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# Three Steps to Reducing Human Error in your System

# About QMII



- QMII has provided best in industry process improvement services since 1986.
- Headquartered in Ashburn VA.
- Global Reach.
- ISO 9001:2015 Certified.
- SBA 8(a) & DBE certified.
- Minority owned business.
- GSA PSS and Schedule 70 Holder.



# About QMII



**US Coast Guard**

**FHWA**

**US Navy**

**NJ Transit**

**US Army**

**Amtrak**

**DOT**

**US Air Force**

**US Marines**

**GPO**

**DOC**

**Commercial**



# Why Are We Here?



Understand how to reduce human error



Understand how to increase buy-in to the system



The importance of creating a culture where nonconformities are not hidden



# What is Human Error



An erroneous action can be defined as an action which fails to produce the expected result and/or which produces an unwanted consequence.

(Hollnagel, 1993)

Either an action that is not intended or desired by the human or a failure on the part of the human to perform a prescribed action within specified limits of accuracy, sequence, or time that fails to produce the expected result and has led or has the potential to lead to an unwanted Consequence.

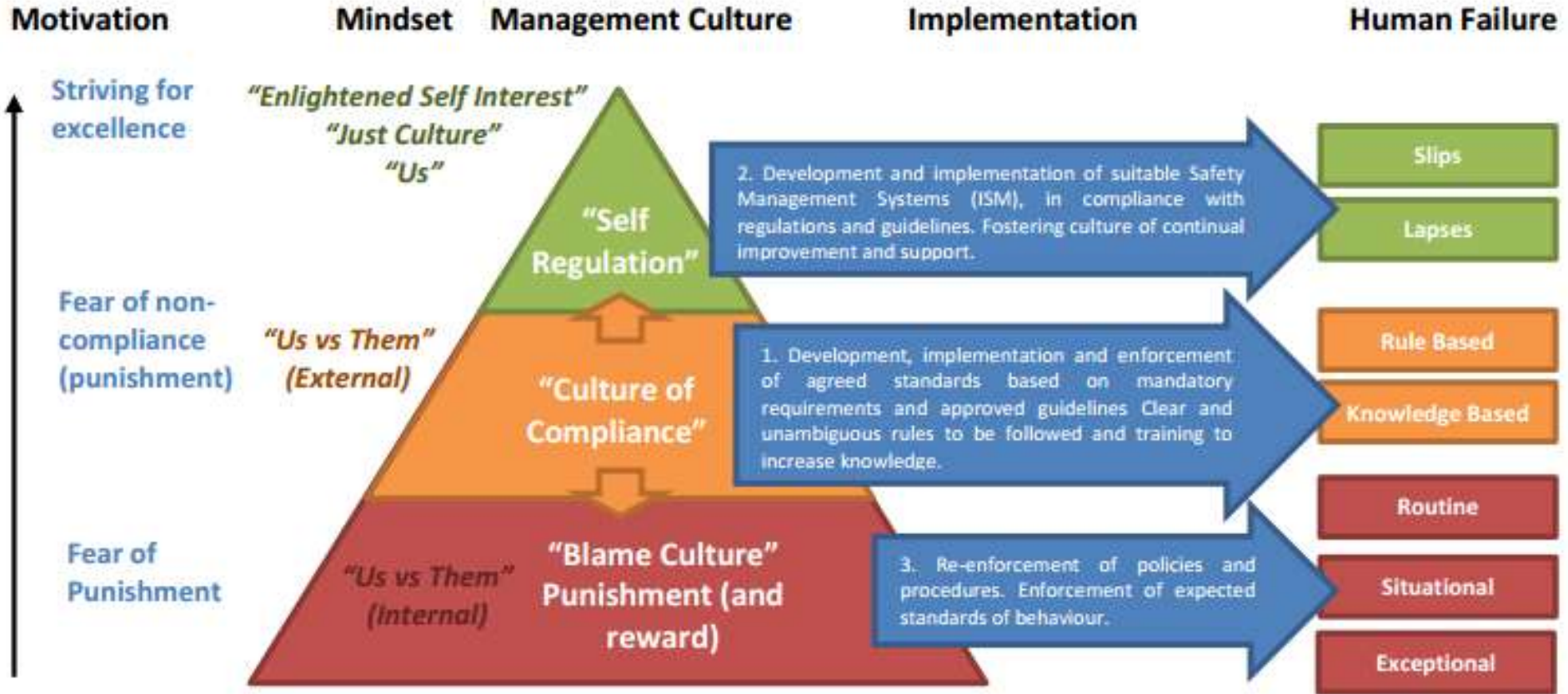
(NASA, 2008)







# How systems influence outcomes



# Common Causes



- Activity Influencers
  - Inadequate guidance
  - Inadequate communication
  - Complexity of task
  - Time constraints
- Personal Influencers
  - Fatigue / Stress
  - Competence / Motivation
  - Workload
- Organizational Influencers
  - Safety Culture
  - Leadership / Supervision





# Step 1 – Blame the System



- Mature organizations, when things go wrong ask
  - How did the system fail the individual
  - Why did the system fail the individual
- They do not blame the person but blame the system
- Operator error may be the cause in some situations, but repetitive occurrences should lead to systemic corrective action



## Step 2 – Improve Buy-in



- Gain workforce inputs:
  - In the system/process development
  - During safety meetings
- Promulgate effectiveness of meeting objectives and success stories
- Leadership commitment evident through:
  - Provision of resources to meet objectives
  - Walking the talk
- Identify and remove obstacles to participation:
  - Failure to respond to worker suggestions
  - Language or literacy difficulties



## Step 3 – Instill a Pro-active Culture

- Be mindful of objectives being set – Do they encourage reporting of non-conformities
- Policies should encourage worker participation
- Minimize barriers where they cannot be removed
- Create an atmosphere of trust, encouraging and rewarding people for providing essential safety-related information

***Look for risks not fault!***

# *The Smoking Volcano*



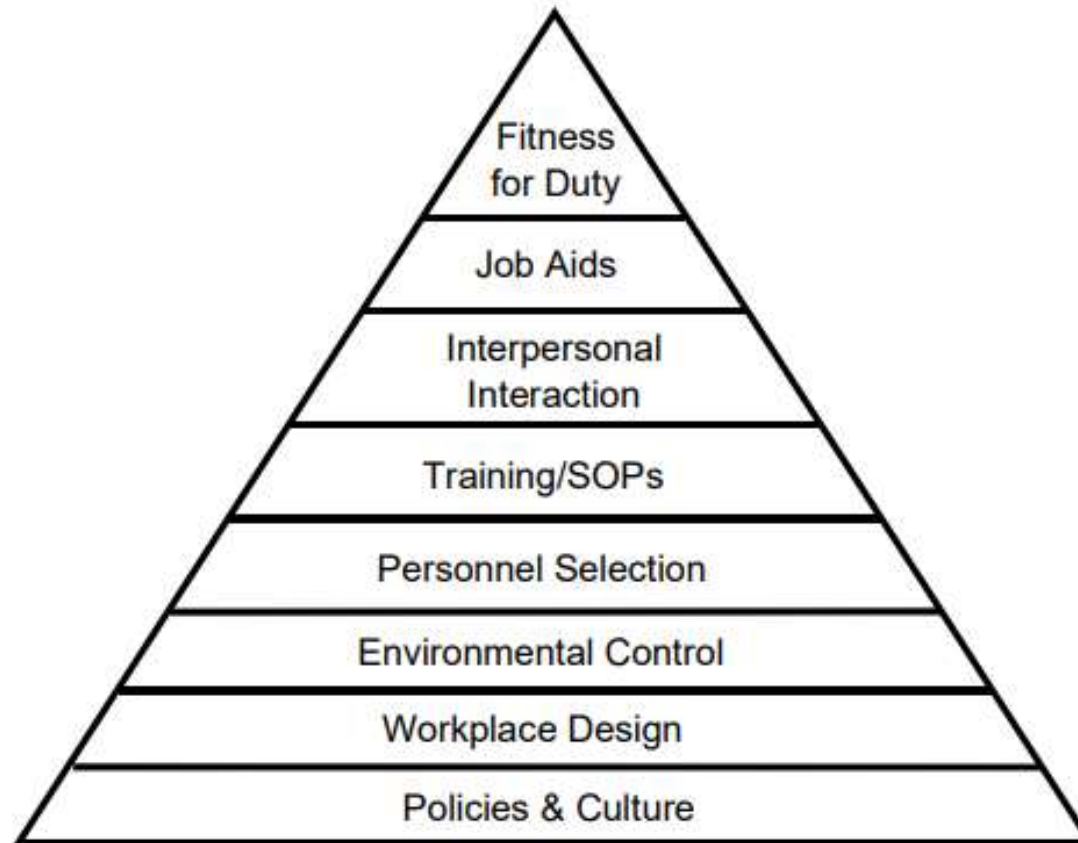
LEADERS  
CREATE POLICY  
AND OBJECTIVES

THE CROSS-FUNCTIONAL PROCESSES ARE  
MISSING FROM THE MANAGEMENT SYSTEM

SEPERATED DEPARTMENTS  
"HOW TO" INSTRUCTIONS  
(OFTEN CALLED SOPs)



# Triangle of Effectiveness



Source: Gerry Miller et al, 2000

Barriers that can be used to prevent or mitigate errors

# Building an Error Tolerant System



- Consider FMEA
- Consider Mistake proofing where possible
- Build oversight and reminders in the process
- Everyone is on the lookout for errors
- Everyone empowered to question perceptions and actions





# Remember ....



1. Blame the system
2. Look for risks not fault
3. Error Proof where possible
4. Love thy non-conformity

*"The only bad non-conformity is the one you do not know about" – Dr. IJ*



# Procurement Options



**GSA MAS (Schedule 70): 47QTCA20D0050**  
**DUNS: 82-5610108**  
**CAGE: 1GFC9**

**SDVOSB Partners**  
**WOSB Partners**  
**HUBZONE Partners**  
**Other Vehicles**



# Thank You!!!



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