Learning, 3.1 + 3.2: Learning, Blame and Compassion

Part 1 Summary: Learning and Blame

- One of the key features of good teams and healthy cultures is their capacity to learn.
- The human tendency is to blame as it simplifies problems and gives us a sense of control. But this creates shame, encourages people to hide mistakes, and is inaccurate - most issues at work are due to a much more complex range of causes. As such, blame creates unnecessary harm and decreases learning.

Questions

1) Think about the last time you blamed yourself for something going wrong. Is there a different story to tell that recognises that you were just being human? Is there a story that recognises the wider causes of why it happened, rather than pinning it on you?

2) Think about the last time something went wrong at work. How did you respond? How did others respond? To what extent was there blame? To what extent was there compassion? What might you want to do differently?

Resources and links:

- https://pmc.ncbi.nlm.nih.gov/articles/PMC6802475/ Brief editorial on why blame is unhelpful in healthcare settings, and what approaches offer more insight
- https://www.youtube.com/watch?v=RZWf2_2L2v8 Nice little video with psychologist Brene Brown on why we blame and the impact it has
- https://cdn.who.int/media/docs/default-source/patient-safety/curriculum-guide/resources/ps-curr-handouts/course03_handout_systems-and-the-effect-of-complexity-on-patient-care.pdf Brief WHO summary of complexity and blame in healthcare

Part 2 Summary: Compassionate behaviours

- A more compassionate approach - such as suggested in the PSIRF framework - can be supported by some key behaviours.
- Firstly, we need to take seriously the fact that the vast amount of mistakes and errors are inevitable, and the result of complex issues rather than individual malice. We need to be kinder to ourselves and others when things go wrong.
- Secondly, we need to create spaces where praise is consistent - the sense of safety and competence this builds makes it easier for people to face mistakes with curiosity and learning.
- Thirdly, conversations around mistakes need to be framed with supportive, developmental, and emotionally aware language.
- Finally, we need to learn from what goes well, as well as what goes wrong. Much of what reduces mistakes and error is in the stuff that goes well - we risk neglecting this if we don't take it seriously.
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Exercises:

3) How often do you praise other people? How often does your team share praise? Who could you praise next time you are at work?

4) What might hold you back from praising others? Is there anything you could do to move past that?

5) Think about the last conversation you had about someone doing something wrong. How might you frame that conversation as a supportive, developmental conversation?

6) Think about three incidents at work that have been handled really well.
) Why did it go so well?
) What were the direct causes? What wider factors enabled those causes?
) What are the key learnings from that incident?
) What are the shared patterns between those incidents?

Resources and links:

- https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/ PSIRF framework

- https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-018-2994-0 Paper synthesising complexity-informed approaches to healthcare and their implications for learning
- https://qualitysafety.bmj.com/content/13/suppl_2/ii3.short Paper summarising evidence and theory of how psychological safety enhances learning from mistakes
- https://www.england.nhs.uk/signuptosafety/wp-content/uploads/sites/16/2015/10/safety-1-safety-2-whte-papr.pdf White Paper on 'Safety II' - summarising the importance of learning from what goes right

Evaluation:

We would really appreciate your feedback through these short questionnaires on the videos and their usefulness. Your feedback will help us improve future content.

Prior to watching the videos

After watching the videos