HUMAN AND ORGANIZATIONAL PERFORMANCE (HOP) FUNDAMENTALS

THE 5 PRINCIPLES

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THE PRINCIPLES

1 **PEOPLE MAKE MISTAKES.**
Destigmatizing failure improves innovation.

2 **BLAME FIXES NOTHING.**
Failure is hidden as a result of fear.

3 **LEARNING AND IMPROVING IS VITAL.**
The people doing the work are the experts.

4 **CONTEXT DRIVES BEHAVIOR.**
We must be deliberate about learning and improving.

5 **RESPONSE MATTERS.**
Our reaction creates or hinders a learning environment.

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TRADITIONAL VIEW VS NEW VIEW OF SAFETY

TRADITIONAL SAFETY

- Workers are the
  We fix safe
  better
- what to do and,
  portantly, not to do.
- ety is the absence of accidents

PREVENTING THINGS FROM GOING WRONG.

NEW VIEW OF SAFETY

- Workers are not t
  are the probl
- W ons what to
  ey need.
- ot the absence of accidents.
  e presence of capacity.

MAKING SURE THINGS GO RIGHT.

(Conklin, 2019, p. 17)

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Workers are as safe as they need to be Without **being** too safe in order to be **productive.**

Our work is

not

inherently safe.
People create safety in practice.

ERROR IS NOT A CHOICE.

Shift your thinking from "Who Failed" to "What Failed"

8

Principle:

Blame fixes nothing.

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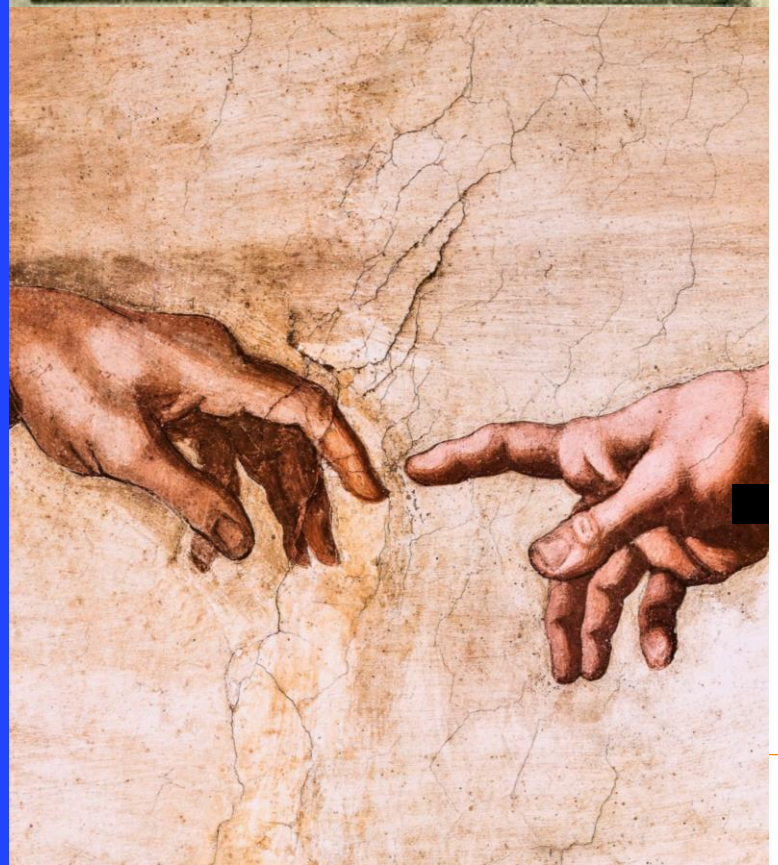
From Middle Ages to Renaissance: Fundamental Beliefs of Cause and Effect Thinking



- Belief #1

  Complete understanding of the universe is possible.

- Belief #2

  The world can be understood through analysis – breaking things down to their most basic level.

- Belief #3

  All relationships can be described through simple cause and effect relationships.

(Ackoff, 1993)

Cause and Effect Relationships

1. A cause is *necessary* for an effect.

   The effect will not occur unless the cause does.

2. The cause is *sufficient* for the effect.

   If the cause occurs, then the effect must follow.

(Ackoff, 1993)

Three Fundamental Doctrines Of Cause and Effect Thinking

Explanations

If we want to explain a phenomenon, all we have to do is find its cause.

To further explain that cause, we treat it as an effect and find it's cause.

Vacuums

Cause and effect thinking enabled us to have an environment-free theory of explanation.

Determinism

Everything that occurs is the effect of an earlier cause.

Nothing ever occurs spontaneously or by chance.

(Ackoff, 1993)

- What is the ‘cause’ of an oak tree?

- Would you say ‘an acorn’?

I NEED TO FIND A CAUSE BECAUSE…

1. NOT KNOWING WHAT CAUSED AN ACCIDENT IS DOWNRIGHT SCARY.
2. HEADQUARTERS, MANAGEMENT, OR THE REGULATOR REQUIRE A CAUSE.
3. WE NEED TO PUNISH THE GUILTY.
4. WE MUST DEVELOP CORRECTIVE ACTIONS.
5. WE WANT TO KNOW HOW TO ADJUST OUR ORGANIZATION'S SYSTEMS AND BEHAVIORS TO AVOID THE SAME KIND OF TROUBLE HAPPENING AGAIN.

(Conklin,2012, p. 67)

Don’t limit yourself to the quest for worker error or procedural non-compliance.

You will always find both.

(Conklin,2019, p. 51)

What's the quickest way to blame?

The Cramer Fire became an extended attack fire at approximately 1938 on Sunday, July 20. This should have triggered a need for a complexity analysis and a wildland fire situation analysis (WFSA). No complexity analysis or WFSA was prepared on July 20, 21, or 22.

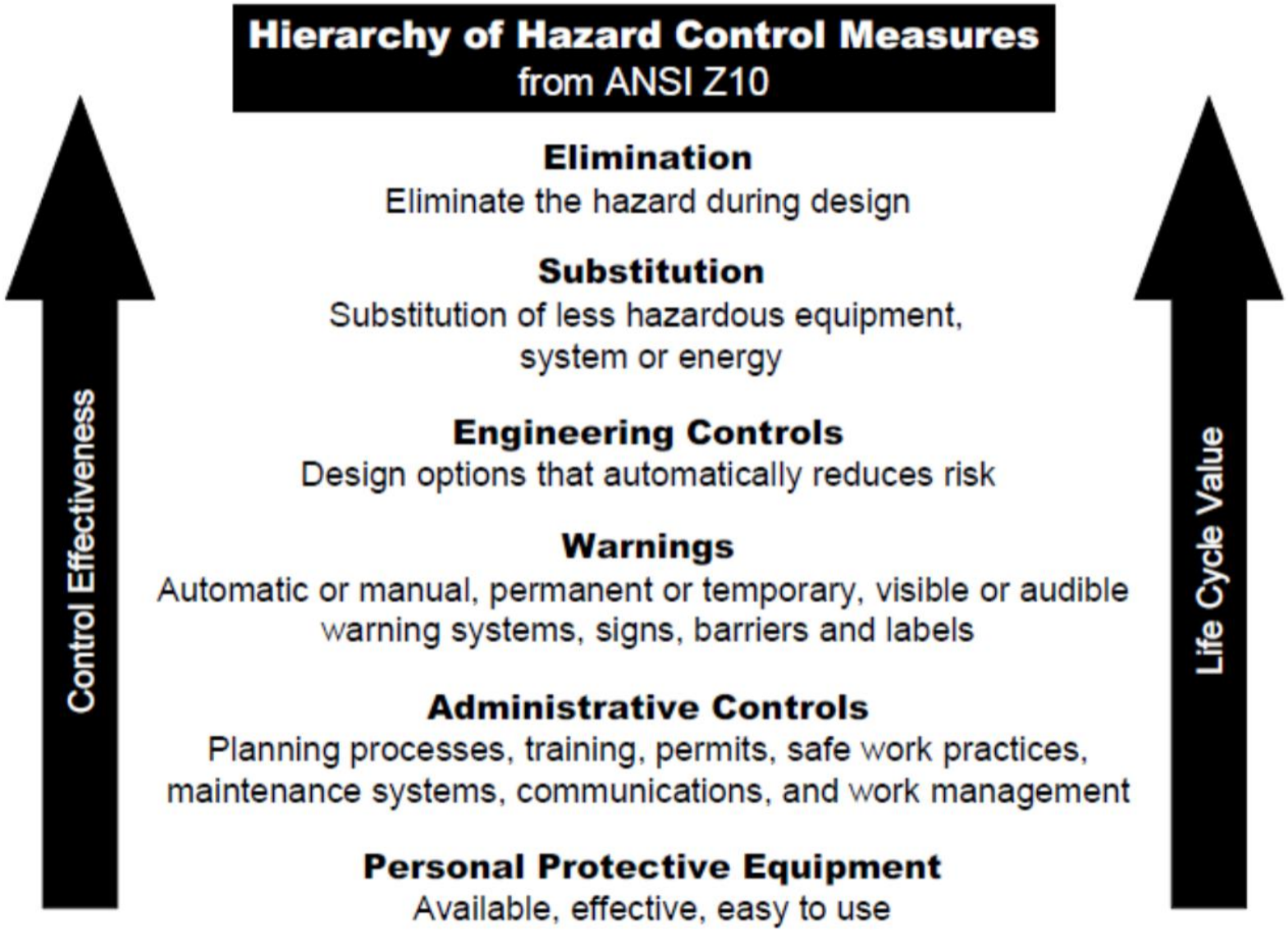
Causal Factors

Nine causal factors, developed from the findings, are listed below. They are acts, omissions, conditions, or circumstances that started or sustained the accident on the Cramer Fire.

1. Management oversight was inadequate.
2. The IC did not adequately perform his duties to execute safe and effective suppression operations.
3. The IC's attention was diverted to issues other than the Cramer Fire.
4. There was a failure to comply with policy.
5. There was a failure to recognize and adjust suppression strategy and tactics when initial fire suppression efforts failed.
6. There was a failure to accurately assess the fire situation, hazards, and risks on the Cramer Fire.
7. There was inadequate integration of the H-2 operation into the Cramer Fire operation.
8. There was a delay in formulating and executing a plan to retrieve the rappellers from H-2.
9. The rappellers were caught in a burnover.

Investigate what should have happened.

(UDA,2003, p. 1 & 4)



Note. From H. Floyd (2015), A practical guide to applying the hierarchy of hazard controls to electrical hazards. *IEEE Transactions on Industry Applications*, *51*, fig. 1.

Shame is the feeling that washes over us and makes us feel so flawed that we question whether we're worthy of love, belonging, and connection.

- Brene Brown, PhD, LMSW

(Brown, 2018, p.75)

We want our organizations and operations to become more . . .

Reliable and Resilient!

We have to move beyond –

Blame and Punish

Even beyond Error Prevention

To Error Tolerant systems

“Fundamentally,

people come to work to do what?

Good work!”

Response to an event

We need to answer the question . . .

*Do we want **retribution?***

or

*Do we want **restoration?***

*We can **blame and punish?***

or

learn and improve?

But we can't do both!

Principle:
Blame fixes nothing.

Assumption:
The worker is the problem.

Assumption:
We need to hold people accountable.

Belief:

- Blame is common because it is easier to blame than improve.
- Some of our biases make blame our first reaction.
- Blaming an individual will not change the probability of a similar event.

“It doesn’t take phenomenal ability to realize that a person who is given blame learns how to avoid the blame next time, while the person who gives blame learns nothing. As a result, things continue to go wrong . . .” Bill Salot

“…blame is the enemy of understanding.”

(Andrew Hopkins)

Questions?

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