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# Leadership, Team Climate, and Psychological Safety as Predictors of Quality of Care in Palliative Nursing Units

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**Abstract**

Quality of care in palliative nursing units emerges from interactions among professional judgment, communication, coordination, organizational resources, and the capacity of teams to recognize and respond to changing patient needs. Leadership, team climate, and psychological safety are frequently associated with favorable nursing and safety outcomes, yet these constructs operate at different analytical levels and should not be treated as interchangeable predictors. The analysis also preserves competing structural pathways involving staffing, practice environment, organizational support, surveillance, escalation capacity, and professional role configuration. The resulting account therefore treats psychological safety as an important but neither necessary nor sufficient mechanism of care quality. It proposes that leadership effects depend on successful translation across individual, team, unit, and organizational levels, with feedback from team responses and care experiences capable of strengthening or eroding subsequent climate and safety.

**Keywords:** Palliative nursing, Leadership, Team climate, Psychological safety, Speaking up, Quality of care

## Introduction

Leadership has become an increasingly prominent explanation for variation in nursing work environments and perceived quality of care [1]. Multi-source evidence also indicates that staffing, the nursing practice environment, patient surveillance, and escalation capacity can influence clinically consequential outcomes through pathways that do not depend on a particular leadership style [2-4].

This requirement is especially important in palliative care, where symptom complexity, changing goals, prognostic uncertainty, psychosocial needs, family involvement, and professional role interdependence make coordinated interpretation central to care. Ethnographic work demonstrates that interprofessional collaboration in palliative settings involves continuing negotiation of responsibilities and expertise rather than simple parallel completion of profession-specific tasks [5-7].

*Conceptual problem*

A central conceptual difficulty is the tendency to compress leadership, work environment, team climate, psychological safety, employee voice, and quality outcomes into a single favorable-organizational-culture construct. Systematic evidence on nursing leadership instead shows heterogeneous outcome patterns and substantial dependence on how leadership is enacted, what outcomes are measured, and which intermediate workforce and organizational conditions are present [8, 9]

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Evidence linking transformational leadership with patient-safety outcomes illustrates why these distinctions matter. Structural-equation analyses have supported indirect pathways through professional empowerment, job satisfaction, or related workforce conditions rather than a simple unmediated leadership-to-outcome effect [10-12]. A multilevel account must therefore specify translation. These possible discontinuities form the analytical problem addressed throughout this article.

*Theoretical foundations*

Psychological safety provides one foundation for understanding the interpersonal component of this translation process. The broader literature similarly demonstrates that psychological safety has been operationalized across different analytical levels and connected to multiple organizational theories and outcomes [13, 14]. Treating it as a generic synonym for trust, satisfaction, teamwork, or positive climate would therefore remove distinctions that are necessary for a multilevel explanation [15, 16].

Healthcare teamwork provides a second foundation. High-quality care depends on more than the aggregation of individual competence because professionals must exchange information, integrate different forms of expertise, monitor changing conditions, coordinate action, and correct emerging problems [17]. Healthcare-specific synthesis of psychological-safety research reinforces its relevance to communication, learning, work experience, and team processes, while also showing that evidence connecting psychological safety directly with patient outcomes is substantially less developed than evidence concerning proximal professional and team outcomes [18, 19]. This difference between proximal and distal evidence is important: a psychologically safer environment can plausibly facilitate care without itself constituting care quality.

Palliative nursing adds a third foundation. Competency syntheses identify communication, collaboration, leadership, clinical assessment, coordination, ethical practice, and relational work as recurring elements of palliative nursing across levels of care [20, 21]. These competencies place nurses within networks of dependence involving physicians, allied professionals, patients, and families. The theoretical task is consequently to explain how organizational and interpersonal conditions affect whether such competencies become coordinated collective action.

**Table 1.** Analytical separation of the principal constructs in the multilevel account

| Construct | Primary analytical level | Core analytical question | Observable expression | Must remain distinct from | Function in this article |
|---|---|---|---|---|---|
| **Leadership** | Leader/manager with organizational authority | What behaviors, signals, priorities, and responses are repeatedly enacted by those with formal or informal influence? | Inclusion, responsiveness, resource advocacy, reaction to concerns, prioritization | Shared team climate | Upstream influence on norms, resources, and interpretation |
| **Team climate** | Team/unit | What expectations and working norms become shared across repeated interaction? | Patterns of cooperation, support, participation, information exchange | Individual psychological safety | Meso-level environment through which leadership is socially translated |
| **Psychological safety** | Individual-within-team and potentially shared team state | What interpersonal consequences are expected if a person questions, admits uncertainty, disagrees, or reports concern? | Willingness to accept interpersonal risk | Speaking up itself | Proximal condition enabling or constraining voice and learning |
| **Voice and speaking up** | Individual/team behavior | Are concerns, uncertainties, dissent, and errors actually expressed? | Questions, challenge, reporting, escalation, disclosure | Psychological safety | Behavioral conversion point |
| **Interprofessional learning and coordination** | Team/interprofessional system | Does expressed information alter shared understanding or coordinated action? | Joint interpretation, role integration, learning, adaptation | Voice alone | Converts communication into collective care processes |
| **Quality of care** | Team/unit/service outcome | Does collective work produce safer, responsive, patient-centered care? | Missed care, safety performance, perceived quality, coordinated response | Any single upstream construct | Distal outcome requiring multiple mechanisms and resources |

*Leadership in palliative nursing units*

Leadership in a palliative nursing unit is analytically relevant when it changes how professionals interpret priorities, access decision makers, manage uncertainty, allocate attention, respond to concerns, and coordinate across role boundaries. What matters is the repeated pattern through which leaders invite contribution, respond to uncertainty, protect professional participation, resolve competing priorities, and demonstrate what happens after a concern is raised [22, 23].

Palliative-unit leadership also operates within limits imposed by staffing, service organization, referral pathways, professional jurisdiction, and available expertise. Leadership should therefore be positioned as an upstream source of signals and enabling conditions whose consequences depend on whether those signals are reinforced by the organization and recognized consistently across the team.

*Team climate*

Team climate concerns shared patterns of expectation rather than the private attitudes of isolated professionals. Within palliative nursing units, the relevant issue is whether professionals repeatedly encounter norms that support participation, timely information exchange, mutual assistance, role negotiation, and response to emerging concerns [24, 25].

Team climate is therefore situated between leadership and psychological safety without being reducible to either. Likewise, a generally cooperative climate does not guarantee that every team member experiences equal freedom to challenge senior colleagues or disclose uncertainty.

*Psychological safety*

Psychological safety concerns the anticipated interpersonal consequences of taking a professionally relevant risk. In practice, the question is whether a nurse, physician, pharmacist, or allied professional expects that asking for clarification, acknowledging uncertainty, questioning a decision, or identifying a possible error will expose them to humiliation, retaliation, exclusion, or loss of professional standing [26].

Clinical discussions of psychological safety similarly emphasize that it involves interpersonal-risk conditions rather than universal comfort or absence of disagreement [27, 28]. Its relevance to quality therefore lies in what it permits teams to detect, discuss, and learn from—not in maintaining harmonious affect.

*Voice, speaking up, and error recognition*

Speaking up is the behavioral stage at which psychological and organizational conditions become observable. A qualitative metasynthesis of nurses' speaking-up experiences identified hierarchy, anticipated responses, interpersonal relationships, organizational conditions, and perceived consequences as recurring influences on whether concerns were expressed [29].

Interpersonal threat can interrupt this conversion. Evidence concerning workplace bullying and bystander conditions demonstrates that the social environment surrounding nurses is associated with differences in willingness to speak for patient safety [30, 31]. Conversely, silence does not necessarily indicate indifference or lack of knowledge; it may reflect an organizationally learned response to previous consequences [32].



Speaking-up behavior is also more heterogeneous than a binary voice-versus-silence distinction suggests. Cluster analysis among clinical nurses has identified different patterns of speaking-up behavior associated with organizational culture, teamwork, and working conditions [33]. Different concerns may cross different professional and hierarchical boundaries, so the pathway from safety to voice cannot be represented as a single uniform response.

*Interprofessional learning and coordination*

Voice becomes clinically important only when a team can receive, interpret, and act on what is expressed [34]. These functions illustrate why interprofessional learning should be separated from psychological safety: psychological safety may enable information to enter collective discussion, whereas learning concerns how collective understanding changes thereafter [35].

Organizational support for learning can extend beyond isolated training events. Networked initiatives among palliative-care educators likewise demonstrate how professional learning can be maintained through communities that cross local occupational and institutional boundaries [36]. Although educational evidence cannot establish direct care-quality effects, it clarifies an important organizational mechanism: teams require routines and infrastructure that allow expressed concerns and new information to alter shared practice [37].

Coordination is the care-delivery counterpart of that learning process. The proposed account therefore places interprofessional learning and coordination after voice in the analytical sequence, while allowing reciprocal interaction: coordinated teams can make later speaking up more useful, and constructive responses to voice can strengthen subsequent expectations that participation matters.

*Quality of care as a team-level outcome*

Quality of care is positioned as a distal team- and unit-level outcome because it emerges from coordinated work under organizational constraints. This relationship does not make safety culture and psychological safety interchangeable; it demonstrates that collective organizational conditions can become visible in whether necessary care is completed [38].

Specialized nurses can also contribute to patient-safety culture through clinical expertise, coordination, surveillance, communication, and enactment of safety practices, although such contributions depend on workload,

professional support, and organizational conditions [39]. Longitudinal evidence concerning perceived organizational-support climate further shows associations with nurse well-being and healthcare-unit performance over time [40].

Consequently, psychological safety should neither be treated as a sufficient explanation of quality nor dismissed because it is distal from clinical outcomes. Whether those processes improve care depends on resources and whether the organization can act on the information generated.

*Leadership-to-team-climate mechanisms*

Leadership can influence team climate through repeated social signals about participation, authority, error, uncertainty, and response. Because this evidence is observational, the mediation should be treated as support for a mechanism worthy of testing, not proof of a fixed temporal sequence [41].

Context alters that mechanism. Yet crisis findings cannot simply be transferred to routine palliative-unit practice. Among hospital nurses, servant leadership has shown a strong positive association with psychological safety [42]. Across these studies, the common analytical element is less the formal style label than whether leadership behavior signals inclusion, responsiveness, support, and legitimate participation [43].

Cross-level evidence also indicates why team climate should not be omitted from this account. At the same time, leadership may operate through empowerment and other pathways that are not identical to psychological safety. Team climate is therefore proposed as one collective translation layer, not the exclusive mediator of every leadership effect [44].

The interaction structure relevant to speaking up can now be specified without treating any one determinant as universally decisive.

**Table 2.** Organizational conditions governing the conversion of concern into speaking up and error recognition

| Organizational condition | Interpersonal-risk appraisal | Likely effect on voice or error recognition | Primary responsibility locus | Characteristic failure signal |
|---|---|---|---|---|
| **Consistent invitation for questions and challenge** | Reduces anticipated status cost | Makes early expression of uncertainty more feasible | Unit leadership and senior clinicians | Invitations exist rhetorically but concerns remain delayed |
| **Respectful response after disagreement or error disclosure** | Shapes expectations for future interactions | Supports repeated voice rather than one-time disclosure | Leader and whole team | Staff speak once and subsequently withdraw |
| **Stable peer support** | Provides social reinforcement when interpersonal risk is taken | May facilitate challenge across role boundaries | Team | Concerns circulate privately but are not raised collectively |
| **Hierarchical rigidity** | Increases perceived professional and relational cost | Suppresses upward voice and escalation | Organization, professions, leadership | Safety concerns remain within lower-status groups |
| **Bullying, ridicule, or punitive interaction** | Converts speaking up into a personal threat | Encourages withholding, avoidance, or selective voice | Organization and local team | Silence persists despite formal reporting systems |
| **Clear interprofessional responsibilities** | Makes the destination and ownership of concerns more predictable | Supports transfer from recognition to action | Service leadership and professions | Concern is voiced but no profession assumes follow-through |
| **Organizational support and adequate response capacity** | Makes speaking up consequential rather than symbolic | Increases likelihood that voice becomes corrective action | Organization/unit | Recurrent issues are reported without visible response |
| **Severe staffing or workload constraint** | Raises opportunity costs and reduces response capacity | Can weaken both recognition and follow-through | Organization/system | Teams know problems but lack capacity to resolve them |

*Team climate-to-psychological-safety mechanisms*

The proposed transition from team climate to psychological safety concerns how shared patterns of interaction become expectations about interpersonal risk. Inclusive leadership evidence indicates that such expectations can also vary according to cultural orientations [22], while team-climate evidence suggests that shared working conditions are meaningfully associated with professional experience at the group level [25].

Organizational support adds another layer. Longitudinal findings on support climate indicate that shared perceptions of organizational support have relationships with both staff well-being and unit performance [40]. Conversely, a supportive institutional context may reinforce local leader signals.

The transition is proposed as probabilistic. Psychological safety should be expected to be strongest when inclusive leader behavior, supportive team norms, organizational response, and previous interpersonal experience converge.

*Psychological safety-to-care-quality mechanisms*

The evidence base is strongest when psychological safety is linked first to proximal behaviors. Speaking-up research demonstrates that interpersonal and organizational conditions influence whether nurses express concerns [29], while mediation evidence directly connects psychological safety with voice and error-reporting behavior [41]. This supports placing speaking up and error recognition between psychological safety and more distal care outcomes.

A second conversion is required after voice occurs. Palliative-care collaboration and interprofessional learning research indicate that teams need structures for sharing expertise, interpreting uncertainty, and coordinating responses [5]. Interprofessional education provides evidence that these capabilities can be deliberately developed [35]. Patient-safety culture evidence then demonstrates an association between collective safety conditions and missed nursing care [38]. None of these sources by itself verifies the complete pathway. Together, however, they support an evidence-bounded proposition that psychological safety becomes clinically meaningful when it improves the flow of relevant information into collective interpretation and action.

The same logic explains why quality can remain poor in a psychologically safe team. If staffing is insufficient, escalation mechanisms are ineffective, relevant expertise is unavailable, or the organization cannot respond, high-quality interpersonal communication may expose problems without resolving them.

*Cross-level feedback processes*

The relationships described so far should not be interpreted as permanently one-directional. Professionals learn from what happens after they speak, disclose uncertainty, report an error, or request help. Repeated dismissal, retaliation, symbolic acknowledgement without action, or visible organizational incapacity can produce the opposite effect.

Longitudinal evidence concerning organizational-support climate supports the broader principle that organizational and staff conditions may influence one another over time [40]. Voice research likewise shows that anticipated responses are central to whether concerns are expressed [29]. Its qualitative findings do not establish intervention effectiveness, but they reinforce the importance of implementation context and collective response [45].

The proposed feedback process therefore operates through remembered organizational consequences. Leadership behavior influences team interpretation; team climate shapes interpersonal-risk expectations; psychological safety affects the likelihood of voice; and the response to voice becomes new evidence from which the team updates expectations about leadership, climate, and future risk.



**Figure 1** represents these relationships as a multilevel field rather than as a simple chain. It retains a parallel structural route to care quality so that staffing, practice environment, organizational support, surveillance capacity, and other resources are not incorrectly subsumed under psychological safety.

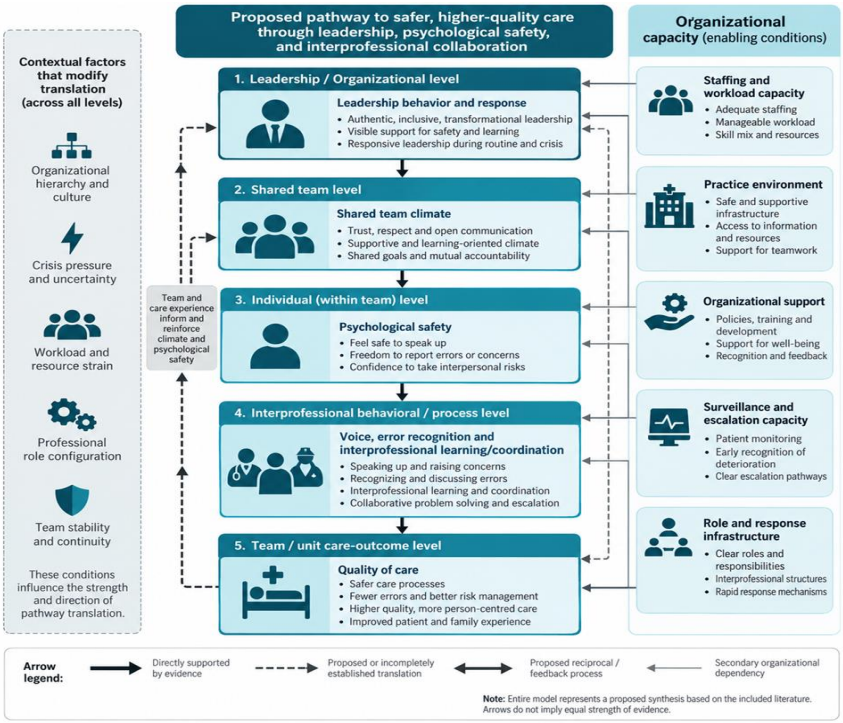



**Figure 1.** From Leadership Signals to Care-Relevant Team Action: Multilevel Translation, Structural Constraints, and Feedback in Palliative Nursing Units

*Proposed multilevel conceptual model*

The proposed model integrates leadership, team climate, psychological safety, voice, interprofessional coordination, and quality of care without collapsing them into a single organizational-quality construct. Psychological safety is positioned more proximally to interpersonal risk because it concerns whether individuals expect that questions, dissent, error disclosure, or uncertainty can be expressed without unacceptable social consequences.

The model then separates psychological safety from its behavioral consequences. Voice, speaking up, and error recognition constitute a conversion point: favorable interpersonal expectations become care-relevant only when information is actually expressed. A second conversion occurs through interprofessional learning and coordination, where expressed information is interpreted, combined with other expertise, assigned to responsible actors, and translated into action. Quality of care is therefore situated downstream from multiple organizational and team mechanisms rather than attributed directly to any one psychological construct.

The integrated model thus permits several valid configurations: leadership effects transmitted partly through psychological safety; structural quality improvement without measurable psychological-safety change; psychologically safe teams that remain unable to improve care because response capacity is inadequate; and feedback from organizational responses that changes subsequent team climate [3].

**Table 3.** Application and boundary-condition matrix for the proposed multilevel model

| Observed unit condition | Likely mechanism interpretation | Immediate management question | Appropriate organizational response | Boundary or caution |
|---|---|---|---|---|
| **Supportive leadership with weak speaking up** | Positive leader signals have not fully translated into interpersonal-risk safety or voice | Are staff experiencing hidden hierarchy, prior punitive responses, or unequal status? | Examine actual responses to disagreement and error disclosure; assess professional and peer dynamics | Do not assume leader accessibility equals psychological safety |
| **Favorable team climate with persistent silence around difficult cases** | General cooperation coexists with risk around dissent or uncertainty | Which topics, professions, or situations remain unsafe to question? | Identify issue-specific and status-specific barriers to voice | Team climate and psychological safety may diverge |
| **High reported psychological safety with unresolved care problems** | Voice may occur without adequate coordination or structural response | What happens after a concern is raised? | Strengthen ownership, escalation, interdisciplinary follow-through, and response capacity | Psychological safety is not sufficient for quality improvement |
| **Frequent reporting with little visible change** | Voice exists but organizational responsiveness is weak | Are concerns acknowledged, assigned, acted on, and closed? | Establish accountable response and feedback processes | Repeated non-response can erode later safety |
| **Poor care indicators under severe staffing or workload pressure** | Structural capacity may dominate interpersonal mechanisms | Are staff able to deliver known required care? | Address staffing, workload, surveillance, and escalation capacity | Interpersonal interventions cannot substitute for essential resources |
| **Improved care after structural redesign with unchanged psychological safety** | Quality improvement may be operating through a parallel structural pathway | Which operational mechanism changed? | Preserve effective structural redesign while separately evaluating team processes | Psychological safety need not mediate every quality gain |
| **Crisis, rapid turnover, or temporary team formation** | Shared climate and safety may be unstable or weakly developed | Have team expectations had enough time to become shared? | Use explicit role clarification, rapid briefing, accessible escalation, and visible leader response | Stable-team assumptions may not hold |
| **Interprofessional conflict over responsibility** | Voice is present but jurisdiction and ownership are unresolved | Who has authority and responsibility for follow-through? | Clarify decision rights and cross-professional accountability | More communication alone may not resolve role ambiguity |

*Formal propositions*

The conceptual model generates seven propositions that are sufficiently specific to guide empirical testing.

Proposition 1. Supportive, inclusive, or relational leadership will be associated with a more favorable team climate when leader behavior is reinforced by organizational support, role clarity, and adequate working conditions [22].
Proposition 2. A favorable team climate will be associated with greater psychological safety, but the two constructs will remain empirically distinguishable because general cooperation does not necessarily imply safety for dissent, error disclosure, or challenge [25].
Proposition 3. Psychological safety will show stronger and more immediate relationships with voice, speaking up, error recognition, and learning behavior than with distal care-quality outcomes [29].
Proposition 4. Associations between psychological safety and care quality will be partly transmitted through speaking up, error recognition, interprofessional learning, and coordination [41].
Proposition 5. Leadership effects on psychological safety and voice will weaken where hierarchy, bullying, poor staffing, low organizational support, ambiguous responsibility, or ineffective response to concerns persists [30].
Proposition 6. Care quality may improve through structural mechanisms—including staffing, practice-environment redesign, surveillance, escalation capacity, and organizational support—even when psychological safety does not materially change [3].
Proposition 7. Organizational responses to voice, error disclosure, learning, and care outcomes will feed back into later perceptions of team climate and psychological safety, producing reinforcing or deteriorating cycles over time [45].

*Boundary conditions*

The proposed relationships are expected to vary across palliative nursing settings. Cultural orientation may modify how inclusive leadership and participation are interpreted [22]. Crisis conditions can magnify dependence on leader accessibility while simultaneously reducing time and organizational capacity for deliberation [6, 30].
Palliative teams also differ in professional composition, service model, case complexity, staffing stability, and access to specialist expertise. Psychological safety may also function differently in stable teams and rapidly assembled teams because shared expectations require repeated interaction to consolidate [20].
Resource conditions are another major boundary. A team can identify problems accurately and communicate them openly while remaining unable to act because workload, staffing, equipment, access to senior review, or organizational authority is insufficient.

*Failure configurations*



The model is designed to identify configurations in which apparently favorable organizational features fail to produce expected downstream effects. One configuration is leadership intent without structural capacity: leaders encourage participation but cannot secure staffing, time, specialist input, or organizational response. A second is positive general climate without psychological safety, where teams cooperate in routine work but sensitive disagreement, uncertainty, or challenge remains socially risky.
A third configuration is psychological safety without effective response. Staff may speak freely yet find that no profession assumes responsibility, escalation pathways remain weak, or recurring problems receive no organizational action. A fourth is voice without follow-through, where reporting systems accumulate concerns while staff see little visible closure. Qualitative evidence from nurse middle managers illustrates the gap that can arise between an organizational ideal of speaking up and the practical reality of doing so within hierarchical and operational constraints [46].
Finally, structural improvement without psychological-safety change is not necessarily a failure. The model treats this as an important rival explanation rather than forcing every favorable outcome through the psychological-safety pathway.

*Leadership interventions and organizational levers*

Intervention should target identifiable mechanisms rather than rely on generic exhortations to create a positive culture. Evidence linking leadership with care-related outcomes also indicates that empowerment can function as an important intermediary mechanism [47].
Local interventions should therefore combine interpersonal and structural levers. At organizational level, staffing, workload, escalation capacity, access to expertise, role clarity, and institutional support must be sufficient for voice to become action.
Psychological-safety interventions should also be evaluated as implementation processes. A technically sound intervention may therefore produce limited change where prior punitive experience, hierarchical norms, workload pressure, or organizational non-response remains unaddressed [45].

*Implications for palliative nursing management*

For palliative nursing managers, the framework shifts attention from asking whether a unit has "good leadership" to examining where translation across levels succeeds or fails. Conversely, frequent disagreement can be

compatible with healthy team functioning when concerns are raised early, interpreted collectively, and followed by coordinated action.

Management assessment should therefore examine at least four linked questions: whether staff perceive that participation is invited; whether interpersonal risk is acceptable across professional and status boundaries; whether concerns are actually expressed; and whether the organization can respond once they are expressed [5].

The practical implication is that psychological safety should be managed as part of a wider care-production system. Interpersonal openness cannot compensate indefinitely for insufficient staffing or weak escalation capacity, while structural investment may underperform when professionals do not feel able to identify emerging problems. Unit leaders therefore need simultaneous visibility of relational conditions and operational constraints.

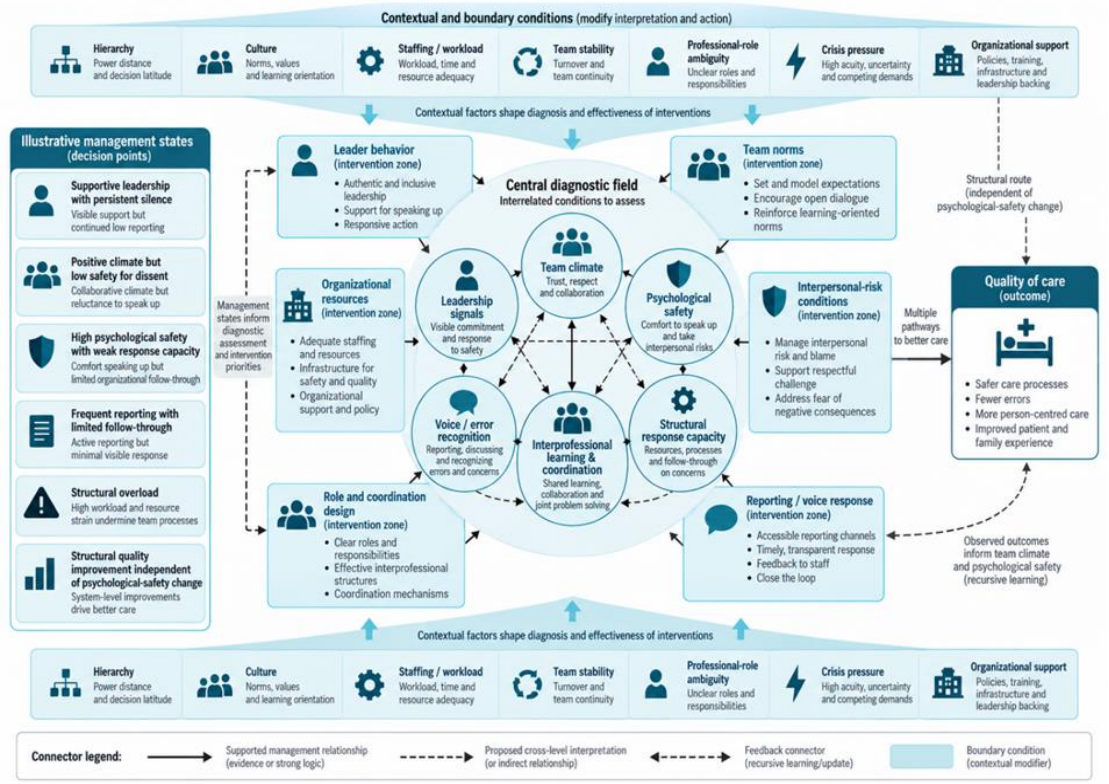



**Figure 2.** Translating the Multilevel Model into Management Decisions: Boundary Conditions, Failure States, and Organizational Levers

*Research agenda*

The strongest test of the framework would use longitudinal multilevel designs that separate individual perceptions from genuinely shared team properties. Temporal ordering is especially important because most available evidence is cross-sectional.

Research should also test competing pathways. Structural improvements may alter quality independently of psychological safety, while psychological safety may affect proximal voice without producing detectable downstream care change. Studies should therefore compare mediation models rather than assuming a single chain. Intervention research should document whether leader behavior changes first, whether team climate subsequently shifts, whether changes become shared, and whether behavioral outcomes follow.

Team stability requires particular attention. Palliative services that rely on rotating professionals, cross-service consultation, or temporary staffing may therefore require different measurement and intervention assumptions from stable specialist teams [44].

Appropriate studies could examine speaking-up behavior, escalation processes, missed care, coordination failures, learning events, patient- or family-reported care experience, and clinically meaningful unit-level quality indicators, provided that such outcomes are prospectively defined and matched to the mechanism under investigation.

## Results and Discussion

Its central contribution is to separate constructs that are often treated as interchangeable and specify the transitions required for an upstream organizational influence to become a downstream care process.

Leadership is positioned as an important source of social and organizational signals, but not as an autonomous determinant of quality. Voice then represents behavioral enactment, while interprofessional learning and coordination determine whether expressed information changes collective action.

This separation clarifies several findings that can otherwise appear contradictory. Favorable leadership may coexist with silence when hierarchy or previous responses make challenge costly. These are not anomalies within the model; they are expected configurations.

The palliative-care context makes these distinctions especially salient because care depends heavily on communication, role negotiation, repeated reassessment, family interaction, and coordination across disciplinary boundaries. The model should therefore be regarded as a theoretically integrated account requiring direct evaluation in palliative nursing units.

*Limitations*

The framework is limited by the heterogeneity of the underlying evidence. Statistical mediation in such studies cannot establish temporal or causal mediation.

Transfer of organizational mechanisms into palliative settings is theoretically plausible but should not be assumed to be uniform across hospices, specialist inpatient services, hospital consultation teams, community services, and generalist care environments.

It also treats quality of care as a team- or unit-level outcome for conceptual clarity, although individual patient outcomes are heterogeneous and shaped by disease trajectory, treatment goals, and factors outside organizational control.

Finally, the complete integrated pathway has not been tested as a single model. Its value lies in specifying distinct mechanisms, rival pathways, feedback processes, and failure configurations that can be examined empirically.

## Conclusion

Leadership, team climate, and psychological safety are conceptually related but operate through different organizational and interpersonal processes in palliative nursing units. Leadership may shape the conditions in which team norms develop; team climate may influence expectations about interpersonal risk; and psychological safety may facilitate speaking up, error recognition, learning, and coordination. These processes can contribute to quality of care only when expressed concerns can be translated into effective collective action.



The framework therefore treats psychological safety as one important mechanism within a wider organizational system, not as a universal explanation of care quality. Staffing, workload, professional roles, organizational support, surveillance, escalation capacity, and response to voice can strengthen, interrupt, or bypass the proposed pathway. Future multilevel and longitudinal research should test these alternative routes directly and determine when leadership and team processes become clinically consequential in palliative care.

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