Literature Review

Introduction

An existing problem in some healthcare organizations is a perceived lack of healthy work environments and high turnover rates. Contributing factors to unhealthy work environments include a lack of effective communication between caregivers, which contributes to individual work dissatisfaction, turnover, and a reduction in patient safety and quality outcomes (Wei et al., 2018). Hallmarks of a healthy work environment include a workplace that is safe, empowering, and satisfying (Wei et al., 2018). The American Association of Critical Care Nurses published standards for establishing and sustaining healthy work environments, which includes skilled communication to integrate shared knowledge and skills between multidisciplinary team members through frequent, respectful interactions (2005). To enhance a culture of safety and quality, organizations should prioritize the development of communication skills in nurses, just as clinical skills are prioritized and developed. While it is known that disrespectful, disruptive, or intimidating behaviors can occur in the healthcare environment and collaborative communication is essential in high stress patient care situations, not all nurses are equipped to communicate effectively in those situations. One example of a lack of effective communication in healthcare includes the absence of Speaking Up Behaviors (SUB) for patient safety and professionalism. Speaking up behaviors involve a nurse using his/her voice to make known to someone in positional authority information that might make a difference in ensuring a safe patient outcome (Sayre et al., 2012a).

In a rural community hospital, a negative trend in the Agency of Healthcare Quality and Research Culture of Safety biannual survey results in 2017, 2019, and 2021 has been illustrated by an increased score for the survey question, “staff are afraid to ask questions when something

does not feel right." In addition, bedside registered nurse (RN) turnover rates have increased from 14.5% to 19.4% from fiscal year 2020 to fiscal year 2022 to date. In a recent survey taken in November of 2021 by RNs when asked, "have you ever chosen not to contact a provider for fear of their response," 23% of the nurses responded affirmatively, citing provider anger, hostility, yelling, fear of retaliation, feeling that nothing would change anyhow, and concern for job security. A *Speaking Up Behaviors* intervention will be implemented to evaluate its impact on patient safety outcomes, nurse perception of comfort and confidence in the use of voice for patient safety and professionalism, and nurse retention.

Speaking Up Behaviors to mitigate risky or deficient actions of others have been linked to safety outcomes in healthcare organizations, with a relationship found between safety culture scores and barriers to speaking up (Etchegaray et al., 2020). While barriers to SUB include both personal and leadership barriers, methods to promote SUB include leadership promotion of speaking up behaviors to healthcare professionals in varied settings as well as provision of formal development opportunities to learn and practice speaking up. The Institute for Safe Medication Practices (ISMP) (2019) recommends that all healthcare providers learn to become observant questioners, a behavioral choice that can prevent errors in patient care. As some healthcare professionals choose silence instead of speaking up when patient safety is at risk, it is important to evaluate what factors influence the decision to speak up and how the organization can provide an environment that motivates colleagues to utilize SUB (Okuyama et al., 2014).

Aim

This aim of the literature review is to examine current evidence on SUB including its definition, what factors are barriers to SUB and what interventions, cultural, and environmental factors promote SUB. Additional aims are to examine the relationship between SUB and patient

safety outcomes, healthy work environments, and nurse retention. Finally, the literature review aims to examine whether a SUB intervention impacts nurse perceived comfort and confidence in use of SUB. Questions guiding this literature review include:

1. How is SUB defined?
2. What factors serve as barriers or promotors of SUB?
3. What is the relationship between SUB and patient safety outcomes?
4. What is the relationship between SUB and perceived health of work environments?
5. What is the relationship between SUB and nurse retention?
6. Does a SUB intervention impact nurse perceived comfort and confidence in use of SUB?

Search Strategy

A literature search was performed using the inclusion criteria of articles published between 2012 and 2022, those written in English, and those that appeared in academic journals. Databases utilized in the search included Academic Search Complete, CINAHL Plus with Full Text, Health Source: Nursing/Academic Edition, MEDLINE Complete, and PubMed. This search occurred between October 2021 and February 2022. Key words and phrases guiding the search included: *speaking up behaviors, speaking up, speaking up for patient safety, nurse, patient safety, retention, healthy work environment, and intervention.* The Boolean operator "AND" was used to connect combinations of the keywords and phrases. Exclusion criteria were any articles published before 2012, those not in academic journals, and those not written in English.

Results

The initial search generated 62 articles. Abstracts were reviewed for relevance to meeting the aims of the literature review and doctoral project, which resulted in 56 articles remaining. The articles included case studies, cross-sectional studies, descriptive articles, a Doctor of Philosophy dissertation, expert opinion articles, meta-syntheses, qualitative studies, randomized controlled trials, scoping reviews, and systematic reviews. It was desired to find articles on speaking up interventions based in healthcare organizations in the United States, but many published studies occurred in other countries. Due to the generalizability of speaking up interventions, articles with a study setting in other countries remained in the literature review. The articles were scanned for SUB topics that could apply to hospital settings, described interdisciplinary healthcare provider teams and/or nurses, and involved interdisciplinary communication and not just self-reporting. Additionally, articles that focused exclusively on students were excluded so that the focus would remain on practicing healthcare providers. This selection criterion decreased the retrieved article number to 34.

SUB Definitions, Concepts, and Models

As nurses are patient advocates, they are obligated to speak up as part of their professional responsibility and in deference to the nursing code of ethics when there is a concern about patient care (Hall et al., 2018). Kane (2018) defines SUB as a healthcare professional identifying a concern that might impact patient safety and using his or her voice to raise the concern to someone with the power to address it. Yee-Shui Law and Chan's (2015) SUB definition specifies the message is given to someone in higher authority to improve safety. Okuyama et al. (2014) state that SUB is prompted by "risky or deficient actions of others within healthcare teams in a hospital environment" (p. 1). The actions of SUB can include the use of

voice to assertively communicate privately held information about patient safety and can include sharing information, questions, or opinions (Sayre et al., 2012b; Schwappach & Richard, 2018). Kim et al. (2020) expanded upon speaking up prompts as including speaking about not only patient safety issues but also unprofessional behaviors. The authors add to speaking up actions by including the actions of offering alternatives and suggested solutions and anticipating a response and action from the listener.

Within the healthcare environment, a person who is considered to have the power to do something about an issue is relative to the person who possesses the concern (e.g, a nursing student may defer to the nurse employed at the site to take action, a bedside nurse may defer to a charge nurse, and a medical resident may defer to an attending physician). Farrell et al. (2021) described sources of power as informational in the case of a nurse possessing detailed information about a patient presentation, policies, or procedures. Additional sources of power described include positional or legitimate power that is possessed by individuals within an organization that has the freedom to influence decision-making, relational power that involves reliance on an established interpersonal relationship to provide safety when a SUB must occur, and referent power, where individuals with similar ranks or titles communicate to resolve an issue (Farrell et al., 2021). Speaking up is influenced by hierarchies and power, as individuals with greater power may influence the perception of psychological safety by those who will decide whether to speak up (Kim et al., 2020; Morrow et al., 2016). Additionally, Morrow et al. (2016) found the perceived acceptability of speaking up varied by hierarchical status. In other words, some positions will not receive and respond to speaking up voice from someone not in an equal hierarchical position or will only entertain the information if another person of authority backs the speaking up individual with their support.

Lee and Dahinten (2021) found speaking up and withholding voice are two distinct concepts that may be impacted by the variables of inclusive leadership and psychological safety. Therefore, a final aspect of defining SUB is the exploration of withholding voice or choosing silence. Silence is described as a communication breakdown in which employees intentionally withhold issues, knowledge, opinions, facts, or information that compromise patient safety, or suppresses ideas on how to improve patient safety. This communication breakdown may be the result of personal factors or due to structures and culture within the organization (Kritsotakis et al., 2022). Labrague and De los Santos (2020) expand on the definition of silence by including silence may also be unintentional, and they provide the categories of acquiescent, defensive, or prosocial silence. Acquiescent silence involves the choice to remain silent due to the belief their SUB would not be valued. Defensive silence involves withholding information as a form of protection from repercussions for speaking up, and prosocial silence involves withholding information for the protection of a co-worker, manager, or the organization (Labrague & De los Santos, 2020). Schwappach and Richard (2018) described there are also three parallel types of using voice, acquiescent, defensive, and prosocial, depending on the motivation of the speaker.

The literature revealed several concepts, theoretical frameworks, and models associated with speaking up. Kane (2018) described *Speaking Up* as its own multidimensional concept that is used as a global term for raising concerns about patient care. The concept of SUB is multidimensional as it involves an individual's decision to take action (e.g. to speak or remain silent), involves a recipient of the message that may have the power to change an outcome, and the decision by the recipient of the message on whether to take action (Kane, 2018). Rainer (2015) presented a theoretical framework for speaking up combining the concepts of patient advocacy, Oppressed Group Theory, generational differences, organizational and safety

evidence, cultural differences, and moral distress into a new model. The theoretical framework begins with a patient who needs advocacy or rescue. The decision to speak up or not speak up shows either the resulting affirmation of moral courage or the resulting patient harm or moral distress. Speaking up or failing to speak up behaviors in this framework are supported by personal culture, generational status, and organizational culture (Rainer, 2015). Rainer and Schneider (2020) explored the influences of organizational culture, personal culture, and workforce generation from the 2015 theoretic model on speaking up behaviors in registered nurses via a cross-sectional survey. The results showed organizational culture was a strong predictor of speaking up and speaking up partially mediated the relationship between organizational culture and moral distress, whereas generational differences did not impact speaking up.

Okuyama et al. (2014) presented a literature review resulting in the development of the *Speaking-Up for Patient Safety* model, tailored from Morrison's model of employee voice. The model involves the motivation to speak up to help the patient while interacting with multiple contextual and individual factors that can positively impact speaking up. Morrow et al. (2016) relate the "Exit, Voice, and Loyalty (EVL)" model to the themes relating to safety voice. In the EVL model, employee utilization of voice results in more effective organizational decision-making, use of voice is considered a right of employees, and use of voice is positively related to employee loyalty to the organization (Morrow et al., 2016).

SUB Barriers and Motivators

Personal and Interprofessional Barriers and Motivators. Barriers to SUB include personal and professional image concerns, fear of negative impacts, not having the tools to speak up, and lacking an environment to speak up. Exploring nurses' personal and professional image

concerns, Dahlke and Stahlke (2017) examined the impact of caring theories on nurses' silence from a philosophical viewpoint. The authors argued integration of expected emotional caring behaviors of nurses in organizations silences their speaking up voice about nursing practice concerns. The authors described the reality in healthcare institutions is nurses assume any workload, emergency, or patient behavior they encounter, which competes with their ability to feel they provide expected emotional caring behaviors. The resulting impact is nurses may be silent about unsafe patient care situations to maintain their professional image of being good, caring nurses who can handle any workload. The concept of professional image concerns serving as a barrier to SUB was supported by Morrow et al. (2016), as the authors described there are embedded expectations for nurse behavior and in many cases, nurses are not expected to speak up or to become "too emotional" when voicing concerns.

Several barriers to SUB were fear-based, as nurses fear receiving negative feedback if they speak up, they fear others perceiving their SUB as unfavorable and potentially damaging relationships or resulting in isolation, they fear being wrong, and they fear disciplinary or disruptive behavior repercussions (Etchegaray et al., 2020; Farrell et al., 2021; Kane, 2018; Labrague & De los Santos, 2020). Not having the tools to speak up was described as a lack of specific training for communication techniques to successfully speak up, and not understanding the human clinical factors that can occur in stressful situations, impairing decision-making capability (Kane, 2018; Reid & Bromiley, 2012). Not having an environment to speak up consists of interprofessional power and hierarchy differences as well as interprofessional behaviors resulting in an emotional response impacting a personal decision on whether to speak up (Kane, 2018; Farrell et al., 2021). Kane (2018) described the negative emotions of SUB including frustration, discomfort, anxiety, fear, irritation, awkwardness, and intimidation. In a

qualitative study informed by the Theory of Planned Behavior, Omura et al. (2018) found while nurses recognized the importance of using assertive communication to speak up to promote patient safety, they found barriers to do so from doctors, older nurses, or their culture.

Personal and interprofessional motivators of SUB were found to include the themes of internal characteristics, professional mandates, having tools available to speak up, and interprofessional behavior standards. Internal characteristics that motivate SUB were described as having self-perceived agency (includes assertiveness, independence, and persistence) and confidence, which many nurses state was a learned quality from childhood and growing up in their culture (Farrell et al., 2021; Garon, 2012; Jones et al., 2021; Weiss et al., 2014). Professional mandates to speak up included a desire to uphold the nursing code of ethics and a perceived professional responsibility to advocate for patient safety (Hall et al., 2018; Morrow et al., 2016; Yee-Shui Law & Chan, 2015). An internal desire to speak up to do the right thing was described as having thoughts about embracing the power an individual had to speak up or by recalling situations where one had not used SUB in the past as motivation to speak up (Farrell et al., 2021; Garon 2012). Tools to motivate SUB included the use of direct patient information as a source of power to advocate for patients, the use of educational tools providing structure to SUB, the use of policies and procedures to support the desired action, and the use of rapid response teams or multi-disciplinary rounds (Farrell et al., 2021; Kane, 2018). Interprofessional behaviors motivating SUB include the presence of mutual respect and trust, confidence in the team, absence of embarrassment, rejection, or punishment for speaking up, communion (helpfulness, friendliness, and sociability), and a valid, professional response to the SUB, even if there is not agreement (Farrell et al., 2021; Jones et al., 2021; Kane, 2018; Weiss et al., 2014).

Leadership Barriers and Motivators. Leaders either passively or actively respond to SUB attempts to serve as barriers to SUB. Lack of a leader response to a SUB attempt and lack of follow-up were passive responses that led to employees having the fear of no change and therefore choosing not to speak up (Etchegaray et al., 2020; Kane, 2018; ISMP, 2019). Active leadership responses serving as barriers to SUB included instances of retaliation for speaking up, fear of belittlement, an apparent disregard for the employee's opinion, and the leader having a history of suppressing speaking up discussion during meetings, thereby leading to employee silence for future concerns (Etchegaray et al., 2020; Jones et al., 2021). Hall et al. (2018) found in a mixed-methods cross-sectional study of healthcare workers that leadership accountability negatively impacted SUB desire when rules or values were not held up equitably amongst colleagues. A final leadership characteristic found to serve as a barrier to SUB is a general lack of leadership and trust (Alingh et al., 2019; Ginsburg & Bain, 2017).

Motivators to SUB by leaders include the categories of leader approachability and actions, which lead to the overall perception of leadership style. Several authors noted the leader characteristics of openness to communication, having an open-door policy, and being approachable, accessible, available, and visible positively impacted nurse perceptions of safety to speak up (Alingh et al., 2019; Garon, 2012; Ginsburg & Bain, 2017; ISMP, 2019; Lee & Dahinten, 2021). Leader actions found to motivate SUB included support and recognition of staff, providing needed resources for SUB, providing growth opportunities, giving performance feedback, providing the forum for employees to be involved in decision-making, and providing a psychologically safe environment (Frankel et al., 2019; Garon, 2012; Ginsburg & Bain, 2017; Labrague & De los Santos, 2020; Lee & Dahinten, 2021). Alingh et al. (2019) found in a cross-sectional survey nurses who perceive their direct supervisor shows commitment to safety and

role modeling of safety behaviors perceive a psychologically safe environment where interpersonal risks such as speaking up can occur while building a trustful relationship between nurses and their leader.

Organizational Barriers and Motivators. Themes of organizational barriers to SUB included climate and culture, oppression and discrimination, and organizational structures that prevent SUB. One aspect of climate and culture at the organizational level impacting SUB is an organizational silence climate, where employees do not share information that may be valuable for their organization, whether it is intentional or unintentional (Labrague & De los Santos, 2020). When an organization does not take steps to change the climate of silence, important problems are not shared and patient safety and care quality are impacted (Labrague & De los Santos, 2020). Oppression was explored by Garon (2012) as an organizational and environmental influence of speaking up behaviors. Garon describes the role of nurse power relations through Oppressed Group Theory, which states nurses have silenced themselves to avoid conflict, maintain a status quo, and conform to the traditional definition of a "good" nurse (2012). Discrimination was a concept explored by Kritsotakis et al. (2021) as *experienced nursing professional discrimination*, a novel concept in which the authors found a relationship between the nurse work environment and nurse silence. Additionally, organizational structures found to serve as barriers to SUB include hierarchical structures, organizational practices of concealment of issues, and in some organizations, a variety of practice areas with differing priorities and patient needs served as structures for SUB to fail (Best & Kim, 2019; Garon, 2012; Labrague & De los Santos, 2020; Rowland, 2017; Schwappach & Richard, 2018).

Organizational motivators to speaking up consisted of safety communication culture, ability to execute change, and mechanisms in place to support and promote SUB. Jones et al.

(2021) described psychological safety as an organizational characteristic where there is mutual respect and trust supporting SUB. When an organization has a perceived environment or culture that outwardly and proactively promotes speaking up with a commitment to safety, there is a resulting motivation to speak up (Alingh et al., 2019; Kane, 2018; Labrague and De los Santos, 2020; Morrow et al., 2016). Having the ability to execute change at an organizational level can promote SUB, combined with sharing bidirectional feedback between individuals and leaders to review what is working well to promote continuous improvement (Frankel et al., 2019). Additional motivators of SUB include mechanisms such as policies and protocol systems, educational and role-playing programs, structured formats for providing SUB, and individual recognition of SUB attempts (Frankel et al., 2019; Jones et al., 2021; Labrague & De los Santos, 2019).

SUB Interventions

Interventions to promote SUB were categorized as education or workshop programs taking place in the workplace, role-play or simulation exercises, and non-educational interventions and organizational display of SUB support.

Educational Programs. Educational programs consisted of programs designed to take place in the workplace setting as workshops. Some programs included frameworks such as Team Strategies and Tools to Enhance Performance and Patient Safety (Team STEPPS) or Crew Resource Management. Other educational programs were designed to provide didactic and video content as well as the incorporation of focus groups and surveys to measure feedback following the program (Amiri et al., 2018; Best & Kim, 2019; D'Agostino et al., 2017; O'Donovan & McAuliffe, 2020; Reid & Bromiley, 2012; Yee-Shui Law & Chan, 2015). A *Team STEPPS* program was incorporated into a two-day workshop that also presented education about patient

safety culture and speaking out for safety and was used to evaluate the impact of the educational empowerment program on perceived safety culture in adult intensive care units (Amiri et al., 2018). Team STEPPS, developed by the Agency for Healthcare Research and Quality, incorporates communication, leadership, mutual support, and situational monitoring skills into its curriculum to improve patient outcomes (Amiri et al., 2018). A Team STEPPS intervention uses the phrases "I'm concerned; I'm uncomfortable; This is a safety issue" to guide speaking up language (Kane, 2018; Kim et al., 2020). Other educational programs incorporated the Crew Resource Management program, which originated in the aviation industry to reduce human error. The Crew Resource Management program teaches how to optimally use equipment, procedures, and people in situations where human behaviors are altered due to being under stress or pressure, with a goal of improved safety and efficiency (Reid & Bromiley, 2012; Yee-Shui Law & Chan, 2015). Kim et al. (2020) identified gaps in training programs for SUB as not promoting emotional and verbal skills and not addressing power hierarchy and suggest interventions for SUB can be effective by formulating speaking-up phrases, reframing emotional responses into learning opportunities, and creating psychological safety to reduce the power distance when speaking up. A topic recommended for education by ISMP (2019) is training on how to become an observant questioner motivated by having a high index of suspicion for errors. This technique involves questioning or pursuing an issue until it is proven not to be a threat to patient safety (ISMP, 2019).

Role Play and Simulation. Several SUB interventions involved multifaceted programs incorporating interaction, role-play, and simulation. One study intervention included monologues illustrating thoughts and feelings of healthcare providers when involved in high-tension clinical situations, scripted conversation and listening enablers, role-playing simulation, and debriefing

sessions (Ginsburg & Bain, 2017). In an educational program designed by Sayre et al. (2012a), the intervention consisted of video presentations by nursing and physician leadership permitting colleagues to speak up during patient safety situations, presentation of real-life patient safety scenarios, interactive group discussion on obstacles to SUB, creation of individual action plans, and small group activities over two months. Another education program was simulation-based and used patient simulators in the operating room with critical incident scenarios that were debriefed for challenges that occurred in the areas of leadership, situational awareness, and communication (Weiss et al., 2014). Simulation and role-playing types of interventions provided the opportunity to practice and improve SUB skills without a real threat to self or patient while promoting inquiry, information sharing, and assertion (O'Donovan & McAuliffe, 2020).

Non-Educational Interventions. Langois (2015) provided an expert opinion piece describing the way inertia can prevent speaking up behaviors from occurring, and recommended tactics to speak up promptly, allowing for taking action even when circumstances are not ideal, focusing on positive results, and getting support. While not presented as a SUB educational intervention, the concepts presented by Langois could be included in an educational program and promoted by organizational leadership. Similar concepts were presented by Hubbard and Chicca (2022) with four strategic approaches to SUB in the presence of authority: positive, judgment-free communication; closing the loop; persist, especially when perceiving risk; and acting locally while aiming systemically. These four approaches could be incorporated into an education program with organizational leader support promoting the concepts. Additional findings in the literature described forums and facilitated sessions in a psychologically safe space to explore differences in opinions or perceptions of abuse in health care with multidisciplinary teams and video presentations given by leaders and medical providers as SUB interventions (O'Donovan &

McAuliffe, 2020; Sayre et al., 2012a). Strategies impacting the patient safety culture can improve the likelihood of SUB, such as leadership/executive walking rounds (Amiri et al., 2018; Frankel et al., 2019; Jones et al., 2021). *Executive Walk Rounds* (EWR) were introduced by the Institute for Healthcare Improvement and provide a structured opportunity for clinical colleagues to communicate concerns to leaders (Jones et al., 2021). Frankel et al. (2019) described when rounding is done by leaders, insights gained from unit colleagues should be acted upon to change the environment, with leaders supporting the concept that respect is not negotiable regardless of the title of a colleague interacting on a unit.

Unit manager assessment and support of safety culture is another important factor promoting SUB (Amiri et al., 2018; Morrow et al., 2016). Managers promoting interdisciplinary feedback and caring, partnership-based cultures are also successful in improving the SUB of their organization (Morrow et al., 2016). Event reporting systems, Speak-Up hotlines, organizational programs designed to recognize and reward "good catches" before safety events occur, and just-in-time coaching interventions are other mechanisms for promoting a safety culture that enhances SUB (Best & Kim, 2109; Frankel et al., 2019; Jones et al., 2021). Finally, organizations may promote the use of structured communication tools to provide a safe environment for SUB. Available tools include CUS (I am concerned; I am uncomfortable; This is a safety issue), Two-Challenge Rule, SBAR (Situation, Background, Assessment, Recommendation), and DESC (Describe, Explain, Share, Compromise) (Ginsburg & Bain, 2017; ISMP, 2019; Kim et al., 2020; O'Donovan & McAuliffe, 2020).

SUB Outcomes

Patient Safety Outcomes. There is a positive relationship between speaking up and patient safety outcomes, as speaking up has a preventive effect on human errors (Okuyama et al.,

2014; Schwappach & Richard, 2018). An organization with a robust culture of safety and promotion of speaking up behaviors results in the reduction of medication and procedural errors, reduced complications, reduced mortality and morbidity, missed diagnoses, and poor clinical judgment (Garon, 2012; Hall et al., 2018; ISMP, 2019; Kane, 2018; Labrague & De los Santos 2020; Okuyama et al., 2014). The Institute of Medicine has linked patient safety outcomes to the need for changes in work environments, such as collaborative or shared governance, improved interdisciplinary relationships, and all team members knowing the climate promotes freely speaking up (Garon, 2012; Labrague & De los Santos, 2020). Amiri et al. (2018) conducted a randomized controlled trial to determine if an educational empowerment intervention including instruction on how to speak up about safety issues made an impact on the patient safety culture. The results showed a significantly higher improvement in the patient safety culture total score for the experimental group compared to the control group and compared to pre-intervention scores, implying that empowering nurses to speak up will improve patient safety culture, and therefore patient safety outcomes (Amiri et al., 2018).

Healthy Work Environment Outcomes. The use of a conceptual model to serve as the basis for a multifaceted intervention to promote SUB was designed by Ginsburg and Bain (2017). The model has a basis of leadership and organizational support serving as an accountability framework for all SUB interventions. The multifaceted interventions within the model included intentional repeated engagement of stakeholders in SUB, leadership initiatives to establish trust and facilitate speaking up behavior change, and experiential education that consisted of role-playing, reflection, and interactive learning (Ginsburg & Bain, 2017). This SUB intervention resulted in improvement over baseline in teamwork climate score in the intervention group compared to the control group, measured with modified Teamwork Climate Survey

(Ginsburg & Bain, 2017). Jones et al. (2021) performed a systematic narrative review with the aim of determining workplace strategies promoting SUB. The authors presented an iterative model to illustrate the pre-existing societal and workplace culture barriers that create a gap to SUB interventions and illustrated that national or local policy interventions do not bridge the gap, while training and education interventions in the workplace can bridge the gap (Jones et al., 2021). A model of healthcare professionals speaking up using the framework of Morrison's model of employee voice illustrating general contextual factors of an organization, such as team relationships and strong, visible administrative support improve the perceived health of the work environment, thereby promoting perceived efficacy in speaking up attempts (Okuyama et al., 2014).

Likelihood of Speaking Up Outcomes. Two studies measured SUB following an educational intervention and showed improvement in scores measuring the effectiveness of the intervention. In a quasi-experimental study by D'Agostino et al. (2017), findings showed higher confidence levels in communicating patient safety concerns following a communication training program, with subjects reporting they would use the skills learned to impact patient care. Sayre et al. (2012a) performed a quasi-experimental study employing a multifaceted intervention involving scenarios, personal reflection, and peer support to impact SUB, and found the intervention group showed a significant increase in mean speaking up scores from baseline following the intervention. Omura et al. (2017) performed a systematic review of eleven studies to evaluate the effectiveness of assertiveness communication training for healthcare professionals, measuring the outcomes of levels of assertiveness, levels of communication competence, changes in communication behaviors, or changes in patient safety. The authors found seven of the eleven studies showed improved communication behavior change outcomes,

three studies showed improved levels of assertiveness but not communication behavior change, and one study did not show improved outcomes (Omura et al., 2017). An unsuccessful SUB outcome shared by Jones et al. (2021) in a scoping review illustrating a speaking up intervention involving the use of a "Crucial Conversations" curriculum did not result in any significant improvement in comfort during interprofessional conversations. It should be noted the curriculum as described was designed to ask for help or admit errors, not to speak up for patient safety issues. Another scoping review by Kim et al. (2020) identified a gap in a measurement outcome for SUB likelihood, as none of the fourteen SUB training studies reviewed by the authors measured long-term speaking up behaviors.

Retention Outcomes. In organizations where professionals are skilled in patient safety communication and there is a perceived healthy work environment, there is improved job satisfaction and retention (Best & Kim, 2019; Garon, 2012; Wei et al., 2018; Yee-Shui Law & Chan, 2015). Garon (2012) identified improved communication impacting job satisfaction and retention also positively impacted a healthy work environment, while Wei et al. (2018) identified a healthy work environment impacted nurse retention. Narrative inquiry was used by Yee-Shui Law & Chan (2015) to explore the process of newly graduated nurses learning to speak up in practice and described increasing the retention rate of nurses will benefit patient safety.

Discussion

Speaking up for patient safety is defined in the literature and is a professional mandate. Existing barriers to speaking up behaviors were found to comprise the categories of personal and interprofessional, leadership, and organizational. While there are individual barriers to speaking up, without leadership and organizational support and structures in place, speaking up behavior will not be consistent. An identified gap in the readings included that while it is made clear

organizational support is needed to provide the workplace culture and structure to promote SUB, there were no laws or regulatory body guidelines referenced to strengthen the importance of SUB for stakeholders. The implication is organizations must prioritize the need for speaking up and ensure the provision of the appropriate training and tools to make speaking up behaviors successful. Speaking up interventions identified in the literature consisted of multiple methods including educational programs, role play and simulation, and non-educational interventions such as measures promoting SUB within an organizational culture, executive rounds, leader engagement with colleagues, event reporting systems, speaking up hotlines, speaking up recognition programs, and use of structured SUB communication tools.

The positive impact of SUB included positive patient safety outcomes, perceived health of work environments, likelihood, comfort, or confidence in speaking up, and nurse retention. It should be noted while retention was mentioned in some articles, most of the literature did not include retention as an outcome measure specifically for SUB interventions. While barriers, intervention characteristics, and outcomes of successful speaking up behaviors were described in multiple readings, successful listening and responding behaviors were generally not described. An exception to this was found in Kane's (2018) dissertation, where nurses stated they desired a valid, professional response to speaking up, even if it was disagreement. This implies a SUB intervention should consider incorporating expected response behavior for the listener, which would likely require leadership and organizational support for accountability.

Conclusion

The purpose of this literature review was to examine current evidence on SUB including its definition, what factors are barriers to SUB, and what interventions, cultural, and environmental factors promote SUB. Additional aims were to examine the relationship between

SUB and patient safety outcomes, healthy work environments, and nurse retention. The review found there is a need for implementation of speaking up behaviors and speaking up interventions are correlated to patient safety, perceived health of the workplace environment, and nurse retention. Additional findings include a multifaceted approach to promoting SUB can be used, consisting of a combination of educational, interactive sessions, leader roles to engage and support colleagues, and organizational roles to provide the culture, environment, and structured tools, as well as serving as an accountability framework to promote SUB. The literature will be used to guide a doctoral project that designs a multifaceted intervention to promote speaking up behaviors in a community hospital.