Safety  
<https://www.healthcareexcellence.ca/media/gx4l3idd/rethinking-patient-safety.pdf>

## ACKNOWLEDGEMENTS

*ISMP Canada gratefully acknowledges the consumers, health care providers, and organizations that report medication incidents for analysis and learning. The expert review of this bulletin by the following individuals (in alphabetical order) is also recognized and appreciated:*

Shelly Dev MD FRCPC, Department of Critical Care Medicine, Sunnybrook Health Sciences Centre, Toronto, ON, Associate Professor of Medicine, Interdepartmental Division of Critical Care Medicine, University of Toronto; Shirley Drever, Clinical Medication Safety Specialist, Sienna Senior Living; Michaela Kerrissey PhD, MS, Assistant Professor of Management, Harvard TH Chan School of Public Health, Boston, MA, United States; Sanjho Srikantharajah MD FRCPC, Staff Anaesthesiologist North York General Hospital, Assistant Professor University of Toronto Department of Anaesthesia and Pain Medicine; Scott Van RPh, BSc. Pharm, Pharmacy Manager, Winnipeg, MB.

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## “Off-Label” Medication Use: What You Need to Know

A recent consumer newsletter from SafeMedicationUse.ca described the need for transparency about “off-label” use of medications, as well as the need to share pertinent information with patients and caregivers so they can make informed decisions.

In the incident example, a medication was prescribed for an infant on an “off-label” basis. The infant’s caregiver felt uneasy, knowing that the medication was not approved for use in this age group. Only after asking questions to understand the benefits and risks did they feel comfortable starting the medication.

**The following tips are shared with practitioners who may prescribe/dispense medications for “off-label” indications and are intended to support informed decision-making by patients and caregivers:**

- Before prescribing/dispensing a medication for an off-label use,
  - if possible, inform the patient and/or caregiver of the reasons for the proposed use of the medication and specify that it is an off-label use (ideally, the indication for use will appear on the prescription)
  - share information about the benefits, risks, and available evidence supporting off-label use
  - document the main points of this conversation
- Recognize that drug information, including prescribing and monitoring guidelines, is less readily available for off-label use of medications<sup>1</sup> and that it will change as updated evidence is published and disseminated.

**Consumer newsletter to share with your patients/clients/residents:**

<https://safemedicationuse.ca/newsletter/off-label-medication-use.html>

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## Medication Routines—Keep Them Simple

As a medication regimen becomes more complex, so can the likelihood of errors. Factors that influence the complexity of a patient's regimen include the number of medications, the number of administration times per day, and whether different doses are to be given on different days. Efforts to simplify the medication routine can help to reduce errors.

SafeMedicationUse.ca received a consumer report describing a error that involved a patient's schedule of levothyroxine, with doses of 100 mcg and 125 mcg to be taken on alternate days. The patient had a prescription for both tablet strengths, but the pharmacy dispensed an incorrect strength when the patient requested a refill. Although the reason for prescribing 2 different strengths is unknown, and the error did not result in patient harm, this case highlights an unnecessarily complex regimen, which could have been replaced with a daily dose of 112 mcg, taken as a single tablet.

**SafeMedicationUse.ca has the following tips for practitioners to help simplify medication regimens:**

- Consider the complexity of the prescribed regimen when any new medication is added. Discuss the addition with the patient and their care partners to better understand any barriers to optimal use of the medication.
- When adding a new medication to a patient's regimen, review other medications that the patient is already taking and consider options for simplification. Examples include switching to more convenient formulations (e.g., single-pill combination or long-acting formulation), avoiding the use of alternating schedules when possible, and deprescribing unnecessary medications.
- If it is not possible to simplify a medication regimen, work with patients and their caregivers to identify individualized strategies to help with medication management (e.g., blister packs/pill organizers, support from family members/caregivers).



**Consumer newsletter to share with your patients/clients/residents:**

<https://safemedicationuse.ca/newsletter/medication-schedule.html>





The Canadian Medication Incident Reporting and Prevention System (CMIRPS) is a collaborative pan-Canadian program of Health Canada, the Canadian Institute for Health Information (CIHI), the Institute for Safe Medication Practices Canada (ISMP Canada) and Healthcare Excellence Canada (HEC). The goal of CMIRPS is to reduce and prevent harmful medication incidents in Canada.

Funding support provided by Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.



The Healthcare Insurance Reciprocal of Canada (HIROC) provides support for the bulletin and is a member owned expert provider of professional and general liability coverage and risk management support.



The Institute for Safe Medication Practices Canada (ISMP Canada) is an independent national not-for-profit organization committed to the advancement of medication safety in all healthcare settings. ISMP Canada's mandate includes analyzing medication incidents, making recommendations for the prevention of harmful medication incidents, and facilitating quality improvement initiatives.

## Report Medication Incidents

(Including near misses)

**Online:** [www.ismpcanada.ca/report/](http://www.ismpcanada.ca/report/)

**Phone:** 1-866-544-7672

ISMP Canada strives to ensure confidentiality and security of information received, and respects the wishes of the reporter as to the level of detail to be included in publications.

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[www.ismpcanada.ca/safety-bulletins/#footer](http://www.ismpcanada.ca/safety-bulletins/#footer)

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