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R.I.G.H.T. AS A MODEL OF HEALTHY LEADERSHIP PSYCHOLOGICAL SAFETY SATISFACTION AND RETENTION IN CZECH ORGANIZATIONS

Markéta Šimková,
PhDr. Ing. mgr. D. Ed., LL.M., doktorand DTI Dubnica nad Váhom, Slovakia
orcid.org/0009-0001-5538-3809
marketas3@seznam.cz

David Mazák,
PhDr. Ed. D., MBA, doktorand DTI Dubnica nad Váhom, Slovakia
orcid.org/0009-0008-5789-5622
mazak@email.cz

Summary. The R.I.G.H.T. model represents an innovative and human-centered approach to leadership based on five interrelated behavioral principles: recognition, engagement, growth, health, and teamwork. It aims to integrate emotional intelligence, organizational psychology, and evidence-based management to create resilient, value-oriented workplaces. This study examines how the model can be effectively adapted and implemented in the Czech work environment, with particular emphasis on the education and healthcare sectors – areas characterized by high emotional demands, burnout risk, and complex hierarchical structures.

A mixed-methods design was employed, combining qualitative interviews, quantitative surveys, and longitudinal observation within three types of schools and three healthcare institutions. The research analyzed how leaders and employees internalize the R.I.G.H.T. principles through daily routines, communication practices, and institutional culture. The model's implementation was assessed in terms of interpersonal dynamics, perceived fairness, openness to feedback, and supportive leadership behaviors. The study also explored organizational factors that either facilitate or hinder the sustainable adoption of the model, such as leadership training, institutional autonomy, and management attitudes toward psychological well-being.

The findings demonstrate that the systematic application of these five principles leads to measurable improvements in interpersonal relationships, job satisfaction, and psychological safety, while simultaneously reducing staff turnover and conflict incidence. Participants reported greater coherence between organizational vision and individual motivation, contributing to a stronger sense of belonging and shared responsibility. The data confirm that the R.I.G.H.T. model is not merely a theoretical construct but a practical framework capable of delivering tangible outcomes for workplace culture and employee mental health.

In the Czech context, its introduction aligns well with ongoing reforms in leadership education and healthcare management, providing a replicable model for human-centered institutional transformation. The results highlight its potential to enhance long-term organizational sustainability, promote ethical leadership, and strengthen collective resilience in high-stress environments.

Keywords: R.I.G.H.T. model, behavioral leadership, mental health, psychological safety, teamwork, education, healthcare.

1. Introduction

In recent years, the issue of mental health and psychological safety has become a key topic not only internationally, but also within the Czech work environment. Education and healthcare are sectors where long-term strain, staff shortages, and high demands on adaptability often lead to exhaustion, loss of motivation, and disruption of team collaboration. The COVID-19 pandemic has further highlighted these issues, revealing that traditional approaches to people management are insufficient to maintain organizational stability and effectiveness. In response to these challenges, there is a growing emphasis on leadership focused on wellbeing, psychological safety, and the long-term sustainability of teams. The R.I.G.H.T. model, which emerged from behavioral theories and is also inspired by international experience, offers concrete and practically applicable principles for systematically developing a healthy work environment. Its five pillars from recognition, engagement, growth, health, and teamwork, correspond not only to current management trends but also to the specific needs of Czech schools and healthcare institutions.

The aim of this thesis is to present the possibilities for adapting the R.I.G.H.T. model in the Czech context and, based on case studies, to demonstrate how its implementation can contribute to improving workplace atmosphere, increasing satisfaction, reducing turnover, and strengthening the psychological

safety of teams. The work also reflects the understanding that real change is not a matter of a single intervention, but rather the gradual building of trust, openness, and respect for the needs of individuals and entire collectives.

2. Principles of the R.I.G.H.T. Model and Their Significance for Healthy Leadership

The R.I.G.H.T. model identifies five key behavioral domains that leaders in educational and healthcare institutions can intentionally cultivate to support psychological health and the long-term sustainability of their teams. Each of these principles is grounded in both research findings and practical applications in organizational development. The following subsections present the individual dimensions of the model, accompanied by examples and references to relevant Czech scholarly literature that demonstrate their importance within the local context.

Recognition

Recognition represents one of the most fundamental behavioral elements of healthy leadership, directly impacting motivation, workplace well-being, and long-term employee engagement. It involves the conscious appreciation of work outcomes, approaches, personal effort, or the value-based attitudes of individuals. In educational and healthcare settings, where employees often perform their duties with a high degree of personal commitment while being exposed to prolonged stress, resource shortages, and societal pressures, the effect of recognition becomes a particularly significant protective factor for mental well-being. From a psychological perspective, recognition functions as feedback that fulfills basic needs for competence and belonging. In this context, recognition is not merely a formal act but a tool through which leaders affirm the value of individuals in their professional roles. As noted by Bedrnová, Nový, and Jarošová (2012), recognition strengthens employees' identification with organizational goals, enhances intrinsic motivation, and contributes to a sense of meaningful work. These authors emphasize that the absence of recognition can lead to internal distancing, decreased engagement, and subsequently to deteriorated team dynamics and overall performance. The importance of recognition is further elaborated by Frankovský and Lajčin (2012), who describe it as a key element in managing challenging situations in managerial work. Their research findings indicate that systematic work with recognition helps reduce employee stress, increases resilience to frustration, and positively influences the long-term stability of work teams. In their view, recognition is not merely a matter of personal leadership style but a strategic competence of leaders that reflects in the overall atmosphere and trust within the organization.

However, in the Czech context, recognition often lacks a systematic place within personnel management tools. The informal culture of many organizations relies on the assumption that employees "know they are doing good work" without the need for explicit confirmation. This approach can be problematic in the long term, as the psychological need for appreciation is universal. Especially in high-demand institutions such as hospitals and schools, the need for recognition is strongly linked to burnout prevention. Practical implementation of the recognition principle may include not only individual employee appreciation but also collective recognition of teams for achieved results or overcoming challenging periods. Recognition can be expressed verbally in daily communication but can also be part of the internal culture through regular performance reviews, annual awards, or sharing positive feedback among employees. In the educational context, recognition can be applied through public acknowledgment of teachers' contributions at staff meetings, school newsletters, or communication with parents. In healthcare, recognition may take the form of direct appreciation from supervisors or nomination systems by patients and colleagues. The R.I.G.H.T. model places recognition as the foremost of its five key pillars, underscoring its crucial role in the daily practice of healthy leadership. Leaders who consciously and consistently work with recognition create a work environment that is not only productive but also sustainable in terms of mental health. Systematic integration of recognition into organizational processes represents an investment in long-term stability, reduction of turnover, and building employee loyalty.

Involvement

Employee involvement in decision-making processes represents a key principle of healthy leadership that significantly contributes to creating a psychologically safe work environment, as employees who feel part of decision-making structures are generally more motivated, engaged, and loyal to the organization.

In the education and healthcare sectors, where workloads are high and decisions often affect not only work efficiency but also people's health, participation is crucial for sustaining work performance and employees' mental well-being. As Koubek (2015) notes, employee participation in decision-making influences not only their motivation but also the quality of decision-making processes. Leadership that enables employees to actively co-decide gains a broader spectrum of information, thus achieving a more comprehensive and realistic view of the issue. Armstrong (2007) adds that participative management positively impacts the development of an organization's knowledge potential because employees are more willing to share their know-how when they perceive their voice as having weight and impact within the organization. In healthcare, the effectiveness of involvement has been demonstrated by research from Roussel, Thomas, and Harris (2022), who found that healthcare staff participation in decision-making leads to increased professional autonomy, improved team collaboration, and reduced turnover. In clinical settings, there is also an increase in the sense of responsibility and willingness to accept changes when employees are invited to co-create strategies or work processes. This similarly applies to education, where participative leadership of teachers leads to a more positive school climate and higher professional identity among educators (Katrňák and Vaculík, 2013). Edmondson (2018) emphasizes that participation is inseparably linked to psychological safety, meaning the individual can freely express their thoughts without fear of negative consequences. In environments that support open communication and where employees experience that their opinions are taken seriously, not only does team cohesion grow, but also the organization's innovative potential and adaptability to change. In the Czech context, participative approaches are increasingly regarded as effective management tools, although their implementation may initially be influenced by cultural habits and traditionally hierarchical leadership styles. Practical tools that leaders can use include regular team meetings, guided discussions, anonymous satisfaction surveys, workshops, or facilitated sessions focused on joint problem-solving. Long-term practice shows that these forms of participation lead to increased trust, improved internal communication, and reduced psychological strain (Katrňák and Vaculík, 2013). The R.I.G.H.T. model includes involvement as one of the five pillars of healthy leadership because participation is not only a means to better decisions but also a way to create an engaged, stable, and psychologically resilient work culture. For the management of educational and healthcare organizations, this means the need to create transparent structures for employee participation and simultaneously implement feedback mechanisms that not only collect opinions but actively work with them. This makes participation an integral part of organizational life rather than an isolated initiative.

Growth

Employee growth and development represent a fundamental pillar of psychologically healthy leadership, understood within the R.I.G.H.T. model as the continuous support of both professional and personal evolution of employees. In educational and healthcare institutions, where rapid social and technological changes occur, the need for growth is particularly urgent. A lack of development opportunities is often a factor leading to demotivation, stagnation, and gradual alienation of the employee from their professional role. Nešpor (2019) emphasizes that continuous education and internal development contribute not only to professional competence but also have a direct impact on mental resilience and the ability to manage work-related stress. Growth in this context does not only mean increasing qualifications but also cultivating skills that enable employees to effectively manage their emotions, relationships, and personal goals. Such skills, sometimes referred to as life competencies, include self-management, the ability to plan and adapt to changes, resilience to frustration, and the ability to collaborate across professions. From an organizational leadership perspective, supporting employee growth is a highly effective human resource management strategy. As Koubek (2015) notes, modern HR approaches view education as part of a broader human capital development system. Employees who perceive that their leadership supports their growth are more motivated, demonstrate higher levels of engagement, and are more willing to take responsibility for complex tasks. Such a work environment also strengthens loyalty, reduces turnover likelihood, and creates conditions for an innovative culture. In practice, growth can be supported by various tools. These include offering internal and external training, implementing mentoring and coaching programs, providing supervision, enabling professional internships, or access to challenging projects. A specific form of development may also be the opportunity to participate in research or development

activities within the institution or to temporarily assume a management role. In educational settings, growth often occurs through community sharing of best practices or participation in the development of school curricula. In healthcare, growth can be supported through rotation between departments, participation in professional conferences, or involvement in quality project management. Incorporating growth and development into the framework of psychologically healthy leadership reflects the belief that people have a natural need to learn, develop, and be supported in their professional trajectory. Growth is not a one-time event but a process that must be continuously supported by organizational culture and leadership attitudes. Management that systematically creates conditions for development not only enhances organizational performance but also fosters an environment where employees feel valued, competent, and intrinsically engaged.

Health

Employee health and safety constitute an inseparable part of psychologically healthy leadership. Within the R.I.G.H.T. model, this pillar is understood as the leadership's responsibility not only for physical working conditions but also for supporting mental well-being, preventing burnout, and systematically cultivating the work environment. The legal framework of the Czech Republic (for example, Section 101 of the Labor Code) clearly stipulates the obligation of employers to care for the safety and health protection of employees at work, which concerns both physical and mental health. According to Paulík (2010), mental hygiene should be actively supported in organizations as an integral part of healthy management. Psychological resilience is not only an individual's personal attribute but is significantly influenced by organizational culture, leadership style, and the resources available to employees for stress management. Kolář (2021) adds that prolonged psychological pressure without adequate support leads to chronic stress and reduces performance and recovery capacity, increasing the risk of burnout and somatic issues. In recent years, the approach to workplace health has shifted from individual responsibility towards the concept of *"wellbeing"* as a systemic category, as reflected in international documents such as the World Health Organization's Healthy Workplace Framework (WHO, 2010). Organizations that support employee health report not only a decrease in sick leave but also increased productivity, higher satisfaction levels, and lower turnover rates. This is especially true in professions with high responsibility and emotional demands, such as educators and healthcare personnel. A practical example of implementing the health and safety principle within leadership is the case of the University of Social Sciences and Security, where an internal psychologist is employed. Their presence, along with the availability of regular consultations for employees, has led to a significant increase in job satisfaction, higher levels of sharing among colleagues, and reduced stress during the academic year's crisis periods. This approach demonstrates that supporting mental health need not be complicated if it is systematic and receives targeted attention from leadership. From a practical perspective, health and safety can be supported through psychoeducational programs, supervision, group workshops focused on stress management, training for leaders in psychological safety, and the creation of so-called supportive work environments. It is crucial that these activities are long-term, regular, and not limited to addressing acute crises. Involving employees in co-creating mental health programs further enhances their effectiveness and strengthens trust in leadership. A psychologically healthy workplace is a prerequisite for the efficiency, stability, and professional dignity of all its members.

Teamwork

Teamwork represents not only an effective organizational tool but also a fundamental element of employees' psychological well-being and professional identity. Within the R.I.G.H.T. model, it is understood as the leadership's ability to create an environment where team members are connected by trust, shared goals, and supportive communication. Teams characterized by psychological safety enable individuals to contribute openly, participate in decision-making, and effectively resolve conflicts without fear of negative consequences. Frankovský and Lajčin (2015) state that teams with supportive leaders exhibit not only higher work performance but also lower stress levels and greater mutual trust. These authors emphasize that psychologically safe teams are not afraid of mistakes because they perceive failure as an opportunity for learning. They also mention that shared leadership, where team members take responsibility for specific areas, leads to higher engagement and the development of collective intelligence.

Supporting teamwork is particularly important in education and healthcare settings, where teams consist of diverse professional groups that often differ in approaches, language, and expectations. In these contexts, the quality of teamwork is one of the main determinants not only of job satisfaction but also of outcomes for clients, whether students or patients. Team cohesion contributes to improved interdisciplinary collaboration, reduces the occurrence of conflicts, and strengthens the organization's resilience to crises. A good practice example is the experience of the University of Social Sciences and Security, where regular interdepartmental consultations and case meetings conducted in a facilitated sharing style were introduced. This approach improved communication across departments, increased trust among colleagues, and fostered greater willingness to help each other, especially during crisis periods. This example confirms that teamwork need not be the result of chance circumstances but the consequence of a deliberately supported culture of sharing and mutual respect.

Teamwork can be strengthened through multiple levels of management. Key tools include the introduction of regular meetings focused not only on performance but also on team relationships, support for collegial feedback, development of communication skills, and strengthening of team identity. It is also advisable to enable teams to co-decide on work methods, reflect on successes and failures, and jointly create work goals. A significant factor is the presence of a leader who can not only coordinate but also motivate and listen. Incorporating teamwork into the framework of psychologically healthy leadership shows that sustainable performance and a healthy work environment arise primarily where people feel they can be themselves, rely on others, and bring their uniqueness to the team. Psychologically safe teams are not only more productive but also more stable, innovative, and resilient in the long term.

2. Research and Application Studies of the R.I.G.H.T. Model

The R.I.G.H.T. model represents a behavioral leadership framework aimed at fostering a psychologically healthy work environment. Following the presentation of its theoretical principles and their grounding in scholarly literature, this section focuses on the model's practical application. The purpose is to demonstrate how the individual dimensions of this approach influence workplace climate, psychological well-being, and the overall functioning of organizations in education and healthcare. Both sectors have long struggled with excessive staff workload and require systematic support in human resource management. Instead of a uniform quantitative survey, case studies were selected to allow for a more detailed observation of the implementation process, perceived benefits, and potential challenges. Case studies provide a deeper understanding of how the individual principles of the R.I.G.H.T. model are put into practice and how employees and management respond to them. This approach makes it possible to monitor not only outcomes but also the context in which changes occur. In each sector education and healthcare three case studies are presented. Their selection takes into account differences between organizations in terms of size, professional focus, and organizational structure. Within these studies, mixed methods were used, combining surveys with qualitative techniques such as semi-structured interviews, focus groups, and analysis of organizational documents. This integration of quantitative and qualitative data enables not only the tracking of the extent of change but also an understanding of employees' subjective perceptions of the model's principles. The findings from these studies can serve as a foundation for developing methodological recommendations, proposals for leadership training, and systemic measures in the field of occupational health. The aim of this section is to show that the implementation of behavioral leadership principles is not a matter of isolated initiatives, but can be part of a long-term strategy that supports sustainability, performance, and the psychological stability of the work environment.

Introduction to the Case Study Design

To verify the practical relevance of the R.I.G.H.T. model, a case study approach was chosen, which allows for the examination of organizational phenomena in their natural environment. This approach captures not only the outcomes but also the processes and contexts that led to them, making it particularly suitable where changes are closely tied to organizational culture, management style, team dynamics, and interpersonal relationships. The selection of case studies includes diverse types of organizations with the aim of understanding how the R.I.G.H.T. model is perceived and implemented by employees, leadership, and support structures. The combination of quantitative indicators (e.g., satisfaction, stress,

cohesion) and qualitative methods (interviews, focus groups, document analysis) enables a comprehensive picture of the changes. The goal is not only to determine whether the model works but also to explore how its implementation varies across different environments and which conditions support or hinder it. This approach provides not only theoretical insights but also practical recommendations tailored to various types of organizations. The findings are valuable both for the academic community and for the practice of leadership and team development.

Education – Case Studies

The R.I.G.H.T. model has proven to be an effective tool in the education sector for supporting mental well-being, participation, and the professional development of teaching teams. Unlike one-off interventions, it enables a long-term transformation of the school's internal culture without disrupting its identity. The pillars of recognition, involvement, growth, health, and teamwork are applied in Czech schools in various forms, depending on the specific context and initial situation. Case studies thus make it possible to observe how concrete steps have influenced relationships, atmosphere, and learning outcomes.

Elementary School

An elementary school in the wider center of Prague had long been regarded as a stable institution with a strong foundation and openness to pedagogical innovation. Nevertheless, in recent years a sense of internal exhaustion began to spread among teachers, a feeling not outwardly visible but increasingly present within the faculty. The staff room transformed into a place marked by caution and distance. Deeper conversations gave way to formal meetings, collegial support weakened, and feelings of overload and isolation became common experiences. The school's atmosphere was quietly ripening for change. The school's advantage was an in-house psychologist who had long perceived the growing risk of burnout, mistrust, and team alienation. It was his sensitive suggestions that the leadership accepted, deciding to focus on restoring basic relational bonds. The goal was not a revolution but patient steps to bring recognition, collaboration, and psychological support back to the faculty. The school began gradually introducing selected elements of the R.I.G.H.T. model, especially in the areas of relationships and care for mental well-being. The transformation started subtly but with clear intent, as the school leadership initially concentrated on strengthening a culture of recognition. At staff meetings, expressions of gratitude and appreciation became a regular feature, directed not only at performance but also at willingness to help, humanity, and collegial support. This impulse quickly took root and became a natural part of daily school life. Teachers began to notice small acts of kindness more often, encouragement and humor increased, and the previously tense atmosphere started to relax. One of the new features was the faculty café, an informal monthly gathering without an official agenda where inspiration from teaching, both strong and weak moments, and above all simple human presence were shared. These moments, where there was no need to solve tasks but simply to be together, brought a return to collegial contact that was so needed. The third pillar of the transformation became regular supervision led by the school psychologist, where every three weeks teachers could come to a safe space to speak openly about their emotions, vent tension, and seek solutions to difficult situations together. It was here that many, for the first time in years, found the courage to say what was truly troubling them. For example, Ms. Siváková, who just a year ago was considering leaving the teaching profession, now says with a smile that it was thanks to open conversations and new relationships in the staff room that she rediscovered her desire to teach and to give children not only knowledge but also joy in life. *"In supervision, for the first time in a long time, I felt I was not alone in everything. Suddenly, I could talk about my doubts and joys and realized that others felt the same way. That calmed and encouraged me immensely,"* she confides. Of course, change did not come without challenges. Some colleagues initially considered gestures of recognition artificial and supervision an intrusion into their personal space. Here it was very helpful that leadership did not force anyone but offered participation. Everything was voluntary, transparent, and openly communicated. A key role was played by trust in the psychologist who had been a long-term part of the school and whose presence felt natural. After about two months the atmosphere began to shift, initial distrust faded, and teachers became more willing to try new things and share their experiences. A turning point came when during one staff meeting spontaneous applause broke out after a colleague was thanked for her patience with new students. At that moment many realized that the school's atmosphere was truly changing. Positive changes soon translated into pedagogical practice.

Relationships between homeroom teachers and assistants improved, willingness to participate in team teaching increased, and minor interpersonal conflicts in the staff room receded. An internal survey showed that psychological well-being scores increased by more than 20%, and student questionnaires more frequently mentioned teachers' approachability and willingness to listen. One student in the upper grades wrote, *"I feel like teachers are more relaxed now and smile at us more."* With the transformation came personnel changes. Two teachers who had long disagreed with the school's new direction and refused to participate in joint activities decided to leave. Their departure was accepted with respect, without drama, as a natural part of the transformation process. For the rest of the team, however, it meant more space and, paradoxically, even greater internal cohesion. New colleagues who joined during the second semester were systematically integrated into team structures from the start and received support through adaptation mentoring. The experience of this school confirms that even in a traditional environment where fatigue and loss of trust have set in, patient and sensitive leadership can transform work culture. It was not about one-off interventions but about gradually building relationships, meaningful forms of collaboration, and open communication. The school leadership demonstrated that a psychologically healthy environment does not arise by chance but through the courage to slow down, pay attention, and reconnect not only with the institution's goals but above all with the people who make it up. Because a school is not just a building and a timetable, but above all a living community of people who are not afraid to be together in both joy and hardship.

High school

A secondary high school in a small town with a long-standing technical and industrial tradition had for many years been seen as an institution that kept pace with modernization in terms of equipment and teaching, yet remained rather conservative in its management and team collaboration. Teachers had little opportunity to influence the school's direction and often felt more like executors of instructions than creators of a shared future. Repeated changes in the teaching staff in past years disrupted relationships and deepened mistrust toward the leadership. Willingness to participate in change was minimal and the atmosphere in the staff room resembled a waiting room rather than a place where new ideas are born. The turning point came when the school leadership realized that the school would not move forward without the active involvement of teachers. They decided to apply the principles of the R.I.G.H.T. model, which emphasizes participation and growth. Three working groups composed of teachers were established to seek new ways to revise the school curriculum, improve vocational training, and reassess the student evaluation system. The group focused on information technology instruction, for example, proposed connecting teaching with real assignments from local companies. Another team suggested that students should try working in various workshops and at partner workplaces, which significantly strengthened their relationship to practical training. Development interviews with leadership also became part of the changes. Teachers could openly articulate their professional goals and areas in which they would like to grow. The most common desires were for greater methodological sharing, support in class leadership, and more opportunities for further education. One teacher said, *"For the first time in years, I finally feel that someone is interested in my experience and that I can breathe professionally here."* These words became a symbol of the new atmosphere emerging at the school, but the path to change was not easy. Part of the staff responded with distrust and rejection, and some teachers feared that more work would be expected of them without real influence on decision-making. Leadership had to address time demands and differing motivation among teams, yet informal leaders emerged who were able to encourage colleagues and became drivers of change. Patient and transparent communication by the leadership played a major role, presenting changes as an opportunity for collaboration rather than an obligation, and the first implemented proposals and clear feedback significantly strengthened trust between leadership and teachers. After a year, it was clear that most positive changes not only persisted but continued to develop. Working groups transformed into active methodological teams that became a natural part of school life. Regular meetings for sharing best practices brought new impulses, and some innovations were even presented at a regional conference. Teachers began to see greater meaning in their work, relationships between departments visibly improved, and the atmosphere in the classrooms changed as well. Teachers noticed that students responded better to lessons, appreciated new forms of work, and became more actively involved, which

led the school to record a decrease in disciplinary offenses and better attendance, something leadership attributed to greater internal stability among the teaching staff. Anonymous surveys showed that most students found the teaching more interesting and valued the opportunity to participate in projects with real impact. The experiences of this school were also monitored within a regional network of vocational secondary schools. Where similar changes had not been introduced, uncertainty and low teacher participation in decision-making persisted. In contrast, the school that was not afraid to innovate and involve teachers in creating new approaches was seen as open and inspiring. The leadership also took inspiration from Finnish vocational schools, where teamwork and teacher involvement in curriculum development are standard practice. Some elements had to be adapted to the Czech context, but the idea of shared responsibility and experience sharing proved universal. Recent Czech research also highlights the benefits of visualization and innovative methods in secondary vocational education (Šimek, Gawrych & Vojtášová Berová, 2024). However, even this journey was not without losses. In the first few months, seven teachers who had long refused teamwork and shared responsibility left the school. Leadership communicated this openly and offered remaining colleagues support through mentoring and workload sharing. The arrival of new teachers, who were integrated into the team approach from the outset, brought new energy to the school and confirmed that cultural change is not only possible but also sustainable. The story of this school shows that even in a traditional environment, it is possible to initiate change that brings greater belonging, meaningful work, and better results not only for teachers but especially for students. The key to success is openness, patience, and a willingness to seek new paths together.

University in Prague

A university in Prague, rooted in established academic traditions, began facing new challenges in recent years. It became increasingly clear that traditional methods were no longer sufficient for the needs of modern students or the demands of today's world. Discussions gradually developed within the faculty about how to make teaching more relevant to reality and how to offer students more than just theoretical knowledge. The first impulses for change came when the university leadership began systematically monitoring trends in innovative education and drew inspiration from the publications of Šimek and Lengyelfalusy (2020), who advocate experiential learning, open teaching, and visualization as key elements of modern pedagogy. The decision to implement these approaches into regular teaching was not easy, but the leadership believed that this direction could create an environment where both students and teachers would feel safe, motivated, and able to grow. Changes were introduced gradually and with respect for the pace and needs of all involved. Initially, working groups composed of teachers from various disciplines were formed to propose specific adjustments to teaching, pilot new methods, and share experiences. Great emphasis was placed on experiential learning, which allows students to experience the subject matter firsthand, engage their emotions and senses, and actively participate in the creation of knowledge. Visualization became an integral part of teaching, whether through interactive aids, digital tools, or the creation of their own projects.

The R.I.G.H.T. model became the key framework for the entire transformation, emphasizing participation, growth, openness, teamwork, and transparent communication. Thanks to the consistent implementation of this model, it was possible to create an environment where both students and teachers felt engaged, respected, and motivated to develop further. Teachers were actively involved in decision-making processes, had the opportunity to influence the form of teaching, and shared their experiences across disciplines. Students were encouraged to be independent, take responsibility for their own education, and share their opinions openly, and their responses to the new methods were overwhelmingly positive. Classrooms became lively with activity, discussions, and genuine curiosity. Students appreciated the opportunity to learn from concrete examples, develop critical thinking, and acquire skills useful in practice. One of the most remarkable moments was when Simona B., a third-year psychology student who had previously been afraid to speak in front of the class, was able to confidently present her project to an expert committee thanks to experiential learning. She later admitted that the opportunity to learn in a safe and supportive environment gave her the courage she would never have gained in traditional teaching. Similar stories multiplied and the atmosphere at the university began to change. *"For the first time, I feel that what I am learning really makes sense,"* said one student. Another summarized his progress by

saying, *"Thanks to the direct and open teaching at the university, practice is easy for me and I ask more questions, I am more engaged."* A teacher who underwent training in new methods added, *"I started looking forward to work. I see that students respond, are active, and want to create."* A crucial turning point came when the university leadership introduced new applications of teaching methods that were carefully selected with regard to students' needs. It became clear that innovation is not just about changing content but primarily about changing approach. It was necessary to rethink the very foundations of teaching, moving from lecture monologues to interactive dialogue, from linear explanation to meaningful involvement. The atmosphere at the university changed noticeably and interest in studying began to grow. Teamwork among students and teachers deepened significantly and the university became a place where it is a pleasure to teach and to learn. However, these positive changes were not self-evident for everyone, as some teachers could not identify with the new direction, clung to traditional practices, and refused to collaborate in teams. A typical example was a psychology teacher who insisted on memorizing the birth and death dates of important figures, while practical skills and diagnostics remained neglected. The university leadership offered everyone the opportunity for development and familiarization with innovative methods as described by Šimek and Lengyelfalusy (2020). Those unwilling to accept the change eventually left the university. This step opened space for genuine collaboration and sharing of experiences among teachers who embraced innovation. To better understand the impact of the changes, the university conducted a survey among one hundred twenty students and thirty-two teachers. The questions focused on perceived teaching quality, level of engagement, motivation to participate, and the feeling of safety when expressing oneself actively. Among students, perceived clarity of the curriculum increased by 35%, intrinsic motivation to participate in seminars by 28%, and willingness to express their own opinions by more than 30%. Among teachers, 81% of respondents rated the new teaching style as beneficial for student skills development, and 75% stated that the new approach improved the atmosphere in teaching groups. Reflections from the university leadership show that the hardest part was giving up the classic image of the lecturer as an authority. It was necessary to overcome fears of losing control and to accept the role of a facilitator who listens, connects, and supports. The Vice-Rector for Studies stated that the greatest change was not in methodology, but in internal attitude, to stop controlling content and start creating conditions for growth. This shift was not without uncertainty and mistakes, but proved to be crucial. Today, the university is an example of how thoughtful implementation of modern educational methods and the R.I.G.H.T. model can change not only the way of teaching but also the overall atmosphere and internal culture of the institution. Teaching is flexible, open, reflects students' needs, and aligns with trends that are now key for the competitiveness of universities not only in the Czech Republic but also in Europe. The university actively collaborates with partners from both academic and applied fields, supports student involvement in research projects, and creates opportunities for lifelong learning. The experience of this university shows that investing in innovation and expanding educational offerings brings not only higher teaching quality but also greater resilience to societal challenges, better employability of graduates, and higher prestige for the entire institution. The university seeks to inspire other institutions in the region and is ready to share its experiences. It believes that openness, courage, and teamwork are the keys to success in modern education and that true education does not begin with a textbook, but with the courage to change the world around us, and above all, within ourselves.

Summary of R.I.G.H.T. Implementation in Education

Three case studies demonstrate that the R.I.G.H.T. model can be successfully adapted to diverse school structures, cultures, and challenges. In all cases, improvements were observed in interpersonal relationships, strengthened team collaboration, and increased employee participation. These changes resulted in a reduction of disciplinary infractions, higher teacher engagement, and better communication across schools. The transformation was not the outcome of one-off interventions but the result of consistent and sensitive leadership that fostered authentic involvement. The key was creating space for dialogue, respect, and a willingness to learn from mistakes. As a result, schools became more open, cohesive, and effective. The model supported not only the professional growth of teachers but also the personal development of students, who perceived the school as a space for their own voice and engagement. These experiences can serve as inspiration for other schools seeking a path toward quality and human-centered

education. R.I.G.H.T. confirms that real change is possible where trust, respect, and the courage to do things differently are embraced.

Healthcare – Case Studies

In healthcare, the R.I.G.H.T. model is primarily applied as a tool to support staff stability, manage stress, and strengthen team resilience. Healthcare facilities face high turnover and psychological exhaustion. Even with advanced technical resources, maintaining high-quality care is impossible without a motivated team. The model is built on five core principles: recognition, involvement, growth, health, and teamwork. These elements can be easily integrated into daily practice, helping to reduce burnout and enhance psychological safety. Case studies illustrate specific impacts in a hospital, a dental clinic, and a specialized private facility. Across all settings, a common feature is the emphasis on mental health as the key to sustainable care. Research confirms that staff satisfaction and psychological safety are crucial for retention, team performance, and the overall quality of care. Applying the R.I.G.H.T. model supports not only technical excellence but also the well-being and cohesion of healthcare teams, making it an effective strategy for addressing the complex challenges of modern healthcare.

Municipal Hospital – Surgical Department

A surgical department in a municipal hospital in a larger regional city was under immense tension just a year ago. The main reasons were long shifts, repeated coverages for absent colleagues, and fatigue that accumulated with each additional duty. These problems were a daily reality, and there were days when healthcare workers felt they had nothing left to give, yet they had to continue. The atmosphere thickened, smiles disappeared, and meetings increasingly discussed who on the team was considering leaving. The hospital management faced the challenge of stopping this silent wave of exhaustion that threatened to sweep away not only the team but also the quality of patient care. At this moment, a decision was made to try something that is still not common in the Czech healthcare environment. The management decided to give space to humanity, openness, and genuine teamwork and chose the R.I.G.H.T. model, whose fundamental pillars are participation, growth, openness, health, and teamwork. However, it must be noted that no one at the time realized how profound a transformation such a change could bring. Initially, it was not easy, especially when the management announced the introduction of regular supervision sessions with an independent clinical psychologist. Many shrugged and thought it was just another pointless top-down project. One of the doctors, the head physician, later admitted that he regretted how little they believed in the project, thinking it was just another nonsense from the hospital's top management, but now he sees that it could have come much earlier. He literally said: *"I regret that we did not believe much in the project, we thought it was just another nonsense from the hospital's top management, but now I see it could have come much earlier."*

The first meetings were awkward; some colleagues remained silent, others kept their distance, but after a few weeks, something began to change. It started when a young doctor, who was on the verge of leaving due to long-term stress, openly said for the first time that she used to feel lost in it all, but now she knows she has someone to talk to when she feels bad and that she is not alone. The room fell silent and then relief spread. She literally said: *"I used to feel lost in it all, now I know I have someone to talk to when I feel bad and that I am not alone."* These words helped break down barriers and showed others that shared burdens are halved. Supervision gradually became not only a safe space for sharing concerns but also a place where new trust was born. The staff became more cooperative, communication between shifts improved, and the number of misunderstandings during acute situations significantly decreased. Suddenly, it was no longer just about surviving the shift but about being a better team for themselves and for patients. The greatest success was that within a year of implementing the R.I.G.H.T. model, not a single employee left the department, and sick leave dropped practically to zero. In an environment where someone left every month until recently, this was a small miracle, and the change was also visible in the approach to patients. Coordination of work improved, teamwork strengthened, and above all, empathy increased. Patients began to notice that something was happening; one long-term patient even asked directly: *"Has the management here changed? You all seem somehow better, smiling, and no one yells like before."* Some even sent commendatory emails to the hospital management, which had not happened before. Simple human gestures, thanks, or kind words became part of everyday operations. The change was not immediately accepted;

some employees considered supervision unnecessary and were afraid to openly share their feelings. Here, it helped that management emphasized voluntariness and a safe environment. Patience and willingness to learn from mistakes proved to be key success factors, and as the saying goes: *"Nobody is perfect,"* and it was precisely this humanity and understanding that helped create new foundations for the department, where no one had to pretend to handle everything alone. The team, consisting of nine doctors, twenty-two nurses, and ten auxiliary staff, was directly involved in implementing the R.I.G.H.T. model. For comparison, a hospital with a similar staff size in the North Moravian region was used, where without this implementation, significant declines in staff satisfaction and stability occurred. The results showed that while the municipal hospital experienced team stabilization and increased satisfaction, the reference facility faced increased turnover, worsened team communication, and an 18% increase in sick leave. These differences attracted the attention of the second hospital's management so much that one of the managers visited the Prague department and began preparations for their own adaptation of the R.I.G.H.T. model. A year after the model's introduction, a survey was distributed among employees, showing maximum satisfaction with the work environment. Moreover, no employee left, sick leave dropped to a minimum, and the overall atmosphere of the department and the entire hospital significantly improved. The implementation was rated as 100% successful and became an inspiration for other healthcare facilities in the region. Based on this evaluation, the hospital management plans to expand elements of the R.I.G.H.T. model to other departments and to support a culture where employee care is as important as patient care in the long term. The established approach promises improvements not only in working conditions but also in the quality of care provided and the overall operation of the hospital. The story of the surgical department shows that even in the demanding healthcare environment, change can begin with one honest conversation and continue to transform the entire workplace culture. The R.I.G.H.T. model here is not just a method but a true path to a better work environment, higher employee satisfaction, and better patient care, because ultimately, whether standing at the operating table or in the nurses' station, it is humanity, openness, and trust that hold the team together and give work real meaning.

Private Dental Clinic Cheb – Dental Department, Dental Hygiene

Private dental clinic in Cheb was, until a year ago, a place where tension was palpable and every morning started with the feeling that the impossible had to be managed. The number of patients was increasing, the staff was overloaded, and the atmosphere thickened with each shift. The team consisted of six dentists, two surgeons, three dental hygienists, four laboratory workers, three receptionists, and six dental nurses, but in reality, it functioned more as a collection of small, mutually competing groups. Cooperation between the laboratory and doctors was poor because each had a different idea of the time needed to produce prosthetics. Additionally, nurses and receptionists struggled with high turnover, absenteeism, and reluctance to contribute to improving the clinic's operation. Conflicts were a daily occurrence, and the collective fragmented into isolated islands where everyone defended their own interests, which made the clinic's operation impossible. The clinic's management realized that if the situation did not change, the entire facility was at risk of collapse. At this critical moment, an extraordinary meeting was convened with a psychologist and the new clinic manager, where a fundamental decision was made to implement the R.I.G.H.T. model, which is based on involvement, recognition, teamwork, and open communication. The first steps were very cautious but crucial. Regular joint meetings and work sessions began in a relaxed atmosphere where everyone had the opportunity to express their opinion, whether doctors, lab workers, nurses, or receptionists. For the first time in a long time, a space opened where it was possible to safely point out problematic areas without anyone fearing consequences. One of the dental hygienists recalls how she was initially afraid to voice a new idea because proposals were often dismissed before. However, after the introduction of anonymous suggestions, she came up with an innovation in the appointment system, and colleagues not only listened but together implemented her idea. *"For the first time, I felt that my voice truly mattered,"* she says today with a smile. These small changes in approach began to change the clinic's atmosphere from within, and people started to notice that their ideas had a real impact on daily operations. The psychologist who accompanied the team through the change admits that the biggest obstacle was initial distrust and fear of openness, as he says: *"When I first saw people start to confide and support each other, I knew we were on the right path."* Gradually, it became clear that anonymous suggestions were not

just a formal gesture but a real tool for change. Management introduced a rule that every criticism must be accompanied by a specific solution proposal, which led to constructive ideas instead of mere complaints. Some proposals concerned better shift organization, others suggested improvements in patient communication or changes in material suppliers, leading to faster and higher-quality prosthetic production. However, it was not only rules and new processes that transformed the clinic but also the willingness of everyone to engage in solving problems together. One day, the laboratory failed to deliver prosthetics on the original deadline. Instead of the usual blaming, doctors and lab workers met, agreed on a new solution, and jointly informed patients. Everyone was surprised at how smoothly and stress-free the situation was resolved. This moment was pivotal for many because it showed that teamwork is not just a phrase but a real strength that can change the clinic's operation. Changes at the clinic were not without difficult decisions. It was necessary to part ways with two dental nurses and two receptionists who had long disrupted the collective and refused any cooperation. For example, a new receptionist with a lower limb disability was hired part-time. Although many initially had doubts, it quickly became clear that she was not only a full-fledged team member but also brought a new perspective and energy that united the collective. True teamwork began to function, which soon reflected in client satisfaction. For example, a new dental nurse who replaced a colleague who previously disrupted the collective said: *"I never imagined such a great cooperation system could exist, it is a joy to come to work."* Patients noticed changes in appointment times and staff attitude. One long-term client who uses both dental hygiene and regular dental services remarked: *"This approach is something that has never happened here before, please continue, now I like coming to you. Before, I always wanted to leave as quickly as possible."* The feedback from the long-term client is a clear sign of success. The clinic owner himself admitted that the clinic was on the brink of total collapse and that implementing the R.I.G.H.T. model saved it. He openly said: *"I was a fool, I couldn't see beyond my ego, and it almost cost me the company."*

Eight months after the system was introduced, an anonymous survey comparing the state before and after the change showed that employees were satisfied, turnover and absenteeism were zero, and the system of shift coverage by agreement worked flawlessly. The survey also revealed a significant increase in perceived cooperation between departments and greater trust in management. Most employees now feel part of the team and are more motivated to participate in the clinic's further development. Joint meetings are held every fourteen days, and the manager and psychologist are available to all employees. The greatest benefit comes from anonymous improvement suggestions, which have led to many new steps and a truly constructive culture. The psychologist adds*: "After six months, it was clear that people not only endured but wanted more, they propose, create, and stick together. Such transformations are still rare in healthcare but all the more valuable."* Today, the clinic is a place where people look forward to work, and patients feel welcomed and respected. The introduced form of constructive criticism, where every suggestion must include a solution, has brought not only a calmer work environment but also new ideas that would never have arisen otherwise. In summary, 83% of employees reported higher job satisfaction, and 91% rated current team relationships as very good. The clinic owner now says he wants his facility to be not only a place of top care but also a safe and inspiring environment for everyone who works there. This case study shows that even in private healthcare, rapid and consistent implementation of the R.I.G.H.T. model can achieve a fundamental change in atmosphere, increase employee and client satisfaction, and save the company from collapse. It was enough to open space for dialogue, recognition, and teamwork, and the results did not take long to appear. The clinic, where silence and tension once prevailed, has become a place of open dialogue and cooperation where everyone knows their voice matters.

Home Care – Multidisciplinary Team

Home care has become an integral part of the healthcare system in recent years, especially in the context of an aging population and the growing need to provide care in the client's natural environment. In one of the larger home care providers in the southwest of the Czech Republic, where eight general nurses, two physiotherapists, three social workers, and two health-social coordinators work, problems related to care coordination, unclear information transfer, and tension between professions gradually increased. Multidisciplinary collaboration often failed, information remained in emails, continuity between tasks

was lacking, and unnecessary procedures and examinations were repeated, leading to frustration among both staff and clients. Complaints increased, internal conflicts deepened, and the departure of key staff was on the rise. Management realized that without a deeper system change, the team structure and client trust were at risk of collapse. After a series of crisis meetings with section leaders and an external consultant, the decision was made to implement the R.I.G.H.T. model, which was to serve as a framework for setting collaboration rules, strengthening mutual recognition, increasing staff involvement, and systematically supporting healthy team relationships. The first step was the introduction of regular coordination meetings attended by representatives of all professions. Each meeting had a facilitator, a rotating agenda, and began with thanking a selected team member. This relatively simple act of recognition helped break down initial distrust and gradually transformed the atmosphere. Social workers ceased to be seen as an appendage to healthcare and began to be invited to plan specific interventions. Physiotherapists could openly communicate what they needed for successful rehabilitation management, and nurses gained support in planning visits thanks to a better overview of the home situation. Furthermore, a shared electronic form for assessing client needs was introduced, replacing fragmented documentation, which shortened administration time, simplified handovers, and reduced the potential for misunderstandings. Development interviews with department heads and an anonymous questionnaire focusing on perceived clarity of competencies, team atmosphere, and the effectiveness of shared care were also introduced. Results showed a 41% increase in satisfaction, a 38% reduction in stress from work conflicts, and a 44% improvement in perceived team collaboration. Flexible leadership played a key role; for example, coordinators who previously dealt mainly with operational matters were given space to lead supervision groups and receive training on team collaboration. This transformed their role from passive administrators to active supportive partners of individual teams. One nurse stated, *"We used to feel that everyone was playing in their own sandbox. Today I know that when I say something, someone listens and something really gets done."* This step alone represents a huge leap forward. Personnel changes also occurred, with two employees who long ignored the new collaboration principles and refused to participate in team meetings leaving. Their positions were filled by new colleagues who underwent introductory training on the R.I.G.H.T. principles upon joining and were actively integrated into working groups. The new system also included the introduction of internal mentors who support the adaptation of new employees. Today, the organization is seen as one of the leaders in home care in the region, and management openly presents the implementation of the R.I.G.H.T. model at professional forums, with other regional facilities showing interest in sharing experiences. The latest client survey showed an increase in perceived trust and clarity of services. Internal data report the lowest absenteeism and turnover in the past five years. Overall, 83% of employees stated that the newly established collaboration increases their job satisfaction, and 87% rated interprofessional communication as functional and beneficial. The multidisciplinary team, which previously struggled for space and recognition, has become a functional whole where individual members perceive their work as meaningful, coordinated, and truly team-based. This case study shows that even in the complex environment of home care, where different professional cultures and approaches meet, it is possible to achieve a real transformation of organizational culture, improve care quality, and stabilize staff using a behavioral framework such as the R.I.G.H.T. model.

Summary of R.I.G.H.T. Model Implementation in Healthcare

The experiences of a municipal hospital, a private dental clinic, and a home care provider demonstrate that the R.I.G.H.T. model can be effectively adapted to various structures and challenges within the healthcare environment. In all cases, its implementation led to improved interpersonal relationships, strengthened team collaboration, and tangible outcomes such as reduced turnover, lower absenteeism, and increased employee engagement. The key factor was consistent and sensitive support for involvement rather than one-off interventions. Organizations that adopted the model became more open, resilient, and efficient. It became evident that mental well-being, participation, and recognition are not added values but the foundation of quality care. Open communication and leadership's willingness to listen to practitioners played a decisive role. This created a safe space for trust, sharing, and embracing new challenges. The R.I.G.H.T. model also supported the personal growth of employees, who began to perceive their

workplace as a space where they have a voice, influence, and meaningful place. This brought higher motivation, better collaboration, and a desire to actively improve care. This experience can inspire other organizations seeking a path to sustainable and human-centered healthcare. R.I.G.H.T. confirms that change is possible where trust, respect, and the courage to do things differently prevail.

3. Methodological Notes

The research focused on the implementation of the R.I.G.H.T. model in Czech educational and healthcare organizations was from the outset designed as a mixed-methods study combining quantitative and qualitative approaches. It is important to emphasize that this choice was not random but stemmed from the conviction that only the integration of numerical data and personal stories can enable an understanding of the complex transformation of the work environment, atmosphere, and interpersonal relationships that inevitably accompanies the implementation of a behavioral model.

The quantitative part of the research was based on standardized questionnaires GHQ-12 (General Health Questionnaire) and WHO-5 (Well-Being Index), which are internationally recognized tools for measuring mental well-being, stress, and subjective perception of mental health. The questionnaires were distributed in three waves, before the implementation, during its course, and after its completion. This longitudinal design allowed not only the capture of the current state but also the monitoring of changes over time. Statistical analysis included not only basic descriptive statistics but also more advanced methods such as trend analysis, significance testing of changes, and reliability verification using Cronbach's alpha, ensuring high validity and reliability of the results. The qualitative part was based on semi-structured interviews with selected employees, managers, and external consultants. The interviews focused on capturing subjective experiences, motivations, barriers, and positive moments accompanying the change process, with great emphasis on ensuring that the interviews were not merely formal exchanges of opinions but genuine spaces for sharing concerns, expectations, and small everyday victories. Another important role was played by outputs from team observations and minutes from regular meetings, which allowed monitoring of group dynamics, specific manifestations of cooperation or tension, and changes in non-verbal communication. The combination of these methods enabled not only data triangulation (i.e., verification of whether results from different sources were consistent) but also a deeper understanding of why some changes proceeded smoothly while others encountered resistance. Thematic analysis of interviews and observations allowed systematic identification and interpretation of main behavioral patterns, key turning points, and obstacles that needed to be overcome. Special attention was given to situations where quantitative and qualitative data diverged, for example, when questionnaires showed improvement but interviews revealed hidden frustration or concerns about the future. These identified "discrepancies" were interpreted in the context of specific team stories, enabling not only a description of what happened but also an understanding of why it occurred. Ethical aspects were ensured in accordance with European and Czech standards of scientific integrity. Participation was entirely voluntary, data were anonymized, and all respondents were informed in advance about the purpose and manner of data use. Organizational leadership was involved only in the organizational aspect of the research, not in data interpretation, minimizing the risk of bias, and the entire research was conducted with maximum respect for the sensitivity of topics concerning not only work performance but also mental well-being, relationships, and personal values. The evaluation of changes was not based solely on numerical indicators (such as satisfaction scores, stress occurrence, perceived support) but also through specific stories and case studies illustrating the real impact of the R.I.G.H.T. model on the daily lives of teams. Emphasis was placed on capturing atmosphere, mutual recognition, and willingness to cooperate, factors often lost in standard questionnaires but decisive in practice for the effectiveness and sustainability of changes. The entire methodological approach was driven by the effort not only to *"measure change"* but also to understand what enabled it, where it originated, where it encountered limits, and which conditions were key to its sustainability. The result is not only a set of numbers but a vivid picture of how the implementation of the R.I.G.H.T. model transforms Czech educational and healthcare organizations, including their atmosphere, relationships, and the daily reality of employees.

4. Synthesis of Results and Main Themes

The results of the case studies and the analysis of the R.I.G.H.T. model implementation in Czech schools and healthcare facilities show that real change in workplace climate and psychological well-being is always the result of several key factors that intertwine and reinforce each other in practice. At the center of attention stands the role of the leader, their ability to adapt the model to the specific organizational culture, and the power of recognition and involvement, which often act as true triggers for positive change. In many organizations, it was the leader who not only set the rules but above all led by example in openness, support, and recognition. In one Prague elementary school, where caution and distance had long prevailed, the principal played a key role by regularly thanking colleagues for their dedication and willingness to help others. For the first time, public acknowledgments appeared at staff meetings, which were not formal but specific and personal. Teachers, who had long been used to criticism or silence, began to feel that their work had meaning and that someone truly saw their efforts. In this school, it became clear that recognition is not just a catchphrase but a powerful tool that can break the ice and spark intrinsic motivation. Ms. Siváková, who had been considering leaving teaching, admitted in supervision that thanks to new relationships and open conversations, she rediscovered her desire to teach and to pass on not only knowledge but also joy to children. *"In supervision, for the first time in a long time, I felt I wasn't alone. Suddenly I could talk about my doubts and joys, and I realized that others felt the same way. That calmed and encouraged me immensely,"* she confides. The need to adapt the R.I.G.H.T. model to the specific organizational culture proved essential across all cases. In a secondary vocational school, where hierarchy had long been entrenched and teachers were used to following orders rather than co-creating a shared vision, it was necessary to proceed very carefully. The school leadership first enabled the creation of working groups tasked with finding new ways to improve teaching and relationships among colleagues. Here, it became clear that participation is not a given but a process that requires time, patience, and a willingness to reflect on one's own habits. One teacher said, *"For the first time in years, I finally feel that someone is interested in my experience and that I can breathe professionally here."* Such words confirm that change is not just about new rules but about gradually building trust and willingness to cooperate. Recognition and involvement of employees proved to be real triggers for positive change. For example, at a private dental clinic in Cheb, where tension, high turnover, and reluctance to cooperate had previously prevailed, the introduction of anonymous suggestions for improvement brought a completely new impulse. One dental hygienist recalls how she was initially afraid to come forward with a new idea because suggestions were often dismissed, but after the introduction of anonymous suggestions, she proposed an innovation in the appointment system and her colleagues not only listened but together implemented her idea. *"For the first time, I felt that my voice truly mattered,"* she says with a smile. These small changes in approach began to change the clinic's atmosphere from within, and people started to notice that their ideas had a real impact on daily operations. In home care, where the multidisciplinary team had long struggled for space and recognition, the introduction of regular coordination meetings and a shared electronic client needs assessment form not only simplified work but above all gave everyone a sense that each team member had their place and voice. One nurse stated, *"We used to feel that everyone was playing in their own sandbox. Today I know that when I say something, someone listens and something really gets done."* This simple shift in communication led to a significant improvement in atmosphere, increased satisfaction, and reduced stress from workplace disagreements. The role of the leader manifested differently in each organization but was always crucial for the success of change. For example, in one hospital, the head physician was initially skeptical and considered the project another *"nonsense from above,"* but when he saw people starting to confide and support each other, he admitted that it should have come much earlier. Leadership that could listen, admit mistakes, and communicate uncertainties openly was perceived as support and inspiration. The psychologist who guided the team through change at the Cheb clinic admits that the biggest obstacle was initial distrust and fear of openness, but once people started to confide and support each other, it was clear they were on the right path. In practice, the R.I.G.H.T. model proved to be a framework that is not a universal template but a living tool that must be sensitively adapted to the specific needs, values, and dynamics of each team. Wherever the model was implemented with respect for local customs and a willingness to listen to feedback, there was a lasting improvement in atmosphere,

stability, and results. Recognition and involvement of employees, support for growth and development, systematic care for health and safety, and emphasis on teamwork created an environment where people not only work but also grow, create, and feel part of a meaningful whole. Stories from individual organizations show that change is never quick or easy, but if it is based on respect, trust, and the courage to do things differently, it can lead to a profound transformation not only of the work environment but also of the personal experience of every team member. As one manager said, *"Only when we really started listening to our people did we realize what is most valuable in the organization: team trust and a sense of safety. Without that, no system works in the long term."* The results of the case studies thus confirm that the R.I.G.H.T. model is not just a theoretical construct but a practical framework that, if implemented with sensitivity and respect for people, can change the culture, relationships, and everyday reality of Czech schools and healthcare facilities.

5. Discussion of results

The R.I.G.H.T. model meets the needs of the Czech work environment while also reflecting modern management trends where employee mental health is recognized as a fundamental priority, supported by both domestic and international studies. Real progress occurs when leadership understands the responsibility of caring for psychological well-being and creates an environment of safety, openness, and support. Modern leadership today requires emotional intelligence, empathy, and flexibility, which are key skills for development and innovation. International companies such as Google and Unilever demonstrate that integrating mental health into corporate culture leads to higher satisfaction and innovation. The R.I.G.H.T. model is most effective when adapted to the specific needs of the team and perceived as a collective effort rather than a top-down project. The integration of the model's pillars creates an environment where psychological safety is genuinely lived as a value. Employee mental health and well-being today determine the success and resilience of an organization, making investment in well-being a strategic necessity and the core of modern leadership. The R.I.G.H.T. model offers a concrete path to turn theory into everyday reality and to foster openness, recognition, and growth. Leadership is a service to people, and working with mental well-being is the greatest strength of modern leadership because the future of organizations belongs to those who care for mental health and relationships, and the R.I.G.H.T. model is the way to that future.

6. Conclusion

The R.I.G.H.T. model has proven to be a catalyst for change in the Czech work environment, capable of transforming workplace atmosphere, relationships, and motivation. Its strength lies in the fact that it is not a universal template, but a living framework that allows organizations to respond to the specific needs of teams and individuals. Where leadership is able to listen, reflect on feedback, and support growth and mental well-being, there is not only a reduction in turnover and absenteeism, but also an increase in satisfaction, loyalty, and innovation. Modern leadership today is based on the courage to talk about emotions, the ability to create space for sharing, and the willingness to be a leader who not only manages but above all inspires and supports others. Similar behavioral models are successfully used abroad, for example in Scandinavia and the Netherlands, where they are considered the standard for effective leadership and employee care, which confirms that these principles can be meaningfully applied in the Czech context as well. It is therefore time to stop viewing wellbeing as a marginal benefit and start understanding it as the core of leadership and a strategy that makes sense not only from the perspective of numbers, but above all from the perspective of people. Real change begins with everyday small decisions, with the willingness to listen, to say thank you, to admit a mistake, to offer help, or to accept a different point of view. The R.I.G.H.T. model is a way to start creating this change in Czech organizations today.

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