CRYSTAL LEAN SOLUTIONS

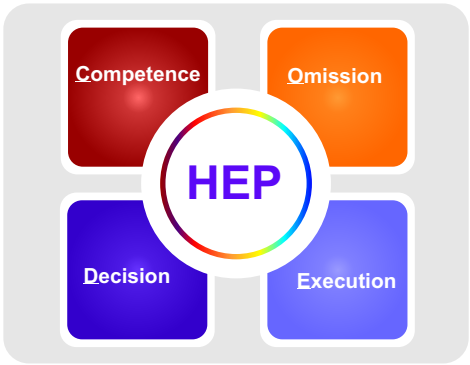
Decoding Human Error

Human Error Prevention

CLS Human Error Prevention

The Human Error Prevention (HEP) process is about understanding that Human Error is never a true root cause for an issue. The basic assumption is that people do not want to make mistakes. Thinking systemically, HEP allows you to peel back more layers of the problem, uncover the true root cause and implement permanent fixes. There are 4 main categories of Human Error, each with its own sub categories (some of which are illultrated over-leaf).

Human Error Categories (the CODE)



Definitions

Human Error: An Action or Decision, involving a human, which results in an *unintended* or *undesirable* outcome.

HERO Baseline: The Human Error Risk Overview score (HERO) provides a process for measuring overall risk of Human Error.

Competence Errors occur when a person did not have the knowledge or skill to perform the task correctly.

Omission Errors occur when a person missed a step or did not perform an action.

Decision Errors occur when a person makes a decision which inadvertently leads to an error.

Execution Errors occur when a task is performed incorrectly, although the person was competent to carry it out.

Human Error Decoded

Benefits of the HEP Process

- Develop a culture of Human Error Prevention
- Minimise Risk of Human Error
  - Near Misses and Accidents reduced
  - Quality Defects reduced
- Improve Job Satisfaction
- Reduce Cost of Poor Quality

The CLS HEP Program

Step 1: Define the Strategy

- Define purpose of the HEP program
- Plan to influence change
- Communication Plan
- Select Pilot Program

Step 2: Training on HEP

- Identify HEP training Requirements
- Leadership Training
- HE Problem Solving Training (see overleaf)
- HE Tools Training

Step 3: Develop HERO Score

- Identify Baseline Human Error Risk Overview (HERO) score

Step 4: Manage the Change

- Create an Action Plan
- Establish a Recognition Process
- Monitor the Change

CRYSTAL LEAN SOLUTIONS

How Can CLS Help You?

Training

- HEP for Leadership
- Human Error Problem Solving Process
- Human Error Risk Overview Score (HERO)
- Toolbox for Human Error Prevention
- Visual SOP Training

Consultancy

- Strategy Development
- Program Mentoring
- HERO Work Shop
- Human Error Root Cause Analysis Facilitation

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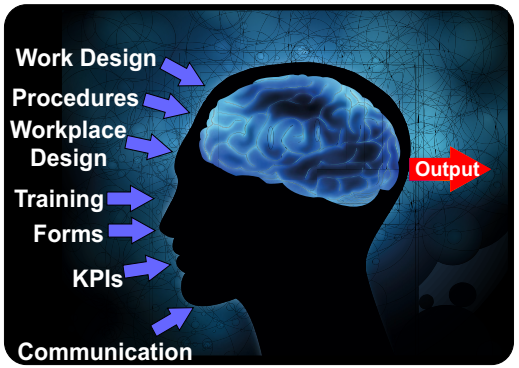


1. Problem Definition

Completed BY : J O Brien + Team | **Date: 10/APR/2017**

The incorrect movie was announced as the winner of the “Best Picture” award at the 2017 Oscars award ceremony. “La La Land” was named as the winner when in fact, Moonlight was the Academy’s choice.

2. Map Out Sequence os events Leading to the Error

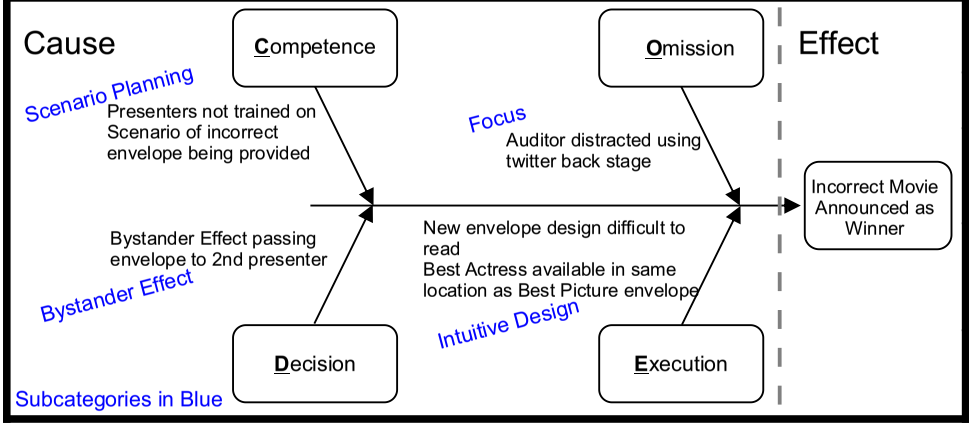
What Happened on the night?

Award Envelopes Sequenced → Award Envelope Handed to WB* → WB & FD* Take Stage with Envelope → WB Opened Envelope and Read → WB Passsed Envelope to FD → FD Read and Announced La La Land → Cast and Crew of La La Land Accept Award → Acceptance Speech Interrupted to Highlight Error

* WB= Warren Beatty FD = Faye Dunaway

3. Identify and Verify Root Cause

3a. Categorise Causes of Human Error



3b. Prioritise and Verify Root Cause

Cause	Likely	Evidence
Difficult to read envelope	Yes	New design (see Below)
Auditor was distracted	Yes	Using Twitter
Actress envelope too close to best picture envelope	Yes	Incorrect envelope handed to WB
Scenario plan for presenters not in place	Yes	Scenario identified but No training provided
Root Cause	Best Actress envelope too close to Best Picture envelope	

3c. 5 Why Analysis of Root Cause

Root Cause	Best Actress envelope too close to Best Picture envelope
Why?	Two envelopes co-located
Why?	Design of envelope staging area allowed it
Why?	It has worked effectively for over 80 years
Why?	
Why?	

4. Preventative Action Plan

No.	Action	Who ?	When ?	Status
1	Design process so only one envelope available at a time	PWC	Jan/2018	Ongoing
2	Make award envelopes visually different for each category	PWC	Jan/2018	Ongoing
3	Training on scenarios for award presenters in the event of an issue arising	PWC	Jan/2018	Ongoing
4	Ban the use of social media for all back stage staff during ceremony	Academy	Jan/2018	Ongoing
5	Redesign of Envelopes similar to 2016 design (easier to read	PWC	Jan/2018	Ongoing

5. Effectiveness Evaluation

The training of the presenters for the scenario of something going wrong needs to be tested for effectivity in rehearsal. After changes are implemented the process will need to be monitored for effectiveness. Monitoring will need to be over an extended period and ongoing improvements should be implemented with each run.

Were Changes Effective?	TBC	Verified by	TBC	Date	April 10th 2018