WISCONSINWELL

REFLECT BACK

TO TALK ABOUT AND LEARN FROM MISTAKES

Making a mistake does not guarantee learning, but processing a mistake is foundational to learning and improvement. In psychologically safe cultures, disclosing an error is respected and supported because mistakes are viewed as opportunities to learn and receive support. Learning from mistakes allows teams to press onward with more wisdom at hand for the next time. Team members anticipate their voices will be heard and concerns will be addressed. Without question, no human service professional engages in perfect, error-free work. Expressing vulnerability through transparent discussion of mistakes is a display of great professionalism and courage. As such, "reflecting back" is a value of safe, engaged teaming (Edmondson, 2019; Perla et al., 2017).

- Structured Debriefs
- Plus-Minus-Interesting
- Substitution Test
- Restorative Accountability
- Balanced Accountability Guide

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STRUCTURED DEBRIEFS

Structured debriefs follow important trigger events. Debriefs can be done as a team or between a case manager and supervisor. It is important to communicate in advance what events will trigger debriefing. Not communicating what events will trigger debriefing can make the process feel less psychologically safe. Team members may worry debriefings only occur when the supervisor believes a team member made a mistake.

Key Concepts

F

Facilitation

Debriefs are leader facilitated discussions that accomplish two important goals:

- Team unity and psychological safety
- Learning and improvement

I

Improvement Focused

Ask three simple questions:

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

Respect is critical. During debriefings, if someone responds judgmentally or unprofessionally, it is important this person receive candid, prompt, respectful redirection.

T

Consistent Triggers

Structured debriefs should follow important trigger events. For example, in public child welfare settings the following events may trigger debriefs:

- Home (placement) disruptions
- Maltreatment recurrence
- Switching to an out-of-home safety plan after an in-home safety plan
- Recurrent hotline calls or child welfare intakes

Facilitator Checklist

- ✓ Is communication clear?
- ✓ Are roles and responsibilities understood?
- ✓ Is situation awareness maintained?
- ✓ Is workload distribution equitable?
- ✓ Is task assistance requested or offered?
- ✓ Were errors made or avoided?
- ✓ Are resources/capacity available?

Implementation

Structured debriefs work best when they follow an agreed upon set of triggering events. These could be negative or unanticipated outcomes, or areas that are the focus of practice improvement efforts.

The goal is learning and growth, not shame and blame.

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PLUS-MINUS-INTERESTING

PMI is a creative thinking activity that prompts teams to retrospectively consider multiple perspectives when looking at situations or events. This strategy helps teams collaborate on problem solving, develop critical thinking skills, maintain an open mind, and identify areas of skill development and growth.

Key Concepts

Plus

List all of the positive things the team can think of. Don't second guess team members during this process.

- What went well?
- What went according to plan?
- What did I/we do that worked so well, and is there anything learned to apply again the next time?

Minus

List all of the negative things the team can think of. Same rules, don't second guess team members during this process.

- What did not go well?
- Was there anything that should not be replicated in a future situation?
- What were the "lessons learned"?

Interesting

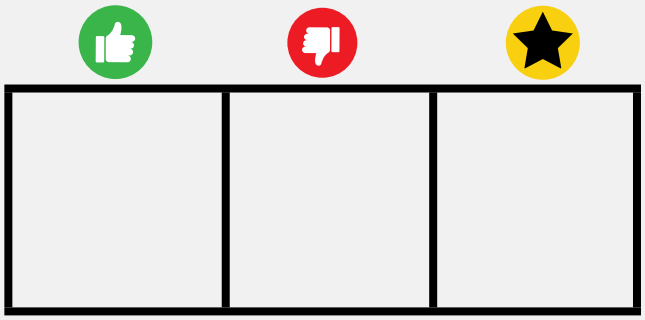
List all the interesting things the team can think of. These are not positive or negative, just points of interest.

- What things were learned that were previously unknown?
- Anything unique or curious and worthy of sharing with others?

Case Example

A supervisor uses PMI with a caseworker working with a new family. The supervisor checks-in to ask: What's going well at the moment? What concerns or barriers have you encountered? Is there anything interesting you've learned along the way? Is there anything that has you curious at the moment?

Sample PMI Chart



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THE SUBSTITUTION TEST

A substitution test is a thought experiment that helps assess the nature of a problem in safety critical situations. People can quickly jump to blaming individuals when things go awry; the substitution test serves as a check on that impulse. It is a reflective, mental activity to consider a person's culpability in context.

Key Concepts

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

YES

- If the answer is yes: The problem is not the individual but more likely an environment which would lead most people to the same action.

NO

- If the answer is no: If similarly experienced individuals would not have acted in a similar manner, it is possible the individual is more culpable and individual accountability more appropriate—whether through services, coaching, formal action, or otherwise.

Case Example

For example, a caseworker accidentally allows a safety plan to lapse for a family with ongoing substance use problems and domestic violence. In determining next steps, the supervisor mentally questions if other similarly experienced professionals would be likely to make the same mistake.

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RESTORATIVE ACCOUNTABILITY

In a retributive culture, an account becomes something to be paid back – something that is owed. In a restorative culture, an account is a story to be told – something to help us learn and get better (Dekker, 2007). We want to consider restorative approaches in every aspect of our work, including how we assess and intervene with families. Restorative accountability isn't just for professionals who do high-risk work. It's also for families.

Key Concepts

The difference between a retributive approach and a restorative approach

Retributive Approach

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

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

Restorative Approach

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

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

Implementation

- Work to achieve buy-in from all members of the organization.
- Train all staff in restorative approach
- Implement with regular progress checks for fidelity and consistency in practices.

Case Example

A case manager working with youth recovering from drug dependency experiences a suicide on his caseload. He is very grieved and worried his last visit with the youth was shortened by an emergency on another case. Affected by the emergency, he had quickly concluded the youth was safe, acknowledging the youth was experiencing a "bad day" but that sufficient support existed for safety. Rather than formal sanctioning, the supervisor offers support and gives the case manager an opportunity to process, share and learn.

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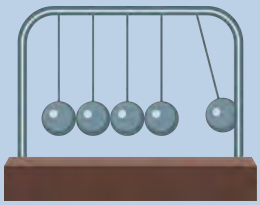
BALANCED ACCOUNTABILITY GUIDE

Intended for use by leadership teams, it helps discern how accountable a system, in contrast to a professional, may be for an action or inaction in the workplace. This guidance resists the assumption a professional has sole individual culpability in a given decision. Sanctioning professionals for well-intentioned, commonplace actions or inactions can have a chilling effect on workforce culture - creating psychological fear instead of safety - and lead to mistakes, concerns and divergent points of view being hidden from leaders who can and want to help. Accountability and psychological safety live side-by-side in healthy organizations.

A ctions and Consequences

Did the professional intend both the action and the consequence?

For example, intentionally missing a visit to a child's home, so that a child is knowingly abused without detection would be "actions and consequences intended."



These situations are rare but if they occur, acting swiftly to protect others and notify appropriate authorities is paramount.

S ubstitution Test

Did the professional intend to depart from standard practice? Would other professionals have likely made the same decision, given the same stressors, knowledge and environment?

Questions to Consider: **Is this about a common workaround? Is the workaround largely the result of systemic pressures or constraints? Are practice expectations clear?**

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BALANCED ACCOUNTABILITY GUIDE

I mpairment

Was the professional experiencing impairment near the time of the action or inaction? If so, what is the context, and is it possible to safely give help?

Questions to Consider:

- **Did the professional describe challenges with - or - from substance use?**
- **If so, are the challenges affecting work?**
- **Is the professional impaired at work?**

K nowledge

We all need the requisite knowledge to do our professional work. Learning and activating knowledge can takes persistence, and systemic supports need to be accessible and effective.

Questions to Consider:

- **Did the professional have the needed knowledge-at-hand? If not, can support be given?**
- **Does the agency have gaps in how knowledge is assessed, developed, and shared?**

S tressors

To what degree was stress, mental health status, trauma, burnout and/or fatigue a factor in decision-making? In the workplace, are factors like low psychological safety or high workload pressures contributing to the professional's actions or inactions?

Questions to Consider:

- **Are any stressors known or suspected?**
- **If so, what efforts to remediate have been tried?**
- **Did heightened stressors exist in the workplace at the time?**

H istory of Unsafe Acts

Everyone experiences performance variability, especially in the context of high-risk, pressured, complex, and often interdependent work. Does this professional have a history of unsafe behaviors?

Questions to Consider:

- **If there is a pattern of unsafe behaviors, has the professional received this feedback? How did they accept feedback?**
- **What interventions or supports were put in place?**
- **Are the unsafe acts largely the result of systemic pressures and constraints?**

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