Team Norm Dimensions

Map and redesign the invisible rules running your clinical team — safety, communication, accountability, belonging, and more

10-Day Challenges

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Part 1 · About this challenge

A ten-day guided journey through the invisible rules that run every clinical team — examining the norms that shape safety, communication, accountability, belonging, conflict, purpose, and learning. One dimension at a time.

Helpers Helping Helpers · Recovery Made Simple

Your Journey

Norm Health Score

Before You Begin

Norms change through honest naming, specific commitment, and consistent practice. Move through one day at a time. Some days will surface things about your team that are uncomfortable to see clearly. That discomfort is the beginning of change.

Team Norm Dimensions Self-Assessment

Take it on Day 1 · Return to it on Day 10

The 10-Day Pathway

DAY 1 · FOUNDATION

What Are Norms, Really?
The invisible rules that run every team — named and unnamed

DAY 2 · SAFETY

The Safety Dimension

Psychological safety as the foundation of high-performing teams

DAY 3 · COMMUNICATION

How We Talk to Each Other

Communication norms: what gets said, what gets suppressed, and what leaks out sideways

DAY 4 · ACCOUNTABILITY

The Accountability Dimension

Holding standards without blame — and what happens when they slip

DAY 5 · BELONGING

The Belonging Dimension

Who feels at home here — and who does not

DAY 6 · CONFLICT

Fighting Well

Productive conflict as a team competency — not a failure

DAY 7 · PURPOSE

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The Mission Dimension

Shared purpose as the anchor for team norms and decisions

DAY 8 · GROWTH

The Learning Dimension

Teams that grow together versus teams that stagnate separately

DAY 9 · DIMENSIONS

Your Team's Norm Profile

Mapping where norms are working and where they need redesign

DAY 10 · INTEGRATION

Building the Team You Want

From diagnosis to design — a norm-building plan

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Part 2 · Team Norm Dimensions Self-Assessment

Team Norm Dimensions Self-Assessment

Rate each statement about your team: 1 (Rarely true) to 5 (Consistently true). Take it on Day 1 as your baseline, and again on Day 10.

Psychological Safety

Team members feel genuinely safe to admit clinical mistakes without fear of judgment

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

Clinicians bring their most difficult cases to consultation rather than managing them alone

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

Disagreement and dissent are welcomed rather than suppressed on my team

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

The leader's response to errors focuses on learning rather than blame

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

New team members can ask questions without fearing they will appear incompetent

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

Personal struggles affecting clinical work can be named without career consequence

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

Taking interpersonal risks (speaking up, naming concerns) is rewarded not punished

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

The least-senior person on the team experiences similar safety to the most-senior

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

Communication & Feedback

Difficult feedback is delivered directly rather than avoided or routed sideways

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

Important concerns get raised in the room where they can be addressed

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

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Feedback between peers is normalized as a mutual responsibility, not only supervisory

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

Communication about conflict happens with the person involved, not about them

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

Meetings are a place where honest exchange happens, not just information transfer

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

The team regularly surfaces topics that are uncomfortable but important

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

Side conversations and parallel communication tracks are minimal

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

My team has a shared language for giving and receiving feedback

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

Accountability & Standards

Clinical and professional standards are consistently maintained across the team

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

When standards slip, it is addressed directly and promptly

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

Accountability is experienced as collaborative and growth-focused, not punitive

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

Team members hold themselves and each other to clear shared expectations

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

Drifts in quality are named before they become entrenched patterns

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

Accountability is evenly applied regardless of tenure or relationship with the supervisor

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

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The team distinguishes clearly between mistakes that require correction and patterns that require intervention

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

Self-accountability (bringing errors forward voluntarily) is practiced and valued

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

Belonging & Inclusion

Every team member experiences genuine inclusion, not just formal membership

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

Cultural and personal differences are treated as assets rather than complications

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

No single subgroup or cohort dominates the team's communication and decision-making

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

The perspectives of newer and less-credentialed staff are genuinely sought and valued

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

Team members in recovery, if present, experience equivalent belonging to those who are not

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

The team's demographic composition is reflected in whose ideas carry the most weight

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

New team members are genuinely welcomed and integrated rather than merely oriented

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

Everyone on the team can name a specific way their unique contribution is valued

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

Shared Purpose & Learning

The team has a living, shared sense of its clinical mission beyond the organizational statement

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

That shared purpose actively guides decisions and norm disputes

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

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Rarely · Always

Hard clinical work is understood as meaningful, even on the most difficult days

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

The team regularly discusses and reinforces its connection to clinical purpose

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

Challenging cases and clinical uncertainty are handled in a learning culture

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

Errors and hard events are debriefed collectively rather than absorbed privately

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

The team continuously improves through shared reflection on what is working

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

Professional development is genuinely supported as a team priority

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rarely · Always

Scoring guide

Each group gets its own score, as a percent.

Higher scores indicate stronger, more consistent norms in that dimension. Your lowest-scoring dimensions are your priority redesign areas. No score is permanent — every norm can be built.

Score: 80% and above — Strong Norm: This dimension is embedded and functioning well. Protect and reinforce it.

Score: 65–79% — Developing: Real progress here. Continued intentional practice will strengthen this dimension.

Score: 45–64% — Needs Attention: This dimension is inconsistent. Focused norm-building work is warranted.

Score: below 45% — Priority Redesign: This dimension is significantly undermining team health. Make it an explicit redesign target.

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Part 3 · Day 1 · What Are Norms, Really?

DAY 1 OF 10 · FOUNDATION

The invisible rules that run every team — named and unnamed

Today's Reading

Every team runs on norms — the unwritten, often unspoken agreements about how people behave, communicate, resolve conflict, and treat each other. Some norms are explicit: meeting times, documentation standards, on-call rotations. But the norms that most powerfully shape a team's culture are invisible. They are the things everyone knows without being told: whether disagreement is safe, whether vulnerability is protected, whether struggling is something you can admit out loud, whether leaders say one thing and do another.

In SUD and mental health treatment settings, norms carry particular weight because the team's relational culture directly shapes the treatment milieu. A team that models psychological safety, honest communication, and genuine accountability creates a therapeutic environment where patients can practice those same things. A team that is fragmented, guarded, or norm-inconsistent teaches patients — often without anyone intending it — what relationships in the real world look like.

The challenge with norms is that by definition they are rarely examined. They just are. The team member who has been there for years enforces them without knowing it. The new hire learns them through observation and small corrections. And when norms are toxic — when they protect dysfunction, silence dissent, or reward performance over honesty — they are the hardest things to change because they are not written anywhere that can be revised.

This ten-day pathway is organized around one central question: what are the norms actually running your team right now — and are they the ones you would choose?

Reflect

1. Name three unwritten norms on your current team that everyone knows but no one has formally agreed to. Where did they come from?

2. Which existing norm most directly supports the clinical mission? Which most directly undermines it?

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3. If a new clinician joined your team tomorrow, what would they learn about "how we do things here" within the first week — without anyone telling them directly?

Today's Work

Three unwritten norms currently operating on your team (name them specifically):

Be concrete — not "we communicate well" but what actually happens...

Where did each norm come from? (A previous leader, a founding team, a significant event, organizational culture?)

Trace the origin...

Which norm most supports clinical excellence — and which most undermines it?

Name both honestly...

Set Your Baseline

Take the Team Norm Dimensions Self-Assessment now as your baseline. On Day 10 you will return to it and see how far your thinking has shifted.

Carry Forward

One thing from today I am carrying into how I lead or participate on my team:

A single insight, intention, or commitment to act on...

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Part 4 · Day 2 · The Safety Dimension

DAY 2 OF 10 · SAFETY

Psychological safety as the foundation of high-performing teams

Today's Reading

Google's Project Aristotle — one of the most rigorous studies of team effectiveness ever conducted — found that the single most important factor distinguishing high-performing teams from lower-performing ones was not talent, experience, or intelligence. It was psychological safety: the shared belief that the team is a place where it is safe to take interpersonal risks. To speak up without fear of ridicule. To admit uncertainty without being seen as incompetent. To disagree without damaging the relationship.

In SUD treatment, the stakes of low psychological safety are unusually high. Clinicians who do not feel safe to bring a difficult case, name a clinical mistake, or express a concern about a colleague's practice are silently carrying risk that supervision and peer consultation exist precisely to manage. The cases that most need to be discussed — the one that is keeping you up at night, the one where you are not sure what you missed — are the exact cases that get withheld when safety is low.

Psychological safety is not niceness. Safe teams argue, disagree, and hold each other accountable. What makes them safe is that the disagreement does not damage relationships, the accountability is focused on learning rather than blame, and the vulnerability of admitting a mistake is met with curiosity rather than judgment. The leader's response to the first significant mistake sets the entire team's expectation of safety — more than any policy, value statement, or orientation session.

Today you examine the actual safety level on your team — not the espoused value, but the lived reality. What does a clinician on your team actually believe will happen if they bring their hardest client, their most significant doubt, their most uncomfortable clinical reaction into the room?

Reflect

1. On a scale of 1 to 10, how psychologically safe does your team actually feel — not how safe you believe it is, but how safe the most junior or most vulnerable member experiences it? What drives that number?

2. What would a clinician on your team need to believe about the response they would receive before they brought a clinical mistake or a genuine struggle into supervision or peer consultation?

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3. Name one specific moment in the last six months that either built or eroded psychological safety on your team. What did it teach people about what is safe here?

Today's Work

Apply today's dimension to your actual team — what do you observe?

Specific, honest, grounded in real behavior patterns...

One norm you want to build or change in this dimension:

State it behaviorally — what would it look like in practice...

Who on your team most models this dimension well — and what can you learn from them?

Name the person and the specific behavior...

Carry Forward

One thing from today I am carrying into how I lead or participate on my team:

A single insight, intention, or commitment to act on...

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Part 5 · Day 3 · How We Talk to Each Other

DAY 3 OF 10 · COMMUNICATION

Communication norms: what gets said, what gets suppressed, and what leaks out sideways

Today's Reading

Communication norms govern more than what is said. They govern who speaks first in meetings, whose concerns get weight, how disagreement is handled, whether difficult feedback is delivered directly or avoided until it becomes a formal complaint, and whether conflict is addressed or simply transferred into eye-rolls, side conversations, and the quiet withdrawal of engagement that erodes team morale without a single documented incident.

The most common communication failure on clinical teams is not conflict — it is its absence. Teams that cannot fight productively tend to store tension until it explodes in ways that damage relationships permanently, or they perform harmony on the surface while real concerns circulate in the hallways, the parking lot, and the group texts. The price of not being able to say the difficult thing directly is that the difficult thing gets said everywhere except where it could actually be resolved.

Feedback norms are a subset of communication that deserve particular attention. Does your team give honest, direct feedback to peers when clinical work is concerning? Or is feedback the supervisor's exclusive responsibility, leaving colleagues to watch and worry in silence? Does feedback land as information, or as personal attack — and does the answer depend on who is giving it and who is receiving it? And how does your team handle the clinician whose communication style has become a source of collective anxiety that no one has ever addressed with them directly?

Today you map your team's actual communication patterns — not the ideal, but the real. Where does honest communication flow freely? Where does it pool and stagnate? And where are the conversations that need to happen and are not?

Reflect

1. Where on your team does communication most consistently break down — between specific people, in specific contexts, around specific topics? What makes those conversations difficult?

2. What is the most important conversation currently not happening on your team — the one that everyone knows needs to happen and no one is having?

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3. How does feedback work on your team: is it mutual and peer-driven, or is it primarily top-down? What is the cost of that pattern for clinical quality?

Today's Work

Apply today's dimension to your actual team — what do you observe?

Specific, honest, grounded in real behavior patterns...

One norm you want to build or change in this dimension:

State it behaviorally — what would it look like in practice...

Who on your team most models this dimension well — and what can you learn from them?

Name the person and the specific behavior...

Carry Forward

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Part 6 · Day 4 · The Accountability Dimension

DAY 4 OF 10 · ACCOUNTABILITY

Holding standards without blame — and what happens when they slip

Today's Reading

Accountability is perhaps the most misunderstood dimension of team norms. In teams with low psychological safety, accountability becomes blame: a punitive process that teaches people to hide errors, minimize problems, and perform competence rather than develop it. In teams with high psychological safety, accountability is a growth mechanism — a shared commitment to standards that everyone has genuinely agreed to and that everyone participates in maintaining.

The distinction matters enormously in SUD treatment. A team that can say "that clinical decision concerns me — can we talk through the reasoning?" is a team that catches problems early, develops clinicians through peer learning, and maintains quality without depending entirely on the supervisor to notice everything. A team that cannot have that conversation — because it feels like betrayal, or because the culture has taught people that raising concerns gets you labeled as difficult — is a team that silently accumulates risk.

Accountability also has a self-directed dimension. The clinician who holds themselves accountable — who brings mistakes into supervision voluntarily, who seeks feedback on their own practice rather than waiting to be evaluated — is practicing the same discipline that recovery asks of the clients they serve. Recovery is built on rigorous self-honesty. Clinical practice at its best is too.

The hardest accountability conversations are not about documented failures. They are about the slow drift: the clinician whose documentation has gotten consistently late, the team member whose attitude in meetings has shifted from engaged to dismissive, the patterns that everyone notices and no one names until they have become so entrenched that addressing them feels enormous. Today you look at how accountability actually works on your team — who holds it, who avoids it, and what the implicit message is when standards slip without consequence.

Reflect

1. When a standard slips on your team — documentation quality, clinical expectations, meeting engagement — what actually happens? Who says something, and to whom? What is the typical outcome?

2. Is there a current drift on your team that everyone is aware of and no one has directly addressed? What is the cost of that silence?

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3. What would change in your practice and your team's functioning if accountability were genuinely mutual — a shared peer responsibility rather than exclusively a supervisory one?

Today's Work

Apply today's dimension to your actual team — what do you observe?

Specific, honest, grounded in real behavior patterns...

One norm you want to build or change in this dimension:

State it behaviorally — what would it look like in practice...

Who on your team most models this dimension well — and what can you learn from them?

Name the person and the specific behavior...

Carry Forward

One thing from today I am carrying into how I lead or participate on my team:

A single insight, intention, or commitment to act on...

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Part 7 · Day 5 · The Belonging Dimension

DAY 5 OF 10 · BELONGING

Who feels at home here — and who does not

Today's Reading

Belonging is the experience of being genuinely included — not tolerated, not accommodated, but actually valued as a full member of the team whose perspective matters and whose presence changes what the team can do. It is distinct from mere presence on the team roster. A clinician can attend every meeting, complete every required task, and never truly belong to the team — because belonging is relational, not administrative.

In diverse clinical teams — and SUD and mental health treatment teams are often diverse in age, background, credential, race, recovery status, and clinical philosophy — belonging is not automatic. The norms that govern who speaks most in meetings, whose ideas get built on versus ignored, whose concerns are taken seriously versus deflected, and whose cultural knowledge is considered relevant clinical data determine who actually belongs on that team beyond their technical employment.

Belonging has a direct connection to clinical quality. Clinicians who feel genuinely valued bring more of themselves to the work. They raise concerns rather than suppress them. They contribute ideas. They stay. The inverse is also true: clinicians who feel like outsiders on their own team are less effective, more likely to leave, and more likely to transfer their disconnection — subtly, invisibly — into the therapeutic relationships they hold.

The peer specialist, the youngest clinician, the staff member from a different cultural background, the person in recovery on a team that has mixed views about hiring in recovery — today you look honestly at whether belonging is equally distributed on your team, and what the norms are that make it more or less available to different people.

Reflect

1. Who on your team most fully belongs — feels genuinely valued, heard, and included — and who is least likely to experience that? What makes the difference?

2. Where do your team's norms around belonging serve some members better than others? What cultural, demographic, or credential-based dynamics are at play?

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3. If a peer specialist or a clinician in early recovery joined your team tomorrow, what would the actual experience of belonging look and feel like for them in the first 90 days?

Today's Work

Apply today's dimension to your actual team — what do you observe?

Specific, honest, grounded in real behavior patterns...

One norm you want to build or change in this dimension:

State it behaviorally — what would it look like in practice...

Who on your team most models this dimension well — and what can you learn from them?

Name the person and the specific behavior...

Carry Forward

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A single insight, intention, or commitment to act on...

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Part 8 · Day 6 · Fighting Well

DAY 6 OF 10 · CONFLICT

Productive conflict as a team competency — not a failure

Today's Reading

The goal of a high-functioning team is not the absence of conflict. It is the ability to fight well — to surface disagreement, work through it productively, and remain relational throughout. Teams that cannot have direct, honest conflict are not conflict-free; they are conflict-avoidant, which is something very different. The suppressed disagreement does not disappear. It goes underground, where it is far more corrosive than a direct conversation would have been.

Conflict on clinical teams typically concentrates in a few predictable areas: philosophical disagreements about treatment approach, workload distribution and perceived fairness, communication and personality friction between specific individuals, and values conflicts — disagreements not just about what to do but about what matters. Each type requires different handling, and none of them resolves itself.

The team norm around conflict is one of the most important — and most difficult to change. Teams that have learned to avoid direct conflict are often not aware of how much emotional energy goes into maintaining the avoidance: the careful navigation of specific topics, the alliances and exclusions that manage tension without addressing it, the leader who privately mediates the conflict between two clinicians rather than helping them resolve it together.

Fighting well requires a specific set of skills: the ability to name a concern directly rather than circuitously, to focus on behavior and impact rather than character and motive, to hear a challenge without becoming defensive, and to stay in relationship while in disagreement. These are the same skills that effective clinical work requires — and they can be built, practiced, and normed into the culture of a team that chooses to prioritize them.

Reflect

1. Describe the last direct conflict on your team that was addressed productively — worked through, resolved, and strengthened the relationship. What made that possible?

2. Where is unresolved conflict currently running silently on your team — in avoidances, alliances, or the way certain topics are never raised in certain rooms?

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3. What would your team need to believe about safety and repair in order to surface the conflict it is currently managing by avoiding?

Today's Work

Apply today's dimension to your actual team — what do you observe?

Specific, honest, grounded in real behavior patterns...

One norm you want to build or change in this dimension:

State it behaviorally — what would it look like in practice...

Who on your team most models this dimension well — and what can you learn from them?

Name the person and the specific behavior...

Carry Forward

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A single insight, intention, or commitment to act on...

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Part 9 · Day 7 · The Mission Dimension

DAY 7 OF 10 · PURPOSE

Shared purpose as the anchor for team norms and decisions

Today's Reading

Teams that are anchored in a clear, shared sense of clinical purpose navigate norm disputes more easily than teams that are not — because they have a reference point that is larger than any individual preference. When the question is not "who gets their way" but "what serves the people we are here to help," the conversation changes. Not always easily, but fundamentally.

Mission alignment is more than a shared value statement. It is the daily experience of understanding why the work matters, feeling connected to that meaning, and having that sense of purpose reinforced rather than eroded by the organizational context you are working in. In settings with high initiative fatigue, administrative burden, or chronic underfunding, the connection to mission is among the most important things a team can protect — because it is one of the strongest buffers against burnout and the cynicism that follows.

Purpose also functions as a norm-setter. A team that has genuinely shared clarity about what it stands for clinically — what excellent treatment looks like, what it owes to the people it serves, how it wants to show up — can evaluate proposed changes, competing priorities, and difficult decisions against that shared standard. Without that anchor, decisions about norms tend to be driven by whoever has the most social capital in that moment, which is a considerably less reliable process.

Today you look at how connected your team is to its clinical mission — not the words on the wall, but the living sense of shared purpose that shows up in how people make decisions, support each other, and talk about the work on hard days.

Reflect

1. When your team is at its best — most energized, most aligned, most clinically effective — what is the shared sense of purpose that is most alive in that moment?

2. What organizational conditions most erode your team's connection to clinical mission? What does the team do to protect that connection?

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3. If your team's shared purpose were an explicit team norm — "this is what we stand for and how we make decisions" — what would it say, and how consistently would it actually guide team behavior?

Today's Work

Apply today's dimension to your actual team — what do you observe?

Specific, honest, grounded in real behavior patterns...

One norm you want to build or change in this dimension:

State it behaviorally — what would it look like in practice...

Who on your team most models this dimension well — and what can you learn from them?

Name the person and the specific behavior...

Carry Forward

One thing from today I am carrying into how I lead or participate on my team:

A single insight, intention, or commitment to act on...

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Part 10 · Day 8 · The Learning Dimension

DAY 8 OF 10 · GROWTH

Teams that grow together versus teams that stagnate separately

Today's Reading

Learning culture is a team norm, not an individual trait. Some teams have a shared expectation of ongoing development — that everyone is always learning, that clinical uncertainty is normal and discussable, that a challenging case is an opportunity for collective growth rather than an individual burden to manage in private. Other teams have a norm of performed competence — where knowing is valued and not-knowing is risky, where seeking consultation can feel like admission of inadequacy, and where professional development is an HR requirement rather than a genuine priority.

The difference matters enormously for clinical quality. In a learning culture, the clinician who encounters a presentation they have not seen before brings it to consultation. The one who makes an error learns from it in a supported environment. The newest member of the team contributes knowledge that longer-tenured colleagues do not have. In a performed-competence culture, the same clinician manages the unfamiliar case alone, minimizes the error, and the team's collective knowledge fails to grow.

Learning culture is also closely linked to resilience. Teams that routinely debrief hard events — patient losses, crises, organizational changes — integrate those experiences rather than absorbing them in silence. They develop a shared understanding of what they have been through and what it means, which both protects against collective trauma and builds the identity that sustains the team through future difficulty.

Today you look at the learning norms on your team: what gets learned together, what stays private, what the culture says about uncertainty and growth, and what would change if learning were genuinely a shared team practice rather than an individual responsibility.

Reflect

1. When a clinician on your team encounters a challenging case or makes a significant error, what actually happens? Where do they take it — and does that support their learning and protect their patients?

2. How does your team debrief hard events: patient losses, crises, organizational upheaval? Or does it not? What is the cost of that pattern?

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3. What would a genuine learning culture look like on your team — specifically, what norms would need to be different from what exists now?

Today's Work

Apply today's dimension to your actual team — what do you observe?

Specific, honest, grounded in real behavior patterns...

One norm you want to build or change in this dimension:

State it behaviorally — what would it look like in practice...

Who on your team most models this dimension well — and what can you learn from them?

Name the person and the specific behavior...

Carry Forward

One thing from today I am carrying into how I lead or participate on my team:

A single insight, intention, or commitment to act on...

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Part 11 · Day 9 · Your Team's Norm Profile

DAY 9 OF 10 · DIMENSIONS

Mapping where norms are working and where they need redesign

Today's Reading

Over the past eight days you have examined your team through eight dimensions of team norms: safety, communication, accountability, belonging, conflict, purpose, and learning. Each dimension has its own norm profile — the unwritten rules that govern how that dimension functions on your specific team. And each dimension interacts with the others: low safety erodes communication, which undermines accountability, which weakens belonging, which increases conflict avoidance, which disconnects the team from purpose, which slows learning.

The value of this framework is not just diagnostic — identifying what is broken — but design-oriented. Norms can be changed. Not easily, not quickly, and not through announcement alone. But through consistent, deliberate practice by enough members of the team, over enough time, with enough reinforcement, norms do shift. The team that was unsafe becomes safer. The team that avoided conflict learns to fight well. The team that had no shared language for accountability develops one.

Norm change follows a recognizable pattern. It begins with naming — making the invisible visible, often for the first time. It continues with commitment — a shared decision to build a different norm, with enough specificity to be actionable. It requires practice — repeated new behavior in the real conditions of clinical work, not just in a training room. And it needs reinforcement — the leader and peer modeling that catches the old norm reasserting itself and redirects toward the new one without shaming the person who slipped.

Today you build your team's norm profile across all eight dimensions — honestly, specifically, and with an eye toward what you most want to change.

Reflect

1. Across all eight dimensions, which is your team's greatest strength — the norm that most consistently serves clinical mission and team wellbeing?

2. Which dimension is most urgently in need of redesign — where the current norm is most actively harming clinical quality, team health, or both?

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3. If you could change one norm on your team in the next 90 days, and that one change would have the greatest positive ripple effect on everything else, what would it be?

Today's Work

Your Team Norm Profile

Rate your team across all five norm dimensions. Be honest — not about the team you want, but the team you actually have. This map becomes the foundation for your Day 10 redesign plan.

Psychological Safety

Current norm (what actually happens):

Describe the real behavior pattern, not the aspiration...

Impact on clinical mission and team wellbeing:

How does this norm help or hurt?

The norm you want to build in this dimension:

Specific, behavioral, practiced — not a value statement...

Communication & Feedback

Current norm (what actually happens):

Describe the real behavior pattern, not the aspiration...

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Impact on clinical mission and team wellbeing:

How does this norm help or hurt?

The norm you want to build in this dimension:

Specific, behavioral, practiced — not a value statement...

Accountability & Standards

Current norm (what actually happens):

Describe the real behavior pattern, not the aspiration...

Impact on clinical mission and team wellbeing:

How does this norm help or hurt?

The norm you want to build in this dimension:

Specific, behavioral, practiced — not a value statement...

Belonging & Inclusion

Current norm (what actually happens):

Describe the real behavior pattern, not the aspiration...

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Impact on clinical mission and team wellbeing:

How does this norm help or hurt?

The norm you want to build in this dimension:

Specific, behavioral, practiced — not a value statement...

Shared Purpose & Learning

Current norm (what actually happens):

Describe the real behavior pattern, not the aspiration...

Impact on clinical mission and team wellbeing:

How does this norm help or hurt?

The norm you want to build in this dimension:

Specific, behavioral, practiced — not a value statement...

The single norm change that would most improve your team's functioning overall:

Be specific about what would change, for whom, and what the impact would be...

Carry Forward

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One thing from today I am carrying into how I lead or participate on my team:

A single insight, intention, or commitment to act on...

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Part 12 · Day 10 · Building the Team You Want

DAY 10 OF 10 · INTEGRATION

From diagnosis to design — a norm-building plan

Today's Reading

This is the final day of the pathway and the first day of the actual work. Everything up to here has been diagnosis — developing an honest, specific, multi-dimensional picture of the norms actually running your team. That diagnosis is valuable. But diagnosis without design is just a clear picture of a problem without a path toward anything different.

Norm-building is one of the most underused levers in clinical team leadership. Leaders invest heavily in skills training, workflow improvement, and organizational systems — all important. But the invisible architecture of how people treat each other, what they say and do not say, what is safe and what is risky — the norm structure — often goes unexamined while leaders wonder why their other investments are not producing the culture they want.

Designing new norms requires specificity. Not "we will communicate better" but "in this team, we commit to addressing concerns directly with the person involved within 48 hours rather than routing them through a third party." Not "we will be more accountable" but "in this team, when a documentation standard is missed, the expectation is that the team member addresses it in the next supervision session and identifies what support they need." The more specific the norm, the more it can be practiced, reinforced, and tracked.

It also requires realism. You cannot change every norm at once. The team that tries to redesign its entire culture simultaneously usually ends up overwhelming people and reverting to every prior norm. One or two norms, practiced consistently, reinforced visibly, and given enough time to become automatic — that is how cultures change. Today you name them, commit to them, and design the first practical steps toward the team you are capable of being.

Reflect

1. Looking back across these ten days, what is the single most important thing you have seen about the norms running your team that you could not have articulated before?

2. What specific norm do you commit to building or changing in the next 90 days — stated specifically enough to be practiced and measured?

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3. Who on your team needs to be part of this norm redesign, and how will you bring them into it? What is your first concrete step in the next week?

Today's Work

Step 1: The Honest Diagnosis

The norm currently doing the most damage on my team:

Name it precisely...

The norm currently doing the most good that I want to protect and reinforce:

Name it precisely...

The most important thing I learned across these ten days:

What shifted in how you see your team?

Step 2: The Redesign Commitment

Specificity Is Everything

Not 'we will communicate better' but what specifically will change, when, how, and who will model it. The more concrete the norm, the more it can be practiced and reinforced.

The specific norm I commit to building or changing in the next 90 days (state it behaviorally):

In this team, we will... / In this team, when X happens, we will...

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Who needs to be part of building this norm — and how will I bring them in?

The people, the conversations, the process...

What will practicing this norm look like in the first two weeks — specifically?

First concrete actions...

How will I know it is taking hold? What will be observable?

Specific indicators...

Step 3: Team Norm Charter Draft

Write It to Be Used, Not Framed

A norm charter is a living document. The best ones are short, specific, and owned by the team. Draft it as something you would actually return to in a difficult moment — not a values statement but a behavioral agreement.

My Team Norm Charter Draft:

On this team, we commit to... We will... When conflict arises, we... When a standard slips, we... We hold each other to...

Bring this draft to your team. A charter written alone is a memo; co-created with the team, it becomes an agreement.

Revisit Your Baseline

You set your baseline on Day 1. Return to it now and see how your assessment of your team has shifted through ten days of honest examination.

Carry Forward

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One thing from today I am carrying into how I lead or participate on my team:

A single insight, intention, or commitment to act on...

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