Human and Organizational Performance (HOP) Fundamentals

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Objectives

- Understand what HOP is
- Learn HOP Principles
- Understand where HOP can be applied
- Learn how learning teams work

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HOP is not a program but a **way of thinking**, focused on learning and improving: it is an **employee centered approach**.

"We cannot solve our problems
with the same thinking we used to create them."
-Albert Einstein

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HOP moves culture from external accountability to ownership

HOP helps us understand **how we behave in the context** of our work,

then come together so we can **learn** to find **lasting, workable improvements**.

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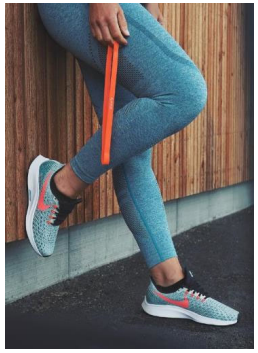
Why HOP?



Improves resilience as we move from prevention to capacity

We can't improve what we don't understand

Real fixes happen that are workable, often cheaper, and better

What we fix, generally **stays fixed, longer**

Increases the return on value (ROV), return on investment (ROI)

Improves productivity

Low upfront investment

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Why HOP?

Can implement **slowly**, by example

Implement HOP related thinking or

HOP related practices to

prime others for **a much larger vision.**

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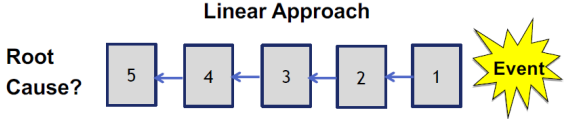
The traditional approach

After an incident, look for a main root cause

Hindsight bias

Linear Approach



Failures are generally **not linear,** and there is almost **never just one** root cause

Post-event hindsight can **bias our judgement** of pre-event context

The **pressure to fix** can outweigh our desire to learn

Employees often become defensive, which inhibits **our ability to learn**

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Contributions from Ryan Ward and Tanya Lughermo

Incident Investigations

Questions are designed to

test a **theory**,
check a **cause**, or
hunt for an **explanation,** and
find out **why**

Analyze: what failed to improve safety?

HOP: A learning mindset

Questions are designed to

encourage people to **teach us** the good, bad and ugly of their work world

Recognizes that the key information **to improve safety resilience** comes when we understand **normal work**

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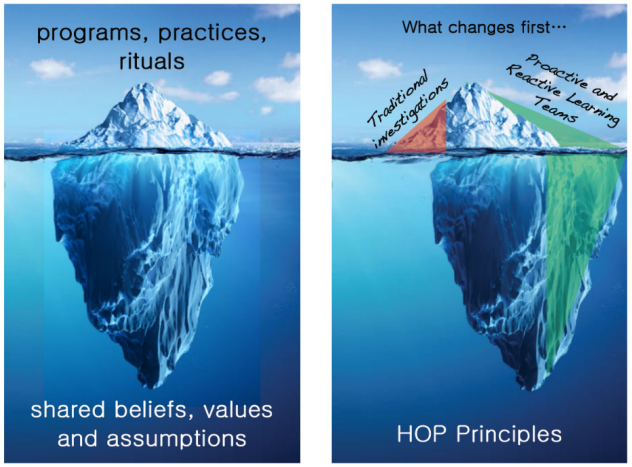

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Use of HOP principles provide

- A deeper, context-rich understanding of work
- Areas for action – defined problem statements
- Employee-owned ideas to improve in the areas for action
- Restoration and healing when an incident occurs

Can the natural way be the "right" way?

Baker, Edwards

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HOP Principles

HOP PRINCIPLE 1. People make mistakes

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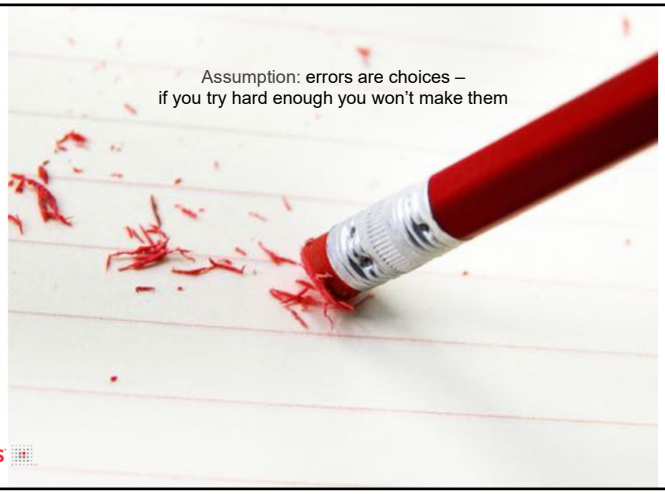

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How many times do you see an " F " or " f " in this sentence?

Finished files are the re-sult of years of scientific study combined with the experience of many years.

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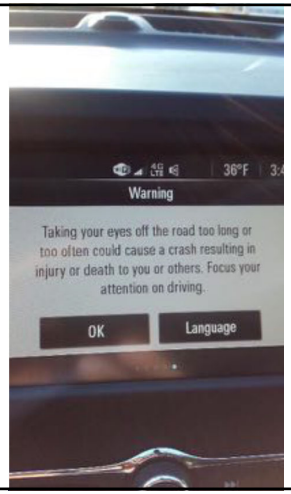

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1) People often behave similarly in similar situations

If one person makes an error or breaks a rule,
the probability is high that other people,
given the same environment and information,
would do the same.

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2) Most us are the same amount of "lazy"

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We drift towards **short-cuts** because
we are hard wired for **energy conservation**

If a rule is broken by a larger subset of the population,
it is a difficulty
within the context or system

Baker

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Great performance is not the absence of error, it's the presence of capacity

- Conklin

This wheelchair has a 250 pound weight limit

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HOP PRINCIPLE 2. Blame fixes nothing

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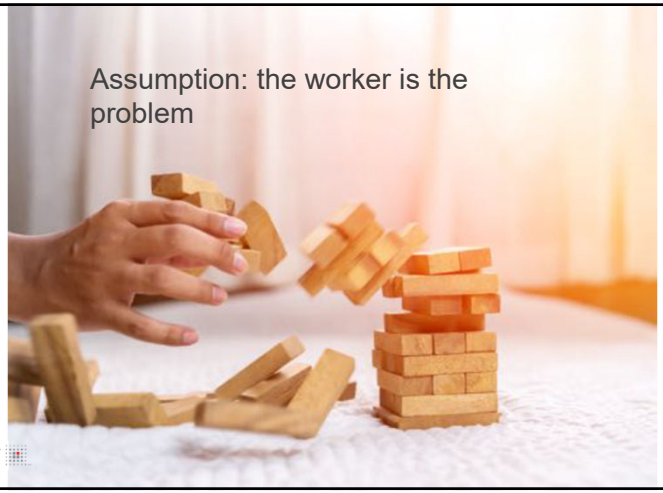

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Blame is common, because it is easier to blame than improve

Some of our biases make blame our first reaction

Blame creates the wrong example because it solves what created pain with **more pain**

Blaming an individual will not change the probability of a similar event

Blame fixes nothing

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We really only have two options

Option 1: Blame and get even

Option 2: Learn and get better

"a person who is blamed 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

-Adapted from Conklin

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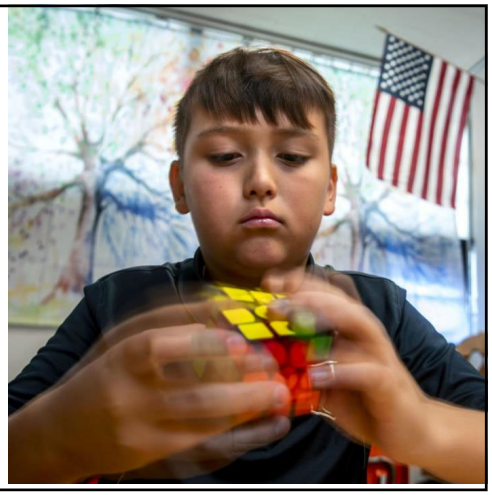
Employees are not the problem,

they are the **problem solvers.**



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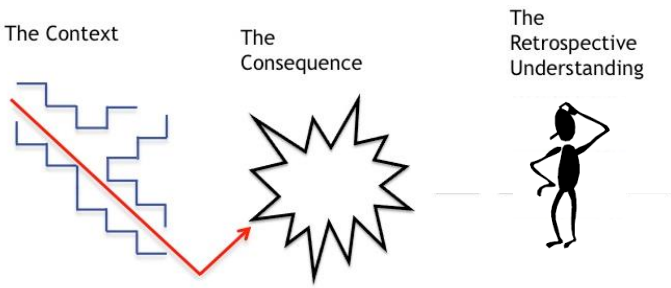
HOP PRINCIPLE 3. Context drives behavior

The three parts of every event



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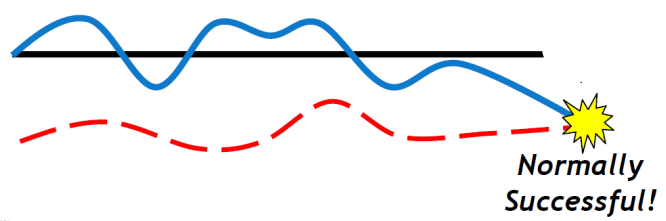
Work as Planned
vs. Work in Practice



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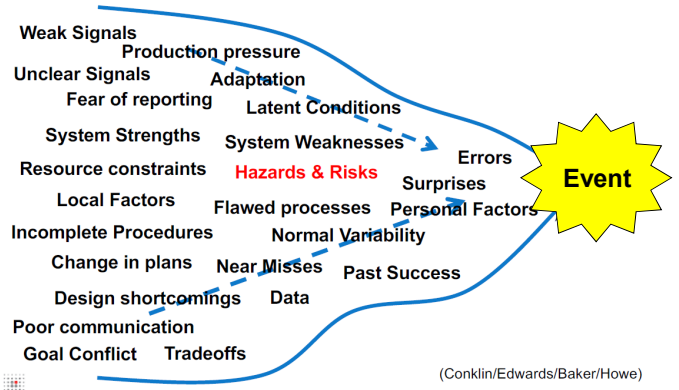
Start back in the process, move towards an event



(Conklin/Edwards/Baker/Howe)

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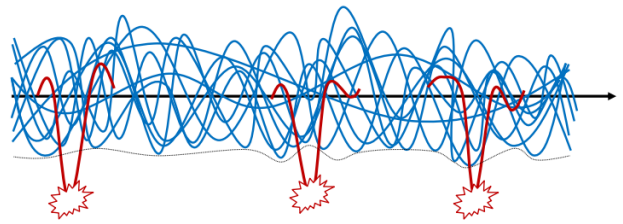
Failure is a combination of normal variability



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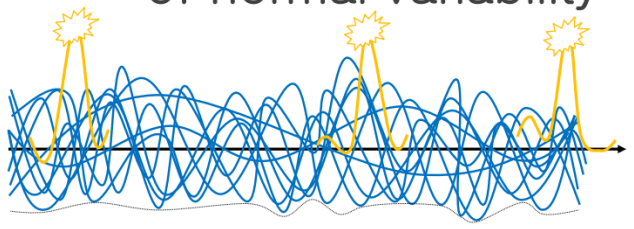
Success

~~Failure~~ is a combination of normal variability



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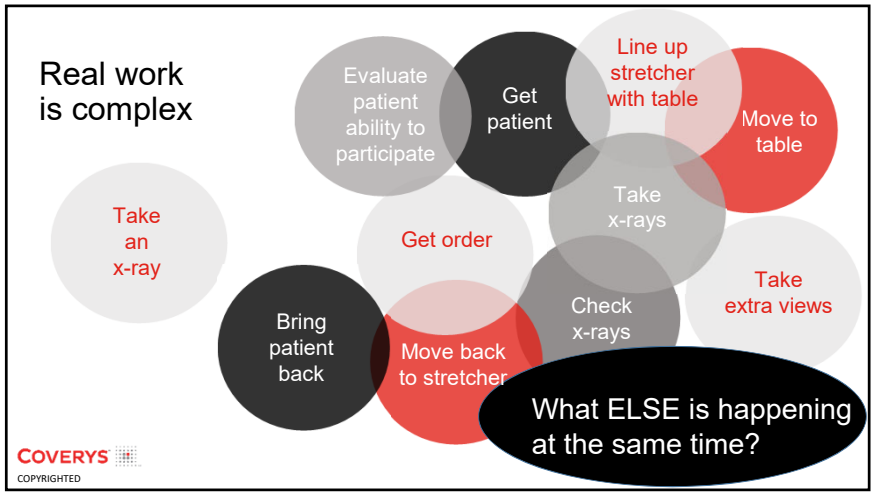

Understand the context

"Our goal is to learn enough that we realize,

given the **conditions** they faced,
the **information** they had,
the **tools and equipment** they used, and
the **pressure** they were under,

that we would probably have made the same decision."

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Edwards

HOP PRINCIPLE 4. To learn and improve is vital

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Learning organizations have

Happy, more confident employees and less turn-over

Better patient care

A sense of community

New ideas and solutions

Infectious success - success based on knowledge sharing

Collaboration from the bottom up, which creates accountability and buy-in

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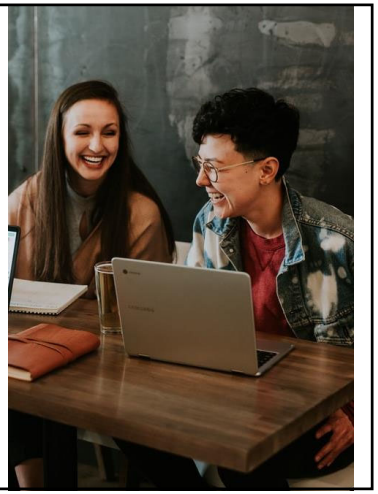
A complex system **cannot be designed perfectly** from the beginning

Resilience is not an end state of design, it is a state of **continuous learning and improving**

We want to be less surprised by human error and failure, and become **a lot more interested in learning**



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HOP PRINCIPLE 5. A leader's response matters

Immediately following an event

Do Ask	Avoid Asking
How are our people doing?	Why did it happen?
How are our patients doing?	Is it a recordable?
Are our operations safe right now?	When will our employees be able to get back to work?
Is this an opportunity for operational learning to help us understand?	What is the root cause?
Tell me the story of how.	Who did this?
What will it take for us to be able to show that it is safe again?	Were they following procedure?

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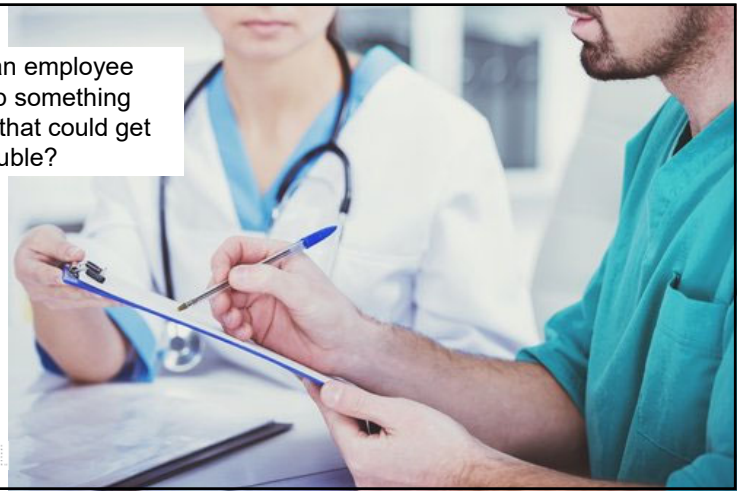
What if an employee brings up something they did that could get them trouble?



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There are all sorts of ways to learn

Impromptu conversations and Gemba walks

Huddles

Post-incident learning, other opportunities to improve

Just Culture – Human Error and At Risk Behavior, NOT reckless behavior

Problem solving, process changes, procedures – how it works in real life

Opportunities to duplicate what is going well

Safety surveys, culture surveys

Climate safety question: "Tell me something that we are doing well in relation to safety, or something we can improve."

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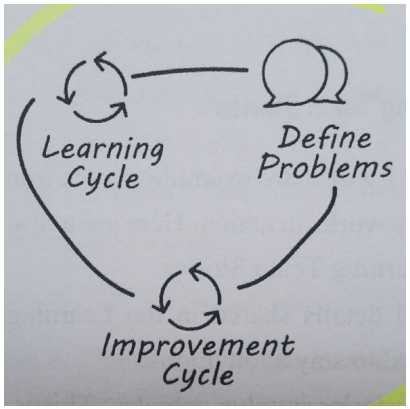
A change in thinking impacts our world view

Learning Teams



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A learning team is one method of operational learning

Bring together a small group of people [5-7 max] to have this discussion

Tone is relaxed, informal

Looks at the overall health of a task or system, not just a specific event or concern

It is not meant as a "fact finding" mission to discover cause, it is meant to look at the complex interaction of normal variables

A learning team intentionally creates space and desire to hear a story; a messy story, the stork of work

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What makes a learning team more than a meeting?

1. Psychological safety
2. Learning about ***normal*** work
3. ***How*** we ask questions
4. Soak time – time to think
5. Learning ***before*** defining what to improve
6. The focus is the team's output or product

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1 Psychological safety

If we build a space where the focus is on learning, restoring and improving, (rather than punishing), **trust is possible**.

If trust is too much to ask, start by building a space to talk about work where people can be **open and honest**.

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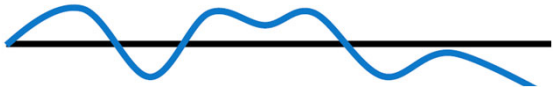
2 Learning about ***normal*** work



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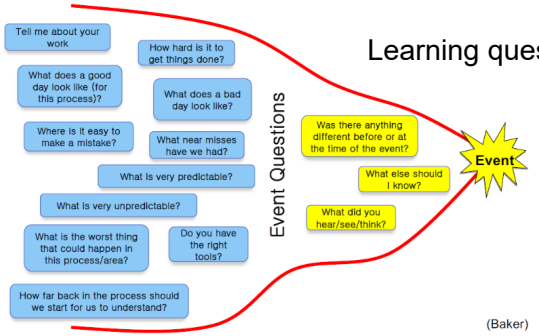
3 ***How*** we ask questions

Use **new eyes, be curious and open**, not judgmental, fact finding and solution finding



Learning questions

(Baker)

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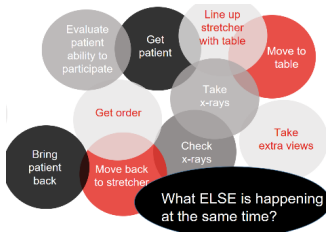
Fundamentally, **people come to work to do good work**

Don't try to simplify – real work is often **complex**

Move from "why" questions to **"what" and "how"** questions

Start back in the process



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4 Soak time – time to think

Best is overnight, second best after lunch

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5 Learning ***before*** defining what to improve

Learning is deliberate and intentional

When we believe we know the answer,
we stop asking questions,
we stop listening,
and we stop learning

The power to ask the right questions comes
from acknowledging that you don't know
the right answer.

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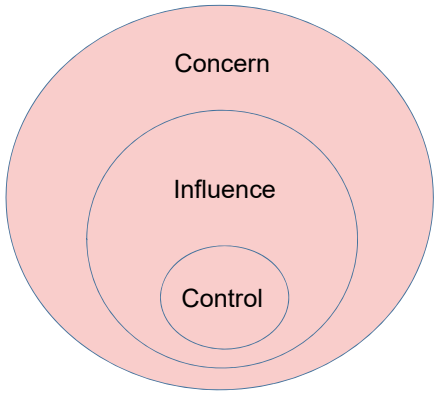
6 The focus is the team's output or product

What is in the team's control to change?



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"I have never been especially impressed by the heroics of people convinced they are about to change the world. I am more awed by those who struggle to make one small difference."

(Ellen Goodman)

Pharmacy IV Room

The scalpel cut deep into the left hand muscle below the thumb.

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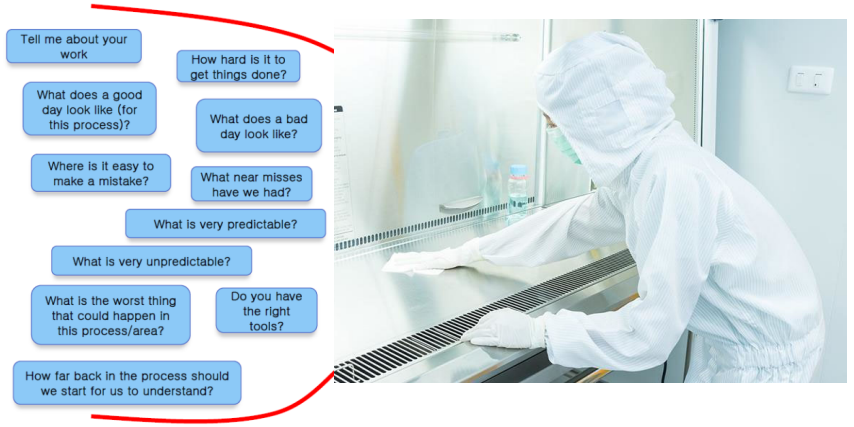
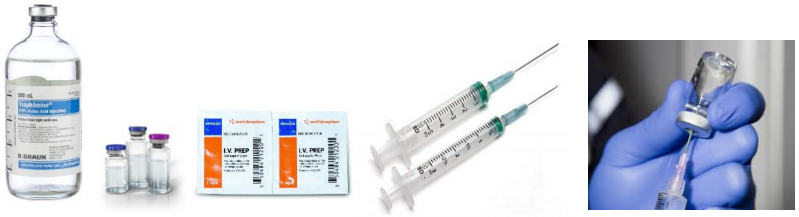


Can you walk me through what it takes to make the TPN? Start where it makes sense.



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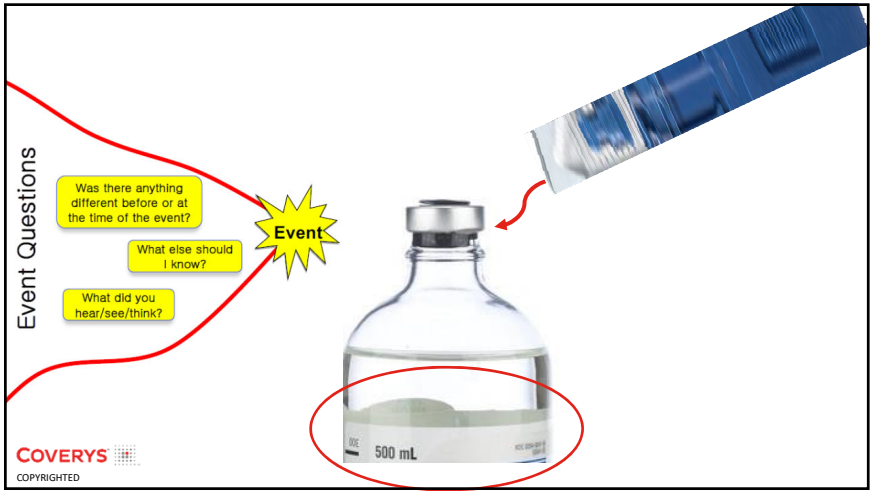

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Learning and Discovery

Intent is to **emphatically learn** about what it takes to get work done – focused on a specific process or task

Can you teach us about any near misses or injuries you had while making IVs?

What near misses have others had?

You mentioned that the tab breaks off. Can you tell me more about what happens in those times?

A few of you talked about some frustrating parts of the process. What I heard is, _____. Are there any more you can think of?

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Use new eyes and be curious and open, not judgmental, fact finding and solution finding

- Tell me about your work
- How hard is it to get things done?
- What does a good day look like (for this process)?
- What does a bad day look like?
- Where is it easy to make a mistake?
- What near misses have we had?
- What is very predictable?
- What is very unpredictable?
- What is the worst thing that could happen in this process/area?
- Do you have the right tools?
- How far back in the process should we start for us to understand?

Learning and Discovery

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Define areas for action

aka problem statements

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What are your next steps?

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Sources and resources

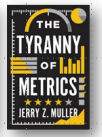
www.hophub.org

Todd Conklin, PhD

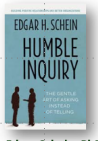
Bob Edwards
Andrea Baker

Chris Clearfield
Andras Tilcsik

Weick & Sutcliffe



Jerry Muller



Edgar Schein, PhD

Sidney Dekker, PhD

Don Norman

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Questions

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