ABOUT THIS BOOK

The Self-Correcting Organization

So what makes for a "Self-Correcting" organization?

In the same way that high functioning performers use mental models of what normal situations or performance must look like, so too organizations build proactive performance and learning systems which require a clarity of standards or references to "normal" performance. This is the starting point for reliability and the prevention of future error events.

In *Safety Management - The Challenge of Change* (Hale & Baram, 1998) the authors include a chapter by Mathilde Bourrier titled "Elements for Designing a Self-Correcting Organization: Examples form Nuclear Power Plants". After a caution regarding the dangers of investigator bias following error events, she references several points that describe the "normal functioning" of high-risk organizations:

- …paradoxical as it may sound…in order to follow procedures, one has to be able to modify them on the way. As one mechanic…explained: "*We have a procedure. We are expected to follow it exactly. But it's easy to come to a point where it doesn't work. But we have to follow it…a failure to follow and you are in big trouble*."

– The rigidity of a highly proceduralized Safety Management System may even endanger the integrity of the organization and its members, mainly because adaptation is not quick enough.

– What are the underlying organizational factors that account for rule following as opposed to rule breaking? It depends on the work structure, the design of responsibilities and/or access to resources, whether the unavoidable modifications to procedures will take place, either openly and legally or secretly and illegally. The reason that such modifications do not always take place openly and legally is that only some organizations have *built-in processes* that enable workers to modify rules and procedures.

So the performer who identifies the need to adapt a procedure to get the job done, but who believes that if they do they'll be in "big trouble", will be unlikely to make such adjustments. If they do make the adjustment they will be unlikely to report it for fear of punishment. So organizational growth and learning stall, except for the informal sharing amongst peers of the "secret" tricks to make things work.

Alternately the performer may just call their supervisor every time there's a variance and take no initiative. Again organizational learning and adaptation stall. And hapless supervisors find they don't have enough hours in the day to do all the trouble shooting.

Interestingly in our Leadership training workshops, such supervisors are the ones who seem to be called out most often to answer calls from work. Most of these calls come in two categories – either people don't know what to do and they have competency problems in dealing with variances, or they need permission to do something and there are problems with distribution of authority. Often these supervisors present with

overt expressions of stress and work/life balance issues. These, in turn, affect their ability to maintain resourceful states on a daily basis.

Bourrier goes on to say: "A successful self-correcting organization can thus be described as an organization capable of inventing explicit (as opposed to tacit) mechanisms to cope with unavoidable tensions between prescriptions and the reality of work situations."

She adds by quoting M. Landau (1973) *On the concept of a self-correcting organization*, Public Administration Review, 33(6) 53-539: "'Scientifically managed' systems cannot be scientific unless and until they are set on the foundations of criticism. For this is the only way to make an organization accountable, effective and reliable."

And even though organizations often perceive themselves as open and encouraging feedback, the reality in staff or safety meetings is that few will speak up (except amongst themselves at the break after the meeting). They feel it's not safe to speak. I spoke up last time and got shot down. I offered input but never heard back. I spoke up and my peers ridiculed or ostracized me afterwards.

So let's imagine an organization with built-in mechanisms that offer continuous improvement (Self-Correction) without any wrenching system changes! These mechanisms wouldn't demand new "programs of the year", but only that we continue to do what we've already been doing, albeit more thoughtfully and carefully.

But how?

In Part 1 we consider three proactive mechanisms that address the characteristics of Self-Correcting Organization referenced above. Chapter One addresses how we move authority around as operational context changes and how training must adapt

to accommodate each shift. Chapter Two provides a set of questions to analyze any performance management problem. And Chapter Three asks us to reconsider our training designs – particularly task analysis.

In Part 2 we examine a fourth opportunity, one actually required by law in many jurisdictions - Incident Investigation. Within Incident Investigation lies the golden opportunity to improve organizational function with the least amount of turmoil – by reshaping perceptions of blame. This fourth opportunity links back to the other three proactive, pre-incident activities that build reliable performance.

A *caution* regarding Part 2 - as we examine Investigation, particularly in response to human error in the workplace, we'll encounter troubling questions about past practices and assumptions. This section invites us to conduct Investigations quite differently than they have traditionally been done. I'll explain as we go, but first…

Cancer makes you better looking?

I had a cancer experience a number of years ago and learned a remarkable thing - cancer makes you better looking!

This may sound preposterous but it's fully evidence-based and to date there have been no exceptions. Here's how I know. Up until that cancer experience no one ever walked up and spontaneously told me how good looking I was. But afterwards, without exception, people have come up and remarked that I was looking really good. (They often omitted the "for a guy who should be dead" part.) This continues to the present day. Were we to meet in person it would probably be obvious to you as well.

If you're questioning my logic, you're not the first. Yet I regularly find logic like this in the workplace. Many "pundits" profess that

their programs for transforming a workplace are highly successful and that their success is "evidence-based." Apparently this is because they installed a program and then something changed.

Now I'm a big fan of things that work. And I'm always delighted when a cause/effect relationship can be shown to explain something that's otherwise puzzling. But personally, the "pundits'" logic often escapes me.

The most reliable process to "prove" a cause/effect relationship in the physical world is the scientific method. We hold all variables constant except for the one that we control and change. Then we study the effect and determine if a relationship can be established.

But in my 30-plus years of consulting and training in the workplace, I don't see much rigorous scientific methodology "proving" that programs delivered anything more than a Hawthorne Effect (See Wikipedia – Hawthorne Effect). Instead I see situations involving multiple variables within dynamic changing workplaces where erroneous assumptions about cause and effect are regularly made. Such assumptions, particularly where human error is a factor, often lead, not to progress, but to blame and other unwanted effects on the operation.

As physicians know, the first responsibility is to "do no harm." Likewise, managers, human resource and safety professionals, external consultants, and really all of us within a system are responsible, at the very least, to not make things worse.

Yet many of our current models of "causation" and our assumptions about how things work can fall prey to this same "correlation/causation confusion." This is akin to my proving how much better looking I apparently am after the cancer experience. Things that are related to one another do not necessarily imply a causal relationship.

In fact, searching for "the cause" is a big part of the problem. It leads to the question "Why". And, as we'll learn in Part 2, asking "Why?" in relation to human action is problematic unto itself.

So I make no claim here that *The Self-Correcting Organization* is a scientifically researched program that will transform your world. In fact it is not a "program" at all. It does however draw from extensive practical experience. And it offers a carefully chosen collection of approaches that encourage a different way of thinking about building reliability and responding to error in the workplace (and beyond should you so choose). And it includes a set of techniques that have proven useful in reducing the risk of doing more harm and in promoting faster organizational recovery. As such these will bring transformation with them. Many are currently in use in high reliability organizations such as aviation and nuclear power generation.

Websites and workshops are dangerous?

When the precursor to this book, *The Art of Safety*, was published, one of the promotional strategies was to submit it to professional associations for consideration and review. The goal was to have the book included in their resource libraries or to become a choice at their bookstore.

Many of these associations were kind enough to review the book. One decided not to include it in their bookstore because the book made suggestions to go to a website for additional free resources and to consider workshop attendance to learn behavioral skills associated with the book's content. These were skills which could not be mastered without practice. Such suggestions were dubbed professionally inappropriate.

If you have similar concerns, you risk limiting your professional development. Many of the skills described herein are best mastered with practice and feedback. I encourage you to seek out related information, do your own research, talk to others

and find learning events that allow for skills acquisition. You can find resources at the end of the book. At the very least grab a learning partner and practice.

Non-verbal communication expert Michael Grinder has often lamented the tendency to "over-train and under-implement." You can reverse that trend by finding appropriate learning opportunities that provide the skill practice and behavioral feedback required to master your new skills. When you consciously repeat them, they become automatic parts of your repertoire.

What to expect

Again The Self-Correcting Organization is *not a program*. It is a **way to think** about reliable performance, operational failures and errors, and your response to them.

And it offers a **series of techniques** from which you can pick and choose.

It *is* about:

- How different operational contexts require different management approaches
- How to easily diagnose performance management problems
- The power of effective Task Analysis
- Investigator mindset
- Personal skill enhancement
- Developing respectful influence
- Enhanced interview techniques
- Accountability and forgiveness
- Analysis through learning teams
- Recommendation Analysis

It is not about:

- Physical conditions and systems (i.e. engineering or ergonomic analysis)

Human unreliability and equipment risk cannot be managed in the same way. Equipment does not present itself with free will, competing interests, variable attention or intentionality, at least not yet.

Application

These approaches and techniques can be applied across the spectrum of workplace experience:

- Performance Management
- Training and Development
- Patient Safety
- Response to:
  - Errors
  - Failed Plans – Strategic or Operational
  - Injuries, incidents
  - Equipment damage
  - Environmental discharge
  - Violence/harassment/discrimination
  - Organizational failures
  - Problem solving
  - Audits

Many of the interview techniques are also immediately transferable to employment interviews and counseling applications.

And why bother with the investigation piece?

When things happen the eyes of the organization focus on that operational area, those people, that process. There's a rare pause in day-to-day operations that allow us to examine our

systems and figure out how well they are working or not working. Investigations offer that pause. And, in many jurisdictions, investigations are required by law. Management and workers are expected to cooperate in analyzing and developing responses. What a unique opportunity!!

The expected outcomes, of course, are recommendations to prevent further downgrading incidents and improve operations. Performance reliability improvements are at the heart of such recommendations.

Try this thought out.

If prevention is the primary goal of investigation and you're still experiencing repeat incidents, it's likely your current investigations are not working the way you hoped.

Read that again.

When a mechanism intended to provide continuous improvement doesn't work, the effects ripple through every part of the system.

Consider this. Every question asked within the organization is a mini-intervention. If I ask someone, "What can we do to improve things around here?" I've already created an expectation in that person that something will happen as a result of their input. If nothing ever happens, or they never hear back, then the next time I ask how we should improve I'm more likely to get an "I don't care, whatever you want" response.

We directly shape people's experience of the organization by how well we handle ourselves interpersonally, particularly during investigations and inquiries. This will then shape their performance in "normal" performance situations and their response to variance when adaptability is required.

If an innocent question like "Why?" can take us where we least expect, then imagine where in-depth interventions, clumsily handled, might lead.

An organization's level of error tolerance will profoundly shape its culture.

Keep in mind that an organization's response to error and its level of error tolerance will directly shape its safety and organizational culture in profound ways.

Stop thinking about investigation as a chore!!!

It's *the* on-going mechanism to make your organization a self-correcting one.

And embrace the fact that performance happens in a variety of contexts that demand different approaches.

Any of us can literally be the change agents who transform an organization simply by adopting different approaches to tasks you're already doing.

Will it be easy? No.

Will it happen overnight? Definitely not.

But can it be the most satisfying experience of your career? **Without doubt.**

Having committed many of the classic mistakes and moved past them I can personally attest to this.

Pushing against other peoples' beliefs or their ways of doing things, often produces resistance. It took me a long time to accept and recognize that the resistance was a comment on me, not them. I told you this wouldn't be easy.

And having "test driven" the concepts you're about to master in workshops over many years we've received consistent feedback. That it's "about time", "a breath of fresh air" and it's "consistent with what we already know goes on".

Changing beliefs and installing new practices requires that we acknowledge and enter other peoples' versions of reality. It's the only way to build rapport. Once we've demonstrated our willingness to listen and understand their viewpoint, whether we agree with it or no, only then can we move out from that point into new territory. Only then will we begin to hear honest accounts of what really goes on at the front line. And nothing is more satisfying than successfully nudging people toward innovations that make a positive difference for them and the organization.

Remember you don't deal with another department or a layer of management or a stakeholder, you deal with a *person* in that department, at that level or who represents that stakeholder group.

So let's begin with the context(s) within which we work to build reliable performance. After all, "It depends" is not only an answer, it's a path to the appropriate question.

Then we'll examine the current state of performance and error response in many organizations. We'll ask where, despite our best intentions, have we strayed off the path? And how we can get back on course.