Avetta Summit 2025

Confidence BEYOND Compliance

Avetta Summit 2025

Confidence BEYOND Compliance

KEYNOTE

Making Operational Excellence Work

Fisher Improvement Technologies

online.improvewithfit.com

Avetta Summit 2025

Confidence BEYOND Compliance

KEYNOTE

Making Operational Excellence Work

Matt Schlapfer
Senior Consultant
Fisher Improvement Technologies

Fisher Improvement Technologies

online.improvewithfit.com

Who is this guy?

15+ yrs Health, Safety & Training in high-risk Industries (Aviation, Mining, Civil, Oil & Gas, MHF, Medical).

Partnered with Fisher Improvement Technologies 15+ yrs as a Human Factors/Human & Organisational Performance Specialist.

Specialties in:

- **Human & Organisational Performance (HOP) Deployment & Integration**
- **Advanced Error Reduction in Organisations (AERO) Integration**
- **Learning from Success & Failure / Root Cause / Catastrophic Failure Analysis / Incidents and Near Misses/Human Adaptability**
- **Procedure / Programs / Process Excellence**
- **Leadership Coaching**

Conducted over 50 successful integration strategies in:

- Manufacturing / Heavy Industry / Chemical / Oil & Gas
- Utilities / Generation / Transmission / Distribution
- Construction / Mining / Refining / Engineering
- Aviation /Agriculture/Supply Chain

Matt Schlapfer

Personal Background

- Chef
- Underground Mining Technician
- Offshore Safety Coach
- Executive Mentor and Coach
- Tennis Enthusiast

matt.schlapfer@improvewithfit.com

+61 (0)437 511 222

Some FIT Clients

Is it reasonable to **BELIEVE** ?

Why
Human & Organisational Performance?

Three Mile Island, 1979

Chernobyl, 1986

Leaders
Drive Operational Excellence

The Gear Model

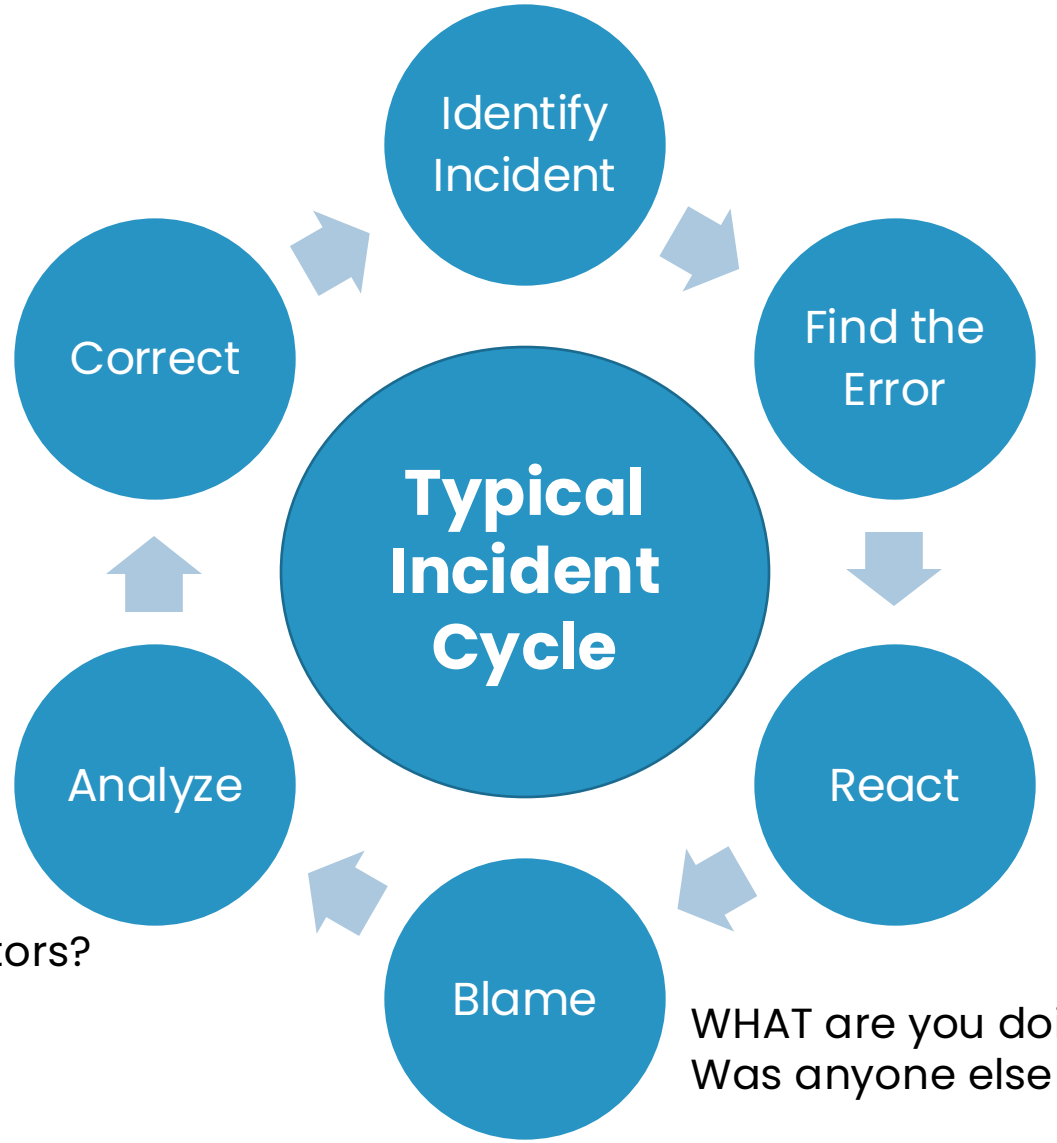
If you want someone to shift their paradigm you must give them a new paradigm that makes more sense to them than the one you are asking them to leave

Dekker - 2019

Where the focus SHOULD be!

Injury?
Quality Upset?

Lost Production?
Operations Problems?
Customer Problems?



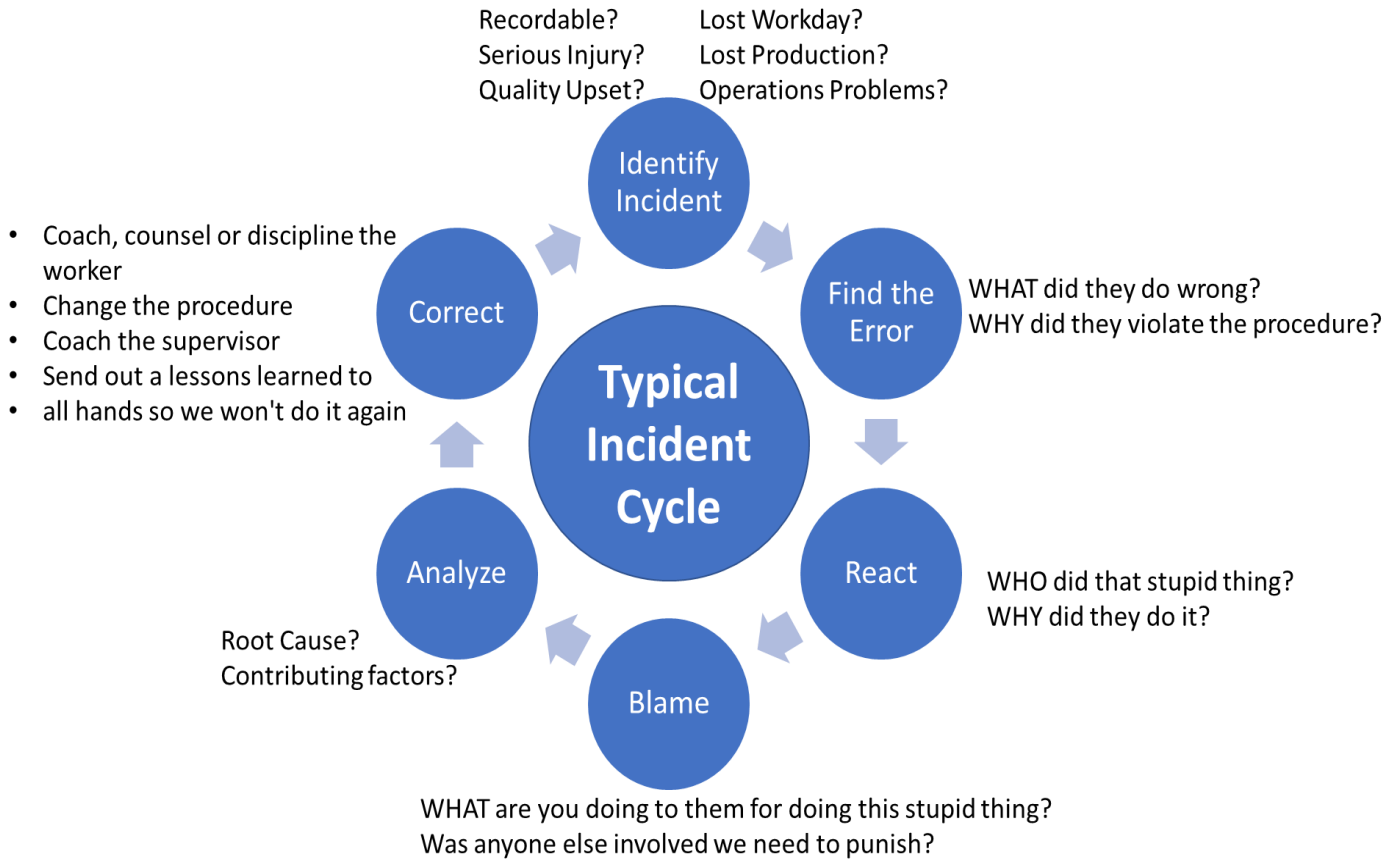
- Coach, counsel or discipline the worker
- Change the procedure
- Coach the supervisor
- Send out a lessons learned to all hands, so we won't do it again

WHAT did they do wrong?
WHY did they violate the procedure?

WHO did that stupid thing?
WHY did they do it?

WHAT are you doing to them for doing this stupid thing?
Was anyone else involved we need to punish?

Root Cause?
Contributing factors?



Typical tools enable this cycle, but it is usually not the tool that is bad but the application of the tool…

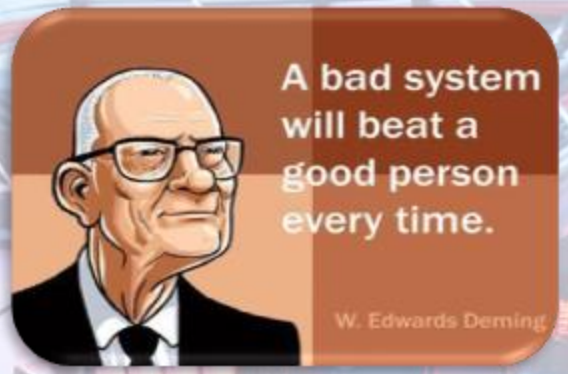
- "Why" Staircases are opinion-based
- Fact-finding meetings DON'T
- Root Cause analyses don't go deep enough to fix the real problems
- Accountability models are there to do just that

How has that been working?

- Serious injuries flat
- Surprised by events
- Repeat incidents
- Low Worker engagement
- Trust is low
- Accountability is always a problem
- High Turnover

We must
***THINK* differently,**
***SPEAK* differently, and**
***ACT* differently**
to do better!

Systems Theory and Systems Thinking



Deming

Rasmussen

Reason

Dekker

Conklin

* - Derived from "Out of the Crisis", W.E. Deming, 1996

The 5 Principles of HOP

Error is Normal

Blame Fixes Nothing

Systems Influence Behaviours

Response Matters

Learning is Essential

Derived from 5 Principles of HOP, Todd Conklin, Ph.D.

Moving From Concepts to Behaviours

Error is Normal

- Science-Based Definitions and Applications
- Performance Modes, Traps, Triggers & Tools

Blame Fixes Nothing

- Blame as a human instinct
- Blame can be managed

Systems Drive Behaviours

- The task-based System, Essential Leadership Cycle
- Deviation and Adaptability Analysis

Response Matters

- Leader Response Matters
- Moving from a Reaction to a Response

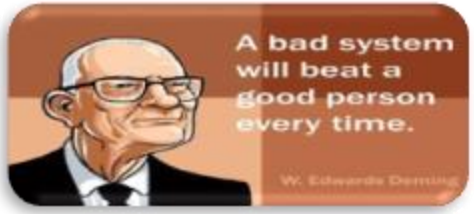
Learning is Essential

- Incident, Near-Miss, and Task Learning
- Essential Leadership Cycle

Most problems in industry are related to **Human Error…**

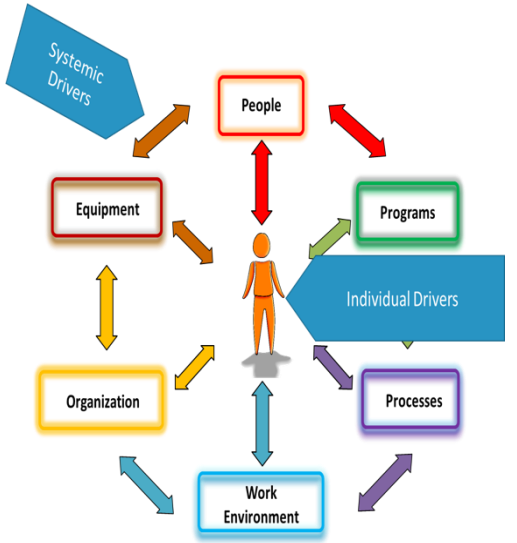
Some Basic Understandings

90% of events are caused by something **OTHER THAN JUST** the individual*



95% of people react very similarly (physiologically) to the same stimuli

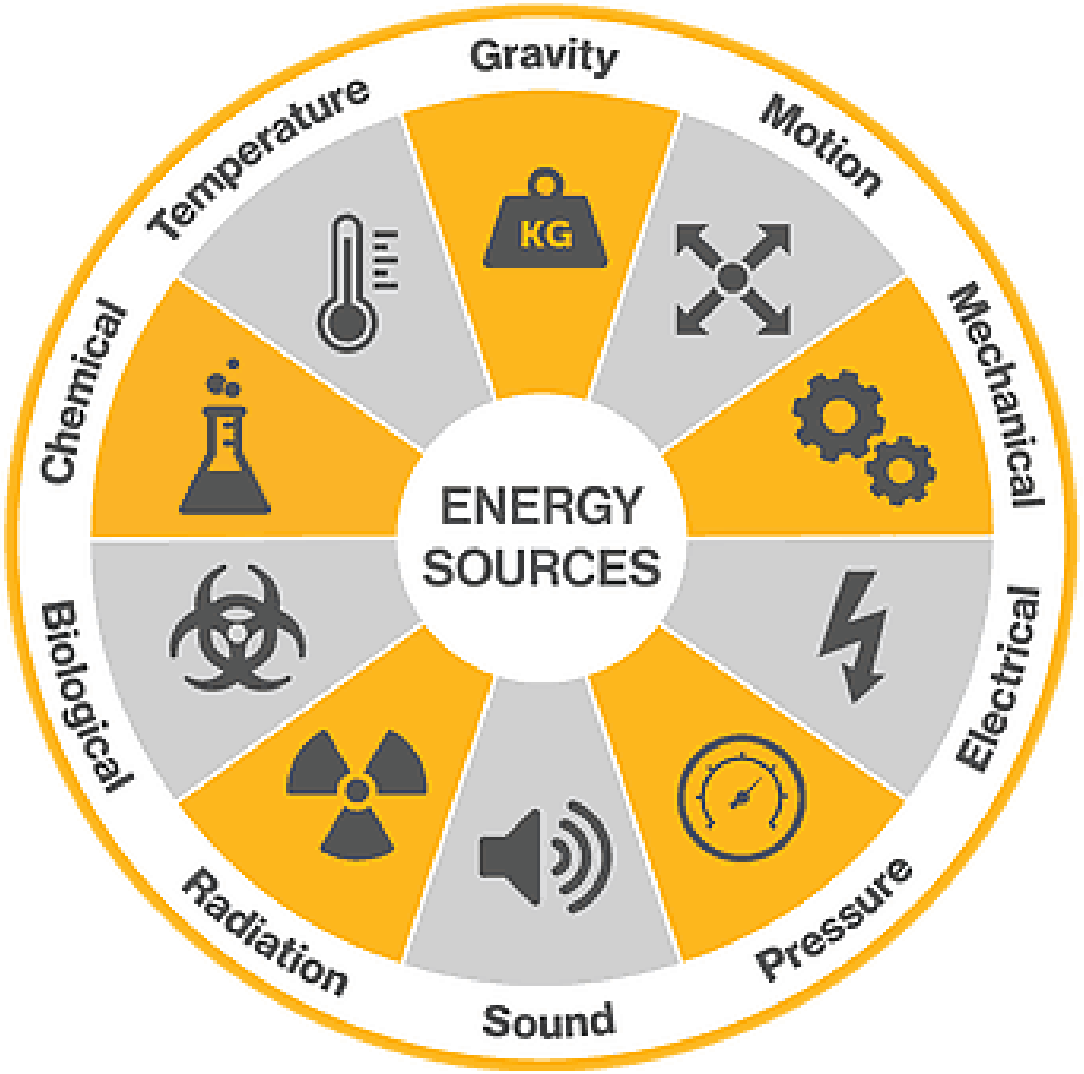
People do what they do, at the time that they do it, for reasons that make sense to them at the time**



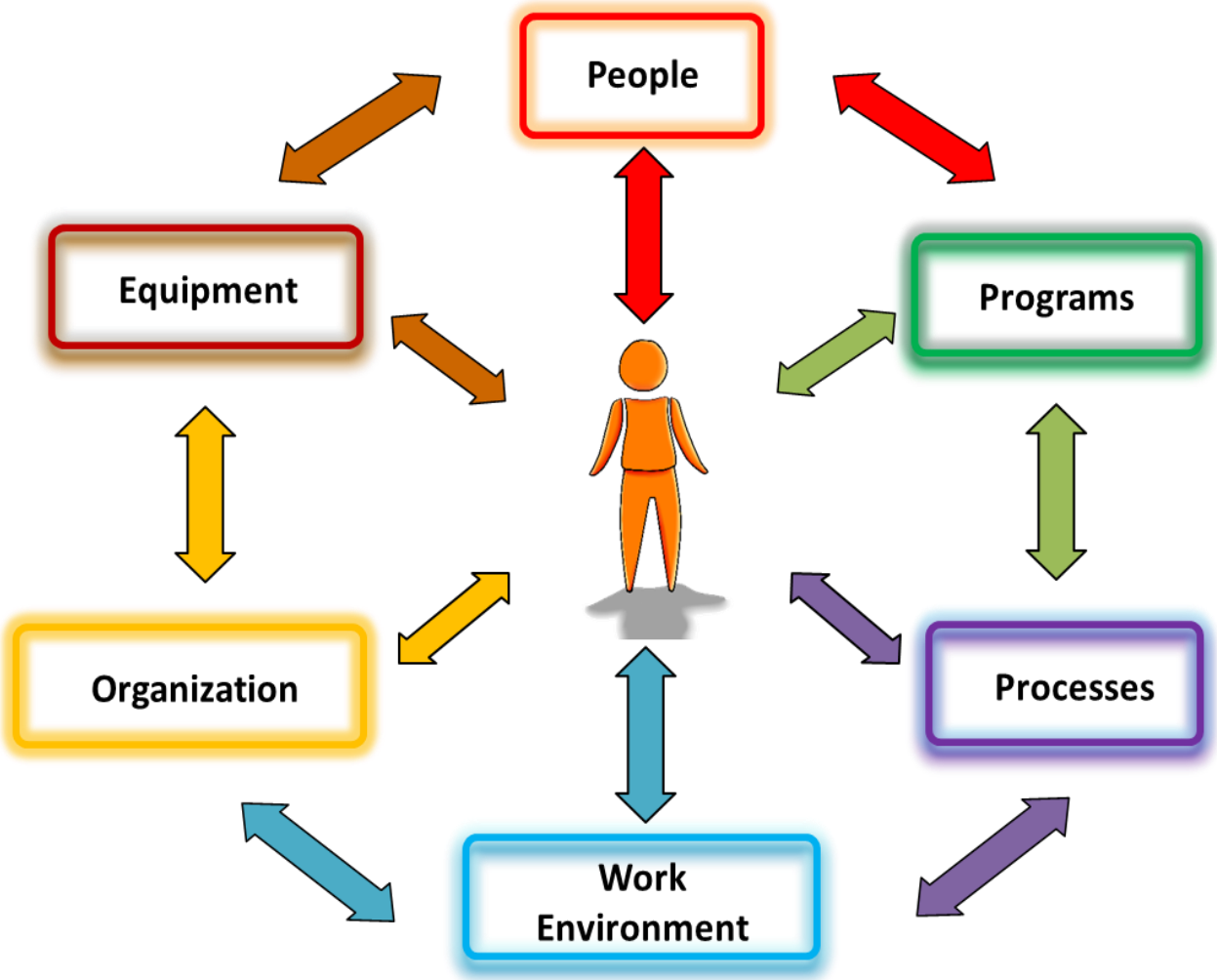
HOP is **NOT** common sense!

* - Derived from "Out of the Crisis", W.E. Deming, 1996
** - Derived from "The Field Guide to Understanding Human Error", Sidney Dekker, 2013

Two Types of Hazards…

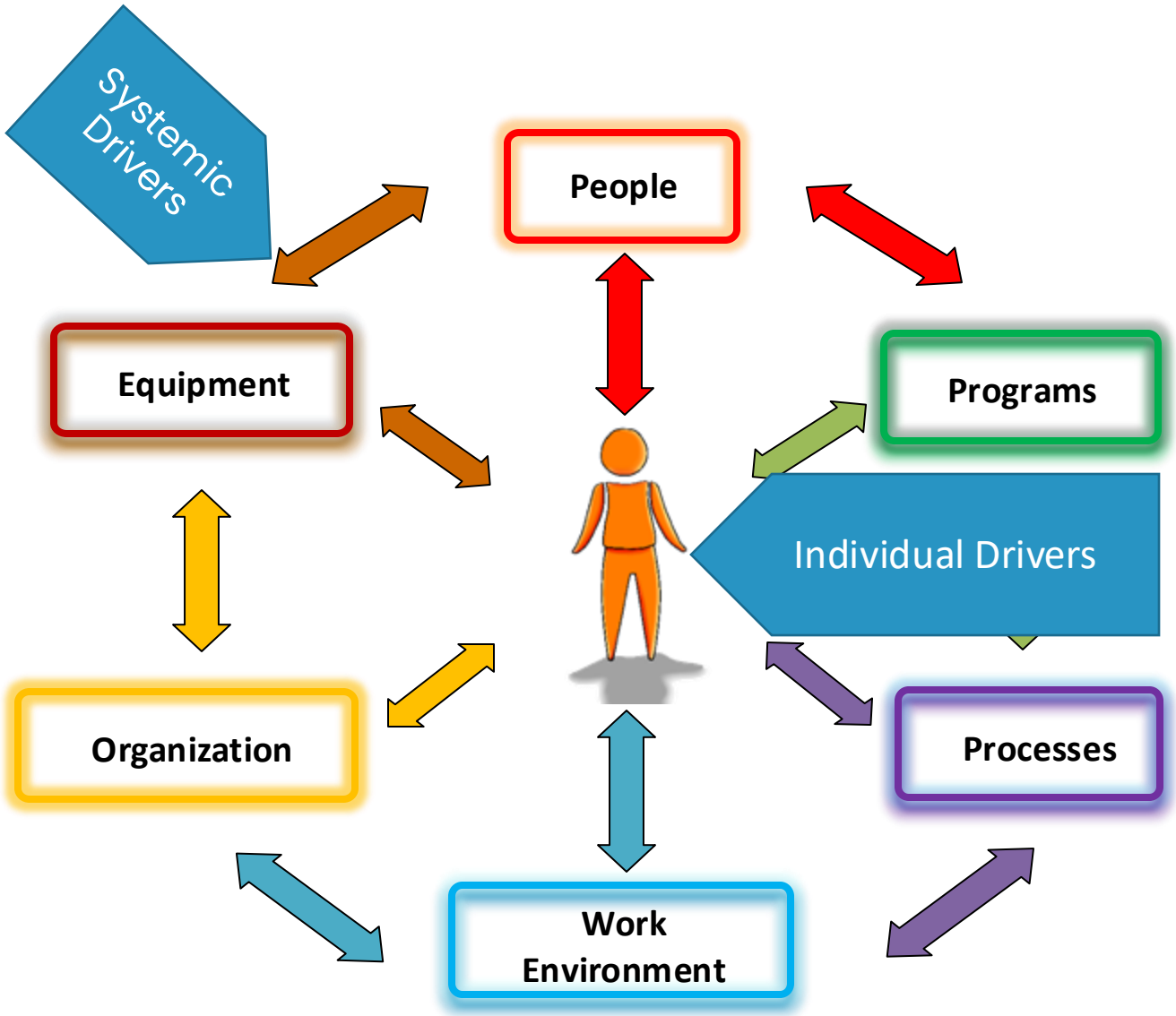


Physical



Performance

The Task-Based System



Science-Based Definitions

Error
An action or inaction that **unintentionally:**
- Results in an undesirable or unwanted condition OR
- Leads a task or system out of limits OR
- **Deviates** from a rule, standard, or expectation

Event (or incident)
The undesirable result of an error, a set of errors or a set of conditions

Deviation
Not strictly complying with a rule, standard or expectation

Violation
An action or inaction that intentionally deviates from a rule, standard, or expectation

Active Error
An action or inaction that results in immediate consequence

Latent Error
An action or inaction that results in consequences that are delayed or create latent conditions

We **MUST** learn to separate the **ERRORS** from the **EVENT**

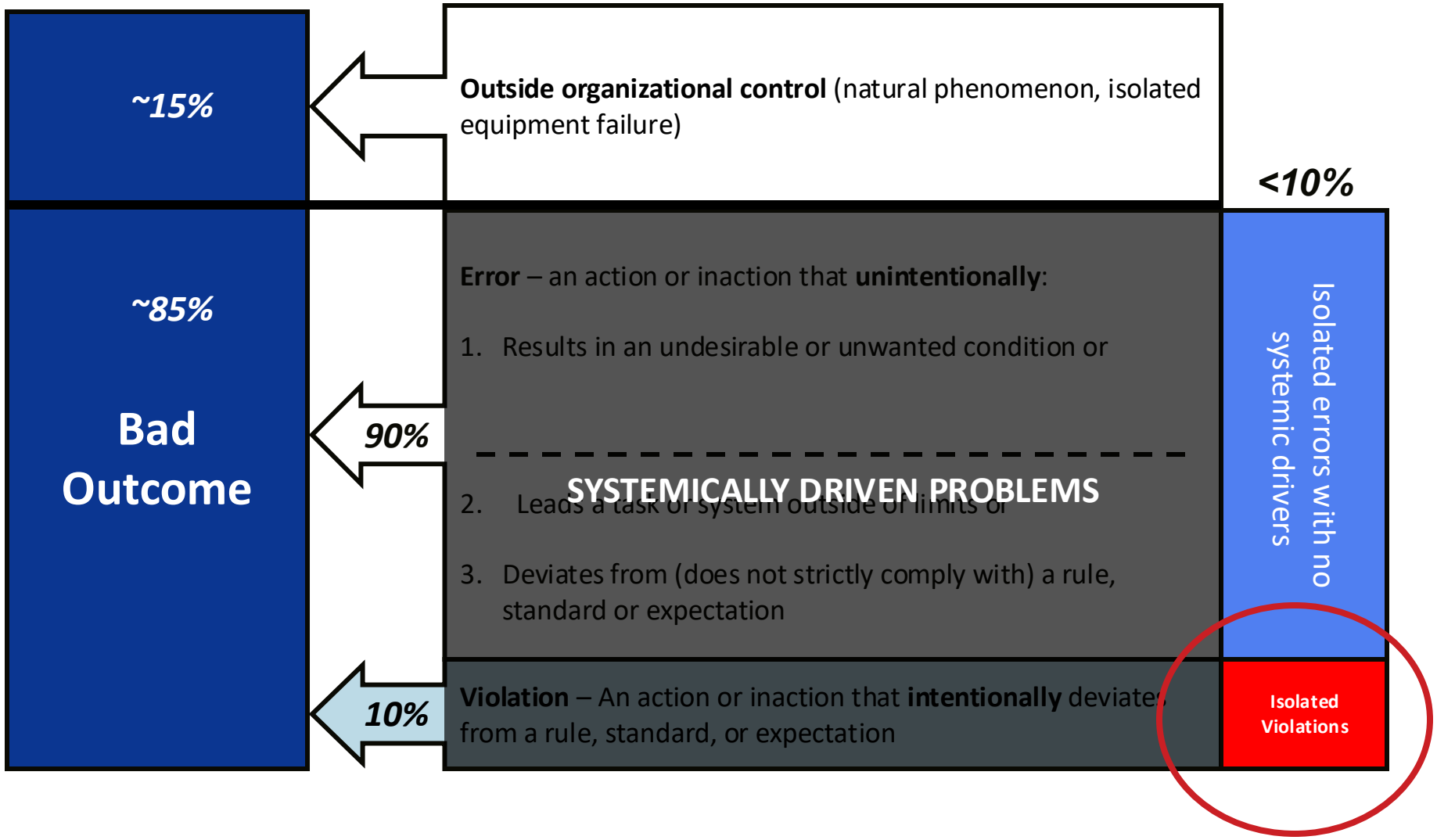
ERRORS and **VIOLATIONS** are **DIFFERENT THINGS**

We **MUST** pay **ATTENTION** to **ALL TYPES** of **ERRORS**

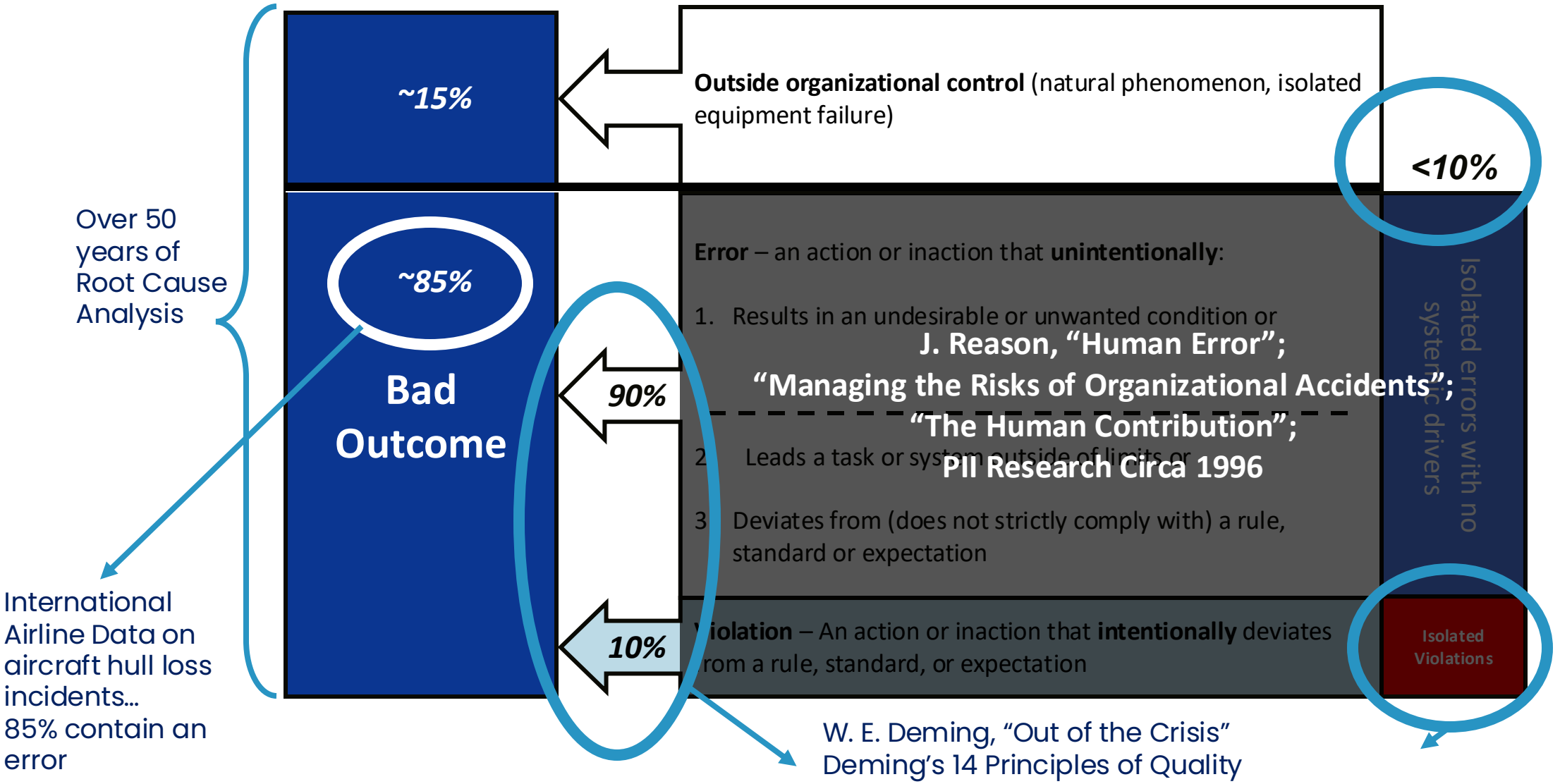
If LEADERS don't know the definition of Error…

it is hard to get the workforce to believe you want to help prevent them.

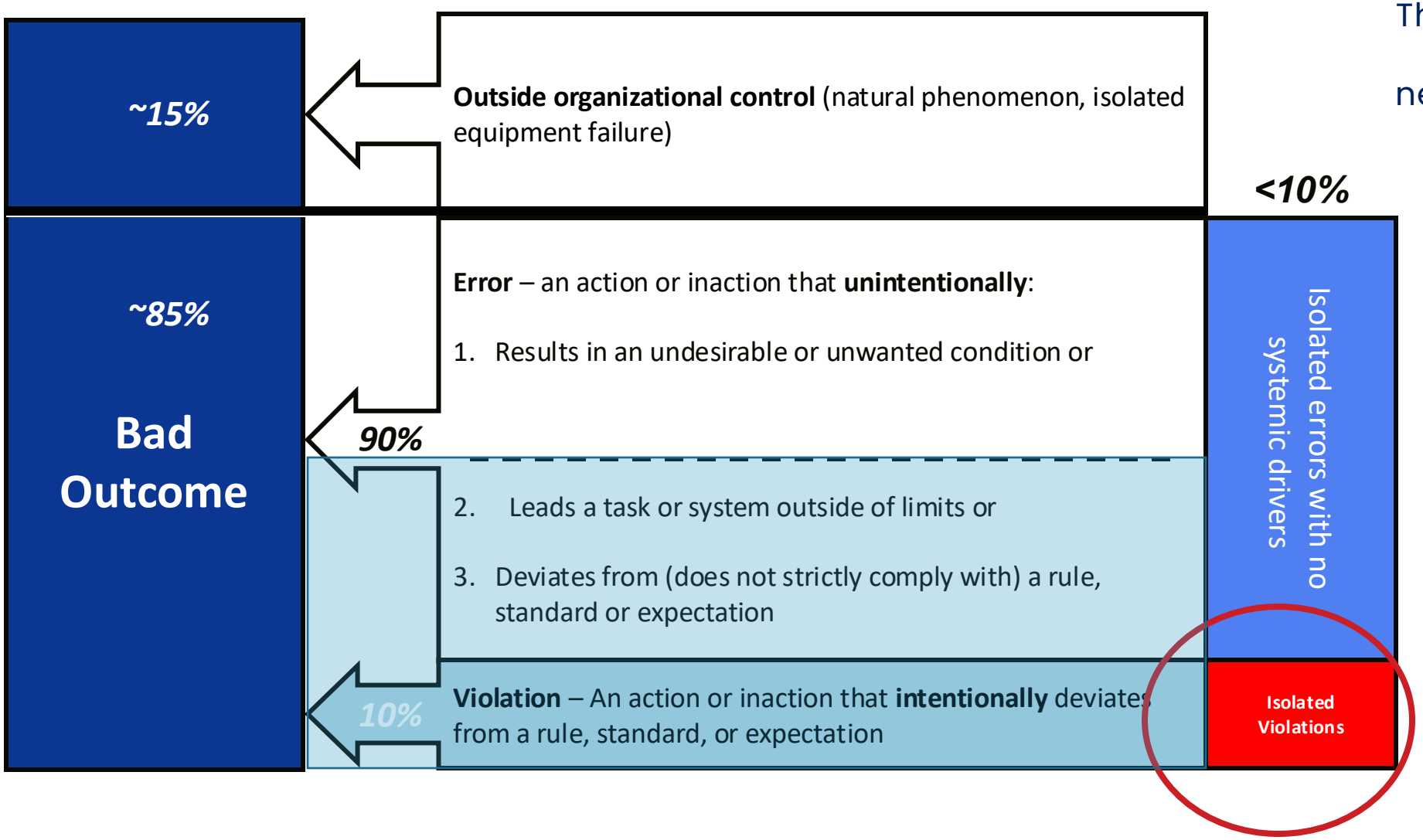
How Bad Things Happen



How Bad Things Happen



How Bad Things Happen



There are two major reasons companies identify fewer near-misses than they really have…

1. The leaders haven't changed their understanding and language around errors and violations, and

2. The leaders revert to old language and behaviours when something bad happens (or almost happens)

Leaders
Ask Better Questions

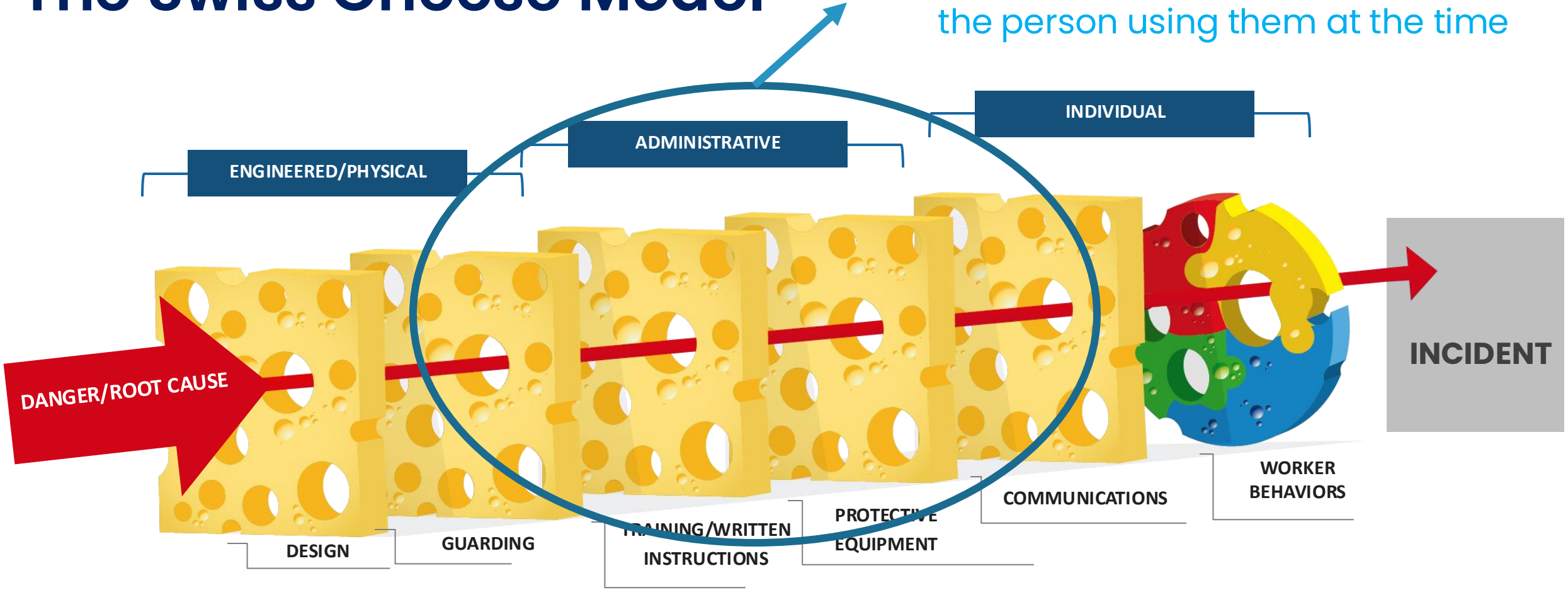
Instead of WHY?

Engage with T E D S

TELL me…	what happened and how it happened
EXPLAIN to me…	the conditions under which this occurred
DESCRIBE to me…	how this played out – how did we get here
SHOW me…	where this happened and other places it could happen

The Swiss Cheese Model*

Administrative barriers fail at the rate of the person using them at the time



Failed Barriers CANNOT be Root Causes

*Designed after Dr. James Reason's Swiss Cheese Model – Managing the Risks of Organizational Accidents

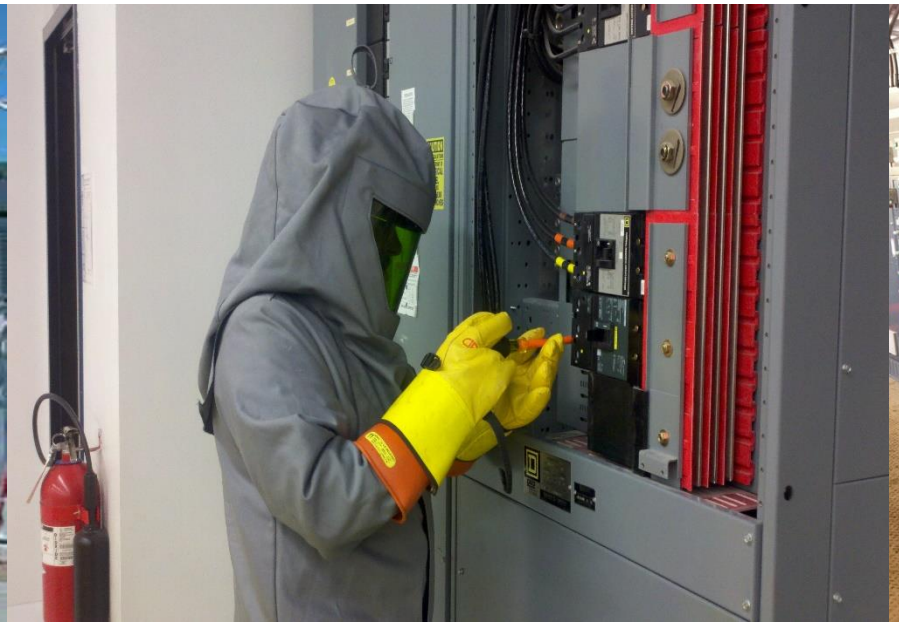
HOP: **Performance Modes**

Performance Modes
Relate to…
This **PERSON** on
This **TASK** at
This **TIME**

HOP: **Performance Modes**

WE ARE HIRED TO DO AN ***OCCUPATION*** OPERATOR-ELECTRICIAN-TECHNICIAN-ENGINEER-WELDER…				
THESE OCCUPATIONS REQUIRE US TO DO ***JOBS***	SWITCHING, WELD, DRIVE FORKLIFT, DESIGN SYSTEM, OPERATE SYSTEM, PERFORM LOCKOUT-TAGOUT			
THESE JOBS CONTAIN ***TASKS***	**LOCK-OUT TAGOUT SYSTEM "A"**	**DRIVE FORK LIFT INTO THIS TIGHT PLACE TO HANDLE THIS LOAD THIS WAY**		
THESE TASKS CONTAIN ***ACTIONS (STEPS)***	Hang locks on each electrical supply	Hang locks on each water supply	Lift load up to see tight space	Load goes into area in truck

HOP: **Performance Modes**



Understanding Performance Modes
improves our abilities at the **TASK** and **STEP** level

HOP: **Performance Modes**

Performance Mode	Characteristics	Error Rate
Skill Based	Habitual tasks that need low to no conscious thought and you don't have to think… (>50 times and <7 steps)	**HABITS** **1:1000**
Rule Based	There is a rule and the person knows the rule exists but does not have to KNOW the rule (we cannot know all the rules)…	**PROCESS** **1:100**
Lack of… **Knowledge Based**	The person does not know what they don't know – they THINK they know but have some doubt… **You cannot THINK your way out!**	**GAPS** **1:2 – 1:10**

What's in it for

WORKERS?

AERO: Why **Performance Modes?**

Avoids having to work in the face of **UNCERTAINTY**

Makes them aware of **PROBABLE FAILURE** rate

Allows them to **APPLY THE RIGHT TOOL** for the situation

HOP: **Performance Modes**

Applying
The
right tool,
The
right way
in the
right situation
reduces
error rates
by a
factor of 10!*

Source: * Using the right tool the right way in the right performance mode reduces your error rate by a factor of 10. Derived from James Reasons creation of GEMS based on Rasmussen's research.

What's in it for

Leaders ?

HOP: Why **Performance Modes?**

When designing or preparing for tasks, consider whether the task may put people in **KNOWLEDGE-BASED MODE**

When observing tasks – knowing the performance mode **"FRAMES" THE OBSERVATION**

When something does happen… allows you to **RESPOND APPROPRIATELY** for the situation

Top 10 Error Traps

- Stress
- Multi-tasking/High workload
- Time pressure

All Feel the Same

- Poor communications
- Vague/poor written guidance
- Overconfidence
- Infrequent or first-time task

Put us in or keep us in Knowledge Based Mode

- Distractions
- First working day following time off > 4 days
- The end of work shift or extended hours

Interact With Other Traps

“We h e good esses…
If we uld ju get eople
to fo w th n we uld
fine!”

Procedure Error Drivers

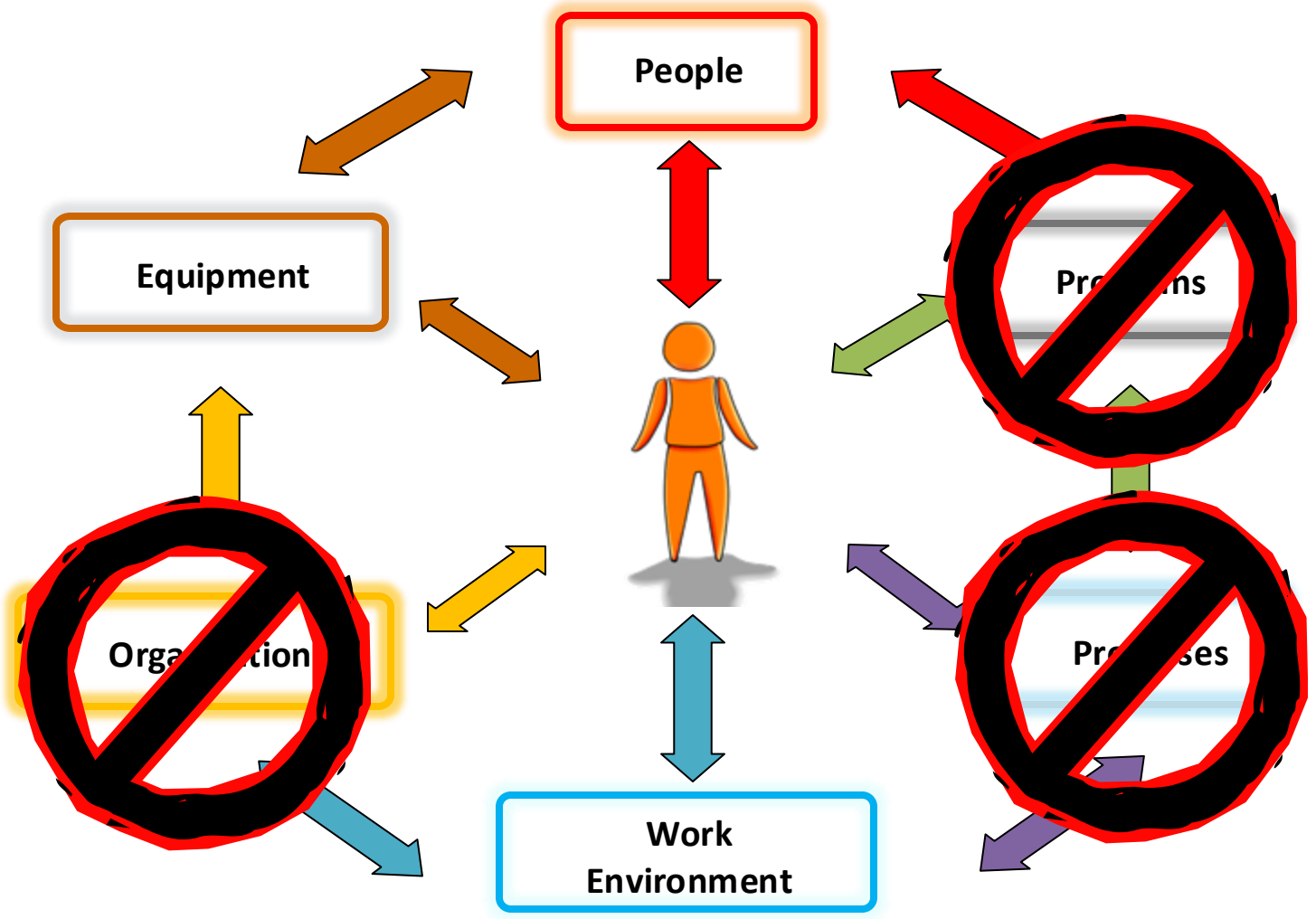
These traps put you in or keep you in Knowledge-Based Performance Mode where the Error Rate is 10%-50%!

There are 20 known error traps that writers put into guidance that *DRIVE* errors!

- Poor communications
- Vague/poor written guidance
- Overconfidence
- Infrequent or first-time task

Triggers for this trap include:
If applicable / when applicable
If needed / when needed
If appropriate / when appropriate
If required / if desired

How many of these traps do you think the average guidance developer knows?



Key Error Reduction Tools

Verbalise, Point & Touch
Step-by-Step
Stop & Seek Out Help

} Individual

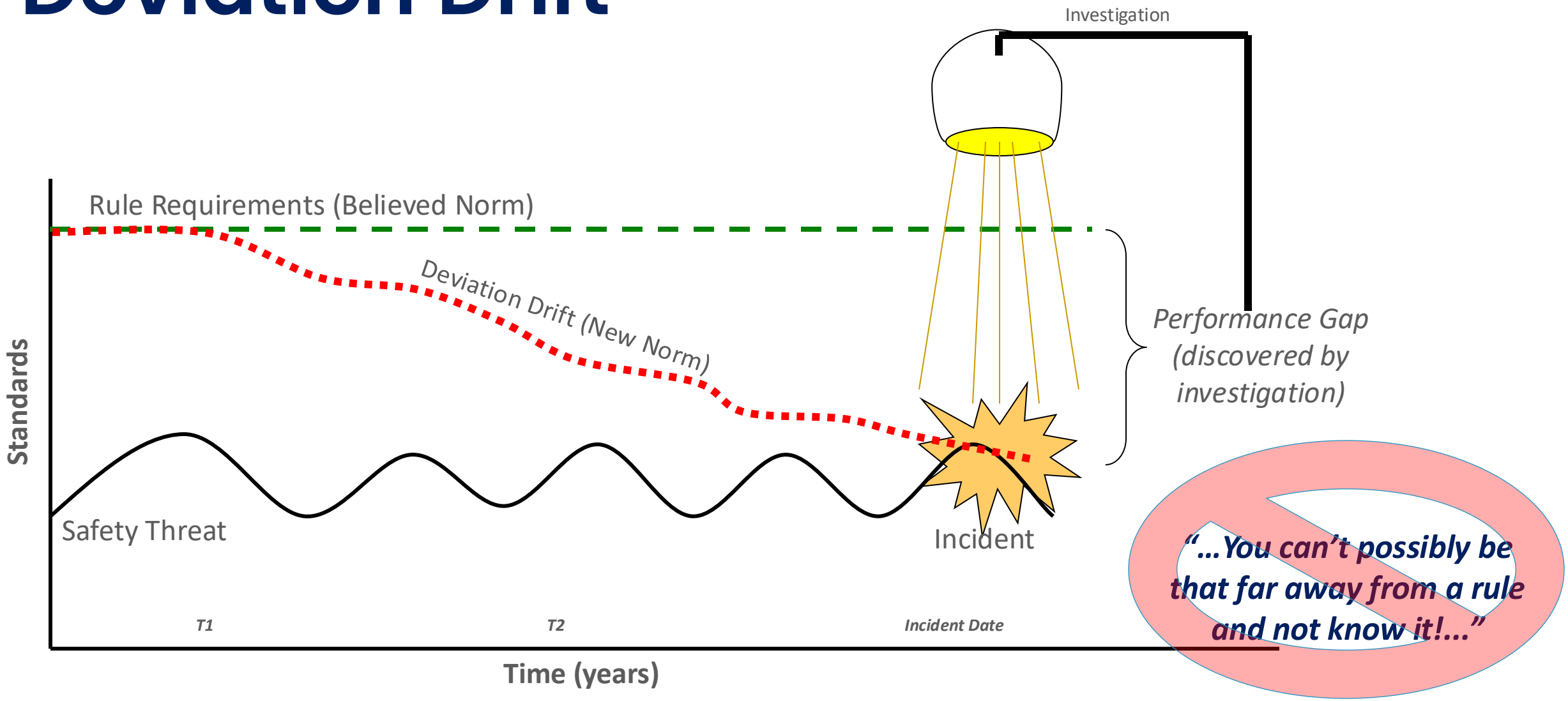
3-Part Communication
Pre-Task Brief & Workflow process

} Group

Show & Tell
Values-Based Engagements &
Method based observations
High-Risk Task of the Day
Essential Leadership Cycle

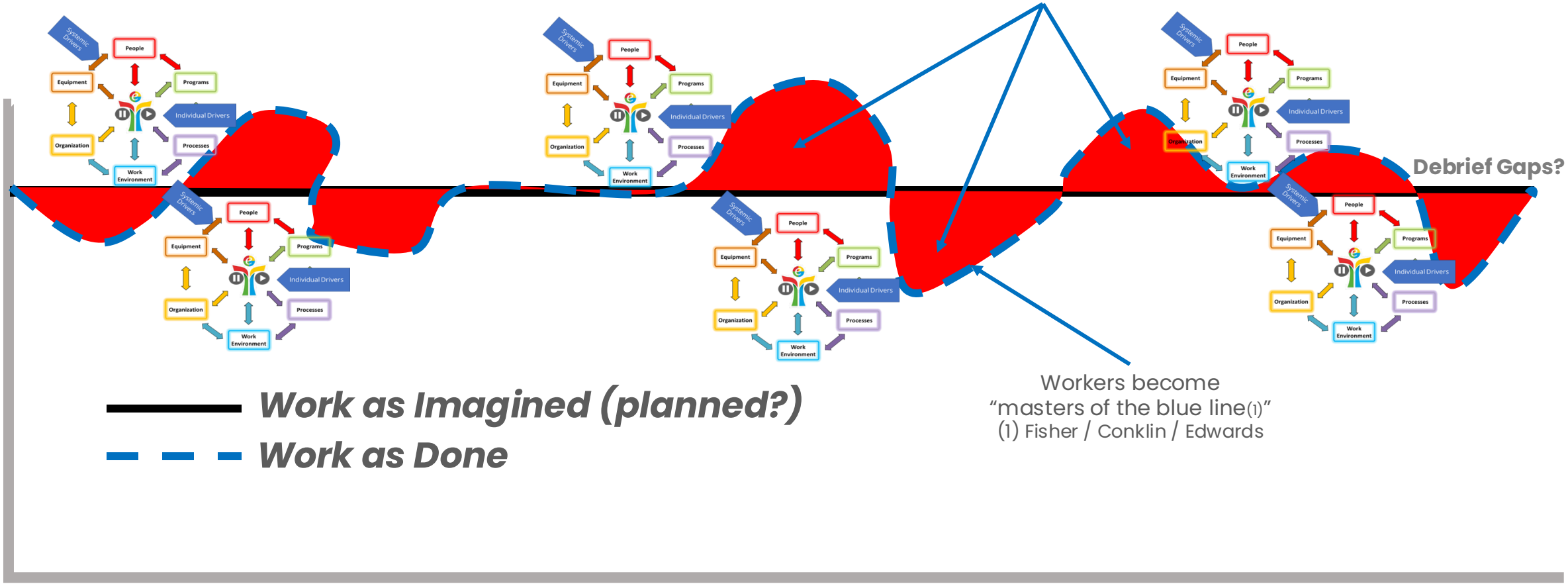
} Leader

Deviation Drift



Real Drift….

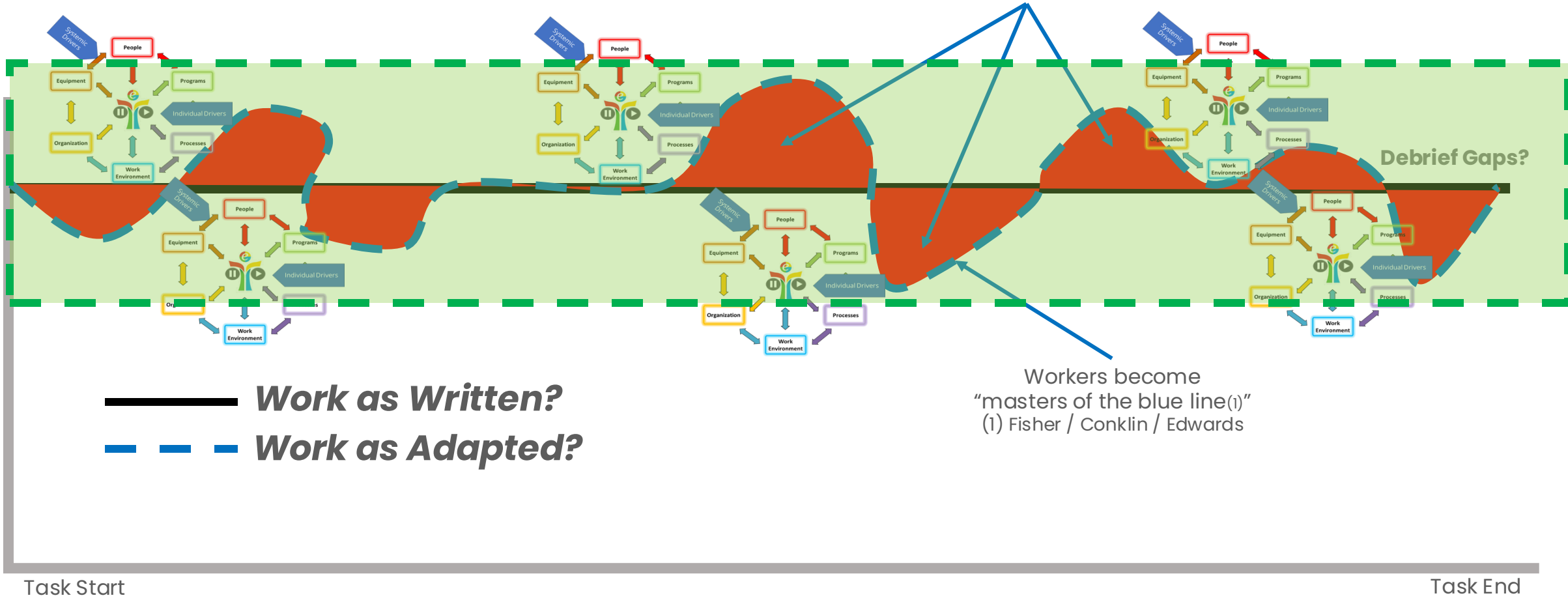
Adaptability



What is the probability that the need for adaptability is systemically driven?

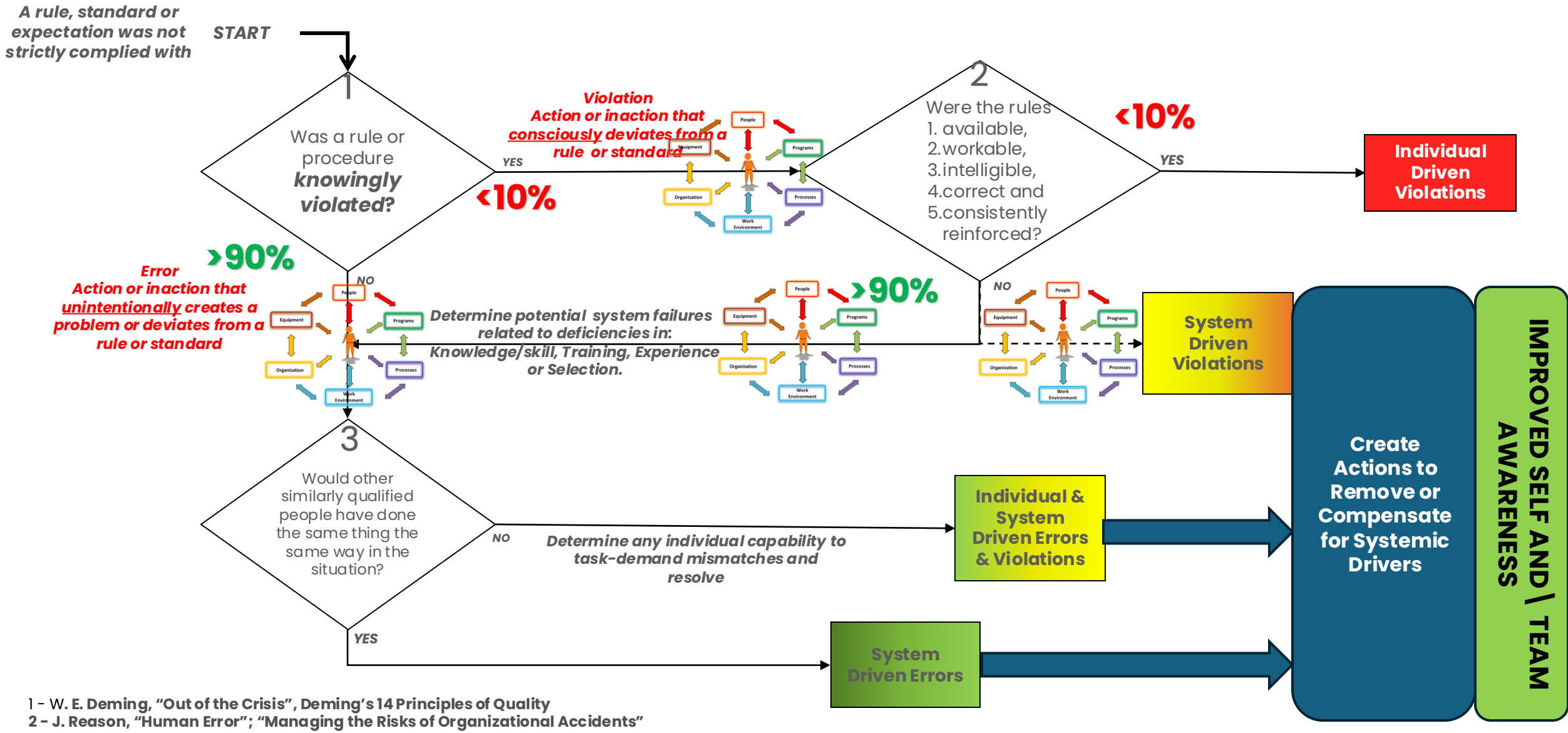
Real Drift….

Adaptability



The WORKERS can tell us the control limits!

Deviation (Adaptability) Analysis



1 - W. E. Deming, "Out of the Crisis", Deming's 14 Principles of Quality
2 - J. Reason, "Human Error"; "Managing the Risks of Organizational Accidents"

Derived from "Managing the Risks of Organizational Accidents", James Reason, 1994, pp 209

ERROR IS NORMAL

If you don't know what it is, how they happen, what drives them, and what you can do about it… it is hard to prevent.

Leaders must know and use the definitions DAILY

Error
An action or inaction that **unintentionally:**
- Results in an undesirable or unwanted condition OR
- Leads a task or system out of limits OR
- **Deviates** from a rule, standard, or expectation

Event (or incident)
The undesirable result of an error, a set of errors or a set of conditions

Deviation
Not strictly complying with a rule, standard or expectation

Violation
An action or inaction that intentionally deviates from a rule, standard, or expectation

Active Error
An action or inaction that results in immediate consequence

Latent Error
An action or inaction that results in consequences that are delayed or create latent conditions

Blame Fixes Nothing

It is not about shifting blame or accountability…

Treat “blame” like the 11th Error Trap

It is about finding the drivers of errors and events and increasing organisational learning.

Top 10 Error Traps

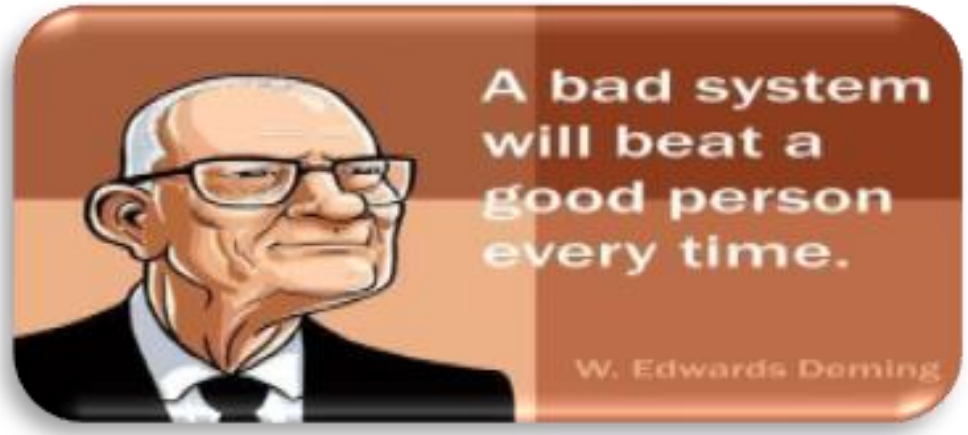
▪ Stress ▪ Multi-tasking/High workload ▪ Time pressure	All Feel the Same
▪ Poor communications ▪ Vague/poor written guidance ▪ Overconfidence ▪ Infrequent or first-time task	Put us in or keep us in *Knowledge Based Mode*
▪ Distractions ▪ First working day following time off > 4 days ▪ The end of work shift or extended hours	Interact With Other Traps

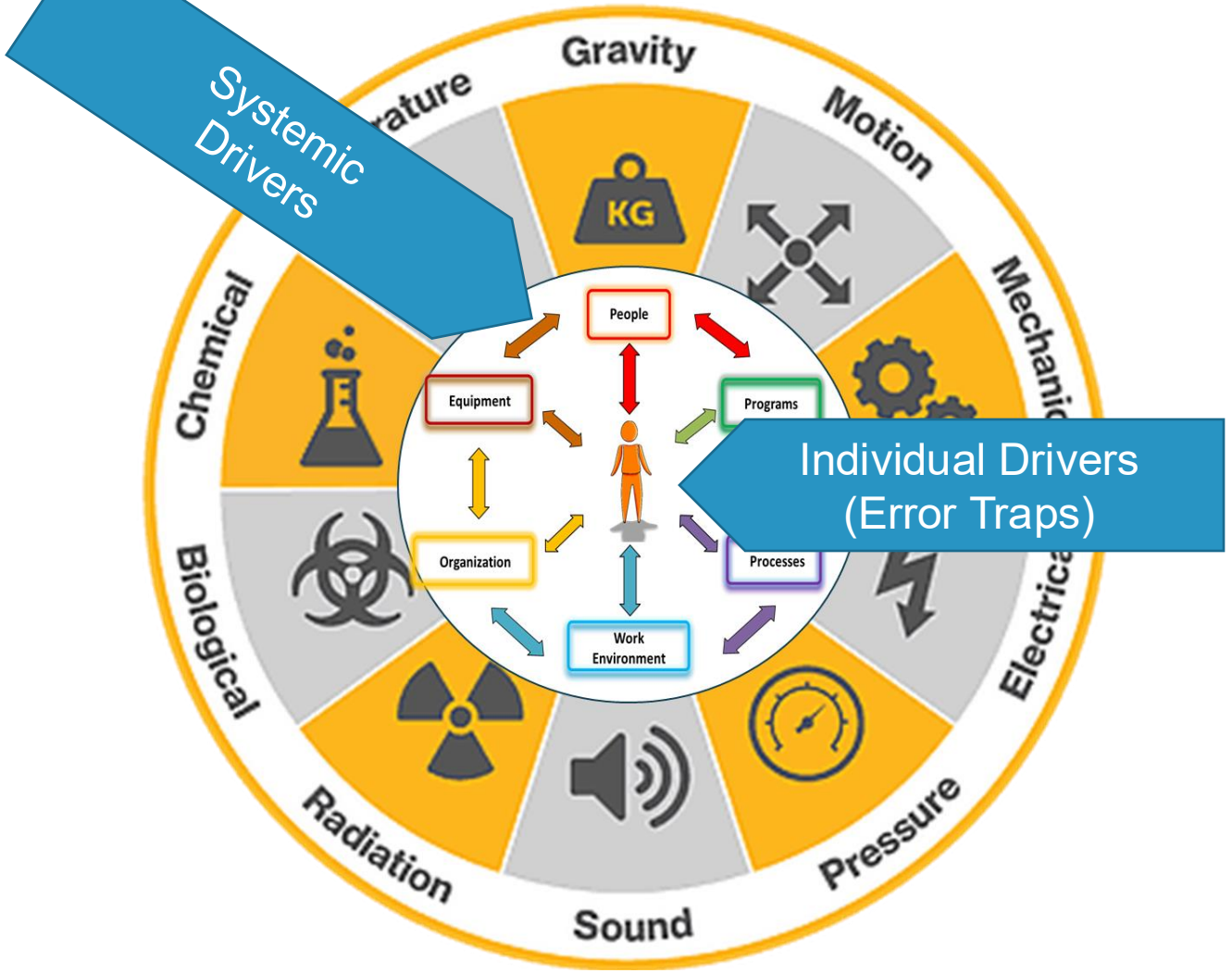
#11 – BLAME!

SYSTEMS INFLUENCE behaviour and CONTEXT DRIVES behaviour

People do what they do, at the time that they do it, for reasons that make sense to THEM at that time!

(Systemic & Individual Drivers)

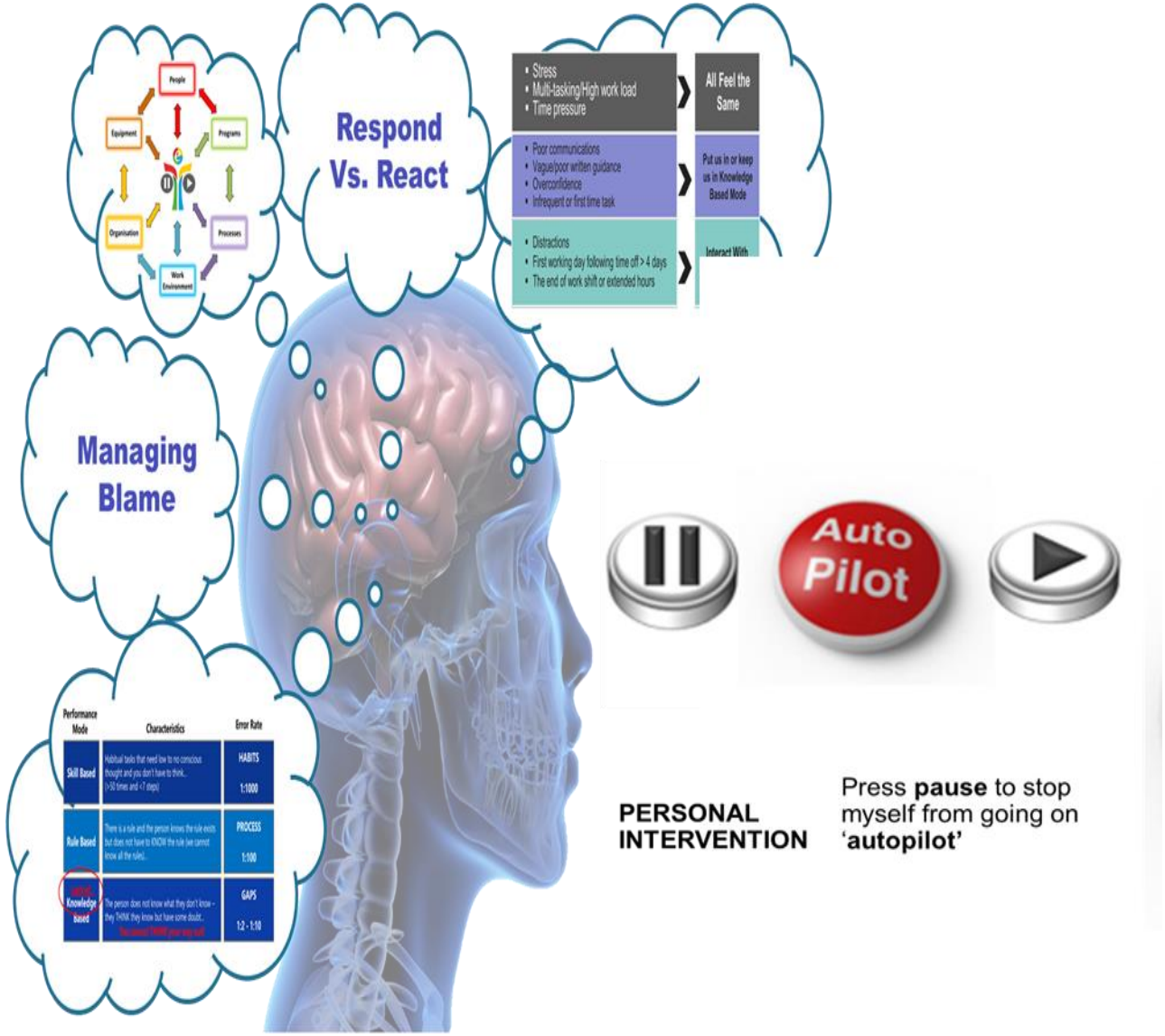




Response Matters

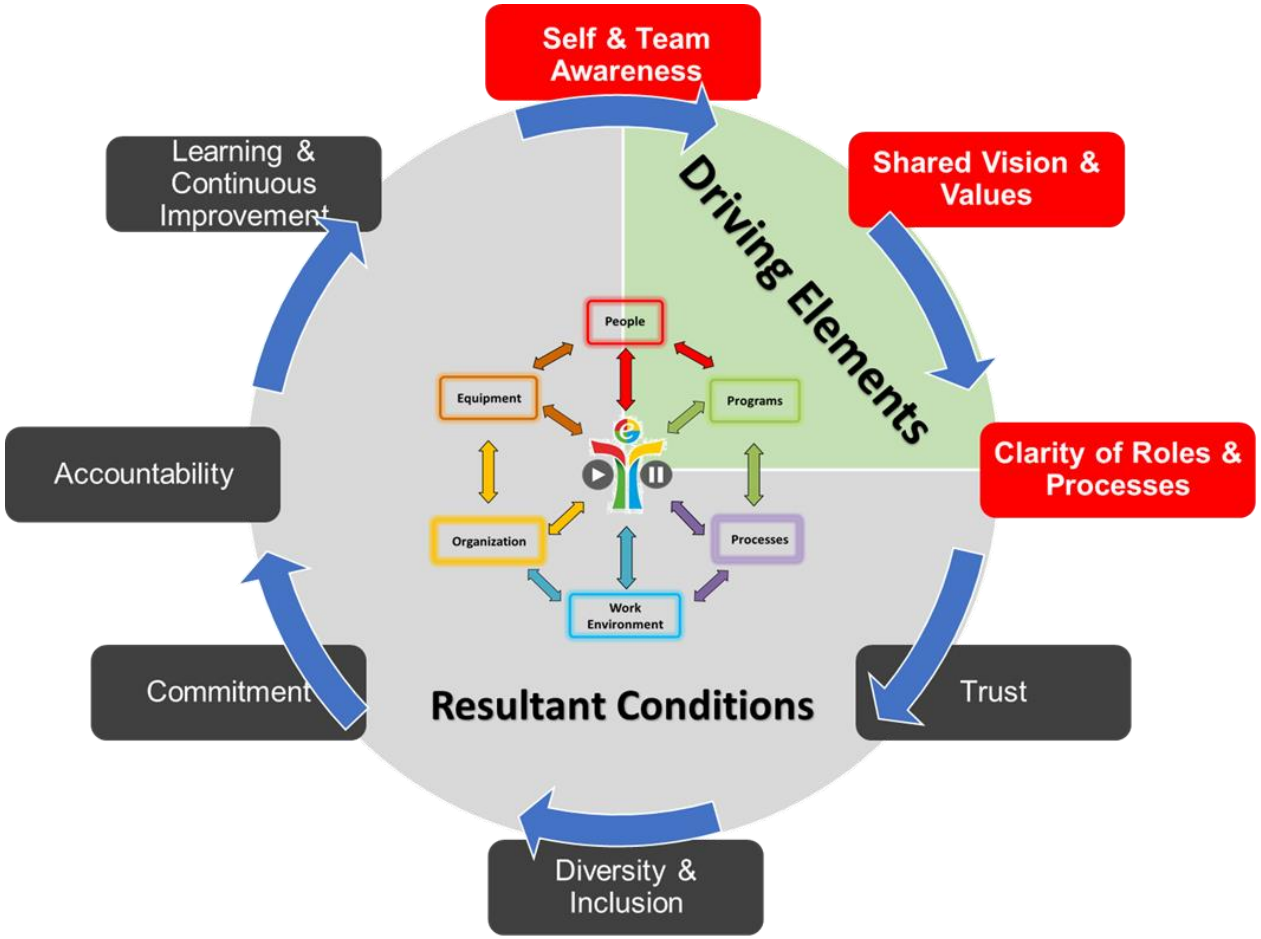
There is a difference between a reaction and a response

Leader response to success AND failure matter



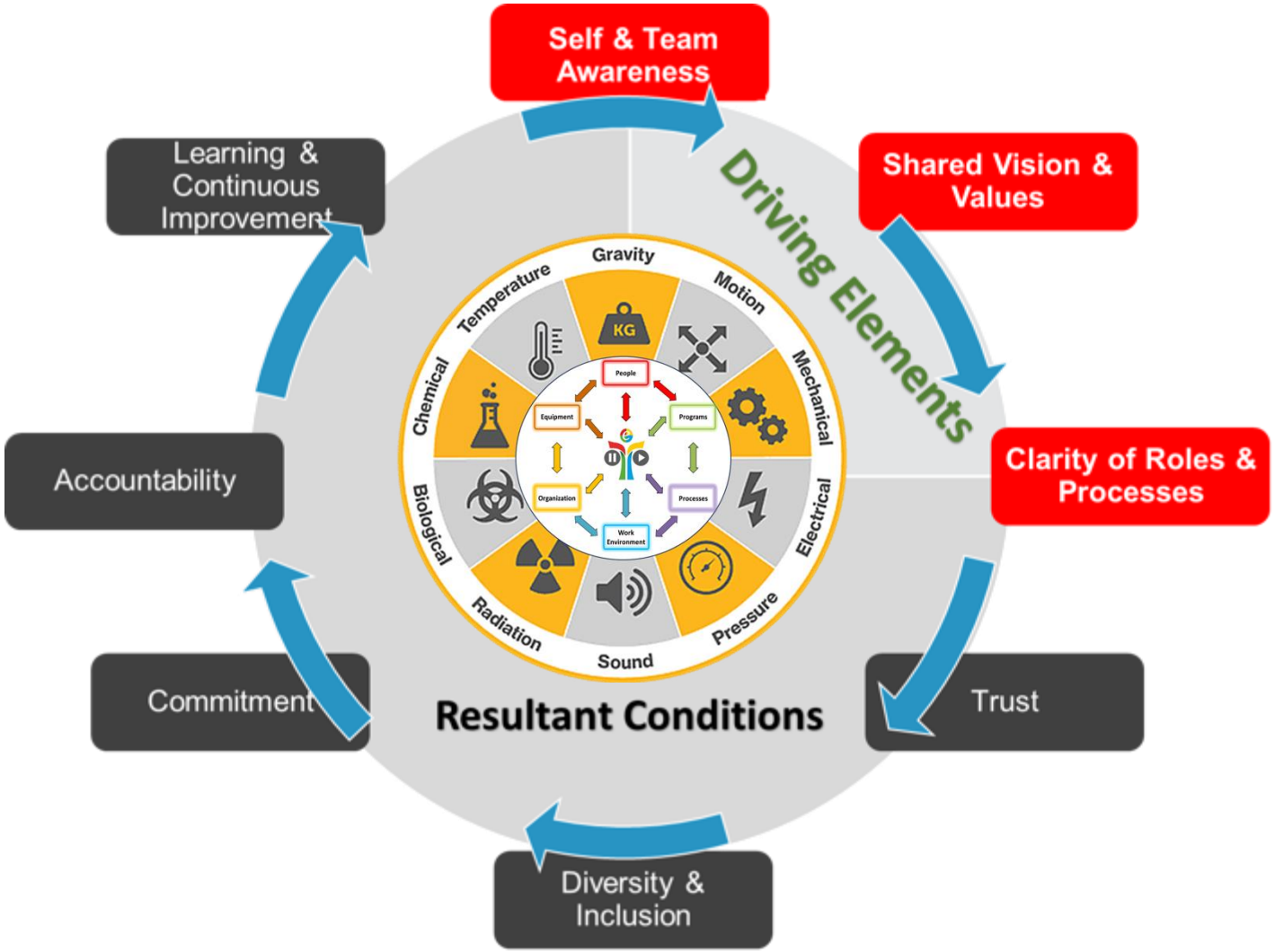
Learning is Essential

Lessons aren't learned until individual and organisational behaviours and systems sustainably change.



Use the Essential Leadership Cycle to manage outcomes

Systems and context influence behaviour



Essential Task Cycle

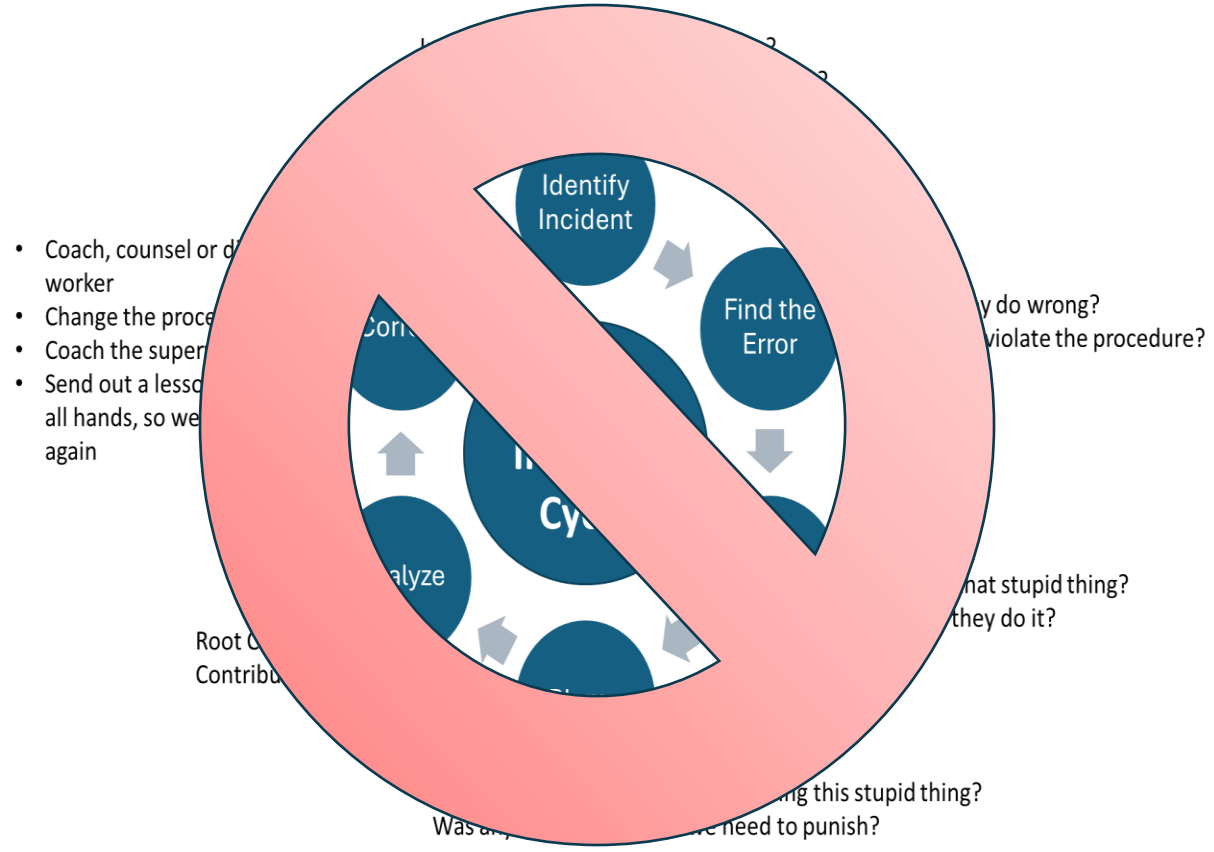
An interdependent system where individuals interact with people, programs, processes, work environment, organization and equipment and manage the physical hazards that produce harm

Essential Leadership Cycle

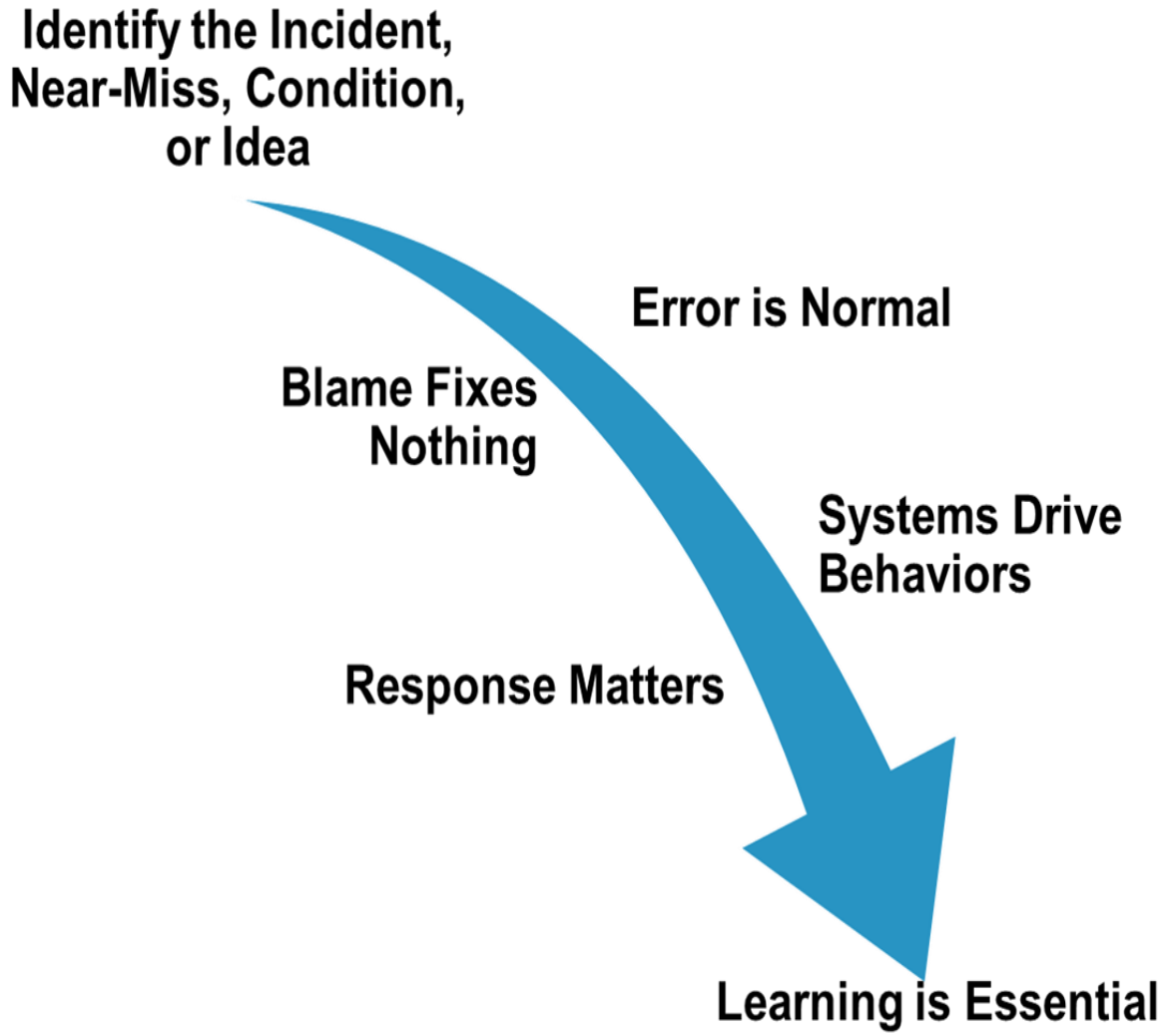
How an organization controls and manages the task-based system.

ELC Podcast

OLD View of Incidents



NEW View



NEW View

Incident Potential

Performance

Identify the Incident, Near-Miss, Condition, or Idea

Error
An action or inaction that unintentionally:
- Results in an undesirable or unwanted condition OR
- Leads a task or system out of limits OR
- Deviates from a rule, standard, or expectation

Event (or incident)
The undesirable result of an error, a set of errors or a set of conditions

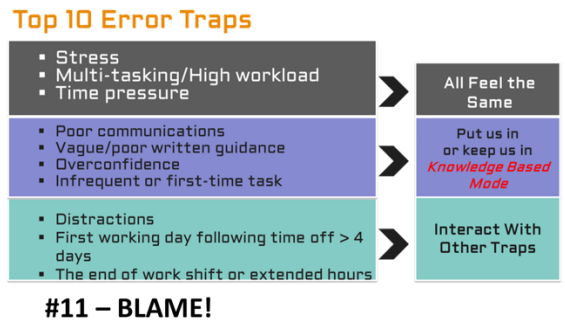
Deviation
Not strictly complying with a rule, standard or expectation

Violation
An action or inaction that intentionally deviates from a rule, standard, or expectation

Active Error
An action or inaction that results in immediate consequence

Latent Error
An action or inaction that results in consequences that are delayed or create latent conditions

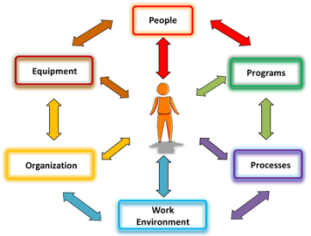
Error is Normal



Blame Fixes Nothing

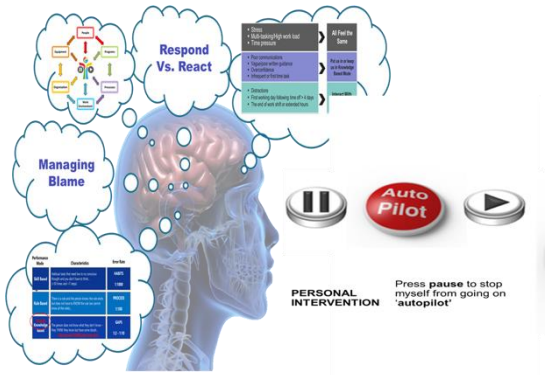
Systems Drive Behaviours

Physical

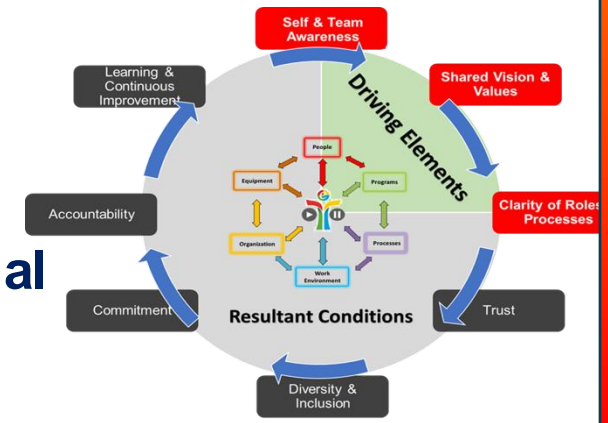


Performance

Response Matters



Learning is Essential



If leaders use models, processes, and tools then the workforce will too!

Things You Can Do Now

1. Use the new language to talk about errors, incidents, deviations and violations – **Ask Better Questions**
2. Use the new knowledge to analyse problems – **Systemic Drivers**
3. Recognise the **Performance Mode** you are in to minimise the error potential
4. Recognise the **triggers** that tell you an **Error Trap** exists that increases the probability and potential for errors

Thank you

Questions?

Fisher Improvement Technologies

Follow Matt Schlapfer on LinkedIn
Additional content available at:
https://online.improvewithfit.com

Avetta Summit 2025

Confidence BEYOND Compliance