Heather Gilmartin: So, my name is Dr. Heather Gilmartin and I’m a nurse practitioner by training, and my PhD is in nursing and health services research, and I’m excited to talk to you guys today.

So, going through, I have no disclosures and this is funded by my Career Development Award.

So, learning objectives today. We are going to--or I am going to--describe speaking up in the psychological safety literature; I’m going to discuss recent studies that have investigated psychological safety and infection prevention practices in particular; and then I’m going to demonstrate the brainwriting premortem focus group method.

So, my research focuses on the role of organizational context on employee health and patient safety; and over my career, I have attended lots of seminars--obviously, not many in the last couple years, but some virtual ones--and I choose ones that talk about approaches to improve patient safety. Some examples include strategies to enhance the use of appropriate medications and standardizing practices through like checklists and stuff, and I always leave those sessions thinking about the role of clinicians in the work, right? So, these programs require staff to speak up if they see something. It's to see something, say something. So, if a medication is not being used appropriately or people are not following a standardized procedure, they say, "It's our responsibility to say something," but my thought always is this is really hard to do; and I know this from personal experience and I also know this from my research. And this topic, to be honest, has gotten even more important because of COVID.

So, infection prevention and epidemiology has been my clinical and research area since 2006. The field of infection prevention historically focuses on healthcare settings and healthcare providers; but in the last two years, we have been called up to teach society how to change their behaviors: hand-washing, social distancing, mask use, and now vaccination. And when we're talking peer-to-peer about not following an evidence-based practice, that can be hard; but what about speaking up to a neighbor because they won't wear a mask? That's even more challenging.

So, the purpose of this talk is to start a conversation about speaking up for patient safety, for it is quite complicated. To get us on the same page, let's define some terms and then we'll look at the literature. Let's start with the term "speaking up", and this is defined as the raising of concerns upon recognizing risky or deficient actions by colleagues in a healthcare environment, and this includes reporting mistakes, lapses, rule-breaking, and failure to follow protocols. The common belief is that speaking up behavior is a personality trait, that someone is brave enough to voice concerns, and this is not entirely true. We have learned a lot about speaking up from other industries who have been studying this, to be honest, a lot longer than we have.

So, speaking up is not unique to healthcare; in other industries, it's called safety voice or employee voice. The critical role of speaking up in healthcare was brought to the forefront in 2005 when Silence Kills: The Seven Crucial Conversations for Healthcare was published. And this book revealed that less than 10 percent of the surveyed clinicians reported that they directly confronted their colleagues about patient safety concerns. Since 2005, healthcare organizations have put structures in place to make it easier to speak up, and this includes incident reporting systems and whistleblower protections. The challenge is that these systems occur after an error has happened. The goal for patient safety is speaking up before harm reaches the patient.

So, where did we start in healthcare? Patient safety experts, they started with analyses of safety events; and the findings indicated that clinicians often knew something was wrong but hesitated to say anything. So, for many organizations, the first step was then to institute assertive communication training and implement high-reliability practices such as checklists. So, many of the tools that we use in healthcare come from the aviation industry which had big issues back in the '70s and '80s, but luckily now touts a pretty impressive safety record. So, techniques like scripted communication such as the SBAR approach have been embraced by most organizations, to be honest.

As far as a method for clinicians to structure their reports, they state the situation, the background, their assessment, and then make a recommendation. And though, this type of communication tool is now used really throughout healthcare, the evidence for the impact on patient outcomes is pretty minimal.

So, why is speaking up so challenging then? I mean nobody gets out of bed and shows up at work with the purpose of being disengaged, passive, or incompetent. The reason it's so hard is because it's really complicated; there's tons of factors of play as depicted in the model, this was published in 2014. So, it's bigger than being brave enough to speak up, they're also organizational and environmental factors at play. So, let's review some of those.

Individual factors include confidence in one's knowledge of the clinical situation; second-guessing yourself happens really quickly in stressful situations. Other factors include a fear of ruining your reputation; if you speak up and potentially, you might be wrong. People report they start to rationalize their actions, wondering if speaking up will even be effective or will actually cause harm to the patient; and then last, many people report they don't know how to speak up to ensure action. Luckily, this is where the SBAR tools come in.

The type of organization you work in and the type of work you do has an impact as well. So, if you are lower on the hierarchical ladder. So, let's say you're an intern and you need to speak up to an attending, that can be hard, right? But what about status differentials? You're a nursing student and you need to speak out to a senior critical care nurse; that can be really hard too. And what about if you've been dressed down by your manager for speaking up to a senior physician? The absence of leadership support is a big reason many don't speak up. And then last, if you are stressed out and tired because your organization does not provide enough resources, you're likely not to speak up.

So, the environment that teams work in plays a factor as well. If all members of a team are focusing on the same thing, it may be easier to note and then speak up if a lapse in practice is observed; however, in the fast-paced multitasking nature of healthcare, how common is it that everyone is observing, for instance, like an IV insertion or a medication administration. To create a mutual focus of attention, timeouts with a checklist or procedural pauses have been developed to help everyone get on the same page prior to a high-risk moment. So, this could look like in a CAT lab, pausing prior to the inflation of the balloon to make sure all tasks are completed and the team is eyes-on, ready to respond if needed. So, this method minimizes competing priorities and puts the focus on the patient.

Another factor are past interactions. If you have been dressed down by someone in the past for speaking up, you're less likely to do it again. However, if your speaking up was well received or if it's to someone you have a relationship with, you may find it easier. Last, if there is an audience, clinicians express hesitancy in speaking up, especially if it comes across as questioning the confidence of a peer in front of families or caregivers.

In summary, there are many factors as to why a clinician may or may not raise concerns upon recognizing risky behavior or lapses by colleagues. Individual, organizational, and environmental factors play a role. So, as I discussed, there are tools and processes such as checklists and timeouts that help.

So, let's now move on to a concept critical to speaking up which is called psychological safety. So, psychological safety is the degree to which employees believe they will not be penalized for making errors, asking for help, or seeking feedback. When your workplace is psychologically safe, you are comfortable speaking up about what looks like a problem or concern to you, or maybe looks like a possible error: yours or someone else's. In psychologically-safe teams, employees trust that sharing a concern would get an attentive ear and an open-minded, respectful response.

So, why does psychological safety matter? Because a psychologically safe work setting has many benefits. These include helping people learn and innovate as it allows speaking openly about what matters. It supports conflict management, accountability, and decision-making. Psychological safety also increases confidence of team members and improves perceptions of leaders. Lastly, psychologically-safe work settings reduce errors, increase safety, and patient experience.

So, those are the benefits. What about the impact of working in an environment that discourages speaking up due to low psychological safety. Individuals in those work settings have reported a loss of trust and pride in their organization and negative feelings about themselves for not feeling supported to speak up; this leads employees to disengage and possibly seek other employment opportunities.

So, how do you know if you have disengaged employees? If you are constantly hearing people say, "Don't shoot the messenger," or "This is above my pay grade," or staff are hesitant or unwilling to take initiative or risk; if staff tattle on each other, they blame others, or there is no reporting of errors at all, or if there's a general negative and can't-do attitude, your employees may have disengaged from work.

So, if you identify disengaged employees and wonder if it is due to low psychological safety, I want to provide some insights. Individual perceptions and personal experiences define psychological safety at work; it's a very personal thing. Feelings of psychological safety reflect a person's past experiences both in the current workplace and elsewhere. Since everyone's past experiences differ, feeling psychologically safe may come easier to some than to others, no matter the setting. And so, due to this, it's not something that you can label as wrong. So, if someone says they don't feel safe, they don't feel safe; the goal is to ensure that most of the people on a team or in a work setting feel psychologically safe most of the time.

So, how do you get started building a psychologically-safe work environment? The first step is to acknowledge that you might have a problem. I have talked to many leaders and they say, "People speak up all the time, it's almost too much; we're fine." But you really should seek out information and truly listen to what people have to say. So, once you have data, recognize, and own the problem or celebrate that you have created a psychologically-safe environment without even knowing it. But if you have work to do, develop an action plan and then implement it.

So, how can you reliably measure psychological safety? Dr. Amy Emondson, who is the one who introduced this concept to us in healthcare, suggests using one or all of the following questions, and I’m going to read them to you. If you make a mistake on this team, it is often held against you; members of this team can bring up problems and tough issues; people on this team sometimes reject others for being different; it is safe to take a risk on this team; it is difficult to ask other members of this team for help; no one on this team would deliberately act in a way that undermines my efforts; working with members of this team, my unique skills and talents are valued and utilized.

So, you can ask these questions to start a conversation. You could ask for recent examples if you're on rounds or just having a one-on-one meeting, or you can send them out as a survey, right? Dr. Edmonson has validated these questions using a seven-point ascending Likert scale. However, I would suggest before you go surveying your team, you should look at your all-employee survey results. This is a topic of great interest in the VA and has been tracked for years.

So, you've learned you have some work to do, perhaps; or you want to proactively create a psychologically safe environment for your team. So, so how do you get started? For team leaders, there are specific actions you can take. The first is to model civility, set the tone for civil and respectful communications; make room for reflection; carve out time for your team to regularly discuss how the team performs; nurture a positive climate, provide feedback to your team's efforts to improve team relationships and functioning; listen and hear; show good listening skills when getting input from team members; be inclusive, seek your team's input and ideas, invite their feedback and encourage participation; communicate effectively, use direct language that is clear, specific, and actionable; reinforce the behavior of speaking up, encourage and praise those who do; support collaboration in your team; adopt team norms that encourage people to help one another; expect learning and innovation; set as the norm, the expectation of continuous improvement; and then lastly show that you learn as well: as a leader, ask for help and share some mistakes of your own that have helped you learn.

So, the actions for team members are really not all that different. Be civil, show civility and respect when you communicate with others. Stay involved; participate in team meetings; act unselfishly; let team goals rather than individual preferences drive your behavior; have a voice, speak up when you are concerned about something; be responsive, show that you have heard the concerns of your team members; act collaboratively, find ways to work together to improve your team's quality of services; and lastly, give and take help; ask for help when you need it and give help when it is needed.

So, to summarize, psychological safety is an individual perception that is informed by current and past experiences, and the environment created by leaders and colleagues. It lives at the team or department level, meaning local leaders have the greatest influence on psychological safety; and it's not a goal in and of itself, it's a pathway towards outcomes that really matter, like patient safety.

I do want to mention that the majority of research on speaking up and psychological safety has been positioned within workplace cultures, and there has been little attention in the literature about the influence of wider societal changes such as racism, sexism, or homophobia on speaking up and psychological safety within healthcare; and to be honest, within all sectors. So, I bring this up for people of color, women, and the LGBTQ community face additional challenges that have been brought to light by these international social justice movements--Black Lives Matter, the #MeToo movement, and the and the Everyday Sexism Project. So, moving forward, we should start to view speaking up and psychological safety within this broader lens.

So, I’m now going to transition to the second objective of this talk, and I will discuss the findings of recent studies that investigated the relationship between psychological safety and infection prevention practices. So, in 2017, as part of my postdoctoral fellowship at the VA, my colleagues and I publish work in the journal of nursing care quality that study the relationship between psychological safety and reported non-adherence to the central line safety checklist. So, this topic interested me for I had been part of the Institute for Healthcare Improvement's 5 Million Lives Campaign. As the nurse epidemiologist at a rural facility, I had found it challenging to implement the central line checklist at my institution. It wasn't until I had finished my PhD and moved to the Veterans Health Administration, that I understood why.

So, the central line bundle was developed by Peter Pronovost and colleagues, and was tested in the Michigan Keystone Project. Due to a significant decrease in central line infections reported, the IHI helped healthcare facilities across the country implement this in other patient safety practices. Early on, people in the field noted that adoption of the policy did not correlate with full adoption of the checklist at the bedside, nor did every facility see a decrease in infections. Because of this, routine audits of bedside central line insertions became a performance improvement metric, and we ended up reporting these to not only joint commission, but also Medicare and Medicaid.

So, this was meant to encourage clinicians to complete every aspect of the bundle on every patient. But here's the thing: who was standing there completing the checklist? Most often nurses.  And what were they asked to do? They were asked to speak up if the clinician inserting the line did not follow every step. In my experience, that was not easy to do, right? I remember being yelled at by a surgeon for pointing out that the drape didn't fully cover the patient; I didn't know what to do to help the nurses that I was working with to implement this program, and to be honest, with surgeons, to get on the same page.

And this study was my effort to understand what happened back then. Once I had learned about the speaking up psychological safety literature, a light bulb went off and I became somewhat obsessed. I went looking for a health care organization that collected employee perceptions of psychological safety and adherence to infection prevention best practices, and that is how I landed at the VA.

In my study, we hypothesized that intensive care units with higher perceptions of psychological safety would have higher rates of reported non-adherence to the central line checklist, and this was based on the work of Dr. Edmondson that suggested that teens with higher psychological safety would be more comfortable speaking up if they witnessed a problem or concern, such as not using a full body drape right for central line insertion. And if a clinician was corrected, we were meant to check a box and that non-adherence would be reported.

So, for this study, I assess psychological safety data from 2008 to 2011 using the VA All Employee Survey for 70 intensive care units across the country; and I match this data to monthly central line bundle adherence rates reported to the VA Inpatient Evaluation Center. So, what did I find? So, the All Employee Survey asked one of the questions from Dr. Edmondson, specifically, "Members of my workgroup are able to bring up problems and tough issues." This is rated on a 1 to 5 scale from "Strongly Disagree" to "Strongly Agree."

So, the median response for the 1900 nurses who worked in the ICUs was a 3, which is neutral, "Neither agree nor disagree." Across the four years, there were units in which 50 percent or more respondents perceived very high levels of psychological safety, and units in which 50 percent or more perceived very low levels, so there was some variation.

The median checklist non-adherent rates range from 0.14 to 0.49, indicating near-perfect adherence to the central line checklist. We used a linear mixed model with a time-by-adherence interaction to test our hypotheses; and our finding, there was no statistically significant differences in psychological safety scores for units with 5 percent or more non-adherence in any year of data. So, this data neither supported our hypothesis nor previous research findings. So, why was this?

In our manuscript, we offer considerations for the study results. One consideration was that, perhaps, every central line was being inserted with every step of the checklist completed, near perfect for four years. However, in non-VA ICUs during the same time period, non-adherence rates, meaning people required a reminder to complete each action, and this was documented and reported to joint commission. This ranged from 37 to 71 percent, right? So, that was interesting to us.

Another consideration was the presence of the auditor. Did this person produce an improvement in performance, which we would call the Hawthorne Effect? It is possible that the clinical team knew they would be monitored and did everything correctly; and this is, to be honest, the goal of quality metrics. But this is what happened in non-VA settings as well. So, what was the difference?

So, a final consideration is that in this sample, nurse observers of central line insertions perceived the risk of reporting non-adherence risky; perhaps, they were concerned that they or their unit may be penalized for reporting negative information; perhaps, they feared that they may be personally blamed for not taking ownership and ensuring everyone on the team had been briefed and set up for success. This consideration is supported by previous VA research that found nurses report lower levels of communication, openness, safety perceptions, and teamwork than other healthcare professionals.

So, what was our takeaway? It is possible that the absence of error reporting in our sample was due to the absence of error, and this would have been phenomenal for patient safety. However, it is also possible that the absence of reports of non-adherence to the central line checklist may be due to low psychological safety.

So, the next study I want to talk about was a national survey study conducted by Drs. Green and Saint from the University of Michigan. So, the study included a random sample of 900 US acute care hospitals; the translating research to practice surveys were mailed to infection preventionists and asked about hospital and infection control program characteristics, organizational characteristics, and the use of practices to prevent common healthcare-acquired infections to examine relationships between psychological safety and the use of specific infection prevention practices that positively impact patient safety. The survey included the seven items proposed by Dr. Edmondson to measure psychological safety.

So, 528 infection preventionists responded. How do they perceive psychological safety in their work setting? 87 percent indicated they assert their views on important issues, even though their supervisor might disagree; 80 percent felt comfortable speaking up when they see a physician not clean his or her hand; 91 reported that when a medical error occurs in their hospital, clinicians are encouraged to discuss mistakes in order to learn how to prevent similar errors; only five percent indicated that mistakes were held against employees, which is great; 77 percent indicated that staff members are able to bring up problems and tough issues; 66 percent indicated they felt safe to try something new at the hospital; and lastly, 15 percent reported that people are too busy to invest time in improvement.

So, we determined that approximately 38 percent of hospitals responded positively for all seven items, which we considered high psychological safety. So, only 38 percent.

We tested for associations with catheter-associated urinary tract infections, ventilator-associated pneumonias, MRSA prevention practice adherence, and psychological safety using logistic multivariable models; and we found that high psychological safety was associated with increased odds of regularly using urinary catheter stop reminders or stop orders; and nurse-initiated urinary catheter discontinuation for CAUTI prevention and also regular use of sedation vacation for ventilator-associated pneumonia. And we were really intrigued with these findings because these practices are more relational than technical; they require communication between clinicians and the willingness to speak up and challenge entrenched customs and practices.

No other associations were noted for the other prevention practices.

So, to summarize, in both studies, the finding that most respondents did not report high psychological safety is concerning but not unexpected. Most leaders don't know how comfortable their staff are to speak up; you now have the background and questions to talk to staff, so you're one step ahead of many of your peers. What the speaking up and psychological safety literature has concluded is that an environment that supports psychological safety does not emerge naturally, it must be fostered, supported, and routinely addressed so teams can realize the positive impacts on patient safety.

So, I have been keeping an eye on the literature to see if there has been any studies looking at the influence of psychological safety or speaking up during the COVID-19 pandemic. And one that really impacted me during the early days of the pandemic was a Viewpoint article published in June 2020. Drs. Shanafelt, Ripp, and Trockel are leaders in the field of burnout in healthcare; and in the first months of the COVID-19 crisis, they hosted eight listening sessions with a total of 69 individuals to understand sources of anxiety for healthcare professionals during the COVID-19 pandemic. They wanted to learn what healthcare professionals were most concerned about and offered suggestions for how leaders could address these concerns. And as I discuss the results in the next slides, think about if psychological safety plays a role.

So, the first request from healthcare professionals to their organizations during the COVID-19 pandemic was to Hear Me, listen to, and act on expert perspectives and frontline experience; create communication channels, and make sure the voice of healthcare professionals are part of the decision-making process. Is this possible if a team or department has not already established some level of psychological safety? I don't know.

The next requests were Protect Me and Prepare Me. They asked for adequate personal protective equipment, rapid access to testing, and resources to ensure they did not get sick or take the disease home to their family. They asked for training and support, but the expectation was that they would ask for help when they needed it. So, again, here's my question: is this possible if a level of mutual trust was not established or speaking up tools were not available?

So, lastly, they asked to be supported and cared for. This included tangible things like meals, breaks, lodging near the hospital, if needed. It also included emotional and psychological support. But how would leaders know if one of their team was truly struggling unless someone spoke up and said they needed help? Last, they requested holistic support for their individual and family needs; and, again, this requires asking for help, which requires an environment of psychological safety.

So, I don't know how healthcare professionals are keeping it together after these very long two years of COVID. My hope is that this crisis has helped teams create psychologically-safe workplaces. That is my hope and the data will soon tell us if this has happened.

So, the last topic I want to talk about today is a method that you can use to help develop psychologically-safe teams. The brainwriting premortem is a focus group method I developed to engage stakeholders in a national implementation study. It's one way to get people on your team to share ideas, become aware and potentially appreciate differences within your team, and come together around a new project.

So, you've all been part of brainstorming sessions, I imagine, where people are asked to come up with ideas or poke holes in a project. This works well in a small group with a facilitator and within an environment that supports psychological safety; if you don't have this type of setting, you often get one or two people who dominate the conversation or it turns into a venting session, which can be fun, but it makes things go completely off-topic. The brainwriting approach is the silent sharing of written ideas in a structured group setting. This could be around a table or even on a Zoom call right where people type into the chatbox. The written approach allows the quiet and thoughtful sharing of ideas by individuals and it can result in the generation of lots of information.

The nice thing is the ideas are written down, so they're immediately available; there's no recording devices or notetakers needed. Plus, writing versus speaking out loud can make it easier for everyone to speak up.

So, the premortem was first suggested by Gary Klein and is a twist on something that we all know about in healthcare, the postmortem. In a postmortem, something bad happens to a patient or a program, and we try to figure out why. But this is after the fact; this doesn't help the patient or the program, of course. So, in a premortem, you tell the story about your program, right: what it is, why it's needed, and all the details about how it was implemented. And here's the key bit: you then ask your group to imagine it's a year later, the program has been implemented, and was a failure, like people died, it was bad. You asked participants to sit on that for a minute, then identify what happened that caused the program to fail. The premortem is unlike typical critiquing sessions that focus on what might go wrong; instead, you're encouraging the use of prospective hindsight by asking people, "What did go wrong?"

So, perspective hindsight, the idea, it's built on the work of Nobel Prize winner, Daniel Kahneman, and it is a form of imaginary time travel. You look back from the future to tell a story about the cause of a program failure. This approach helps people overcome blind spots, helps people use short-term and long-term thinking, and dampens excessive enthusiasm or the great idea phenomena, the groupthink. Lastly, because people are sharing ideas in writing, it minimizes the fear of speaking up for people who aren't willing to raise their hand or even to speak in a small group.

And then we talk about groupthink. So, groupthink is the practice of thinking or making decisions as a group in a way that discourages creativity or individual responsibility. I have a video tutorial to explain the brainwriting premortem method if you have an interest.

So, yeah, if you're interested in trying out this method, you can read about the evaluation of the brainwriting premortem method, plus access the protocol and a training toolkit in our 2019 publication, which was again in the Journal of Nursing Care Quality. For me, the greatest part of the brainwriting premortem sessions that we've held are the feedback from participants across many sites; projects and teams have told us the method is fun, it allows for time to think deeply and provide comments on other people's ideas. And people have been appreciated being asked to talk about a program before it was implemented; most importantly, though, and pertinent to this talk, is that participants shared that the method allowed them to give ideas to the group without fear of criticism, suggesting we created environments supportive of psychological safety.

So, I’ve covered a lot of information. What I hope you'll take away from this presentation is the following: psychologically-safe work settings are crucial to support speaking-up behaviors. If these environments are created, you may see positive benefits, including engaged employees and reporting of more errors, which is a good thing because you, within our learning health system and using high-reliability practices, if we don't learn from and then attempt to correct our errors, we will continue to make them. This is the culture of continuous learning and innovation that we know will result in enhanced patient safety.

So, I’ve given you a roadmap to help you understand the state of psychological safety in your team; I highly encourage you to partner with the folks from the VA national center for organization development who are the ones who do the VA All Employee Survey if you have questions or concerns. I’ve also given things for you to do to create a psychologically-safe work setting within your own department. And then, last, I’ve given you the brainwriting premortem method, which is a tangible process to bring a team together to support implementation of a new program.

So, I want to say thank you for this opportunity, to the CDA Enhancement Initiatives to let me work through these ideas as I keep moving forward with my CDA research. I also want to thank my colleagues at the Denver/Seattle Center of Innovation, my colleagues at the University of Colorado School of Public Health; the Colorado Clinical and Translational Sciences Institute; and, of course, the folks at the University of Michigan Patient Safety Enhancement Program.

So, I have lots of references; and if anyone is interested in reaching out, please let me know. And Rob, I believe it's time for questions.

Rob: Thank you, Dr. Gilmartin. We do have a few questions queued up. Attendees, if you have questions for Dr. Gilmartin, please submit them to the Q&A panel. If you don't see the Q&A panel on the right-hand side of the slides, click in the lower right-hand corner on the ellipsis button and you'll see "Q&A" as an option that you can turn on.

The first person sent in a question and then immediately a follow-up, "Is there ever a way to address a concern without someone personalizing your care? If so, when personalizing is recognized, what's the best way to still be heard?"

Heather Gilmartin: So, I just want to ask clarifying questions. So, "personalizing", does that mean that it's not bringing up a concern, it's bringing up something about their personality? And if yes--the way I approach all of this is I don't know if anyone's ever read The Difficult Conversations book or taking the Crucial Conversations class, but the way that I approach having these kinds of conversations is to do with humble curiosity, meaning coming in admitting that you don't know something; that you've seen something, but you don't know. And so, you ask open-ended questions that allow the person you are speaking to, to, A, see that you are curious; B, that it is not a personal attack, but you think you saw something maybe and you just want to understand more. My experience has been that that takes some of the temperature, if you will, out of the conversation.

But if that's not the question that was asked, please clarify.

Rob: The person wrote back, "Yes, that is the question that was asked." This person writes, "Do you think brainwriting can apply to conversations about diversity and social sensitivities in the workplace?"

Heather Gilmartin: Oh, 100 percent. So, what I brought up is that my work on the brainwriting premortem was done within a national transition of care program, and these were groups that were diverse when they sat in rooms, but we never collected data to determine if some had different expressions or opportunities to speak; did they share that much more because it was a very egalitarian experience? We would have loved to have done it with also then a brainstorming: who spoke up and how much information did we get out?

I think this is an area where someone could test for it, which would be amazing; but I think another way to look at it is that when every voice is equal because it's being written down, that provides everyone an opportunity, and I think that would enhance diversity, equity and make folks feel more included. You have to, though, remember to invite people to the table; this is that invisible worker role; sometimes, we don't include people because we forget they're part of the project. So, when you start a brainwriting or a brainstorming session, maybe look around the room and say, "Who are we missing?" and then hold off until they come. And that might be in infection prevention, so we forget the housekeepers all the time; we forget sterile processing often. Why are they not at the table when we're having these conversations? Because when you bring them, they will bring you the most incredible information.

Rob: So, heather, a follow-up to the previous question, the questioner after writing, "Yes, that is the question," wrote, "Correct, when something you are addressing is heard from a space that feels personal instead of constructive. Thank you."

But we have more questions. So, to move on--this is a comment, actually, just a comment that, "Rolestorming is an interesting concept I’ve run across that could be interesting to include in the brainwriting. The idea is that you ask the participants to imagine themselves in different roles and that playing a role helps people think more creatively when participating in brainstorming-type activities."

Heather Gilmartin: Oh, I like that; that's a very good one. Thank you.

Rob: "What role do you think politeness and deference between team members has to do with whether people speak up versus lack of psychological safety or fear of retaliation, per se?"

Heather Gilmartin: So, I appreciate "politeness", but I like the word "civility" better. Dr. Katherine Osatuke from the National Center for Organization Development here in the VA, she came up with the Civility, Respect, and Engagement in the Workplace program, the CREW. And the civility piece is so different because "polite" in one culture might not be polite in another; politeness between genders and between cultures is very different. But I think civility may be something we have to talk about, what is being civil, is the way I look at it. What does that mean? It means deference to expertise, but it doesn't mean deferring to hierarchy, right? And I don't know where I’m going with this... but it's a good question that requires a fair amount more thought, if that's okay.

Rob: Thank you, Dr. Gilmartin. "This was valuable information and I am optimistic about taking these back to my team. Would you suggest doing these in a leadership meeting or in an all-employee meeting first?"

Heather Gilmartin: Whatever form you have, to be honest. People's time is precious, and if you get people together, I think you bring up some of these concepts. Honestly, this is the point of the all-employee survey, maybe pull your psychological safety data and have everyone take a look at it, and then you can bring back this the stuff I’ve presented today and say, "Is there anywhere we want to work on? Is there anything that we should do better or celebrate? What are we doing really well?" And then you can pass that on to different teams; and then hopefully, it becomes contagious, but in a good way.

Rob: Thank you. "Do you ever offer consultation services or know of any for leaders that are trying to improve psychological safety in their workgroup?"

Heather Gilmartin: I mean I’m happy to talk to anybody; I’m on a career development award, so the areas of my research, I’m absolutely available. However, the absolute experts in the VA are the folks from the VA National Center for Organization Development. So, they are our organization psychologists and they have tools that are freely available on the VA NCOD website; but they also do consultations for free with leaders. So, though I would happy to be happy to help and potentially we can partner for some innovative research, you want quick and you want the smartest in the business, I would go to... I think they have a help desk line VA NCOD. Smart cookies.

Rob: Thank you. "Can brainwriting be adapted to help our ICU teams in high COVID-dense areas find renewed energy about their work and address issues and concerns?"

Heather Gilmartin: Such a cool idea. I would say yes; I mean I would say is pose the question. "So, here's the problem: all of our staff are leaving, our turnover is through the roof. And yeah, it's failing. Why did it fail? Why did our systems fail?" And people may come to you with suggestions, "It failed because you never gave us the time, we never got a break. We have low staffing." Those things are somewhat obvious; but then when you're asking the people who are doing the work why something failed, they might come up with something very brilliant. Once you look at the data, then you move on to the solution focus.

You can do a brainwriting exercise, "Okay, so, we need solutions. Here are problems that we identified; let's all write out solutions." And what you do is you pass your solutions around the table and people read one and go, "Oh, that just made me think of something else, and they write that down." And so, it's sort of this idea that things will build off each other, but it's quiet and it's thoughtful, and then you, as a leader, take back all those ideas and go, "Whoa, some of these we can do, some need to go to leadership, which ones do we want to prioritize? Go." And you have then honored the people doing the work; maybe you will stem the hemorrhage right of turnover in healthcare. I don't know, but I love the idea. Please do it.

Rob: "How does a group work through conflict resolution? There are folks that fan the fire versus collaborate; some leaders set the bar for behaviors."

Heather Gilmartin: Yes. So, my favorite term is something that I think... your organizational culture is set by the worst behavior that you permit. So, if a leader allows someone to be disengaged in the meeting, potentially a passive-aggressive or even verbally abusive in a team, people realize that that's the bar that they have to meet, and so it sort of takes everyone there. What I would suggest is that, again, you go back to the idea of treat others like how you would like to be treated. Be curious: so, if someone is being very confrontational, there's, "I hear you. Help me understand where you're coming from," and then you just listen. And that may have to happen over and over, "I hear you; help me understand." But over time, you are paying them the respect of being present and listening; you can't change another person, but you can at least make them feel understood.

But then also, if we have truly disruptive behavior, that is something that goes to human resources, because that is not safe, that is not healthy, and it shouldn't be permitted.

Rob: Thank you. I think one more question came into the Q&A. But let me just remind attendees: if you have a question for Dr. Gilmartin, could you please enter them to the Q&A panel. It's difficult for me to navigate the chat, and I see some messages coming into chat, I don't want to miss any questions. This person asks, "How do you respond to leaders and teammates who appear to be frustrated and irritated when you ask questions, thus reducing psychological safety?"

Heather Gilmartin: Usually, I take one big, deep breath and determine if it's a conversation that will take me where I want to go. In other words, are you willing to lean in? Because our leaders are humans too, right? They have tough days and we have no situational awareness about what goes on in their world; and so, sometimes, being civil to them, being like, "Hey, whoa, it sounds like you're having a pretty tough day, anything I can do?" or, "Help me understand what's going on because I’m really sorry." Because that's what you would want someone to do for you, right?

If you don't have that kind of relationship, if it is a stranger right, it's the Chief of Medicine who just rips everyone apart, that's the kind of conversation then that you don't get to sit down with them. However, maybe you, as a group, come together and say, "Let's talk about how we can work within the system that we have." Maybe don't come at this person when we see them in a certain way; maybe we submit things to them in writing right so then they have time to thoughtfully comment and stew on it before they come back to you. Reading body language is good because if now is not a good time, probably now is not a good time. And then, obviously, you can take it up the chain of command. Because, again, our culture is set by the worst behavior that is tolerated. And yeah, that is from the medical center director down to lowly researchers.

Rob: Thank you. I’m sorry I muted myself I just had a couple requests for the slides. There was a link in the email that was sent out about four hours ago--five hours ago, now. But I just sent it through the chat which I did earlier in the session. More questions have come in. Dr. Gilmartin, could you repeat that phrase again about the culture? Somebody is asking me to put it into the chat, I think, so they can copy it. "The culture is set by the lowest..."

Heather Gilmartin: Let me find the exact quote. Essentially, the quote is, "The quote is the organizational culture is set by the worst behavior that is tolerated."

Rob: Thank you. Organizational culture. One moment, please. I just sent that out to the chat as well. This person asks, "How do you deal with a culture of helplessness with other colleagues and staff who don't want to speak up because people don't see any changes after giving feedback?"

Heather Gilmartin: Yeah, that is so real. And the term, actually, is called learned helplessness, and there's a whole body of literature around it. And the beauty of it is the solution is through positive psychology, which is a whole nother field--which I have to say is the best thing I’ve ever read in my life. Because positive psychology talks about how it is not in our nature to see unicorns and rainbows, it is in our nature to see everything as dark and stormy. And so, how do you go about changing from learned helplessness, meaning you have been beaten down so many times, you just give up, to, at the end of the day, looking around and thinking, "Well, I had one good thing happen to me today."?

And so, yes, it is an individual trait, but it is also a team culture. And so, if the technician staff are really beat up by the nursing staff, the text is disengaged right, and become sort of what would be perceived as helpless? What can a leader do? A leader can start doing different types of positive psychology practices. For instance, once a week, get everyone together and at the end of the meeting, be like, "Guys, everyone has to share a win. What went well today? What went well this week?" I did some interviews with staff during COVID and I was asking these questions, and many of them just said, "Hey, we didn't get COVID," and I was like, "That's a moment to celebrate." And they're like, "You know what? That is a moment to celebrate." And when you start to, every day, identify that something good happened and then be grateful maybe for some things, that actually changes the structure of your brain. We have a lot of neuroplasticity in our brain that allows us to move from one sort of mood to another, and so you can change your mood; you can go from learned helplessness to a positive grateful state. It does require consistent and constant practice, but it is something a leader can do by just asking really good questions. So, don't give up; it can be done.

Rob: Thank you. We have two more queued up: in terms of brainwriting, how can we engage groups to share how they can de-escalate microaggression and micro knots towards working together as it relates to diversity and inclusion?"

Rob: Absolutely, the whole idea is the brainwriting idea is that maybe you pose that question, but not in a, "Let everyone share," it's everyone's going to now go into corners and write--and you don't want to give people more than ten minutes writing time, and I have this in the toolkit that I developed for the program, because anything past ten minutes and your brain starts to gibberish. So, ten minutes and then you come back, and you put all the ideas in the center, and then you share them, and everyone reads everyone else's, and then someone reads someone else's. So, you're not sharing your personal stuff; and then that idea generation can then move towards problem identification, it can move towards solution-based. So, the writing piece, I think, is a really good experience especially in groups that maybe suffer through microaggressions.

Rob: Thanks. This is the last question that we have queued up at this time, "How can part-time or PRN coworkers be empowered to speak up? It seems like they often have an important outsider perspective, yet they might face numerous barriers to speaking up."

Heather Gilmartin: Ah, that's interesting. So, this, again, goes back to the, "Do you have all the right people at the table?" And so, there are some students who are doing brainwriting premortems in their dissertation work, who are just... they videotaped the story, like, "This was our project and it failed, heads rolled," and so we want you now to write out, for ten minutes, reasons why it failed and please send that to us. And then we will include it in our data and you will be invited to come and reflect with us on the entire data.

So, you could do that with the PRN stuff; you set up a brainwriting, they can't make it to the meeting, totally okay. Have them do the... videotape it or have them listen to the story, or read the story, and then have them write it out and send it in. And so, their voice is heard without them having to come in on a day off or a weekend, or deal with the hierarchy of, "You're only here once a week, your voice doesn't matter."

And it's different than like putting in a suggestion box, which we see a lot, like we have email boxes for VA stuff. That takes a lot of safety to send it in with your email; this truly is a piece of paper that can be slipped under the door of the leader or it can be emailed, but, "Here are my ideas, please share them with the world."

Rob: Thank you. Another question came in while you were answering that one, "How do you make the brainwriting activity anonymous in a virtual format on Microsoft Teams or WebEx?"

Heather Gilmartin: Yeah, it's a bit tricky because we are all tagged with things, all of our names are there. So, what you could do instead is have people type on a document and then email it into somebody, and that person de-identifies it, so they take off the email address and just compile the data. So, that would be one way to do it. How we do it in person is that your handwriting-- everyone has matching pens and so people can tell you apart from the handwriting--but you put in the middle table and people move it around, so that would be the way to go.

The truth of the matter is, though, if you are really fearful that having someone's name be part of it is going to be a problem, you have bigger fish to fry, you need to address the psychological safety in the group.

Rob: Thank you. That was the final question that we have cued up in the Q&A panel.

Heather Gilmartin: Rob, so let me give you the two quotes that reflect on this conversation. So, the quote is, "The culture of any organization is shaped by the worst behavior a leader is willing to tolerate," and that has been attributed to Grunter and Whitaker. And then there's a second quote from Lieutenant General David Morrison, who has stated, "The standard you walk past is the standard you set." And what he means is if he sees a military colleague whose uniform is completely sideways and he just lets it go, then that's considered the standard. So, fix it at the time in the moment, and that sets the standard.

Rob: Thank you. I just wrote those into the chat to the best of my ability as you were reading them off. But that's about all the time that we have, so if you'd like to make closing comments at this time, Dr. Gilmartin?

Heather Gilmartin: I really appreciate everyone taking the time; this is an important topic that we all have work to do on. And you know where to find me if you need me. I appreciate it.

Rob: Attendees, when I close the webinar momentarily, a web page will open up with a few questions regarding the quality of this presentation. Please, do take a few moments to answer those questions; we count on them.

Thank you once again, Dr. Gilmartin. Have a good day, everybody.

Heather Gilmartin: Thanks, Rob. Thanks, Maria.