TeamFirst

A Field Guide for Safe, Reliable, and Effective Child Welfare Teams

ACKNOWLEDGEMENTS

A large number of individuals have collaborated in the development of the TeamFirst Field Guide. Special acknowledgement belongs to Tennessee Department of Children's Services, who, with the support of Casey Family Programs, first tested some of these strategies with their workforce. This TCOM reference guide represents the curation, adaptation and development of a set of strategies, tools and tactics the support more safe, effective and reliable team-driven casework. The history of this approach traces to aviation's Crew Resource Management and The Agency for Healthcare Research and Quality's TeamSTEPPS and CUSP. The copyright for TeamFirst is held by the Praed Foundation to allow for its continued development and ensure that it remains free to use.

For specific permission to use please contact the Praed Foundation. For more information on the TeamFirst Toolkit contact:

Michael Cull, PhD
Center for Innovation in Population Health
364 Healthy Kentucky Bldg.
Lexington, KY 40506
859-562-2734
michael.cull@uky.edu

Tiffany Lindsey, EdD
Center for Innovation in Population Health
364 Healthy Kentucky Bldg.
Lexington, KY 40506
931-797-2705
tiffany.lindsey@uky.edu

Praed Foundation
http://praedfoundation.org
info@praedfoundation.org

TABLE OF CONTENTS

INTRODUCTION

A field guide is a reference book that helps users learn by providing them with real examples from "the field." In his seminal work, *The Field Guide to Understanding Human Error*, Sydney Dekker (2014) introduced us to a new way of thinking about professional behavior in complex systems and gave readers a practical guide for engineering safer systems. Building on the work of Dekker and many others, *The TeamFirst Field Guide* is designed as a reference for safe, reliable and more effective teamwork. Readers will find descriptions of specific team-based strategies and tactics that work and are illustrated with some real-life examples of implementations in the field.

Culture is an implicit pattern of shared basic assumptions among a group of people (Schein, 2010). It can be defined, measured and changed. Culture lives in habit—the implicit routines people enact to problem solve—it is how members "get work done around here." In a Safety Culture, safe and engaged teams practice six enduring habits. These teams…

1) Spend time identifying what could go wrong.
2) Talk about mistakes and ways to learn from them.
3) Test change in everyday work activities.
4) Develop an understanding of "who knows what" and communicate clearly.
5) Appreciate colleagues and their unique skills.
6) Make candor and respect a precondition to teamwork.

In summary, teams in a Safety Culture plan forward, reflect back, test change, communicate clearly, appreciate their colleagues, and manage professionalism. This field guide is a collection of strategies organized by each of the six habits.

REFERENCES

Agency for Healthcare Research and Quality, Department of Defense. TeamSTEPPS. Available at http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/index.html

Criscitelli, T. (2015). Fostering a culture of safety: The OR huddle. Association of Operating Room Nurses. *AORN Journal, 102*(6), 656-659.

Dekker, S. (2007). *Just culture: Balancing safety and accountability*. Ashgate: England.

Dekker, S. (2014). *The field guide to understanding human error.* CRC Press: Baton Raton, FL.

Ebert, J., & Kuhn, T. (2017, March). Response flexibility: Strategies for navigating conflict. Presentation at the Multidisciplinary Perioperative Morbidity & Mortality Improvement Conference, Nashville, TN.

Edmondson, A. (2019). *The fearless organization*. Hoboken, NJ: John Wiley & Sons.

Hilton K., & Anderson A. (2018). IHI psychology of change framework to advance and sustain improvement. Boston, MA: Institute for Healthcare Improvement.

Institute for Healthcare Improvement. 2019. *Tools*. Available at http://www.ihi.org/resources/Pages/Tools

Lencioni, P. (2002). *The five dysfunctions of a team.* San Francisco, CA: Jossey-Bass.

Patterson, K., Grenny, J., McMillan, R., & Switzler, A. (2012). *Crucial conversations*. New York, NY: McGraw-Hill.

Perlo, J., Balik, B., Swensen, S., Kabcenell, A., Landsman, J., Feeley, D. (2017). IHI framework for improving joy in work. IHI White Paper. Cambridge, MA: Institute for Healthcare Improvement.

Portland State University. (2019). The power of gratitude in the workplace. *Science Daily*. Retrieved from https://www.sciencedaily.com/releases/2019/03/190313091929.htm.

Rath, T. (2007). *Strengths Finder 2.0*. New York, NY: Gallup Press.

Rippstein-Leuenberger, K., Mauthner, O., Sexton, B. (2017). A qualitative analysis of the Three Good Things intervention in healthcare workers. *BMJ Open 7*(5). DOI: 10.1136/bmjopen-2017-015826.

Schein, E. (2010). *Organizational culture and leadership*. San Francisco, CA: Jossey-Bass.

Starkey, A., Mohr, C., Cadiz, D., & Sinclair, R. (2019). Gratitude reception and physical health: Examining the mediating role of satisfaction with patient care in a sample of acute care nurses. *The Journal of Positive Psychology*, DOI: 10.1080/17439760.2019.1579353

Tennessee Department of Children Services. (2017). *Safety Culture Toolkit*.

PLAN FORWARD

Spend Time Identifying What Could Go Wrong

By nature, human service work experiences a level of volatility, ambiguity, and complexity rivaling other high-risk industries, like healthcare. Consistently safe decision-making is the result of open-minded, adaptive, shared accountability among a team. The inextricably connected sociotechnical nature of human service work—often highly pressured and under resourced—requires multiple professionals to collaborate as seamlessly as possible. Getting into the cadence of "planning ahead" is central to projecting and resolving risk factors before they lead to harm. The following are strategies designed to cultivate this habit among intact and ad hoc teams of professionals.

Huddles

For example, in child welfare, all professionals assigned to work with a family gather before heading into court to summarize the family's status, verbalize concerns, and project plans for what likely happens next.

Huddles also occur before important meetings where the child and family will be present.

Planning forward is an essential aspect of building and supporting a safety culture. It means that rather than being reactive to situations and events, the team can be proactive. Further, it increases the likelihood that decisions will be thoughtful, intentional, and systematic, rather than last minute and made under pressure.

Huddles are used successfully in many high-risk industries. For example, in healthcare, the use of preoperative huddles reduced the number of surgical errors (Criscitelli, 2015).

GROUND RULES

- Standing is better than sitting
- Keep it short (no more than 15 minutes)
- Start and end on time

PREP = **P**REPARE, **R**EVIEW AND ANTICIPATE, **E**NACT, **P**ROMOTE RESILIENCE

Prepare

- Ensure team members have what they need to prioritize case activities (e.g., referrals assigned, case logs, overdue reports).
- Organize the materials the team needs (e.g., case assignments, family contact logs, overdues, information on any incident reports/new referrals on open cases, etc.)

Review and anticipate

- State the purpose: to update and anticipate
- Provide team-level update (e.g., case closures, caseload data, overdue #s)

- Facilitate case-level updates
- Anticipate care needs/challenges with questioning. Always ask "What are you concerned about?"

Enact

- Mobilize resources to remove barriers.
- Expect team members will experience challenges throughout the day. Build individual resilience and team shared meaning with an eliciting/evoking style and closed loop communications.

Promote resilience

- Close each huddle with a statement that reinforces Safety Culture and promotes resilience.

Checklists

For example, when transporting a child with type 1 diabetes to a new foster home, the case manager consults a checklist to ensure she provides the correct supplies, education, and medical contacts to the caregivers.

Checklists for safety-critical tasks are crucial, especially in building strong casework practices and remembering relevant details during infrequently conducted, safety-centered tasks. For example, a checklist about things to do when removing a child from a caregiver's home can be extremely helpful to a new professional and even to an experienced professional who is affected by fatigue or stress and/or has not completed a similar task in some time.

As an abiding principle, checklists need to be:

- Readily-Accessible
- Clear
- Concise
- Relevant
- Easy to Use

Though checklists can be meaningfully used to list steps on a variety of issues, teams may find checklists are most useful during crucial safety moments, when pressures are high and errors, if made, could have a dire impact on employee, child, or family safety, such as the following: meeting initial response to a home, removing a child(ren) from a home, addressing a safety concern about a family member's mental health, and/or reunifying a family after some time apart.

Be mindful of not creating unnecessary checklists or getting in the habit of marking off checklists without truly reflecting upon each item.

Pre-Mortem Strategy

For example, during group supervision, clinicians use pre-mortem strategy to consider discharge planning for a client with a complex history of psychiatric hospitalizations.

A reflective, mental strategy where you imagine a future state, when a plan has been put into place but failed. The strategy is useful because, in some cases, we know how a plan is likely to fail. Taking the time to think through likely failures gives an opportunity to proactively create safeguards.

Follow these guidelines:

- You've engaged the family in response to an event…
- The plan you wanted to put into place has happened, but…
- The plan has failed…
- What went wrong?

For example, you might use pre-mortem strategy about a child beginning a trial home placement with his father. You imagine the home placement started with desired services (e.g., counseling, case management) in place, yet the trial home placement failed, and the child re-entered foster care. By imagining what could likely go wrong, you consider the father's limited social and mental health supports to raise a child with autism. As a result, he becomes overwhelmed and depressed.

With the outcome of the pre-mortem strategy in mind, a new plan is developed, where the father begins attending a monthly support group for parents raising children with autism, connects with local grant-funded respite services for occasional caregiving assistance, and the father attends individual mental health counseling.

REFLECT BACK

Talk About Mistakes and Ways to Learn from Them

Making a mistake does not guarantee learning, but processing a mistake is foundational to learning and improvement. In psychologically safe cultures, disclosing an error is respected and supported—not because team members engage in pat responses—but because mistakes are viewed as opportunities to learn and receive support to press onward with more wisdom at hand for the next time. Without question, no human service professional engages in perfect, error-free work. Expressing vulnerability through transparent discussion of mistakes is a display of great professionalism and courage. As such, "reflecting back" is a value of safe, engaged teaming (Edmondson, 2019; Perlo et al., 2017). The following are strategies to promote the habit of reflecting back:

Structured Debriefs

For example, a supervisor debriefs with his team anytime a child/youth is disrupted from a foster home.

Structured debriefs should follow important trigger events. For example, in foster care, placement disruptions or maltreatment recurrence could trigger a team debriefing. Being inconsistent and/or not communicating in advance what events will trigger debriefing can make the process feel less psychologically safe, because team members could be worried debriefings only occur when the supervisor believes a team member made a mistake. For example, debriefs could be done as a team or between a case manager and supervisor at the end of certain Child and Family Team meetings or after unanticipated court ordered removals of children to state custody.

Note: During debriefings, if someone responds unprofessionally or disrespectfully towards the person who made the mistake, it is crucial this person receive an honest and prompt correction (see Section Six: Managing Professionalism for related strategies, like OSSCR).

Ask three simple questions:

- What went well?
- What could have been better?
- What will we do differently next time?

Debriefs are a leader facilitated discussion that accomplish two important goals:

- Team unity and psychological safety
- Learning and improvement

Facilitator Checklist:

- Communication clear?
- Roles and responsibilities understood?
- Situation awareness maintained?
- Workload distribution equitable?
- Task assistance requested or offered?
- Were errors made or avoided?
- Availability of resources?

PMI: Plus – Minus – Interesting

For example, a teammate uses PMI while mentoring a new employee to discuss what the new employee is learning from her fieldwork.

An activity where you look at an event or case retrospectively and think through the following questions:

- **Plus**: What went well? What went according to plan? What did I/we do that worked so well, and is there anything learned to apply again the next time?
- **Minus**: What did not go well? Was there anything that should not be replicated in a future situation? What were the "lessons learned"?
- **Interesting**: What things were learned that were previously unknown? Anything unique or curious and worthy of sharing with others?

Restorative Accountability

For example, a case manager working with adults recovering from drug-dependency experiences a suicide on his caseload. He is grieved and worried his last visit with the client was shortened by an emergency on another case. Affected by the emergency on the other case, he had quickly concluded the client was safe, acknowledging the client was experiencing a "bad day" but believing sufficient supports existed to assure safety. Rather than exact discipline on the traumatized case manager, the supervisor offers support and gives the case manager an opportunity to process, learn, and heal.

A **retributive approach** to accountability is concerned with rules, rule-breaking, and sanctions. It assumes blame and the threat of sanctions motivate safe behavior and error avoidance. A retributive approach asks the following:

- Who broke which rule?
- How serious is the violation?
- What is the proportional punishment?

A **restorative approach** to accountability is concerned with learning and assumes the complexity through which mistakes or errors occur. Such an approach achieves accountability through repair, prevention, and learning. A restorative approach asks:

- Who was harmed?
- What do they need now?
- Whose responsibility is it to provide help?

In a retributive culture an account becomes something to be paid back – something that is owed. In a restorative culture an account is a story to be told – something to help us learn and get better (Dekker, 2007).

The Substitution Test

For example, a mental health counselor inadvertently allows a safety plan to expire on a child with ongoing emotional disturbances. In determining appropriate accountability and next steps, the supervisor mentally questions if other similarly experienced counselors in the same situation would be likely to make the same mistake.

A reflective, mental activity to consider a professional's culpability in context.

Would three (3) other individuals with similar experience and in a similar situation and environment act in the same manner as the person being evaluated?

- If the answer is **yes**: The problem is not the individual but more likely an environment which would lead most professionals to the same action.
- If the answer is **no**: If similarly experienced individuals would not have acted in a similar manner, it is possible the individual is more culpable and individual accountability is appropriate—whether through services (e.g., mental health treatment), coaching, disciplinary action, or otherwise.

TESTING CHANGE

Discuss Alternatives to Everyday Work Activities

Implementation science is the study of what factors promote and accelerate successful, scalable, and sustainable improvements. Studies may inform "what" achieves the best client outcomes in human service professions, but guiding professionals (the "who") and offering the motivation (the "why") to change practices can be hard. This adaptive side of leadership and teamwork is challenging but well-harnessed by implementation science (Hilton & Anderson, 2018). Empowering teams to collaborate and conduct "small tests of change" is central to safe, reliable teamwork.

Using Implementation Science Principles

Implementation science underlies successful quality improvement. Whenever you are considering an improvement activity, ask three simple questions:

- **Overall Aim or Goal:** What are we trying to accomplish?
- **Desired Outcome:** How will we know a change is an improvement?
- **Ideas for Strategies, Tools, or Practices:** What changes can we test that will result in improvement?

Small Tests of Change (PDSA CYCLE)

For example, a regional office tries a new on-call schedule for one month in one county and assesses the impact to employee's workhours before implementing on a larger scale.

Rather than trying to implement something big and different all at once with some office-wide "roll-out," testing strategies and tools on a small scale first can be much more effective. The Plan-Do-Study-Act method is a way to test ideas quickly on a small scale.

The Plan-Do-Study-Act (PDSA) methodology is intended to help people move quickly from identifying solutions, strategies, and opportunities to trying them out – on a small scale – in the real world. It is based on a simple continuous quality improvement model in which you plan what you want to do (Plan); you try it out (Do); you think about and review what happened when you did it (Study); and you adjust it based on what you learned (Act/Adjust).

Why Use a PDSA

- Check to see whether the idea will actually result in improvements
- Allow those closest to the work – and those who know the real-world environment best – to test the changes they identify
- Determine whether the idea will work in the real-world environment

- Increase belief from others that your idea will actually result in improvement (gain proof and buy-in)
- Identify possible costs, side effects, or unintended consequences while the impacts and risks are fairly low
- Evaluate how much improvement can be expected from the change

How to Test a PDSA

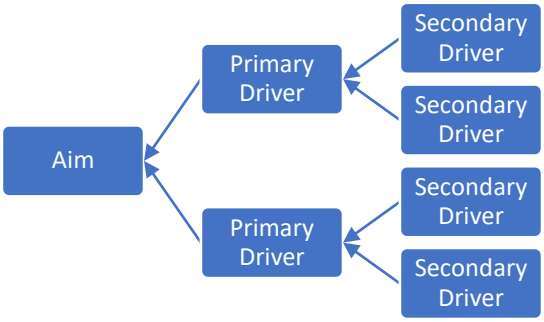
- **Plan:** Identify a strategy or idea you want to test. Think about what it would look like if you just tried it out with one child, one family, one colleague, etc. Remember you are not trying to figure everything out at once, nor do you want to spend time trying to figure out how to make it work for everyone, all the time. You just want to try it once to make sure it is a good idea worth pursuing.
- **Do:** Try it out with that one child, family, colleague, etc. Just do it exactly as you planned.
- **Study:** Reflect on what worked the way you expected and what might have surprised you in the process. Ask the person who you tested this idea on what they thought about it. Did they like it better than whatever happened for them in this situation previously? What worked for them? What did not? What other recommendations do they have for you?
- **Act/Adjust:** Use the results of your 'study' – what you experienced, observed, reflected on, heard from the person you tested it with – to inform how you might make this idea even more effective next time. This 'adjust' phase should feed directly into your next **Plan** so that the next time you do it, you'll have worked out some more of the real-world kinks.

Driver Diagram

For example, a public health director wants to reduce the infant mortality rate. He understands the primary drivers of infant mortality to be inadequate prenatal maternal health, postnatal care, and the presence societal issues like poverty and substance abuse. He decides to hone his improvement opportunity at postnatal care. He studies and identifies drivers of strong postnatal care include caregiver attachment, parenting education, and pediatric care. As a result, he begins a Nurse Family Partnership program in a county with a high infant mortality rate.

A simple, visual diagram of what is theorized to "drive" a goal or achievement. A driver diagram identifies both key and secondary drivers and their relationship to one another.

A driver diagram is used to articulate a theory of what drivers can be changed to result in improvement. It organizes and justifies the changes a team is wanting to make.



COMMUNICATE EFFECTIVELY

Develop an Understanding of Who Knows What

Human service work is high-risk, interdependent and also fast-paced. Though intact teams can struggle to communicate effectively, cross-team communications are even riskier. In those cases, professionals need to work seamlessly to make safe decisions, and vital decision-makers may not even have previously met one another (Edmondson, 2019). Furthermore, safe, engaged teaming requires teammates to know one another's unique skills. A professional regularly receiving the opportunity to use personal strengths is crucial to engagement. In a Gallup poll that asked respondents if they "have the opportunity to do what [they] do best every day," every single respondent who disagreed additionally reported being emotionally disengaged at work (Rath, 2007). An emotionally disengaged workforce cannot reliably make safe decisions. Communicating concisely and to the person with the right expertise helps ensure vital information gets handed off to the right person, the right way, at the right time, and in a manner supporting the recipient's memory retention.

4Cs of Communication

Communication should be:

- **Clear.** Avoid jargon. Be professional.
- **Concise.** Shorter is better. Your colleague will be more likely to retain and use the information you provide if it is kept brief and only focused on relevant information.
- **Comprehensive.** The balance to being Concise. Keep it short, but include all crucial content.
- **Congruent (words match body language and expression).** 55% of communication is done non-verbally. Pay attention to your body language and non-verbal cues.

Briefs

For example, before walking into a family's home, a social worker and Law Enforcement officer quickly brief one another on the current concern, family history, and next steps. They develop quick contingency plans should safety become an issue, and they succinctly remind one another of standard safety procedures (e.g., not to walk in front of the family down a hallway, if sitting stay close to an exit).

A discussion between two or more teammates to succinctly process case-specific information. A brief can be requested by any team member anytime.

A briefing immediately:

- Maps out the current plan for the child or family
- Identifies each teammate's responsibilities
- Assesses if the current plan should be revised and, if so, how
- Articulates safety concerns and plans to ensure safety
- Often uses STEP or SBAR (see below)

Situational Awareness with STEP

For example, a social worker describes a current situation with a client using STEP: " **[Situation]** Neveah appears content and safe in Visitation Room A with her mother, but Neveah was crying and threw a small children's chair in the moments before her mother arrived. **[Team Members]** Amy and I are monitoring the visit together. **[Environment]** Currently, Neveah is playing a card game with her mom, and [**Progress**] their visit has approximately 45 minutes left."

An acronym to quickly communicate a current situation with a child or family (i.e., client)

- **S**tatus of the client
- **T**eam members
- **E**nvironment
- **P**rogress

SBAR

For example, Child Protective Service Investigators use SBAR to present a case to a Department Attorney when considering if a child should be removed from a home. Using SBAR streamlines dialogue and creates an environment where the attorney and frontline investigator communicate well directly, rather than communicating indirectly through a supervisor.

A useful acronym for processing safety-critical information, like a child and family case. For example, SBAR can be used to succinctly describe a case to a supervisor, assisting agency, and other internal professionals who are responsible for making case-specific decisions (e.g., an attorney responsible for evaluating if sufficient evidence exists for exigent removal of a child)

- **Situation.** What is the current status? What's going on?
- **Background.** What is important to know about the service provider, case, child, or family's background? What is the context?
- **Assessment.** What risks do I and/or others see?
- **Recommendation.** What would I do to provide safety? What is the next decision I believe needs to be made?

When listening:

- Avoid mental distractions (i.e., "Tech down; eyes up.")
- Listen intently
- Take notes if possible—and especially if discussing multiple cases or case decisions
- Ask questions
- **Reflect back** always (and use SBAR when you do)

Common pitfalls:

- Assuming you are using SBAR naturally—even when stressed and tired
- Drifting into tangents

Three things you can do right now to increase the structure and efficiency of your communication:

- Write SBAR in your office space or on a notecard to go behind your employee badge.
- Practice…Practice…Practice. Use SBAR when speaking with your supervisor or legal about a case.
- Engage in mindfully staying on task when transferring a case or offering safety-critical information to someone else who is making important decisions.

For example, a social worker uses I PASS to communicate critical information to a colleague who will be temporarily assigned her cases while she is on vacation.

"I PASS"

An acronym to structure the exchange of information during handoffs (e.g., transferring a case from one case manager and/or team to another).

Introduction: introduce yourself and your role/job

Person: provide the child and/or family's name and important identifiers (e.g., age, gender, location)

Assessment: list presenting concerns and current assessment of those concerns

Situation: identify the current situation (e.g., housing, employment, family supports, childcare) and care plan

Safety Concerns: process all current or recent safety concerns

APPRECIATION

Appreciate Colleagues and their Unique Skills

The psychological benefits of experiencing gratitude is well-documented, but a recent healthcare study involving nurses found even physical advantages (i.e., improved sleep quality and adequacy, fewer headaches, healthier eating) to receiving appreciation in the workplace—because appreciation increased job satisfaction (Starkey, Mohr, Cadiz, & Sinclair, 2019). Human service professionals often associate their careers with core pieces of their identity, placing themselves in hazardous conditions and looking out for their clients, at times, even above looking out for themselves (Portland State University, 2019). Expressing gratitude is a crucial and not-to-be-underestimated habit of safe, engaged teamwork.

Intentional Affirmations

A supervisor writes a handwritten note to one of his employees after she testifies in court for the first time. He affirms her efforts to prepare her testimony as well as her sense of professionalism in the courtroom.

Intentional affirmations, particularly ones about character or effort, generate positivity and synergy among teams. Acknowledging specific successes is useful but could become a source of anxiety since successes are closely aligned with performance indicators.

Generally-speaking, intentional affirmations are best when they are:

- Unique to the individual or team
- Administered in a personal way (e.g., a handwritten note)
- Given freely at irregular intervals and not in a regimented or scheduled way

Managing Up

For example, while transferring a case from one social worker to another, the original social worker speaks well of the colleague who will begin work with the family.

Managing up is simple tool for affirming your colleagues and setting the stage for engagement. We "manage up" by speaking positively of our colleagues and genuinely expressing their strengths to others. For example:

> *"Angie is going to begin working with you next week. I know you've only met Angie once, at our last meeting, but I have worked alongside Angie for the past year. She is knowledgeable, compassionate, and great at coordinating services."*

What is the goal?

- Families and youth feel better about their next case manager and experience.
- Families and youth feel more at ease about the coordination of their care.
- Coworkers give/get a head start on engagement.

Manage up at two levels:

- Positively position team members with other team members.
- Positively position team members with families and youth.

Resilience Rounds

For example, an executive leadership team meets with regional staff. While on-site at the regional office, each leader meets with 4-5 frontline regional staff and takes a moment to express appreciation, model values, and asks the group how the leader can better connect and contribute to their work.

Senior leaders can reinforce goals and support resilience through informal conversations with professionals.

Ground Rules

Teams should decide whether to announce the time and place of Resilience Rounds, and the decision should be agreed to by senior leaders and managers. Leadership should reassure professionals information discussed in Resilience Rounds is private.

What are the Goals?

Resilience rounding provides an opportunity for senior leaders to interact directly with frontline professionals to promote resilience. Authentic conversations with leaders can empower field professionals, breakdown communication silos, and inform improvement. Positive affirmation, anticipatory care practices, and supportive professional relationships are among the most effective tools we have for reducing burnout, stress and the effects of secondary trauma exposure. Resilience rounds:

- Promote professionals' resilience through direct affirmation and active listening from leaders
- Model a positive, responsive culture and promote effective team behaviors
- Allow leaders to identify system-level improvement opportunities

What is the format?

A conversation with the leader and three to five employees can be structured in various ways, including:

- Hallway conversations or informal team talks
- Individual conversations in succession
- Group conversations with employees in a specific type function or job

Large formal convenings should be avoided. Look for small, safe, comfortable spaces.

Remember: Two people are likely to do 60% of the talking. The leader's role is to listen and bring everyone into the conversation.

Open with something appreciative:
"Thank you for your work. I appreciate your…"

Discussion Question:
"Does your team spend time identifying activities we do not want to go wrong? For example, placement disruptions."

- Possible follow up from Information Technology staff – How does our electronic case record help you prevent things from going wrong or create barriers?
- Possible follow up from Fiscal Director – How do our fiscal processes help you prevent things from going wrong or create barriers?
- Possible follow up from Regional Leader—How do our monthly reviews help prevent problems or create them?
- *The goal is to encourage open, authentic dialogue in order for the leader to promote safe conversations about issues and to demonstrate genuine interest in understanding how the leader's work is affecting the frontline and vice versa*.

You may also consider the following discussion question if time permits.
"Does your team have opportunities to talk about mistakes and ways to learn from them? Do you feel like mistakes are often held against you?"

"On your team, is it okay to speak up when you disagree with a team member's decision?" In asking these questions, take a brief moment to express values as a leader of the organization.

- "We (leaders) always want people to come forward with concerns."
- "We (leaders) want to foster safe, collaborative conversations about mistakes—not to unfairly judge or blame, but always to learn and improve."

Things to listen for:

- Do teams have the tools and resources they need?
- Who do they go to with tough problems?
- How do they manage the stress of the job?
- Remember tackling and implementing solutions to issues, when possible, and circling back to teams with improvements helps encourage these conversations to continue.

MANAGE PROFESSIONALISM

Candor and Respect are Preconditions to Teamwork

High-stakes conversations are daily practice in human service organizations. Teams need to feel ready—even mandated—to challenge ideas, assertively confront concerns, and learn from successes as well as failures. (Edmondson, 2019). A silent workforce cannot make safe choices, but an overly aggressive and confrontational one cannot either. To that end, candor and respect are preconditions to safe, engaged teamwork. Candor and respect generate the trust teams need to engage in productive, healthy conflict (Lencioni, 2012; Patterson, Grenny, McMillan, & Switzler, 2012). The strategies below are simple yet effective tools in building the habits of candor and respect.

Signal Words: CUS

For example, during a huddle, a new case manager is worried a child is unsafe and needs to be removed from a foster home, but no one else on the team seems to feel that way. Rather than say nothing, the case manager says "Help me **understand**. I don't think this home is safe." When the response does not address her concerns, she says, "Let's **stop** for a minute. I'm worried." As a result, the team gives the case manager an opportunity to more fully articulate her concerns and revises their plan.

Team with a strong safety culture embrace “speaking up” behaviors. With a foundation of trust and positive regard for one another, all teammates are expected to share safety concerns. Even if this leads to conflict, such dialogue is essential in considering all known risks and creating the safest, best outcome for an employee, child, or family. The key is to engage in healthy conflict and use repair when needed.

Assertive statements follow the “two challenge rule”—meaning it is your responsibility to assertively voice a safety concern at least two times. The team member being challenged must acknowledge your concern.

To facilitate “speaking up” behaviors, it is helpful to use signal words, like CUS, that immediately alert team members to the presence of a safety issue.

CUS when necessary

- Can we CHECK-IN
- Help me UNDERSTAND
- Let’s STOP for a minute

I'm SAFE

For example, prior to transporting a child several hours to a residential facility across state lines, a team convenes and uses I'm SAFE to decide which of them are most fit for the long transport.

A mnemonic used to assess fitness to perform safety-critical tasks.

I	**Illness**	Is the professional free from illness?
M	**Medication**	Is the professional affected by any medications that impact physical or cognitive functioning?
S	**Stress**	Is the professional overly worried by life factors? Is the professional managing stress well?
A	**Alcohol**	Is the professional free from alcohol or other impairing substances?
F	**Fatigue**	Is the professional rested and generally sleeping well?
E	**Eating**	Is the professional "fed, watered, and ready to go"?

OSSCR (Oscar)

For example, a supervisor uses OSSCR to express concern when someone repeatedly shows up late for meetings and is not working equitably with teammates.

OSSCR Script is delivered colleague to colleague:

- **OPEN** with specific situation or behaviors; provide concrete information
- **SHARE** how the situation makes you feel and what your concerns are
- **SUGGEST** other alternatives and seek agreement
- **CLOSE** and avoid enabling, don't expect thanks, not a control contest
- **REFLECT** and breathe and move forward

Before having a discussion about a concerning or problematic situation or behavior, mentally ask yourself why a reasonable person would do the problematic or concerning thing. Avoid making unhelpful assumptions about why a problem exists or what it means. While using OSSCR in conversation with your colleague, be both honest and respectful, and ask clarifying questions rather than assume causes or underlying motivations. Being candid and respectful is a key to psychologically safe conversations and to making positive changes.

If a problematic or concerning behavior is recurrent, in spite of OSSCR conversations, be certain you are addressing the right issue, and not just a symptom. For example, a person who is routinely late to meetings, even after communicating concerns and making an agreed upon plan to improve, is breaking commitments, and this (rather than just tardiness) needs to be the topic of an OSSCR conversation.

Healthy feedback is:

- Timely – given soon after the target behavior has occurred
- Respectful – focuses on behaviors, not personal attributes
- Specific – relates to a specific task or behavior that needs correction or improvement
- Framed as an opportunity – provides direction for future improvement
- Considerate – considers a team member's feelings and delivers negative information with fairness and respect. It is both 100% candid and 100% respectful.

Three Good Things

For example, a leadership team commits to journaling Three Good Things every evening for two weeks. Afterwards, over half of the leadership team continues the practice. During meetings, the team is more clear-headed, collaborative, communicative, and solution-focused.

Three Good Things is an evidence-based exercise in positive psychology (Rippstein-Leuenberger et al., 2017). Before bedtime, write or electronically log three good things that happened during the day. To be effective, it needs to be done for a minimum of two weeks, but continuing three good things could be a habit to keep for a lifetime.

Three Good Things works by training your mind to focus on positives. It is normal for our minds to primarily recall negative experiences, because these are the experiences we want to negate in the future. By practicing Three Good Things right before bedtime, you unconsciously train your mind to acknowledge and recall positive experiences as well. It lessens fatigue and the impact of traumatic stress.

Your Three Good Things log might look like this:

- Date:
- Three Good Things that happened today:

  1)

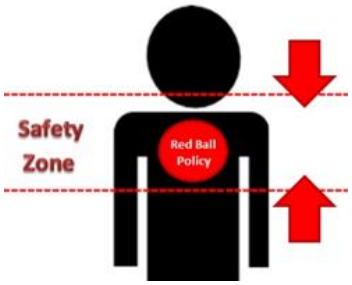
  2)

  3)

Red Ball

For example, a frontline child welfare team keeps an actual Red Ball in their shared office space. When a teammate notices a colleague seems disengaged, he rolls the ball (signifying "ball too low") and asks what's going on. Another time, a teammate is feeling anxious about an upcoming court date and grabs the ball, placing it above her head (signifying "ball too high"). Her teammates take a time out to discuss the court case with her.

The Red Ball (Ebert & Kuhn, 2017) is a metaphor for emotions, especially the way we manage stress, anxiety, and fatigue. It refers to individuals or teams. You can use the metaphor to make sure you and your teammates are seeking balance between your "head and heart" in interactions, discussions, and decisions.



- Ball is too high = Stress and anxiety are high
- Ball is too low = Exhausted, resigned, or frustrated
- Throw the ball at others = Aggressive, yelling, blaming
- Hold ball too tight = Guarded, isolating, "putting up walls"

If we think about our emotional state as a red ball, the goal is to keep it centered. Somewhere between "the head and the heart"—where feelings are energized, psychologically safe, thoughtful, and responsive. This is called the "safety zone."

When the ball is too high, we may feel intense worry, respond in angry/agitated ways, sleep poorly, and make decisions too quickly. When the ball is too low, we may be tired, disinterested, and delay in making decisions or being responsive to others. Sometimes people throw their ball at others by raising their voice or speaking negatively of a colleague, and people can also hold their ball too tightly and become guarded– not sharing their feelings with others.

Individuals can contribute to a team's mindful organizing by regulating their Red Ball and helping their teammates do the same. By acknowledging the constant presence of the Red Ball, we identify our emotional responses and can help keep ourselves and one another in the "safety zone."

TIPS IN USING THE RED BALL:

- Know where your own red ball is
- Reach out to others as needed, and let them help you keep your Red Ball in balance
- Visualize where others' Red Ball is and help keep theirs' in balance
- Overall Goal = Maintain all of our Red Balls in balance, so we can function effectively as individuals and as teams

STRATEGIES FOR KEEPING OUR RED BALL IN THE BALANCED ZONE BETWEEN OUR HEAD AND OUR HEART:

- Create distraction-free zones (e.g., quiet spaces)
- Listen to music
- Go for walks outside
- Open windows (if able); have pictures of nature in your space
- Stretch (e.g., yoga)
- Structure for increased teamwork during high-stress moments (i.e., avoid over taxing any one team member)
- Verbally acknowledging the Red Ball and responding mindfully to teammates