FEAR IS THE MIND KILLER

Psychological Safety

Fear is the Mind Killer

“I must not fear. **Fear is the mind-killer**.

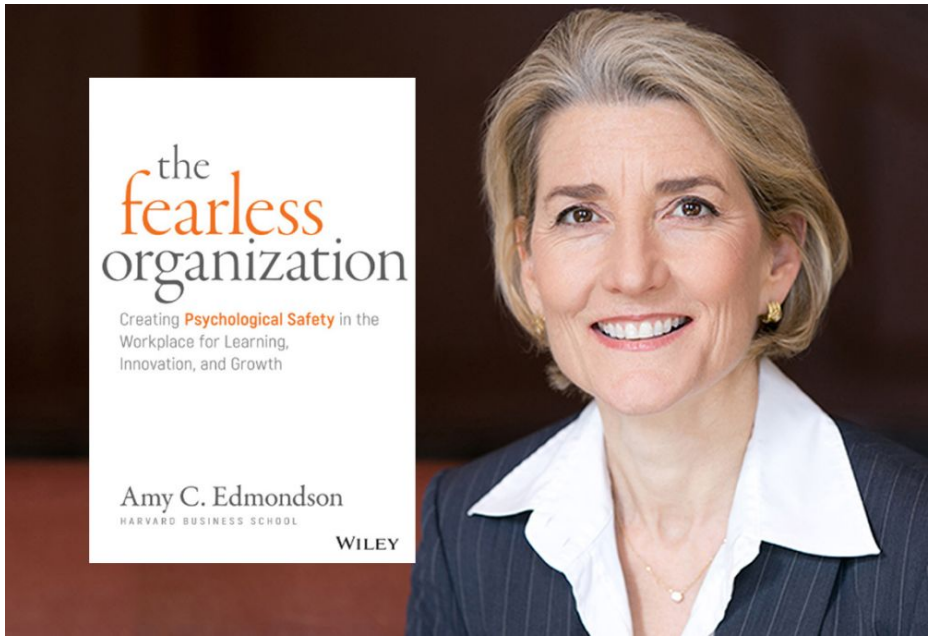
Fear is the little-death that brings total obliteration. I will face my fear. I will permit it to pass over me and through me.”

What is a Psychological Safety?

Amy Edmondson & Psychological Safety

Amy Edmondson – widely credited popularizing the term – defines psychological safety as:

"A belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns or mistakes."

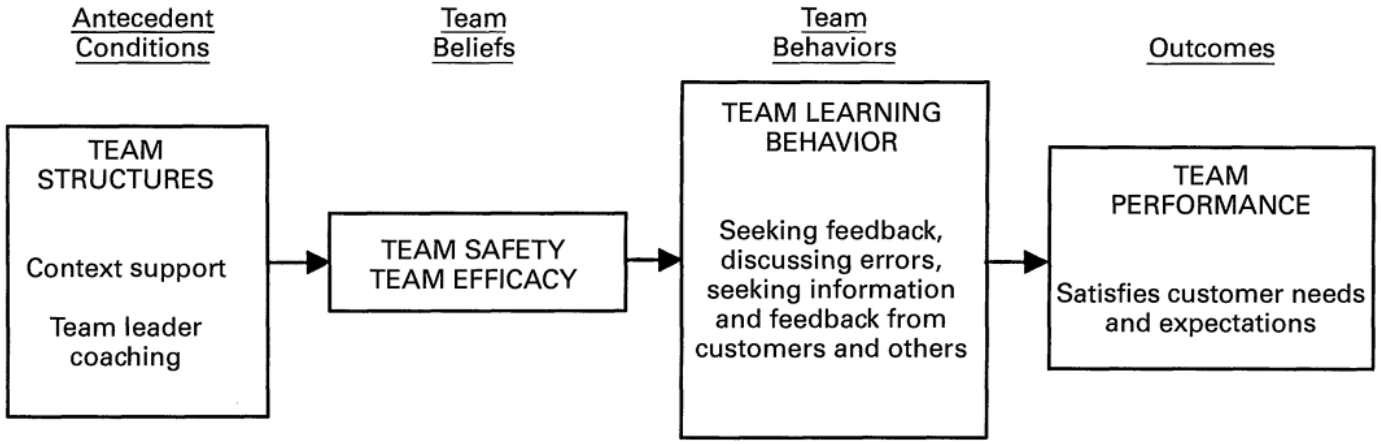


Ted Talk: https://www.youtube.com/watch?v=LhoLuui9gX8

“Finding out that you are wrong is even more valuable than being right, because you are learning.”

In 1999 Amy Edmondson produced seminal research on Psychological Safety

- Engaged with 53 teams at ODI (Office Design Incorporated)
- 3 stage study conducted (Interviews and observation of 8 teams, Survey across all teams, Interviews and observation of 7 teams – top and bottom results from survey)



Relevance to Modern Engineering

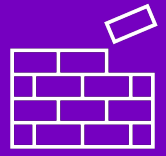
Psychological Safety is the key element in a generative culture

Removes barriers to transformation

Low psychological safety translates into fear of change with teams unwilling to innovate or pick up new techniques

Psychological safety is key to collaboration across the siloes that we are trying to break down within an organisation

Break down the wall of confusion



Accept risk & Embrace Failure

We know that our system is not perfect, the concept of the Error Budget gives us transparency on setbacks in the name of progress

We only benefit from different perspectives within the team if everyone is comfortable speaking up

Cognitive diversity / Safe Space

Measuring the Effects of Psychological Safety

What can Psychological Safety do for you?

Google's re:Work report calls out psychological safety as a key indicator of team performance and McKinsey have also conducted research to the same effect.

74% Less Stress

50% High Productivity

76% More Engagement

40% Less Burnout

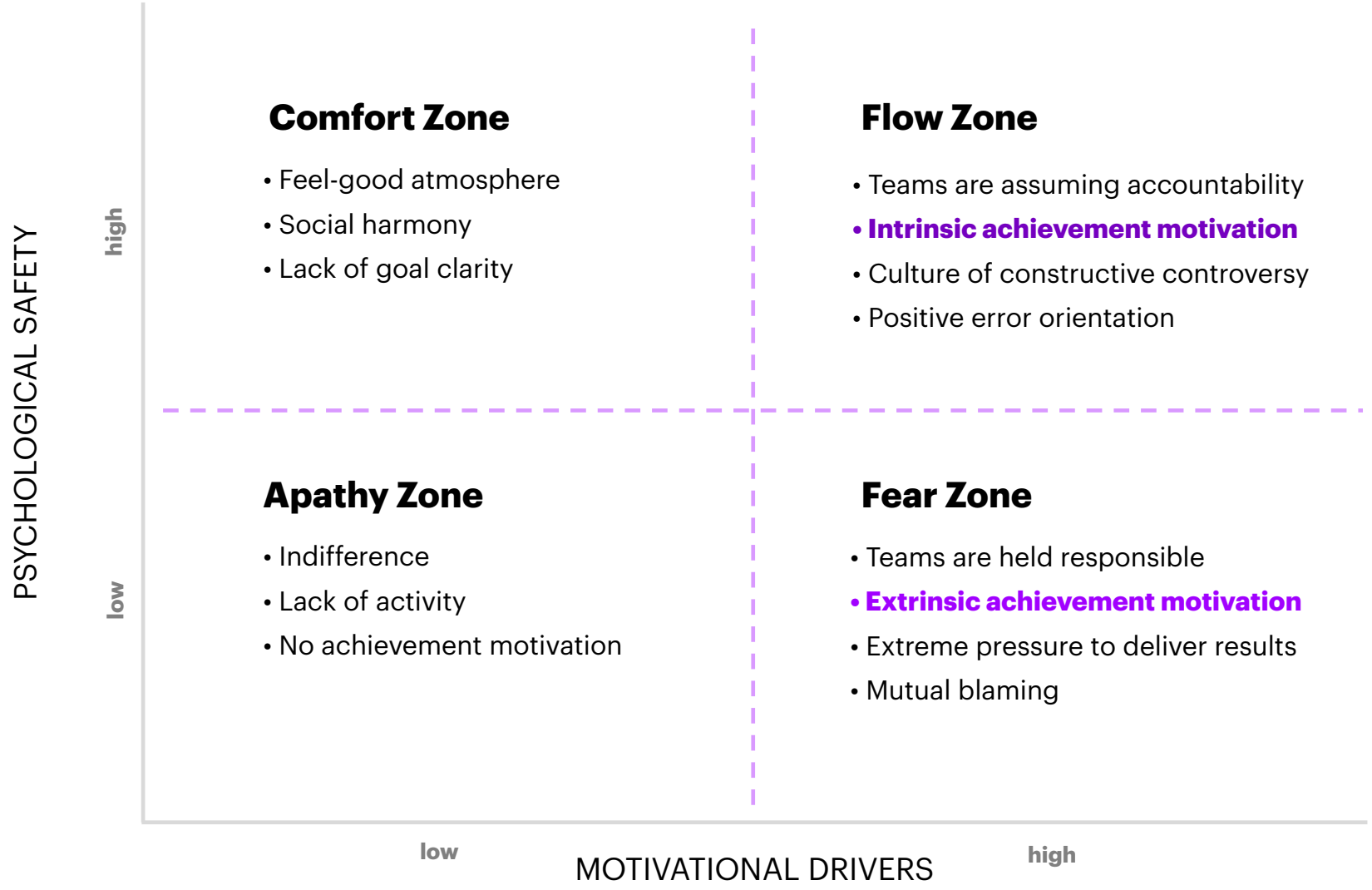
106% Higher Energy

Source: Accenture FS Psychological Safety and Trust Research: https://bankingblog.accenture.com/building-psychological-safety-among-the-fs-workforce

Measuring Psychological Safety

Psychological Safety & Motivational Drivers

Psychological Safety & Motivational Drivers.



Enacting Psychological Safety

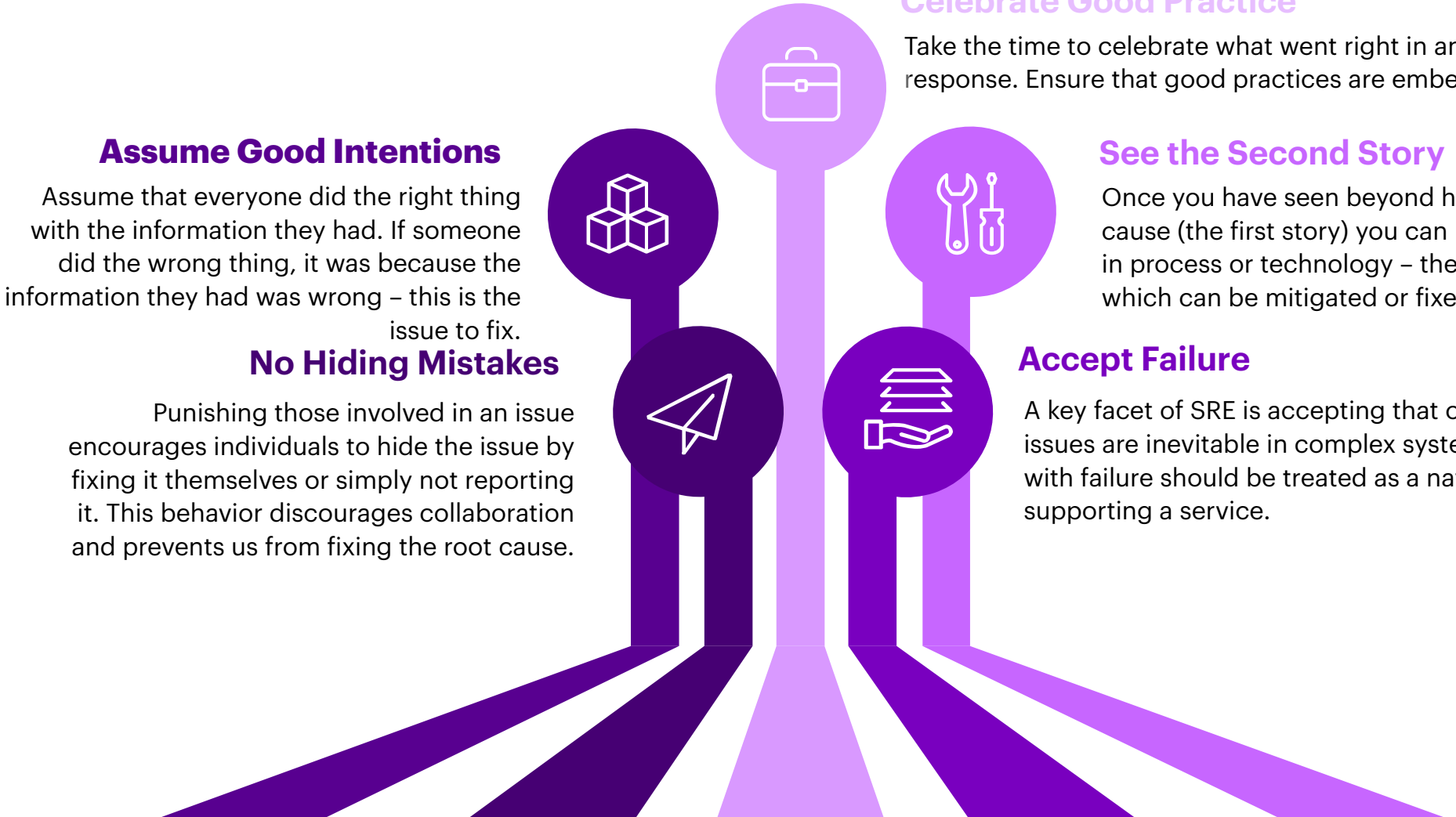
What is a postmortem?

A *collaborative* session conducted after an incident has been resolved resulting in a written record of an incident including:

- a **description** of the incident
- **impact** to the user
- a **timeline** of the incident
- steps taken to **mitigate** or **resolve**
- **root cause analysis**
- follow up **actions** to prevent recurrence

Key Factors for being “Blameless”

Most teams are practicing post-mortems already, the approach offered here emphasizes the blameless element



Celebrate Good Practice

Take the time to celebrate what went right in an incident response. Ensure that good practices are embedded.

Assume Good Intentions

Assume that everyone did the right thing with the information they had. If someone did the wrong thing, it was because the information they had was wrong – this is the issue to fix.

See the Second Story

Once you have seen beyond human error as a cause (the first story) you can look for issues in process or technology – the second story - which can be mitigated or fixed.

No Hiding Mistakes

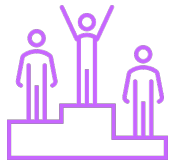
Punishing those involved in an issue encourages individuals to hide the issue by fixing it themselves or simply not reporting it. This behavior discourages collaboration and prevents us from fixing the root cause.

Accept Failure

A key facet of SRE is accepting that outages and issues are inevitable in complex systems. Dealing with failure should be treated as a natural part of supporting a service.

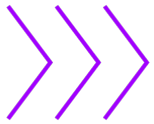
Overall Learnings

There are some general themes that can be taken from the postmortems we have run



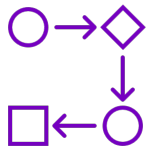
Celebrate wins

- Starting off on a positive – by celebrating the wins – starts the session from a position of psychological safety and makes it easier for people to bring-up positives.
- This was useful in teams where previous incidents have entrenched a blaming culture.



Systemic Causes

- There was an “ah-ha” moment when the team discovered a root cause they had not captured initially e.g. making alerting more user centric
- Performing a root cause analysis exercise allowed teams to see past the immediately obvious



Structured Approach

- Having a formal structure with visual aids for root cause analysis allows the team to capture all aspects of the root cause consistently for every incident.
- We found teams were using an ad-hoc structure without any consistent format for write-ups.

Ownership

- The teams that feel ownership of the process – solving problems rather than following a mandated process – often have a more blameless approach as postmortems improve their work
- We saw this in teams who manage non-production systems – the pressure is still there but the process is not