Learning from mistakes in social work

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Figure 1. Effects of reflecting on mistake.

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Figure 2. Reason’s Swiss Cheese Model (Adapted from Reason, 1990).

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Learning from mistakes in social work

A growing number of cases of professional errors in the realm of health and social services appears on media and raises significant public debate. This article focuses on mistakes in social work and looks at how their negative impact can be reduced through the lens and framework of reflective practice.

Using conclusions from the most relevant literature on this topic and some of the outcomes of recent research, the author describes errors in social work in terms of causes (e.g. lack of time and training, etc.) and results (e.g. damaged relationship with users, failure of action plans, burnout, etc.). Learning occurs when social workers conduct an in-depth reflection, alone or together with colleagues. Since human beings will always err paradoxically reflection on mistakes (with the consequent drop in the harm produced) and not the reduction of their number is the most powerful factor to improve the quality of health and social services. The culture of blame and punishment is one of the main obstacles to an effective social work animated by the true genuine culture of responsibility and driven by the welfare interest of service users.

Keywords: reflective practice; mistake; error prevention system; risk management; shame

Introduction: why reflect on mistakes

The purpose of this article is to highlight the importance of reflective practice and learning from mistakes in social work. Reflective practitioners work in contexts with a high degree of uncertainty and instability, but nevertheless their professional activity is a continuous challenge to fulfill functions and tasks effectively using knowledge and skills constantly improved by structured reflection. The circular sequence of Experience, Reflection, Action, summarised by the acronym ERA, describes reflective practice as a never-ending cycle where different perspectives arising from in-depth understanding of past events give new direction to further and more effective actions (Jaeger, 2003).
Events do not talk by themselves and reflection is the only way to learn from experience. As John Dewey (1933, p. 78) wrote, ‘we do not learn from experience [...] we learn from reflecting on experience’. Reflection ‘involves not simply a sequence of ideas, but a consequence - consecutive ordering in such a way that each determines the next as its proper outcome, while each in turn leans back on its predecessors’ (Dewey, 1910, pp. 2 - 3). The literature on reflection and reflective practice has widened considerably. There are many definitions and even reviews of definitions, also wider reference to specific fields such as for example, social work, education, nursing and other disciplines for the health and social professions (among many: Bolton, 2010; Bulman, 2004; Fook, 2006; Bruce, 2013; Fook, Fung, Huisman, & Chen, 2014; Taylor, 2010; Thompson and Thompson, 2008).

Any event may start this mental process: the first case dealt with in childcare, elderly care or any other field, a success, a failure or any other episode of personal or professional life. However, when something goes wrong there is inevitably the first reaction, a stronger pressure to understand what happened and answer questions like: why? what did I do wrong? what is the meaning of this? On the other hand, an unexpected success does not motivate reflection as much. It gives satisfaction and contentment but soon the attention flies away in other directions. Significant errors or mistakes, on the contrary, are always likely to urge and encourage the search for reasons why something went wrong does not fade away until a satisfactory explanation and some learning for the future are found. In other words, the need to exit from the state of uncertainty produced by a mistake is the most powerful factor guiding the entire process of reflection. When uncertainty is highlighted personal limits, competencies as well as vulnerabilities and weaknesses are forced and involved in responsibility. Some essential factors are the ones guided by the reconstructing principle.
Being wrong is often an unpleasant emotional experience, but it may lead to a productive tension to maximise learning and minimise harm. Figure 1 helps to illustrate this process graphically. It combines learning and harm as outcomes of mistakes and shows different settings of consequences of reflection on mistakes. The horizontal line describes the intensity of harm produced and the vertical one the extent of learning. The four quadrants created by the intersection of the two lines highlight four categories, namely mistakes with:

1. maximum learning and harm;
2. maximum harm and minimum learning, that is the less desirable situation;
3. minimum learning and harm;
4. minimum harm and maximum learning, that is the most desirable form of error, the one where continuous reflection on professional experience should move push the great majority of mistakes.

Figure 1 highlights also the significant deep connection between reflection, discovery and learning in reducing the risk of harm to service users in social work. Every piece of exploration is essential because simple and one-dimensional answers to the challenges of perceived reality may be reassuring in the short term, but soon clash with the complexity of the lived reality of social work and become useless, if not counterproductive. Scapegoats are invariably sought, but this is a dangerous pursuit because it diverts attention and tends to disempower prevention measures and risk management systems. As the analysis of human error in complex organisations shows,
any failure or ‘bad’ accident is the product of a concatenation of factors or, in other
words, the combination of latent failures not immediately evident (Reason, 1990).

However, things are even more complex. Who decides what is wrong and what
is not? Social workers, of course, but also their organisations, their service users, social
policy makers, sometimes even judges or society as a whole. In fact, there are
occasions when those involved are not unanimous in ascribing, determining, the results
as good or bad (and to what degree). Moreover social workers might fully meet the
standards of what is generally considered to be good practice, but nonetheless fail to
achieve what is widely viewed as a good case outcome. How to define mistakes? Not all
tragic outcomes are the result of mistakes but of events and behaviours that cannot be
predicted. Others, of course, are the result of actions or inactions by individuals or
more often a collection of individuals and agencies. In social work, relevant mistakes
accrue because of actions originating in some deficiency in assessment or knowledge and
effecting helping process and people involved (service users, other workers, etc.).

Starting from the thoughts expressed above the next four sections try to guide
readers towards some possible answers to questions like: why reflection on mistakes
is more effective in improving the quality of social work practice? What are the
main facilitators of and obstacles to this form of reflection? And, finally, which
strategies and tools are more successful?

Towards a profile of mistakes in social work

There are errors and professional errors. Reason (1990) defines error as ‘a generic term
to encompass all those occasions in which a planned programme of mental or physical
activity fails to achieve its intended outcome, and when those failures cannot be
attributed to the intervention of some change agency’. He also describes mistakes
as deficiencies or failures in the judgemental and/or inferential processes involved in the selection of an objective or in the specification of the means to achieve it, irrespective of whether or not the actions directed by this decision-scheme run according to the plan (Reason, 1990, p. 9).

He also identifies two forms of errors: errors in execution (I thought well, but I did wrong) and errors in planning or in problem solving (I did well, but I thought wrong). Professional errors are just one of the many possible classifications and, according to Reamer (2008, p. 62), occur ‘when practitioners depart from widely accepted standards and best practices in the profession’.

Intention, competence, harm and learning are four important dimensions to consider when analysing an error in social work, as there are any intention to do that action and/or produce the outcome obtained from the intervention? Did the social worker have the knowledge, skills or experience to do what she/he was doing? Could she/he have done things differently? Was someone harmed? What might possibly be done from the error? Different answers open up totally different scenarios on the identification and management of professional errors. In fact, since reflection is a process nurtured by questions, the better and more focused the latter are, the deeper the understanding and the more effective the consequent practice can be. Any reflective tool, like the one proposed in this article, is fundamentally a system of “smart” questions aiming at shedding new light on the circumstances that led to mistakes and the consequences of the latter.

The material collected over the last decade and aptly included here helps to draw up a representative profile of mistakes in social work and has two sources. Quotations from SW1 to SW6, as well as SW10, come from explorative research carried out in semi-structured and in-depth interviews.
in questions about causes and effects of mistakes, their stories of personal errors and 
reactions to colleagues’ errors (Author’s own, 2010). Quotations from SW7 to SW9 
derive from the application of the ‘SMS technique’ during workshops on mistakes and 
reflective practice with hundreds of social workers in different countries (Italy, 
Portugal, UK, India, South Africa). This technique is a form of reflective writing used 
to describe mistakes where only 160 characters are used, that is the length of a Short 
Message Service or Mobile Phone “text” communication. These very brief accounts of 
professional mistakes are generated after the use of reflective frameworks (like the one 
described in the next section) and “coerce” social workers to find the essence of the 
episode and the learning that can derive from it. This activity aims to make social 
worker experience an accessible and innovative form of reflection on mistakes and 
debate about it with the other social workers attending the workshop. At the same time, 
these 160-character accounts generate data providing an extraordinary opportunity 
to study mistakes in social work. Reflectivity and qualitative research are profoundly 
connected in literature (Engel & Schutt, 2016) and personal and professional narratives 
are recognized as valuable methods of research for enhancing theory and knowledge 
about practice in social work (Gilgun, 2014). Even though they are brief, every account 
such as the ‘SMS’ technique may be treated as a case study, more precisely a ‘local 
knowledge case’ described by Thomas (2011, p. 77) as ‘an example of something in 
your personal experience about which you want to find more’. They are miniature 
forms of account that are really on the nature of complex events, as bonsai have 
plentiful and well formed branches and leaves like other trees of their species, but just at 
much smaller scale. And some workshops on mistakes and reflective practice with 
hundreds of social workers in different countries (Italy, Portugal, UK, India, South 
Africa) helps to draw up a profile of mistakes in social work.
These textual accounts and the semi-structured and in-depth interviews mentioned
before a form of semi-structured interviews can capture and bring out views and
thoughts of personal reactions and responses to colleagues' errors and from the application
of the SMS technique (a form of reflective writing used to describe mistakes with only
160 characters, that is the length of a Short Message Service when this way of
communication by mobile phone was using popular in both rich sources to explore and
explore evidence and try to help to answer some of the basic
questions.

First of all, what is a mistake in social work? A mistake is any event
producing some kind of harm or loss of opportunity to the service user, that is, in other
words, any failure of the project of intervention and any happening causing some
deterioration in the relationship between user and social worker but also the welfare
system as a whole. Two social workers said:

SW1: The main effect is the failure to meet appreciable results. Social workers
work to change situations. Together with their service users, they change
situations, hoping to make them better. That is, they do not want to keep the
existing situation unless this is the objective of the project. So the bad negative
effects are either you do not get any change, or you get the opposite

SW2: A smaller, more immediate, effect is the lack of confidence in the services
and public institutions. That is, basically, the change of perception of the user
that in some way, the social worker is not a figure in the system. Then there are perceptions of injustice, which somehow depend
on the relationship developed by people in the organization providing
services. So, if it is not sufficiently justified and explained, a decision can
determine feelings of distrust of inability, receiving help, or even
of injustice.

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Relationships can be both causes and effects of mistakes in social work. Behaving like a friend or, on the contrary, like a cold bureaucrat (just to mention two extremes) can threaten to derail the whole helping process.

SW3: Surely some mistakes in my field are relational, that is how you connect with people. Because as a consequence of the relationship you establish with the people, with their network, in cases then you get the results or not. Your relational skills are very important. As a consequence, many errors derive from unprofessionalism and from the way you set the initial contact. For example, when you try to establish a kind of a friendship or a cold and distant link.

Ultimately another form of relational harm is to the social workers and their competence and professionalism itself. Misses often have a negative impact on social workers to enter into a stress spiral of mistakes–stress–mistakes or alternatively of stress–mistakes–stress. This happens because the regulatory framework is rigid and unable to adapt to the real needs of the people; there might also be conflicting interests, within the individual social worker, a workload that does not harmonize well with the service users’ wellbeing. This introduces another basic question: what are the main causes of the mistakes made in social work? The most common answers are (Author’s own, 2010):

- **The need for urgent resolutions** and too much work (lack of time);
• inadequate relationship with the user (as already highlighted) or with colleagues;
• inadequate organisation, ineffective management and procedures;
• psychological factors (like lack of attention and/or anxiety), action without reflection and cognitive patterns that hinder a proper assessment of the situation;
• ineffective or lack of relevant training.

Time constraints and poor organisation are often pointed to as responsible for negative outcomes in health and social services:

SW5: So many times mistakes come from the fact that practitioners don’t have enough time to think how to do better; then they don’t have time to discuss with your colleagues or to have supervision on difficult cases. We are always in a hurry, under pressure of the cases and situations that we often do not have enough time to search what is the best thing to do. These circumstances can give rise to a lot of mistakes.

Organisations are often pointed to as responsible for negative outcomes in health and social services:

SW6: Poor and bad organisation… So many errors are dependent not so much on the worker himself/herself, but on the fact that services are organised badly, poorly for a variety of reasons and dysfunctional organisations are error prone.

As highlighted in some of the evidence given by social workers in describing their mistakes, assessment is another major area where many errors occur. Sometimes information is taken for granted and other evidence is not considered because the complexity of the case is underestimated and the related risks
are not fully considered. So social workers may look only for data confirming their first hypothesis, as in the following case:
SW7: Alcoholic and maltreating parents of three children. Attempted but failed construction of support networks. Do not underestimate the data of reality and do not select data that only confirm the possibility of recovery.

As Forbes et al (2014, p.12) highlight when they describe ordinary decision processes:

Since it is rare for us to seek disruptive or negatory (sic) evidence regarding our current beliefs for many decisions 'what we see is all there is'. Such a reluctance to search out broader information set can be seen to underlie three common cognitive biases:

• overconfidence deriving from an inability to accept others know more,
• framing, in accepting how information is wrapped prior to our use of it,
• base-rate neglect, deriving from a reluctance to accept how similar we all are.

The variety diversity of mistakes in every field of human activity are just some examples of what factors can influence the decision making process, as highlighted by the following applications of the SMS technique:

SW8: Perhaps unexpectedly, members of family X become three. I did not reflect enough. How not to forget parts of the network and all the important elements in the situation?

SW9: I called a colleague to cancel an appointment and to agree on further action. I did not realise that the user was there. Do not treat delicate situations in overload conditions!
Being focused on mistakes: what helps and what discourages

The main reason to choose professional mistakes as a focus for reflection and learning has been already highlighted in the introduction: when something goes wrong there is inevitably strong pressure to find a satisfactory explanation for what happened in order to avoid the risk of the same thing happening in the future. This form of reflection has other advantages, but also some factors that militate against it. Among them, there are, in the first group, the need to innovate and explore new paths, the the reduction of pressures to reduce the high cost of safety and the opportunity to discover latent errors; in the second, most of all shame and guilt (very often felt by people thinking only they are responsible when something goes wrong), as well as the fear, felt by practitioners and their managers, of being blamed and made a scapegoat when something bad happens.

First of all, when previous attempts at using ordinary traditional strategies and tools have failed, in many situations it is necessary to stray from the usual path and look for innovative and effective solutions. Exploration and experimentation are sometimes needed, even taking some risks, but with eyes wide open for the opportunities coming from mistakes in order to balance service user protection and social worker’s learning.

These ‘smart mistakes’, as described by Penn and Sastry (2014: 2), have to be ‘small-scale, reversible, informative, linked to broader goals and designed to illuminate key issues’. This search process may be more productive if based on similar instructions: ‘first, seek out new ideas and try new things; second, when trying something new, do it on a scale where failure is survivable; third, seek out feedback and learn from your mistakes as you go along’ (Harford, 2011, pp. 79-80).
situations. Verbal and non-verbal feedback from service users produces more precise
conjectures that, in their turn, are verified in a continuous circular process of
interactions, much as several initial hypotheses are discovered to be helpful
in new ways. (Campanini, 2007).

It is also important to distinguish minor mistakes from major
mistakes. In every field of human activity, the former are often an inevitable
part of any intervention in a complex context and well regarded in the latter. These can sometimes
lead to destructive and grave consequences. Everybody has
the responsibility to know where the line between the two forms of mistakes
are considered very carefully the available options and, only in the most extreme
cases when there are no other choices, undertake a risk laden intervention, but
only after assessing the risk and consulting everyone who might be affected (Tugend,
2011).

However, precautions to avoid harm should not make social work practioners
forget that security has also costs as well as benefits. The inescapable trade-off between
security and its costs and damage caused by mistakes is well described by Reason
(1990, p. 203):

all organisations have to allocate resources to two distinct goals: production and
security. In the long term, these are clearly compatible goals. But, given that all
resources are finite, there are likely to be many occasions on which there are short-
term conflicts of interest. Resources allocated to the pursuit of production could
diminish those available for safety; the converse is also true.

This bipolar dilemma, ‘production or safety’, is aggravated in those fields (like
social work) where the uncertainty of the outcomes is high because there are no
simple cause-effect relationships among the factors involved and where the ambiguity
of the feedback makes it harder to decide which of the two poles to favour. For example, the security of a social worker visiting a potentially aggressive family can be enhanced by a second social worker accompanying the first. But, in doing so the second one has less time to work on other cases. Time is definitely a limited resource.

Another positive effect of habitual reflection on mistakes is the possibility to detect latent errors before their effects are displayed. Some latent errors can even be lethal if ignored. For example, as it could be if a pilot would prefer not to check his airplane after bad noises are heard from the engine. Latent errors are different from active ones because their effects are not felt immediately but lie dormant for long periods and only become evident when combined with others factors (Reason, 1990). Paying attention to sentinel events or minor mistakes is vital in preventing catastrophic errors.

So, in the frame of appropriate error prevention systems, social workers should pay special attention to latent errors and risks, find immediate measures to repair and limit harm, and learn to prevent similar events in the future. This can be easier in those formal or informal error-prevention systems where there is a wide acceptance of the likelihood of mistakes: it is a fact of life and one does not always feel free to admit one made a mistake or one is not supposed to do.

A real acceptance of this principle defines the negative effects of shame, guilt and fear of being designated as a scapegoat. These are negative effects because they are obstacles to developing any in-depth and honest analysis of errors. It is rare to find literature on shame in social work. The phenomenon has been recently explored with [unpublished] service users in the context of how a more robust theoretical framework on shame and recognition could improve practice (Frost, 2016).
But what about social workers? How widespread is this emotion amongst them? Shame as a state of being is rare amongst social workers, but nevertheless, many could have experienced this feeling intensively during their career. Mechanisms of denial and self-defence often obstruct structured reflection and affect the quality of professional development, even if they could be considered natural reactions to any perceived lack of recognition and sense of inadequacy.

“[I made a mistake] is often a difficult sentence to pronounce, especially when blaming someone and looking for scapegoats are considered right things to do. Responsibility is much more effective than guilt as concept guiding to encourage an honest search for reflection led learning in order to prevent any harm caused by mistakes. Moreover, as magisterially described by the ‘Swiss cheese model’, adverse events, as any human affair, have never only one cause but they are always the results of intricate chains of events (Reason, 1990). Complex systems producing services or goods can be represented as a set of layers, one behind the other (Figure 2):

1. decision makers (for example, policy makers),
2. line management (related to operations, maintenance, training and, in general, implementation of the strategies defined at the previous level 1);
3. preconditions (skills, knowledge, attitudes and motivations of any workers involved in the process, environmental conditions, codes of practice, physical and psychological conditions, etc.);
4. productive activities (what happens in the ‘here and now’);
5. defences (any safeguards against foreseeable hazards like, for example, in social and health services an alarm system to activate in case of risk of aggression, or a colleague reading and double checking a report before sending it to the authority that has to decide on sensitive cases).
These layers may have one or more 'holes', which represent fallible decisions, deficiencies or unsafe acts. Only if all of the layers 'have' 'holes' in corresponding positions will the trajectory of a potential adverse event continue until its occurrence.

A hypothetical example could be thought of with regard to the growing and alarming phenomenon of the violence against older people. Policy makers in a period of economic crisis might decide to reduce the general expenditure on social welfare (decision makers). Consequently, managers in public agencies have to reduce the number of social workers and, consequently, the few left are so busy that they have no time to visit people at home. The social worker Anne, who is young and not so experienced, is informed about the broken leg of a 85-year-old woman named Mary who is reported to have fallen down stairs.

Anne is tired after a busy day (precondition) so she does not capture some incongruences in the story told by the woman’s daughter (who lives with her mother who heard the sound of the fall). She writes in her report that there is nothing worrying during this phone conversation (productive activities). Six months later, after another and even worse episode of a ‘fall’, the woman is brought to the hospital in such desperate conditions (bad outcome) that the police have to enter the house. They see that Mary’s living conditions are kept unsafe by her daughter who later, when the case is investigated more extensively, shows signs of mental problems.

If only Anne would have examined the house she would have noticed evidence of Mary’s neglect in the kitchen. The few experienced practitioners working with Anne were too busy working on their cases to help her to examine the situation in detail (defences).
Who is to blame for the lack of preventive action? Anne? Her colleagues? The managers? The policy makers? Mary’s daughter? None of them, or all of them? Each may have a small or bigger share of responsibility but none has all the ‘guilt’. Each had to make choices that he/she thought were the right ones for the problem at hand. Of course, it would be easy to find a “scapegoat” to blame, but this would not avoid similar future occurrences. A reflective framework for errors and failures

Reflection may be considered at three levels: personal, dyadic (one-to-one) and with a multiplicity of people in groups or even in organizations. ‘Smart questions’ are always the core of effective reflection because they enable and encourage probing and examining questions and lead to a search and questioning thinking in new directions and areas. In the case of dyadic reflections Taylor (2010) talks of ‘critical friends’ who do not criticise but offer external perspectives to extend reflective capacity in their reflection partners.

The quality of the questions determines the value and depth of reflection. ‘Smart questions’ may be described by questions practitioners may formulate: ‘smart questions’ or predefined sets of questions, like Gibb’s (1988) reflective cycle and other reflective frameworks created for an in-depth understanding of experience (Borton, 1970; Gould and Baldwin, 2004; Green, Lister and Crisp, 2012; Ingram, Funtowicz, & Judd, 2014; Jasper, 2003; Taylor, 2010; Thompson and Thompson, 2008).

The reflective framework displayed below is focused on errors and failures in social work and has been built by combining some of the concepts described in this article with some of the key questions in the above-mentioned frameworks (Author’s own, in press 2017).
1. DESCRIPTION

(1) What happened, where and when? Who was involved? Where were you? Who else was with you? Why were you there?
(2) What was the context of the event (e.g. routine or normal)?
(3) What were you doing? What were the other people doing?
(4) Which part in what happened did you play? Which part did the others play?
(5) What was the purpose of the intervention/challenge?
(6) What was the result?

2. FEELINGS

(1) What were your emotions (positive and negative) and thoughts immediately before the event started? During? After? Now?
(2) Were there physical reactions and symptoms associated with emotions?
(3) What were your feelings and your thoughts immediately before the event started? During? After? Now?
(4) At what point of the experience did you specifically start to feel each of these emotions, or were they present at the outset?
(5) Were there feelings or emotions that were present at the outset of the event or during the event that may have contributed and how?
(6) What did the words, the interventions, the challenges and the actions of other participants make you think? How did they make you feel?
(7) What did the other people involved in the event do, think and feel? How do you know this?

3. ASSESSMENT
1. What would you describe as positive and what might be described as negative in the experience?

2. Which specific parts of this event and the evidenced error/failure are most important for you?

3. What do you think specifically went wrong and what went right? For whom? According to which technical ideas or ethical principles?

4. Why did you interpret the situation in the way you interpreted it?

5. What other interpretations could there be?

6. ANALYSIS

1. Why did you behave like you did?

2. What were the consequences of your actions for yourself and for others involved?

3. What were your assumptions about this error/failure, held by yourself and others involved? What has shaped these assumptions?

4. In a very few words, how would you label this mistake? What more general failure is this error/failure a specific and concrete example of?

5. Had you made a similar error/failure in the past? When? How often? How is this different from the previous ones? What prevented you from putting a stop to the repetition of this kind of error/failure?

6. What chain of events led to the error/failure? What was the role of each of the following stages/levels?
top level decision makers (social policies, direction, resource allocation);

• line management (i.e. implementation by the executive level of the strategies defined at the above level);

• preconditions (motivations, physical and psychological conditions, equipment, etc.) of the subjects and factors directly involved in the implementation of social work services such as users, practitioners, material resources, etc.;

• productive activities (when the analysed event occurred);

• defence systems (among the issues to be included there is the image of social workers and their services, for example, which side in the social worker-patient relationship conflicts, control procedures, etc.).

5. CONCLUSION

(1) What factors caused the error/failure to happen? What are the three most important factors?

(2) How would this change if X (that is a change in one or more factors mentioned in the previous answer) happened? How would things be different if X had not happened? Given these changes, how different is X to a greater (or lesser) intensity?

(3) What needed to stop in order to fix the problem or for behaviour to change? What evidence do you have to consider these factors as relevant? How much can you eliminate or to what extent can you reduce the strength of these causal factors?

(4) If you could go back in time, what would you do differently?

(5) What could you have done differently? What would the result have been?

6. ACTION PLAN
What can you do differently next time you deal with a similar case?

What actions can be taken to prevent this error/failure in the future? When can you do this? What can you do right now? How will you know you have fixed the problem and the same mistake will not happen again?

What is the goal of improvement that you can choose? What steps should you take to reach your goal? Which resources do you need to achieve your goal? How long does it take for each of these stages? What will be the result of each of these stages? How could you put aside the things that prevent you from improving?

What have you learned from this experience? How has your understanding developed? How will you apply this new understanding in the future on another occasion? What more do you need to know and how do you plan to learn more? How can you apply new learning and strategies?

Two examples of use of this framework are proposed in Table 1 below. One example is an internal experience, told by a social worker who recently attended one of the workshops mentioned in the previous section: the other is a BA social work student reflecting on her field practice experiences in the article. In the first case, the participants in the workshop were divided into couples: one of the two had to ask the questions listed above and the other had to answer to reflect on a professional mistake made personally and then write a short summary. This is an application of the dyadic (one-to-one) reflection with a “reflective friend” mentioned at the beginning of this section. In the second case, the student wrote a more detailed reflective report that was later reduced to less than 500 words.
Four social workers from different services and I met to plan and coordinate our actions to support a child and his parents. We had to decide what happened after the previous and first meeting. After a brief update it was clear that only a few workers had done what was planned. Mutual recriminations started when the coordinator’s impatience detonated the underlying tension. The group even failed to agree a date for a third meeting. (Description)

I felt and still feel discomfort and devalued. I observed anger and mutual accusation in the group and this left a sense of frustration and failure because we were not able to transform the general annoyance into something constructive. (Feelings)

The negative aspect was the deadlock in the intervention. The positive was that many unspoken things from the first meeting emerged, but this did not allow us to incorporate the lesson and move on. It is actually bad that we were not able to do the best for our service users without any delay. At the same time we were not able to have informed responses. (Assessment)

We had not worked together before on other cases. We all work in the same area where services are still struggling to work together and create a stronger network for the community. Maybe top and line management are not convinced enough of this. We also did not fully bind the specifics of our action together at the beginning. The coordinator of the social worker of the organisation that convened the meeting was not assertive enough. I was too shy during the meeting because of my inexperience and do not feel self-confident enough in my professional skills. (Analysis)

The organisation that convened the meeting should have better prepared the meeting explaining the aims more clearly right from the beginning. Lack of experience and coordination, together with weak connections between our organisations are the most important factors that caused the failure. (Conclusion)

In this and similar situations my four colleagues and I have to better understand what we need to take home right from the beginning. We also have to promote better cooperation between our organisations in order to create a framework where social workers can more easily know each other and work together. (Action plan)

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My supervisor and I met a man with ALS in wheelchair and his wife in their house. They asked for house assistance. I started talking and asking to the wife because I...
thought the man was not capable of discernment, even if at the beginning of the
interview, I had some uncertainty when he tried to catch my eye. After my first
questions, the man informed me he could answer and invited me to ask him
directly. Fortunately, he expressed no disappointment. On the contrary, he was
satisfied enough by my mistakes. At the end of the process, he received the service
he asked for (Description).

Before and during the meeting, I was agitated and worried to make a mistake in
relating to the service user. When I realised I was wrong, I felt so much ashamed
and was afraid to have irreparably compromised the relationship. I feared that
the people around me noticed my mistake and was embarrassed. I was also from
their facial expressions. When I think about the mistake today, I feel ok because I
learned a lot and after this experience I carefully reflect on implementing
appropriate interpretations of what is happening (Feeling).

On one hand, I probably hurt the man's feelings. It is not pleasant to be considered
mentally disabled when you have just a physical disability. On the other hand, I
learned a lot and after this experience I carefully reflect on implementing
appropriate interpretations of what is happening (Evaluation).

Before this experience, I met people with mental disability but not yet with ALS.
So I misinterpreted the Silence and the distorted facial expressions of the man. My
ignorance of ALS and my fears of mistakes produced my wrong assessment. The
chain of events leading to my mistakes also includes that my supervisor did not
explain me the situation before visiting the couple. Moreover, I received and used
an outdated checklist of questions mostly built to assess mental disability. This
confirmed my first idea that he was not capable of discernment. So I did not look
for other interpretations of the situation (Analysis).

If I were better informed about the case, I would not have made the mistake, or at
least I would have been much more cautious. If I had more knowledge, I think I
would have addressed the man, without being misled by these factors that
compromised. I would go back to show how I would have approached the case
before visiting the man (Conclusion).

Next time I deal with a similar case, I will study the case more deeply before the
interview. I will meet the people involved with disabled people, listening to the
experiences that may also have been affected. The learning from this experience
may also be useful in other situations not directly related to disability: before taking
something for granted, we must analyse the situation well (Action Plan).
The written material above was created, in the first case, after a detailed verbal narrative and, in the second, as a synthesis of a longer reflective report. These are two examples of reflective writing. Reflective writing is the deliberate use of strategies of writing as a way of reflecting and learning from experience. Reflective writing helps to organize and record events, identify connections between information and to develop critical thinking. Unfortunately, but it is usually a time consuming activity that many social workers cannot afford to perform. Strategies of concise reflective writing are very effective because they produce some very rich material that gives a global view on what happened and is not too much influenced by the latest episodes and the moment when the final reflection is carried out. The above examples have been written with the demand to use less than 500 words.

Combining reflective framework and writing on a regular base is extremely effective in improving the quality of learning from professional experience. For example, after going step by step through the six stages of the reflective framework, it is much easier to find the 'core' of the experience under investigation and use the 'SMS technique' mentioned in the previous section of this article. Writing only 140 characters once a week or once a month to describe mistakes does not require too much time but makes it possible to start 'collecting' stories of mistakes for personal and organisational learning. This is especially useful in challenging workplaces where caseload is demanding and other forms of reflective writings (e.g. reflective journals) would be advisable but realistically inapplicable.
concise reflective writing are very effective because they produce some very rich material that gives a global view on what happened and is not too much influenced by the latest episodes and the moment when the final reflection is carried out.

Conclusion

The title of this article is 'learning from mistakes in social work' but, in the light of the argumentation presented, hopefully clear that it could be turned into "The responsibility to learn from mistakes in social work" because reflection, and above all reflection on mistakes, is not only technically possible but also ethically desirable.

Saying that 'mistakes happen' does not mean a surrender to the inevitable and running toward self-absolution. On the contrary, it should push social workers to stop, think, learn and act anytime something negative happens during their activity. If somehow service users have been harmed yesterday, they have to be healed today and other users can be helped more effectively tomorrow because of the learning coming from an honest and brave reflection on previous failures. Shame and victimisation coming from any form of 'blame culture' are just some of the main obstacles on building a culture of responsibility in health and social services.

Moreover, security has costs as well as benefits but also 'smart mistakes' have benefits besides only costs. The inescapable trade-off between security and damage caused by mistakes is very delicate to handle, even if it should be clear that any error can turn into a precious opportunity for professional development.

After having told his experience about the surprisingly large increase in trust and enhanced relations with a service user to whom he admitted he had made a mistake, a social worker concluded saying...
a mistake is not always a failure in social work because sometimes it opens unexpected paths leading to very effective help for service users.

This is just one of the many 'happy' endings occurring when social workers reflect in depth and turn their mistakes into opportunities for new discoveries and more effective interventions. Many others can come if practitioners and organisations increasingly consider structured reflection on mistakes as an essential factor for their self-improvement.

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