



# Editorial: Psychological Safety in Healthcare Settings

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## Editorial on the Special Issue

### Psychological Safety in Healthcare Settings

Patient safety is a priority in all healthcare systems. Despite this, up to 24% of hospital admissions and around 7% of primary care patients experience adverse events (AEs) annually, with approximately 50% being preventable [1, 2]. In the EU alone, these preventable AEs result in a loss of 1.5 million disability-adjusted life years (DALYs) and a cost of 19.53–43.65 billion euros in 2024 [3], with a significant impact on the quality of care.

Most of these preventable AEs are due to suboptimal working conditions [4]. Uncertainty, overload, fatigue, and complexity are common limiting factors for quality care, including patient safety. Healthcare workers often face psychological trauma from events such as life-threatening incidents, needle sticks, dramatic deaths, violence, patient deterioration, resuscitations, complaints, suicidal tendencies, and errors causing patient harm. These can alter the practice and morale of healthcare workers, impacting patient outcomes. Therefore, workforce resilience is key to providing optimal care. Otherwise, when overwhelmed and lacking coping resources, they become second victims [5]. They are “any healthcare worker directly or indirectly involved in an unanticipated adverse patient event, unintentional healthcare error, or patient injury, who becomes victimized in the sense that they are also negatively impacted.”

Organizational factors and personality traits influence the second victim experience. Providing safe working conditions is part of the WHO’s objectives for safer care [6]. Professionals must feel supported, trained, equipped, protected, rested, and provided with a suitable work environment, reducing the intensity of this experience as second victims. Addressing this involves healthcare authorities, health professions, scientific societies, academia, patient associations, and civil society and requires a commitment to self-care, prevention programs, and emotional support interventions.

Safety culture, particularly Psychological Safety, is crucial. Introduced by Amy Edmondson [7] in 1999, it describes the ability to speak without fear about performance, including mistakes, to improve care. Without this, patient safety is at risk [8, 9]. However, the blame culture remains prevalent in healthcare [10], impacting how professionals address safety incidents. Fear of blame hinders progress toward a safety culture. Many institutions comply with WHO’s safe practices but fail to engage professionals in patient safety, reacting to

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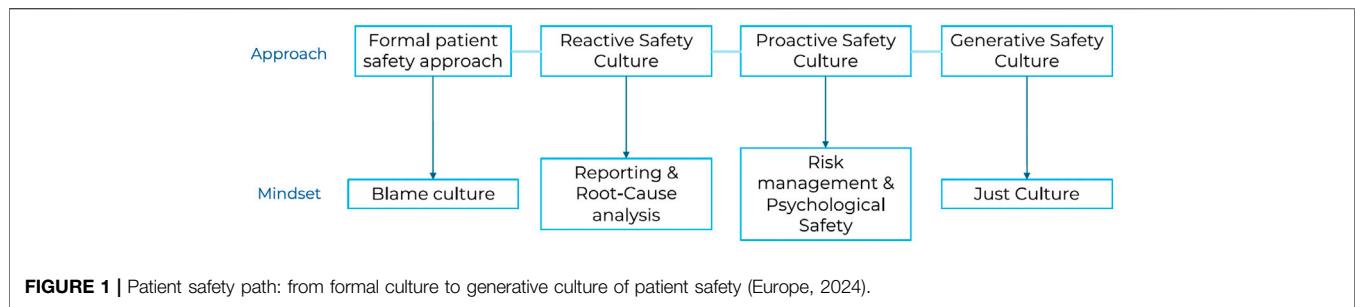
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dramatic events without preventing potential harm. Proactive risk management fosters a culture of safety. These organizations are on the verge of sharing a culture that generates safety (Figure 1).

Since healthcare workers are not adequately trained to warn colleagues of risky behavior, manage reactions, or support second victims (Kupkovicova et al.; Carrillo et al.) [11], educational reforms are needed to address identified educational gaps in patient safety and to integrate second victim support into the training of medical, nursing, and other healthcare students. Equipping future professionals with skills to recognize and address the second victim phenomenon fosters a supportive work environment and improves patient safety outcomes. Ultimately, these changes can lead to improved quality of care, better patient safety outcomes, and a more resilient healthcare workforce.

To support healthcare professionals and prioritize patient safety and wellbeing, organizations must:

1. Create a fair and accountable environment: Implement policies ensuring transparency and fairness in evaluating performance and handling errors, fostering trust and openness.
2. Balance safety and accountability: Understand root causes of errors and address systemic issues to prevent recurrence, balancing individual accountability with systemic improvements.
3. Commit to continuous improvement and transparency: Regularly evaluate safety protocols, using incident data to drive change, and promote openness to build trust.
4. Learn from incidents: Analyze incidents, identify contributing factors, and develop risk mitigation

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strategies, empowering staff to participate in safety initiatives.

5. Promote fairness in incident response: Distinguish between honest mistakes, at-risk behavior, and reckless behavior, focusing on system-wide improvements and creating a supportive environment.

By implementing these strategies, healthcare organizations can better support professionals and cultivate a just culture, benefiting patients. Encouraging self-care, resilience, and emotional support, along with fairness and continuous improvement, creates a more effective and compassionate healthcare system.

## AUTHOR CONTRIBUTIONS

All authors listed have made a substantial, direct, and intellectual contribution to the work and approved it for publication.

## CONFLICT OF INTEREST

The authors declare that they do not have any conflicts of interest.

## GENERATIVE AI STATEMENT

The author(s) declare that no Generative AI was used in the creation of this manuscript.

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