

Transformational Collaborative Outcomes Management

Resilience Reconsidered: Going Beyond Self-Care to Improve Well-Being and Combat Turnover

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Within Our Reach A National Strategy to Eliminate Child Abuse and Neglect Fatalities



Tennessee: Pioneers in Safety Science

The Tennessee Department of Children's Services is implementing some of the elements of safety science through three primary efforts: a systemic approach to Critical Incident Reviews, legislatively protected confidential reporting, and an agency-wide safety culture survey. The agency has developed a revised protocol for critical inci-

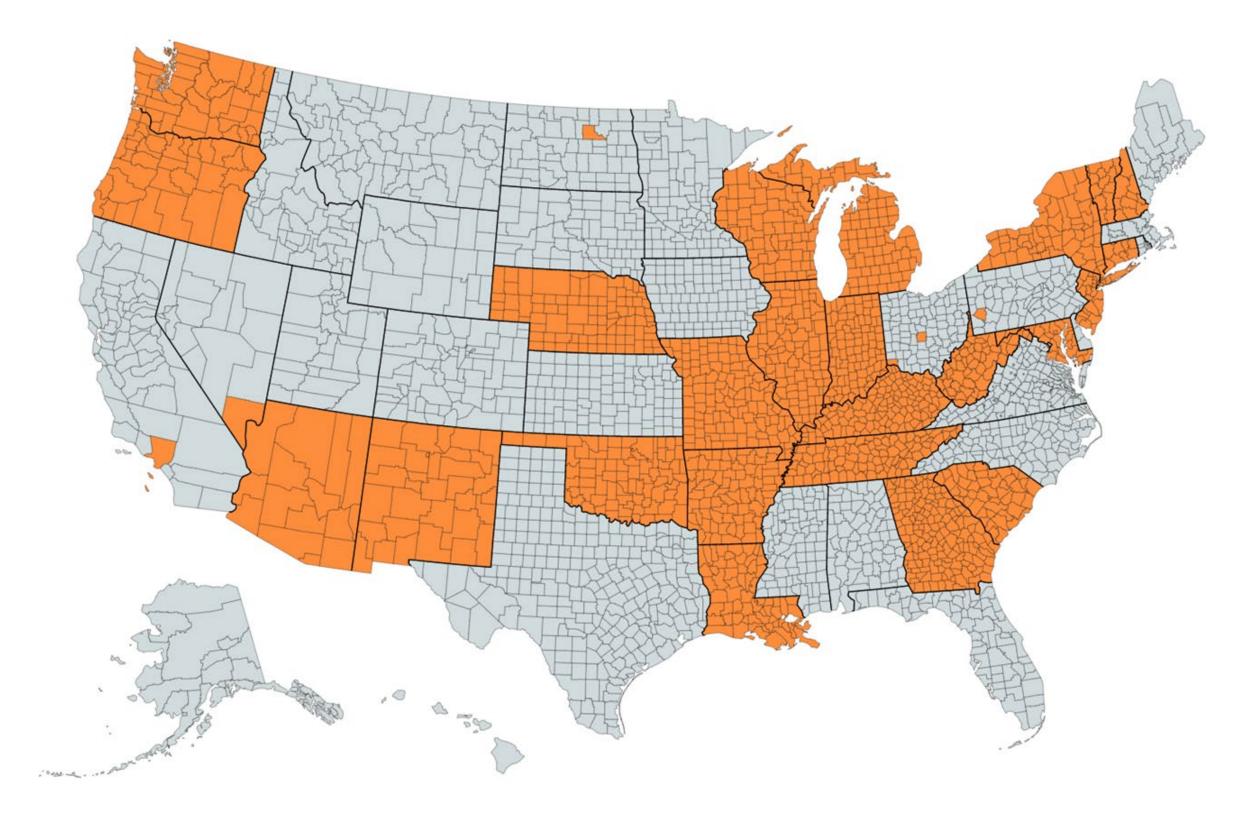
dent reviews the happened and I The state is trai to get at the rea tions and to rec confirmation bi a broad categoi

CPS practice.

ence. With support from a national foundation, Tennessee staff are providing support to three states that have expressed interest in this work.

Fund pilot programs to test the effectiveness of applying principles of safety science to improve





34 Member Jurisdictions:

Allegheny Co, PA Arizona Arkansas Clark County, NV Connecticut Franklin County, OH Georgia Hamilton County, OH Kentucky Illinois Indiana Los Angeles County, CA Louisiana Maryland Michigan Missouri Nebraska New Hampshire New Jersey New Mexico New York City New York State Ohio Oklahoma Oregon Philadelphia County, PA South Carolina Spirit Lake Nation Tennessee Vermont Virginia Washington West Virginia Wisconsin

Safety Culture: Defined





High Risk, High Impact Service

Our work changes the course of youth and families' lives. And it's easy for us to, in every good intention, still get it wrong. Or at least not the best. We need a constant growth and learning mindset. Blameless Candor and Preconditions of Respect

We can't fix what we don't know. Secrets and hidden problems don't help families, or worse – they can hurt. We have to be willing to share our stories, listen and respond with respect, and be willing to grow at-all-levels.



Collaborate and Commit

No single one of us has all the answers. Innovation lies in the spaces within and between our perspectives.

How do we Advance a **Safety Culture?**

PURSUE A NEW LENS

Bias, behavior, fallibility and system interaction

ASK NEW QUESTIONS

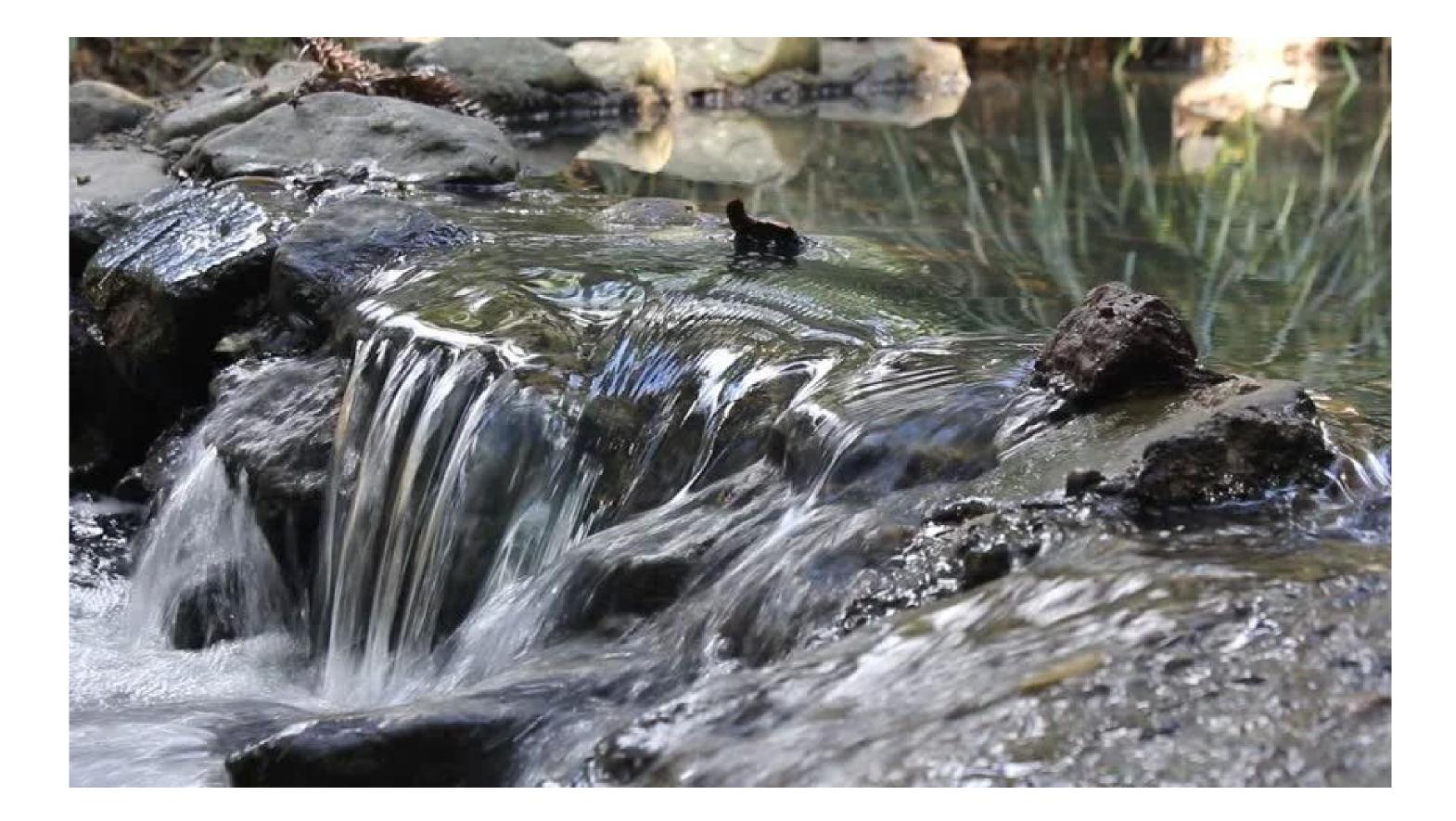
What and how? NOT who and why?



EXPECT DIFFERENT **PRECONDITIONS FOR** WORK

Safe, engaged teams in resilient agencies and systems of care

Cull, Epstein, O'Day & Rzepnecki, 2013



Why Advance a Safety Culture?

Cognitive Bias

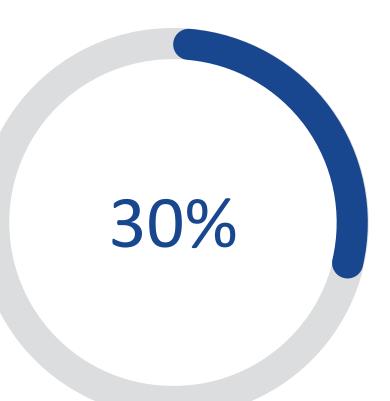
- o Selective attention
- o Fundamental attribution error
- o Confirmation bias
- 0 Hindsight Bias
- o Severity Bias



Stress and Burnout



Child welfare professionals exhibiting signs of emotional exhaustion (Anderson, 2000) Child welfare professionals reporting relatively high levels of secondary traumatic stress (Rienkes, 2020)

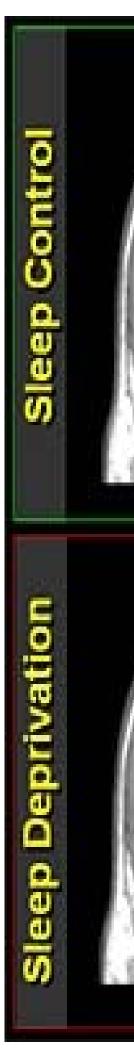


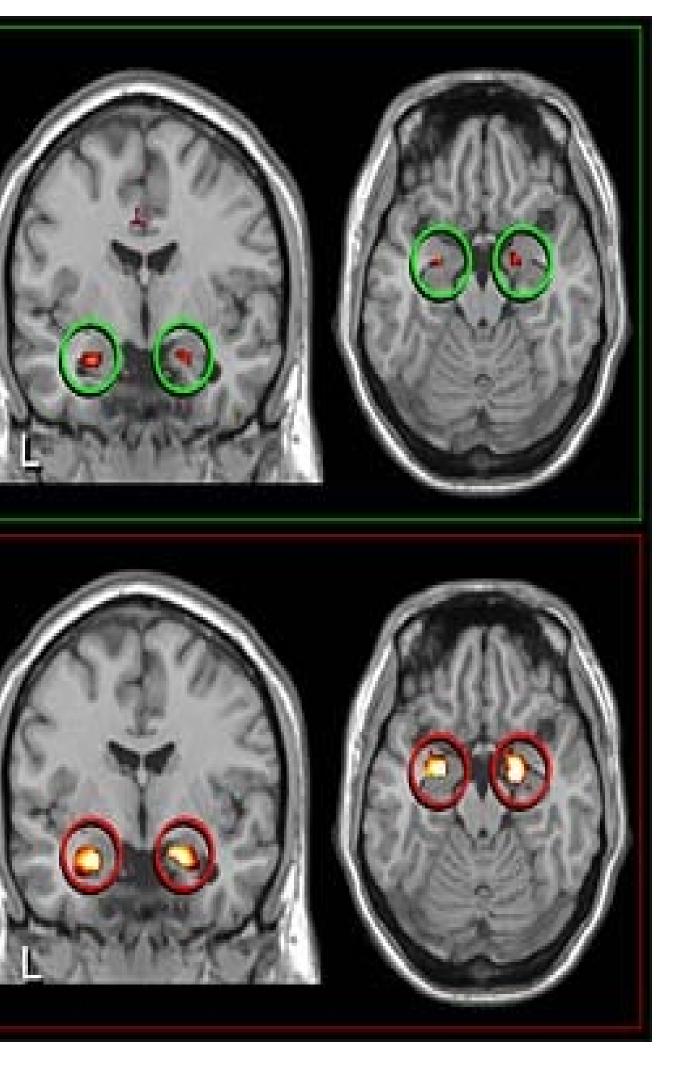
Child welfare professionals reporting severe levels of secondary traumatic stress (Rienkes, 2020)

Interplay of Stress and Fatigue

"The emotional centers of the brain were over 60 percent more reactive under conditions of sleep deprivation than in subjects who had obtained a normal night of sleep,"

Walker et. al., Current Biology, October 2014





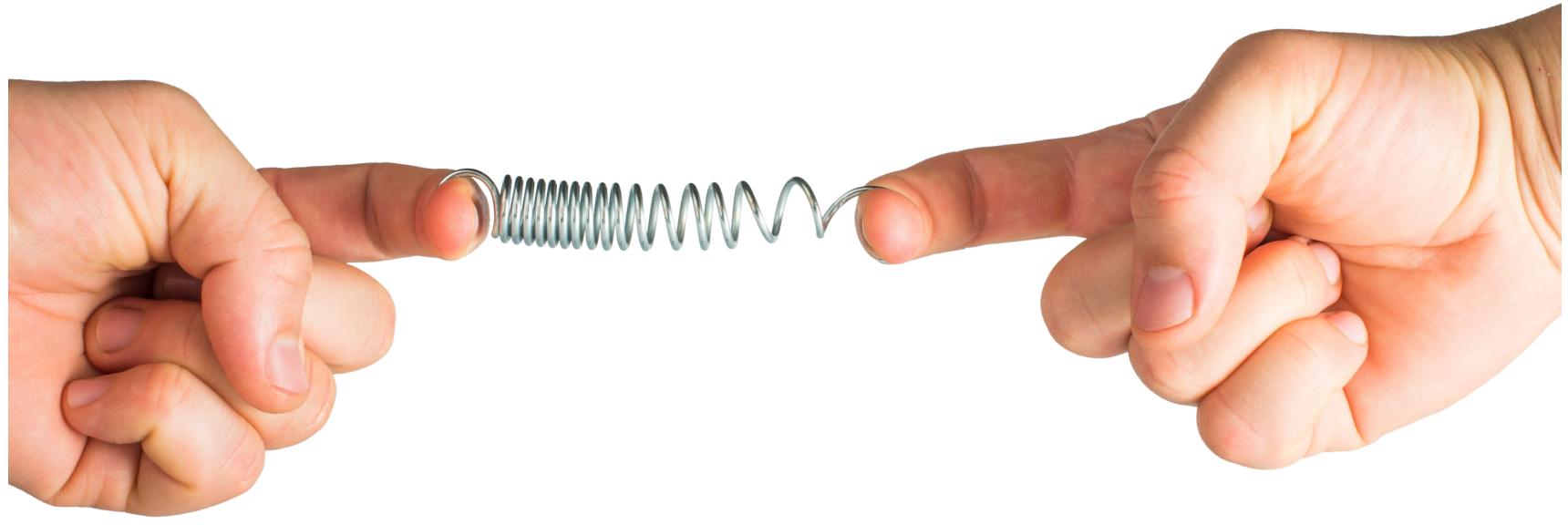
Be aware Take care





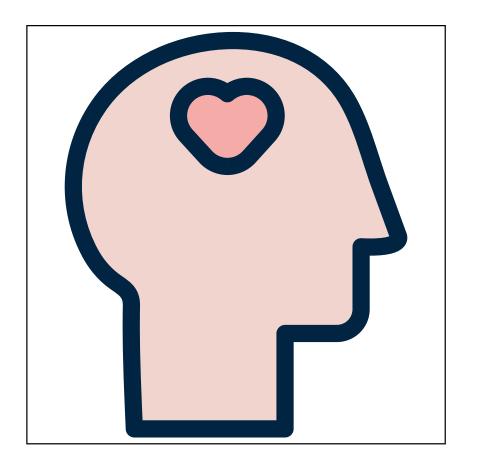
Resilience as a collective property



Building Resilience: Psychological Safety and Mindful Organizing

Psychological Safety

Feeling accepted, respected, supported -- able to disclose an error, mistake, or to respectfully challenge



- Distinctive from Trust (though that's always good)
- Conflated with Comfort (not the same and not always good)

What it is NOT

× Free from accountability

X A place where people always feel comfortable

What it is

- A **shared belief** that comes from shared experiences
- A place where **mistakes** are treated as **opportunities to learn**-not a time to blame and punish
- Anyone can...
- ... Ask questions without looking stupid.
- ... Ask for feedback without looking incompetent
- ... Be critical without appearing negative
- ... Suggest improvements without being appearing disruptive

Psychological safety



The path to psychological safety...

LEARNER SAFETY

- Ask questions
- o Learn from mistakes

•_•

• •

o Grow and Change

CHALLENGER SAFETY

- Candid
- Challenges ideas and norms
- Speaks up with concerns



INCLUSION SAFETY

- Membership
- Valued
- Treated fairly

COLLABORATOR SAFETY

- Engage respectfully
- Equal voice
- Constructive Debate

Clark (2020)

What Is Mindful Organizing?

Mindful Organizing is a team-based practice that allows teams to manage complexity and bias in decision-making (Sutcliffe, 2011).

It is the ways in which teams monitor, plan, innovate, learn, and support one another







Six Habits for Mindful Organizing and Psychological Safety

Spend time identifying what could go wrong Talk inistakes and way rearn from them Test change in

everyd work activities

Develop an understanding of who knows what and communicate

Aproperty colleagues and the unique skills

Make **ndor** and **resp** a precondition

Connections to Psychological Safety

A growing evidence shows us psychological safety is related to



Decreased emotional exhaustion & secondary traumatic stress



Increased workforce retention



Increased workplace connectedness and mindful organizing



Increased innovation

(NPCS data, 2021 and 2022; Vogus et al., 2016; Epstein et al., 2020; Edmondson 1999, 2022)



Connections to Mindful Organizing

Early research tells us that Mindful Organizing is related to



Less emotional exhaustion & turnover in the child welfare workforce (NPCS data, 2021; Vogus et al., 2016; Epstein et al., 2020)



Fewer placement disruptions for children in out-of-home placement Vogus et.al. (2016); Epstein et al (2020)



More parent-child visitation for children in out-of-home placement Vogus et.al. (2016); Epstein et al (2020)



Fewer care interruptions, patient falls, and medication errors in residential treatment centers and hospitals Epstein et al (2020); Vogus (2011)





Habits to Cultivate

- Be Vulnerable
- <u>Resilience Rounds</u>
- Invite divergent points of view
- Ask How not Why
- Restorative Accountability
- Value honest, respectful dialogue
- Frame distress as belonging to the collective

LEADER

"TeamFirst" Field Guide

Plan forward

Reflect Back

Test Change

Communicate Effectively

Appreciation

Manage Professionalism

everyone shares essential information

Plus-Minus-Interesting in Supervision

improve outcomes

Use SBAR or IPASS during decision-making

efforts fail).

families



- Huddles/Briefings: 10-15 minute coordinated sessions where
- Plan a PDSA on a new idea or strategy to collaboratively

- Offer appreciation, acknowledgment, and effort (even when

Managing Up in moments of transition for professionals and

Thank You!



Visit our website

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