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Speaking up behaviours (safety voices) of healthcare workers: A metasynthesis of qualitative research studies

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ABSTRACT

Background: A critical characteristic of effective teams in any setting is when each member is willing to speak up to share thoughts and ideas to improve processes. In spite of attempts by healthcare systems to encourage employees to speak up, employee silence remains a common cause of communication breakdowns, contributing to errors and suboptimal care delivery. Nurses in particular have reported low confidence in their communication abilities, and cite the belief that speaking up will not make a difference.

Objective: To develop an understanding of how nurses and other healthcare workers relate to safety voice behaviors and how this might influence clinical practice. Data Sources: A search of the PubMed, CINAHL, and Academic Search Premier databases was conducted using keywords employee, nurse, qualitative, speak up, silence, safety, voice, and safety voice identified 372 articles with 11 retained after a review of the abstracts. Studies took place in Australia, Bulgaria, Canada, Hong Kong, East Africa, Ireland, Korea, New Zealand, Sweden, Switzerland, and the United States representing 504 healthcare workers including 354 nurses.

Methods: This interpretive meta-synthesis of 11 qualitative articles published from 2005 to 2015 was conducted using a social constructivist approach with thematic analysis.

Results: The four themes identified are: 1) hierarchies and power dynamics negatively affect safety voice, 2) open communication is unsafe and ineffective, 3) embedded expectations of nurse behavior affect safety voice, and 4) nurse managers have a powerful positive or negative affect on safety voice.

Conclusions: Healthcare workers worldwide report multiple social and hierarchy related fears surrounding the utilization of safety voice behaviors. Hesitance to speak up is pervasive among nurses, as is low self-efficacy related to safety voice. The presence of caring leaders, peer support, and an organizational commitment to safe, open cultures, may improve safety voice utilization among nurses and other healthcare workers.

What is already known about the topic?

Extant literature reveals safety voice in **non-healthcare** workers is increased by:

- Perceived organizational support for safety.
- Affect based trust in leadership.
- Relative openness of supervisors.

What this paper adds:

This meta-synthesis reveals safety voice in **healthcare** workers is:

- Impeded by hierarchies and power dynamics.
- Increased by open, supportive managers.
- Perceived as unsafe and ineffective.

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1. Safety voice

A critical characteristic of effective workplace teams in any setting is when each member is willing to speak up to share thoughts and ideas to improve processes (Detert and Burris, 2007). In spite of attempts by healthcare systems to encourage employees to speak up, employee silence remains a common cause of communication breakdowns, and contributes to errors resulting in suboptimal care delivery (Haerkens et al., 2012; O'Dea et al., 2014). In a 2009 survey of 54,000 veteran's administration health care employees, nurses scored significantly lower on communication, openness, safety perceptions, and teamwork than other healthcare employees (Sculli et al., 2013). An additional study revealed nurses exhibit low confidence in the ability to assertively suggest treatment plan changes when faced with rude or confrontational behaviors from other team members (Raica, 2009).

An array of speaking up related safety behaviors are collectively conceptualized as "safety voice" in the extant literature. Safety voice is broadly defined as employee willingness to proactively participate in communication related behaviors for the purpose of improving workplace safety. Examples of safety voice behaviors include willingness to provide constructive suggestions for change, report potential safety risks or violations of safety practice, and to challenge the status quo (Conchie, 2013; Conchie et al., 2012; Tucker et al., 2008; Tucker and Turner, 2015; Turner et al., 2015). Safety voice may be increased in non-healthcare workers by peer attitudes, organizational support for safety (Tucker et al., 2008), affect based trust in leadership (Conchie, 2013), relative openness of supervisors, and perception of psychological safety (Tucker and Turner, 2015).

2. Identified gap and study aim

Safety voice is absent in nursing and healthcare literature and might be used to collectively conceptualize the desired speaking up behaviors for healthcare workers. These speaking up behaviors in the specific context of nursing might be conceptualized as "nurse safety voice". The utilization of safety voice, or nurse safety voice to study desired speaking up behaviors for nurses, and other healthcare workers might better facilitate the teaching, learning, and study of these essential behaviors from an active, voice-centric approach. The aim of this meta-synthesis is to develop an understanding of how nurses and other healthcare workers relate to safety voice, and how this might influence clinical practice and patient safety.

3. Methods

This interpretive meta-synthesis was conducted using a social constructivist approach with thematic analysis. Social constructivism is an inductive methodology that allows for multiple realities to inform and co-construct new realities. Social constructivism takes the position that individual meaning is "constructed" through social interactions, and is informed by historical or cultural norms. The goal of this methodology is to illuminate the complexity of meaning residing within individual accounts (Creswell, 2013). This is an ideal approach to utilize for performing an analysis of a broad range of qualitative studies in a diverse collection of healthcare settings. Theme development was conducted to facilitate the organization of coded data as patterns of new meaning were identified.

3.1. Search strategy and outcomes

A literature search was conducted of the PubMed, CINAHL, and Academic Search Premier databases using a variety of combinations of the keywords *nurse*; *employee*; *speak up*; *silence*; *safety*; *voice*; *safety voice*; and *qualitative*. More than double the number of articles exploring safety voice behaviors in nursing were identified from the passive perspective of silence as opposed to the more active perspectives of speaking up or voice. A total of 372 articles were identified and abstracts were reviewed. After removing duplicates; dissertations; non-related; non-qualitative articles; and all articles prior to 2005; 11 relevant articles were retained for this review (see Appendix A Fig. 1 & Table A1).

3.2. Quality appraisal

Each article was evaluated using the McMaster University Tool for critical review of qualitative studies. This guideline ensured a comprehensive critique of each study's design, methods, data collection, analysis, overall rigor and appropriateness of findings (Letts et al., 2007). Studies took place in Australia, Bulgaria, Canada, Hong Kong, two East African nations, Ireland, Korea, New Zealand, Sweden, Switzerland, and the United States. A total of 504 healthcare workers participated in the 11 studies included in this meta-synthesis and consisted of 354 nurses (staff nurses, nurse managers, clinical nurse specialists, nurse anesthetists), 130 physicians (surgeons, oncologists, anesthesiologists, medical residents), and 20 healthcare workers from other groups (technicians, support staff). Participants possessed from under 1 year to over 30 years of experience in a variety of roles and healthcare work settings. Five studies were qualitative descriptive, five were narrative, and one was a critical ethnography. The most common means of data collection were individual semi-structured interviews and focus groups.

3.3. Data extraction and synthesis

The primary author, a nurse educator and PhD student, read all of the articles multiple times, and the second author, a doctor of physical therapy and PhD student, read all of the articles at least twice. The initial reading was completed to obtain an idea of how each article as a whole contributed to the understanding of safety voice behaviors in healthcare settings. Subsequent readings focused on identifying patterns of meaning within and across these studies. Data were extracted with each reading as ongoing analysis, reflection, and theme refinement occurred. Data analysis methods included manually color-coding units of meaning from each study and organizing these codes into themes as patterns of meaning were identified. These derived analytic themes were organized, shared, and discussed using reciprocal translational analysis until these two authors arrived at a consensus regarding the final synthesis of themes (see Appendix A Table A2). Each author maintained an audit trail throughout the coding process. The third author, a known expert in qualitative methodologies assisted with study design, and offered extensive reflective consultation during analysis, and theme development.

4. Findings

The four main themes identified in this meta-synthesis are: 1) hierarchies and power dynamics negatively affect safety voice, 2) open communication is perceived as unsafe and/or ineffective, 3) embedded expectations of "nurse" behavior affects safety voice, and 4) nurse managers have a powerful positive or negative affect on utilization of safety voice.

4.1. Hierarchies and power dynamics negatively affect safety voice

The dominant, overarching theme across these diverse, international studies is hierarchies and power dynamics are