

# Managing risk and minimising mistakes in children's services

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# Introduction

- On this mistake management thing, there's a culture of shame around mistakes and that needs to be addressed at its core. My teacher used to say "everyone makes mistakes that's why they put rubbers on the end of pencils!" We need to encourage an open culture about mistakes so that we really can learn from them.

Young person

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# Outline

- Warm up
- Presentation and questions
- Group exercise
- Key messages from the workshop
- Closing comments

# Understanding adverse incidents 1

- Person centred approach
  - Individuals who make errors are 'careless, at fault, reckless'
  - Blame and punish
  - Remove individual = improve safety

# Understanding adverse incidents 2

- Systems approach
  - Poor organisational design sets people up to fail
  - Focus on the system rather than the individual
  - Change the system = improve safety

# Ask why

- Assume that people will make mistakes
- Ask what makes it easier for people to make mistakes
- Ask what helps keep children safe despite system failures!

# Why do things go wrong

- Barriers, controls and defenses
  - Latent failures – embedded in the system, associated with the actions of politicians, policy makers, senior managers etc.
  - Active failures - felt almost immediately and are associated with the actions of frontline workers i.e. errors of judgement and lapses in performance

# Our study

- Qualitative research with three referral and assessment teams in England and Wales
- Interviews with 60 social workers, their managers and allied professionals
- Group and individual interviews with 40 young people and parent



# What is a near miss

Near misses involve the following features:

- something could have gone wrong but has been prevented
- something did go wrong but no serious harm was caused.

# Good practice, good learning points

- The 'pew factor'

“Phew that didn't go wrong, but what about next time?”

Near misses contain both a sense of relief that nothing has gone wrong but also allows workers to feel good about themselves

# Involving service users and carers

- Involve in the analysis of incidents
- Recognise expertise of those directly affected by incident

I can't undo my disaster now. It happened. I'm in it. But if we can stop the same thing happening to a few other people, then I'm happy to help.

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# Learning from adverse incidents

- Organisational learning triggered by serious harm
- Lack of forums for analysis, recommendations & action arising from near misses
- Cultures of blame, climates of fear and issues of leadership

# Frameworks for learning

- Critical reflection
- Root cause analysis

For information including RCA training and toolkit visit [www.npsa.nhs.org.uk](http://www.npsa.nhs.org.uk)

# Case study – group exercise

- No harm, so no learning
- Example of active failure at the frontline
- BUT what are the contributory factors that led to it?