Learning from mistakes in social work

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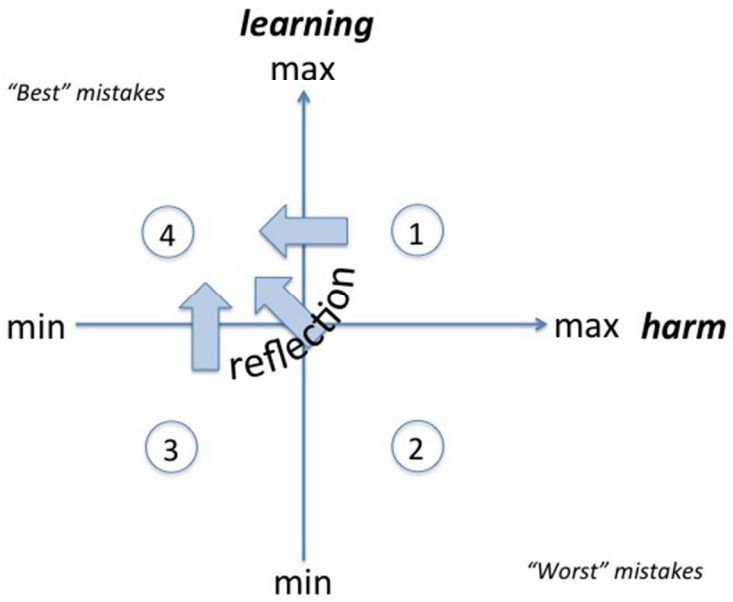

Figure 1. Effects of reflecting on mistake.

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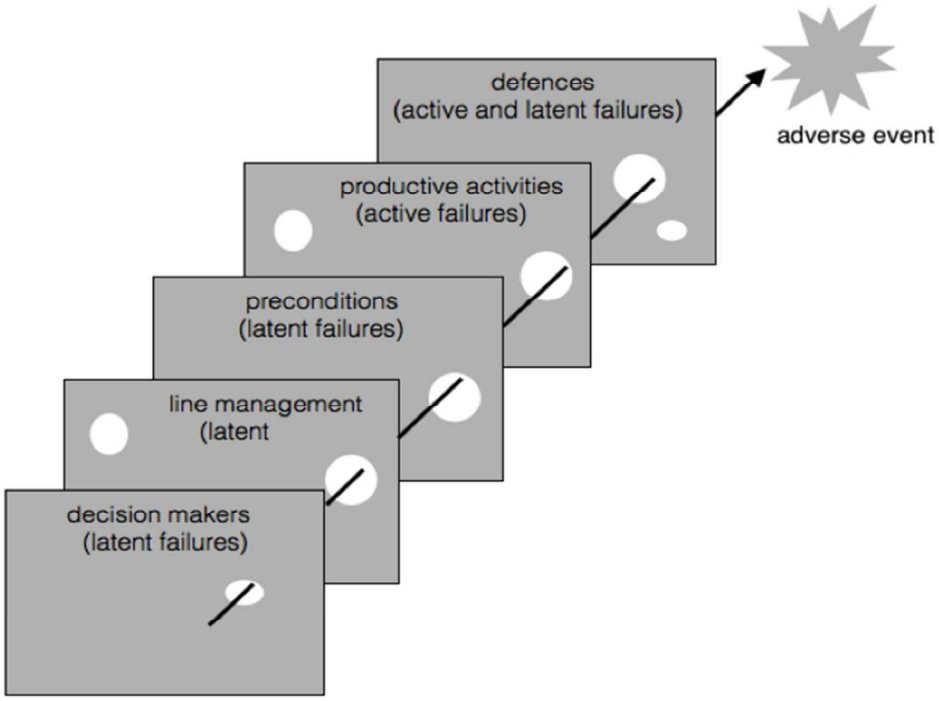

Figure 2. Reason's Swiss Cheese Model (Adapted from Reason, 1990).

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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 impacts might be reduced through ~~can be reduced~~ 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 ~~is described~~ 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 ~~that is~~and ethically driven by the ~~supreme~~ overriding 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 fulfil 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 (Jasper, 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 consistently. N~~and n~~ow there are many definitions and even reviews of definitions, also ~~with reference to specific~~in fields such as~~, for example,~~ social work, education, nursing and other disciplines for the health and social professions (among many: Bolton, 2010; Bulmann, 2004; Fook, 2006; Bruce, 2013; Ingram, Fenton, Hodson, & Chen, 2014; Taylor, 2010; Thompson and Thompson, 2008).

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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, in the first instance, 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~~seldom motivates 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 ~~unrest~~ uncertainty produced by a mistake is the most powerful factor guiding the entire process of reflection. ~~Why? Because errors can highlight personal limits, fragilities as well as vulnerabilities and nobody likes to face and involve the responsibility to be effective practitioners who are guided by the overarching principle~~

~~of 'doing no harm' to service users as stated in the Global Definition of Social Work (IFSW, IASSW, 2014).~~

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 ~~represent~~ 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 ~~serves to highlight~~ the significant~~deep~~ connection between reflection, discovery and learning in reducing the risk of harm to service users ~~in social work~~. 360 degrees ~~During this process c~~Exploration ~~(360 degrees?) in every direction~~ is essential because often simplistic and one-dimensional answers to the challenges of the perceived reality may be reassuring in the short term, but soon these 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 t~~T~~he 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, ~~and~~and sometimes even judges or society as a whole. In fact, there are occasions when those involved are not unanimous in ~~considering~~ 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 ~~and~~ 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 are courses of actions originating in some deficiency in assessment or knowledge and affecting helping process and people involved (service users, other workers, etc.) adversely.~~

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~~ can be 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 activities fails to achieve its intended outcome, and when these 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).

~~In other words,~~ 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'.

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Intention, competence, harm and learning are four important dimensions to consider when analysing an error in social work. ~~:~~ W~~w~~as there an~~y~~ 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?~~Did the social worker know how to do what she/he was doing?~~ Was someone harmed? What might possibly be learnt 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 to the circumstances that led~~leading~~ to mistakes and the consequences of the latter.

The material collected over the last decade and partially 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 ~~during~~ explorative research carried out in some ~~Italy~~Italian health and social services by semi-structured and in-depth interviews

on questions about causes and effects of mistakes, their stories of personal errors and reactions to colleagues' ones (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 they 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 using 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 stories and often contain all the essential elements 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 ~~Texts from semi-structured interviews (on causes and effects of mistakes, stories of personal mistakes and reactions to colleagues' ones) 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 very popular) a~~re both rich sources to explore and empirical evidence ~~perhaps~~ that help to ~~to try to~~ answer some ~~of the most~~ basic questions like~~s~~ ~~'on the topic under discussion.~~

~~First of all,~~ what is a mistake in social work?'. ~~Most of all~~ It is primarily any event producing some kind of harm or loss of opportunity to the service user~~, that is, in other words,~~ It is 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, that you do not get any change, or you get the opposite ~~changes you had hoped for~~.

> 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 right to welfare.~~ In some way, the social worker is seen as a litmus test within a more complex system. Then there are perceptions of injustice, which somehow depend upon the relationship developed by people with the organisation providing services. So, if it is not sufficiently motivated and explained, a decision may determine feelings, of distrust, of inability or resistance to 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)canc~~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, et cetera 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 alternatively a cold and distant link.

Ultimately another form of relational harm is to the social workers and their competence and professional practise; mistakes often have a negative impact leading social workers to enter into a stress spiral of mistake – stress – mistake~~As a kind of damage to the relationship with oneself, mistakes often have a negative impact on social workers themselves who enter into a stress spiral of mistake – stress – mistake~~.

> SW4: Another effect of the errors is the flight of the users but also the flight of the worker because there is a lot of fatigue. This is what they call burnout, isn't it? ~~Sometimes even personal discomfort occurs because of what you have done. And you feel lonely.~~

Sometimes this happens because the regulatory framework is ~~too~~ rigid and unable to adapt to the real needs of the people, there might also ~~be, conflicting~~be conflicting ~~powers and~~ interests, ~~and/~~or the ~~individual~~ social worker~~s~~'~~s communication and~~ ways of working do not harmonise readily 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):

- t~~T~~he need for urgent resolutions and too much work (lack of time);

- ~~inadequate~~ unsatisfactory relationship with the user ~~(as already highlighted)~~ or with ~~the~~ 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~~unfocused training.

Time constrains and poor organisation are often pointed to as responsible for negative outcomes in health and social services:~~When there are too many cases and too many emergencies it is not easy to find time to take care of all the details needed for a successful intervention.~~

> SW5: So many times mistakes come from the fact that practitioners d~~you d~~on't have enough time to think how to do better, then ~~you~~ they do not have time to discuss with your colleagues or to have supervision on difficult cases. We are always so ~~pressed~~ driven by the urgency of the cases and situations that we often do not have sufficient time properly assess 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 him/herself, but on the fact that services are organised ~~badly~~ poorly for a variety of reasons and dysfunctional organisations are error prone.

~~As highlighted by some of the evidence given by social workers in describing their mistakes,~~ Assessment is another major area where many errors occur. Sometimes ~~some~~ information is taken for granted and other evidence is not sought~~searched for~~ or considered because the complexity of the case is underestimated and the related risks

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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 ~~with~~ 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 ~~is rich~~ in social work is rich, as in every field of human ~~activity~~endeavour. Unexpected events, things forgotten, feelings ~~unheard~~ unsaid or unheard and casework overload pushing in the wrong directions are just some examples of what factors can influence the ~~can happen during any~~ helping 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 ~~immediately~~ in the first instance 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~~ is that 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. ~~A~~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 ~~to be taken as~~ 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).

~~Something similar happens when social workers guide interviews with users by using disposable hypotheses and questions to go deeper into the understanding of~~

~~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 communication, even if several initial hypotheses are discovered to be unhelpful (Campanini, 2007).~~

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

However, ~~precautionscarefulness~~precautions to avoid harm~~damages~~ occasioned ~~caused~~ by mistakes should not make social work~~practionerscrs~~ forget that security ~~has~~ also has costs as well as~~and not only~~ 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 safety. 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 ~~pure~~ certain 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 one. 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 ~~they display~~ their effects are displayed. Some latent errors ~~They~~ can even be ~~even~~ lethal if ignored, for example, as it could be if a pilot exercised a ~~would~~ preference ~~not~~ to ~~stop~~ tak~~e~~ing off instead of ~~and~~ aborting and checking 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 sometimes for long periods and only become evident when combined with other~~s~~ 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~~ mitigate 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~~: whatever you do you will always fail from time to time, so why hide it when it happens?~~ and so there is no need to hide failures.

A real acceptance of this principle defuses the negative effects of shame, guilt and fear of being designated as a scapegoat. These are negative effects because they are ~~important~~ significant obstacles to developing any in depth and honest analysis of errors. It is rare to find literature on shame in social work. This ~~issue~~ observation has been recently explored with ~~regard to~~ service users in the context of~~and~~ 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 among them?~~ Shame as a state of being is ~~most likely~~probably rare amongst social workers, but nevertheless many could have experienced this feeling intensively during their career. ~~Nevertheless,~~ M~~m~~echanisms 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~~articulate~~, 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),

(5) line management (related to operations, maintenance, training and, in general, implementation of the strategies defined at the previous level 1);

(6) preconditions (skills, knowledge, attitudes and motivations of any workers involved in the process, environmental conditions, codes of practice, physical and psychological conditions, etc.);

(7) productive activities (what happens in the 'here and now');

(8) 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 where~~if~~ each of ~~all~~ the layers ~~have~~has 'holes' in corresponding~~specific positions~~ positions will the trajectory of a potential adverse event continue~~s~~ ~~until~~until its eventual occurrence.

A hypothetical example could be ~~thought of~~presented with regard to the growing and alarming phenomenon of the violence against older people. Policy makers in a period of economic crisis might~~could~~ 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~~, so ~~consequently~~ the few left are so busy that they have time to visit ~~only a~~ fewer people at home. The social worker Anne, who is young and not so experienced, is informed over the telephone about the broken leg of an ~~85 year old~~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~~incongruence in the story told by the woman's daughter (who~~she~~ lives with her mother) ~~, she listened on the phone~~ , ~~and~~She writes in her report that there is nothing worrying ~~emerges during this phone interview~~ (productive activities). Six months later, after another and even worst 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 ~~and~~ 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~~ had visited~~been in that~~ the house she would have noticed evidence of Mary's neglect ~~in the care of Mary~~. The few experienced practitioners working with Anne were too busy working on their cases to help her to ~~examine~~ explore 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~~has~~ a small or bigger share of responsibility but none has all the 'guilt'. ~~Not even the policy makers who had to solve the problem of how to distribute fewer resources to different areas of activities.~~ Of course, it would be easy to find a 'scapegoat' to blame, but this would not avoid similar future occurrences~~bad accidents happening again~~.

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 organisations. 'Smart questions' are always the core of effective reflection because these probing and examining~~y puzzle~~ questions ~~and~~ lead a search and encourage 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 formulated by practitioners~~Practitioners may formulate 'smart questions' or ~~these may~~ use predefined sets of questions, like Gibbs' (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, Fenton, Hodson, & Jindal-Snape, 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).

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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? ~~What was your role in the event and what was the role of each of the others?~~

(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~~?

(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)~~(3) At what point of the experience did you specifically start to feel each of these emotions, or were they present at the outset?

~~(5)~~(4) 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)~~(5) What did the words, the interventions, the challenges and the actions of other participants make you think? How did they make you feel?

~~(7)~~(6) 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 right? For whom? According to which technical ideas or ethical principles?

~~(4) What is specifically right? For whom? According to which technical ideas or ethical principles?~~

~~(5)~~(4) Why did you interpret the situation in the way you interpreted it?

~~(6)~~(5) What other interpretations could there be?

4. ANALYSIS

(1) Why did you behave like you did?

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

~~(3) How did you influence what happened? Why did it happen? Why did you behave like that?~~

~~(4)~~(3) What were your assumptions about this error/failure, held by yourself and others involved? What has shaped these assumptions?

~~(5)~~(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?

~~(6)~~(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?

~~(7)~~(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 service - for example, which side is the social worker perceived as being on~~experienced colleagues, 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~~? How would things be different if X~~ or happened 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 casual factors?

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

~~(5)~~(4) ~~What could you have done differently?~~ What would the result have been?

6. ACTION PLAN

~~(1)~~ What can you do differently next time you deal with a similar case?

~~(2)~~(1) 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?

~~(3)~~(2) 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?

~~(4)~~(3) What have you learned from this experience ~~(for yourself, about others, etc.)~~? How has your understanding developed?

~~(5)~~(4) 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 ~~An~~ examples of use of this~~e~~ framework ~~is~~ are proposed ~~in Table 1~~below with the synthesis of ~~an~~ two experiences: one ~~told~~ by a social worker who recently attended ~~a~~ one of the ~~seminar~~workshops mentioned in the previous section; the other by a BA social work student reflecting on her field practice ~~on the topic of this article~~. In the first case, t~~T~~he participants ~~in this course~~of the workshop were divided into couples: one of the two had to ask the questions listed above and the other had to answer in order 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.

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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 check 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 convey 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 overcome the impasse and move on. It is ethically 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 use teamwork properly. (Assessment)

We had not worked together before on other cases. We all work in the same areas where services are still struggling to work together and create a stronger network for the community. Maybe top and line management are not committed enough to this. We also did not fully detail the specific goal of our action together at the beginning. The coordinator (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 aim 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 want 'to take home' right from the beginning. We also have to promote better cooperation between our managements in order to create a framework where social workers can more easily know each other and work together. (Action plan) (Author's own, 2017, p. 143)

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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 somehow amused by my mistake. 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 irremediably compromised the relationship. I blushed and so the people around me realised my mistake was unintentional. I saw this from their facial expressions. When I think about my mistake today, I feel ok because I know that any process of growth has ups and downs. (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. Then I violated the principle of "don't judge people before knowing them". On the other had, I learned a lot and after this experience I carefully refrain from implementing superficial 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 on 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 explained me the situation before visiting the couple. Moreover I received and used an out-dated 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 interpretation 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 mislead by those factors that I mentioned. If I could go back in time I would ask my supervisor to tell me more about the case before meeting the man. (Conclusion)

Next time I deal with a similar case, I will study the case more deeply before the interview. I will modify my attitude towards disabled people, holding off the prejudices that may arise, even unknowingly. The learning from this experience may also be useful in other situations not directly relate to disability: before taking something for granted, we must analyse the situation well. (Action plan)

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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,~~ that is the deliberate use of strategies of writing as a way of reflecting and learning from experience. Reflective writing, helps to ~~is~~ order and record events, identify connections between information and to develop critical thinking. ~~very important~~ 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 experiences. For example, a~~A~~fter going step by step through the six stages ~~and as many questions~~ of the reflective framework, ~~as necessary to make such a detailed analysis of a mistake,~~ 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. - W~~w~~riting only 160 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.

~~Reflective writing, that is the deliberate use of strategies of writing as a way of reflecting and learning from experience, is very important 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.~~

Conclusion

The title of this article is 'learning from mistakes in social work' but, in the light of the argumentation~~s~~ presented, ~~it is~~ hopefully it is 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 encourage~~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~~ harm caused by mistakes is very delicate to handle, even if it should be clear that any error can turn into a precious ~~occasion~~ opportunity for professional development.

After having told his experience about the surprisingly large increase in trust and enhanced relation~~ship~~ with a service user to whom he admitted he had made a mistake, a social worker concluded saying

SW10: 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.

References

Author's own (2010). *Errore e apprendimento nelle professioni di aiuto. Fare più errori per fare meno danni?* [Mistake and learning in the helping professions. Making more mistakes to do less damage?]. Sant'Arcangelo di Romagna: Maggioli.

Author's own (~~in press~~2017). *Reflective practice and learning from mistakes in social work*. Bristol: Policy Press.

Bolton, G. (2010). *Reflective practice. Writing and professional development* (3rd ed.). London: Sage.

Borton, T. (1970). *Reach, Touch and Teach*. New York: McGraw-Hill.

Bruce, l. (2013). *Reflective Practice For Social Workers: A Handbook For Developing Professional Confidence*. Maidenhead: Open University Press.

Bulman, C. (2004). An introduction to Reflection. In C. Bulman and S. Schutz (Eds.) Reflective Practice in Nursing (3rd ed.) (pp. 1–24). London: Blackwell.

~~Campanini, A. (2007). *L' intervento sistemico: un modello operativo per il servizio sociale* [The systemic intervention: an operating model for social work]. Roma: Carocci.~~

Dewey, J. (1910). *How we think*. New York: D.C Heath.

Dewey, J. (1933). *How We Think. A restatement of the relation of reflective thinking to the educative process* (Revised edn.). Boston: D. C. Heath.

Engel, R.J. & Schutt, R. K. (2016). *The Practice of Research in Social Work* (4th ed.). Thousand Oaks, CA: Sage.

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Fook and F. Gardner (eds.) (2006). *Critical Reflection in Health and Social Care*. Berkshire and New York: Open University Press.

Gibbs, G. (1988). *Learning by Doing: A guide to teaching and learning methods*. London: Further Education Unit.

Gilgun, J.F. (2014). Methods for Enhancing Theory and Knowledge about Problems, Policies, and Practice. In I. Shaw, K. Briar-Lawson, J. Orme, & R. Ruckdeschel (Eds.), *The Sage Handbook of Social Work Research* (pp. 281-297). London: Sage.

Green Lister, P. (2012). *Integrating Social Work Theory And Practice: a practical skills guide*. London: Routledge.

Gould, N. ~~and~~ & Baldwin, M. (Eds.) (2004). *Social work, critical reflection and the learning organization*. Aldershot: Ashgate.

~~IFSW (International Association of Social Workers) and IASSW (International Association of School of Social Work). (2014). Global Definition of Social Work. Retrieved from http://ifsw.org/get-involved/global-definition-of-social-work/~~

Ingram, R., Fenton, J., Hodson, A. and Jindal-Snape, D. (2014). *Reflective Social Work Practice*. Basingstone: Palgrave.

Jasper, M. (2003). *Beginning Reflective Practice*. Cheltenham: Nelson Thornes.

Penn, K. and Sastry, A. (2014). *Fail Better: Design Smart Mistakes and Succeed Sooner*. Boston: Harward Business Review Press.

Reamer, F. G. (2008). Social workers' management of error: Ethical and risk management issues. *Families In Society*, 89(1), 61-68. doi:10.1606/1044-3894.3710

Reason, J. (1990). *Human Error*. Cambridge: Cambridge University Press.

Taylor, B. J. (2010). *Reflective Practice for Healthcare Professionals* (3rd ed.). Berkshire: McGraw Hill.

Thomas, G. (2011). *How to do your case study. A guide for students and researchers*. London: Sage.

Thompson, S. and Thompson, N. (2008). *The Critically Reflective Practitioner*. New York: Palgrave Macmillan.

Tugend, A. (2011). *Better by Mistake: The Unexpected Benefits of Being Wrong*. London: Riverhead Books.

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~~Table 1. Reflective framework on errors and failures: synthesis of a case study.~~

Figure 1. Effects of reflecting on mistake.

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