

When Things Go Wrong:

A Toolkit for Reflection, Self-care and
Compassionate Leadership



*because
you matter*

St Nicholas
Hospice Care

A Registered Charity No. 287773

Sharon Basson, Director of Care
Katherine Cooper, Senior Registered Nurse
(August 2025)

A letter to our colleagues...

This leaflet has been consciously prepared, drawing on our own personal experience when something has gone wrong in practice. We have been where you are now and understand the significant and lasting impact of making a mistake. If you are reading this, then you may be facing the challenges of having made an error or knowing that something has not gone well. When things go wrong in our work, it can be deeply unsettling.

Whether navigating your own experience or supporting someone else, this resource offers a framework for:

- Practical strategies for effective self-care
- Emotional recovery
- Leading with compassion
- Finding the learning, and moving forward with courage

We hope that it provides you with some clarity, structure and enhances your working relationships.

With very best wishes

A handwritten signature in black ink, appearing to read 'Katherine and Sharon', written in a cursive, flowing style.

Katherine and Sharon

First things first

While this framework focuses on supporting your individual experience, there are some essential steps that must come first:

- Ensure patient safety
- Confirm that the patient is safe and cared for
- Tell the right people, do the right thing every time
- Inform your Manager on Call or Line Manager immediately
- Access immediate support
- Make sure you have the help you need—personally and professionally
- Duty of Candour
- Be open and honest with patients and families as required
- Professional responsibilities
- Complete documentation and incident reporting
- Take steps to prevent further mistakes

These actions can usually be confirmed quickly—but the emotional burden of your experience may mean that this feels heavier. This leaflet is here to help you navigate that journey.

Pause, take a breath

- Unintentional errors occur in healthcare
- Our motivation as professionals is to provide quality care, not to do harm
- Recognise that being involved in an error can feel like a burden
- How would you offer support and show compassion if this was happening to someone else?



Human Systems – Stacey, Aubeeluck and Cook (2018)

After an error, it's not uncommon to feel stuck—or even consumed—by powerful emotions.

As humans, our emotions can be grouped into three systems:

- Threat System – seeking safety, feeling vulnerable
- Drive System - motivated and with purpose
- Soothing System – being content, at peace

Our colleagues challenged us to open our minds to differing responses from individuals involved in errors.

There is no right or wrong emotional response. For example, if you or a colleague lives with neurodiversity, the emotional experience may be different than usually expected or delayed. These are valid emotional reactions that deserve understanding and support.

The impact of neurodiversity

- “We might focus on how other people respond to gauge our reaction and their’s might make our already heightened senses/anxiety increased”
- “Listen to our perspective as we can see it differently – don’t interrupt as this can make stress worse”
- “Give time and space to voice opinions”.
- “Listen to us – use our strengths”
- “Give us space to process the situation and information given”
- “Accept we see things differently and might not understand why people are stressing – explain calmly”
- “Give clear, to the point instructions one at time or write down in order of completion. If you would like several tasks to be carried out let us write it down in order of completion.”
- “Our vocab shrinks during stress, or we might not verbalise at all”
- “Allow us to have our reasonable adjustments”.
- “Might be tired after from masking – give us space to decompress”
- “Don’t bombard or overload us with information”

*Amy Southwell and Faye Campbell,
Hospice Care Assistants, October 2025*

Our initial emotional responses



These words are a representation of our own feelings - perhaps you recognise some of these yourself.

We invite you to write down your own feelings below:

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.....

Your feelings matter

We've included this toolkit to help you move forward with courage and clarity.

The Active Reviewing Cycle (Greenaway, 2015)

This is a useful tool for:

- Understanding what's happening for you
- Guiding your response as a leader
- Taking you through the Facts, Feelings, Findings and Future



Facts: An objective account of what happened



Feelings: Emotional responses and thought processes about the situation



Moving from feelings to findings is key and where your 'self-compassion toolkit' is required. What does this look like for you?



Findings: Concrete learning that can be taken away



Future: Structuring learning for positive change

Using Greenaway's cycle

Facts

- Take time, re-cap and think about what actually happened
- Talk this through, from the start, with someone you trust

Feelings

- Acknowledge how you feel, this may be emotional and physical
- It may help to write down how you feel – use single words to keep this simple

Findings

- What learning can be taken from this experience?
- How can you find meaning from the event?

Future

- How to apply the learning
- How does/will the experience ultimately strengthen your practise and restore your self-belief?

You may wish to develop your own toolkit in response to your needs.

Self reflection...Katherine's personal toolkit

Shared to help you move forward after an error.
You may wish to develop your own toolkit in response to your needs.

1



Meditation exercise: dampens down the intrusion of feelings, thoughts
Resources ~ RAIN: Recognise, Allow, Investigate, Nurture
www.tarabrach.com./rain

2



Writing a factual account
- what actually happened?

3



Writing a more feelings based account with analytical content
- why did things go wrong? What else was happening at the time?
What was your intent and rationale?

4



Being open and vulnerable with colleagues- sharing experiences, exposing weaknesses, human flaws and lapses in judgement

5

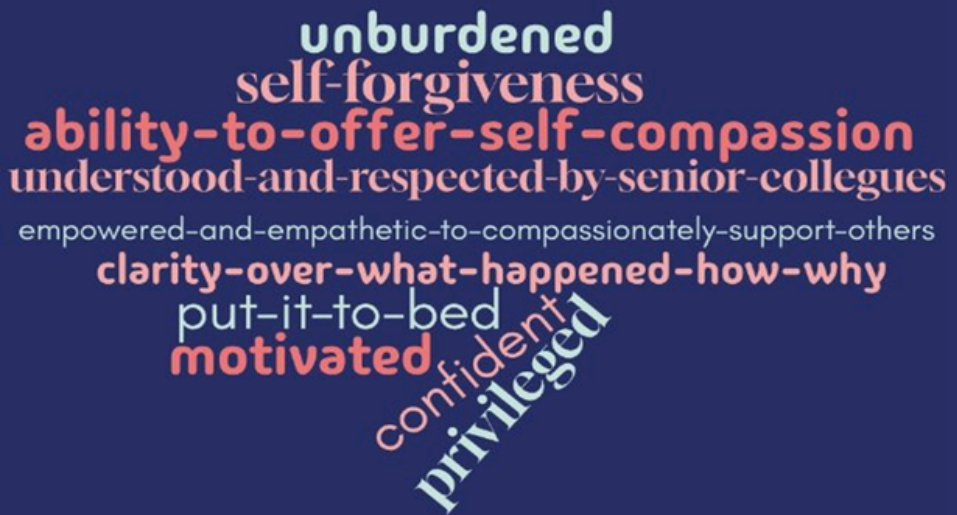


Engaging the soothing system- active and passive rest. Baking, sewing, reading and walking briskly

Your personal toolkit

[illegible]

The outcomes of using a structured approach



A word cloud of outcomes from a structured approach, arranged in a heart shape. The words are in various colors (white, red, and teal) and orientations (horizontal and diagonal). The largest words are 'unburdened', 'self-forgiveness', and 'ability-to-offer-self-compassion'. Other words include 'understood-and-respected-by-senior-colleagues', 'empowered-and-empathetic-to-compassionately-support-others', 'clarity-over-what-happened-how-why', 'put-it-to-bed', 'motivated', 'confident', and 'privileged'.

unburdened
self-forgiveness
ability-to-offer-self-compassion
understood-and-respected-by-senior-colleagues
empowered-and-empathetic-to-compassionately-support-others
clarity-over-what-happened-how-why
put-it-to-bed
motivated
confident
privileged

The Future

Treating colleagues compassionately after an error:

- Does not take more time
- Has a significant impact on patient safety
- Enhances our sense of trust, connection and psychological safety

(West, 2021)

Final Words

The hardest person to show compassion for is often yourself. You will move on from these events—and you need to. It's true that they will stay with you and shape your professional practice, but you can choose to make this experience count.

Best Wishes

A handwritten signature in black ink that reads "Katherine and Sharon". The script is cursive and fluid, with the names written in a single line.

Katherine and Sharon

We are grateful to our colleagues, Amy Southwell and Faye Campbell, for their courage in sharing their perspectives with us.

If you would like to contact us, or you would like us to share our experiences with your teams, please do so:

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Resources and References

Best, C. (2022) The Burden of Medication Error. Available at: qicn.org.uk

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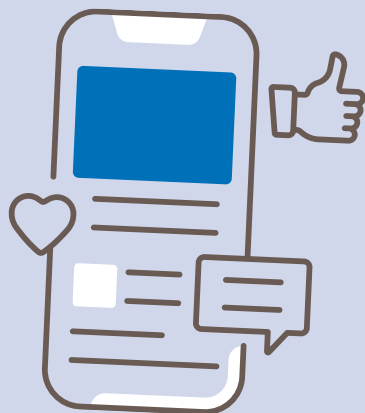
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