Break the Cycle
10 Questions That Make Corrective Actions Actually Work

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What We Will Cover Today

1. About QMII
2. Why Are We Here?
3. Improving Corrective Actions
4. Q & A

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About QMII

- QMII has provided best in industry process improvement consulting, auditing, and training since 1986
- Headquartered in Ashburn, Virginia
- ISO 9001:2015-certified
- DBE-certified
- Minority-owned business
- GSA MAS holder

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About QMII

US Coast Guard	Crowley
FHWA	Harley Marine
US Navy	Interlake
NJ Transit	Indorama
US Army	GE Aerospace
Amtrak	Commerial

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Why Are We Here?



To understand how to push past the “root cause”



To gain insight on when a corrective action is effective



To build on your corrective action skillset by asking better questions

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Observations from Audits

- Companies are good at closing nonconformities.
- They are less consistent at eliminating them.
- Many never really measure effectiveness of actions taken, including:
  - Residual Risks
  - Consequential risks

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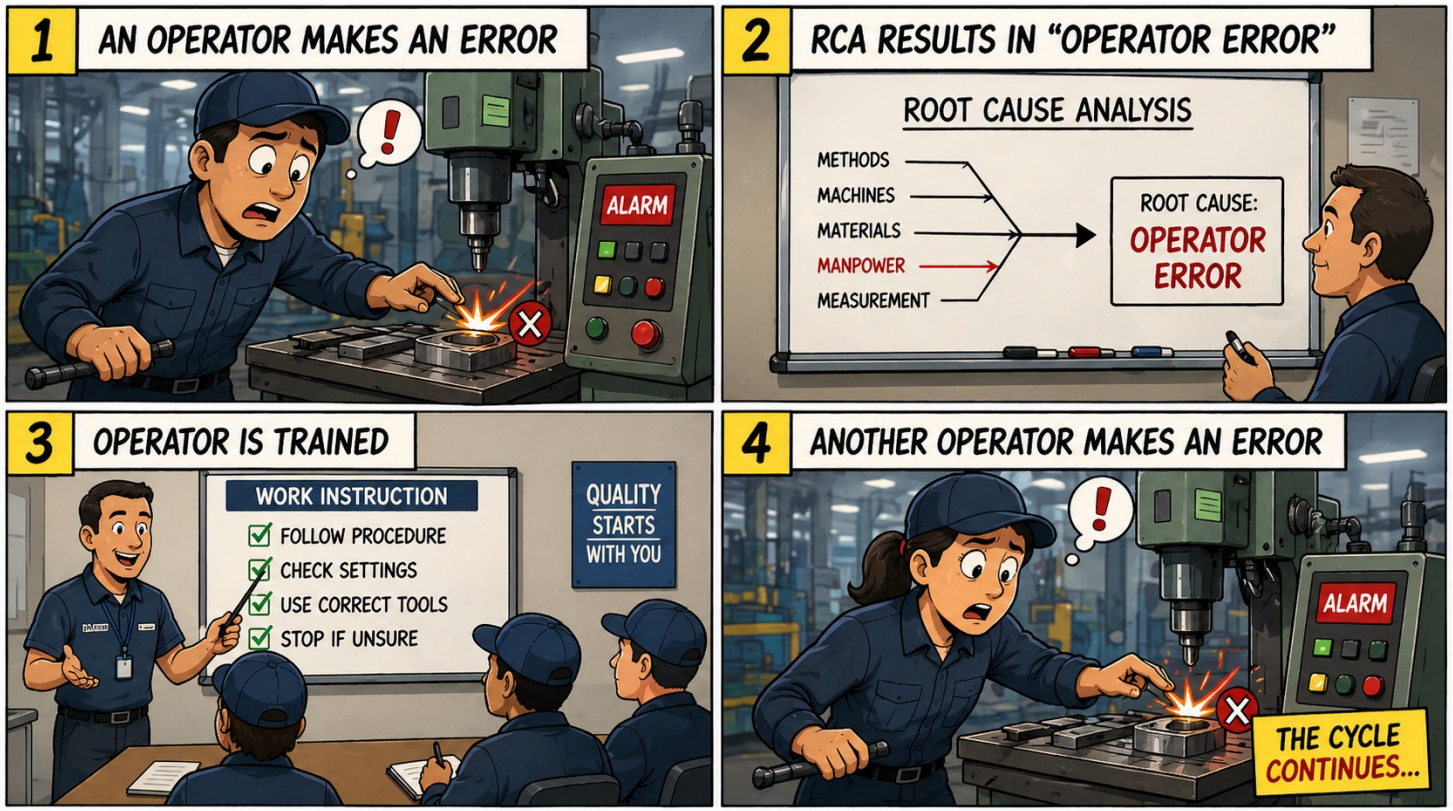
Dreaded Human Error



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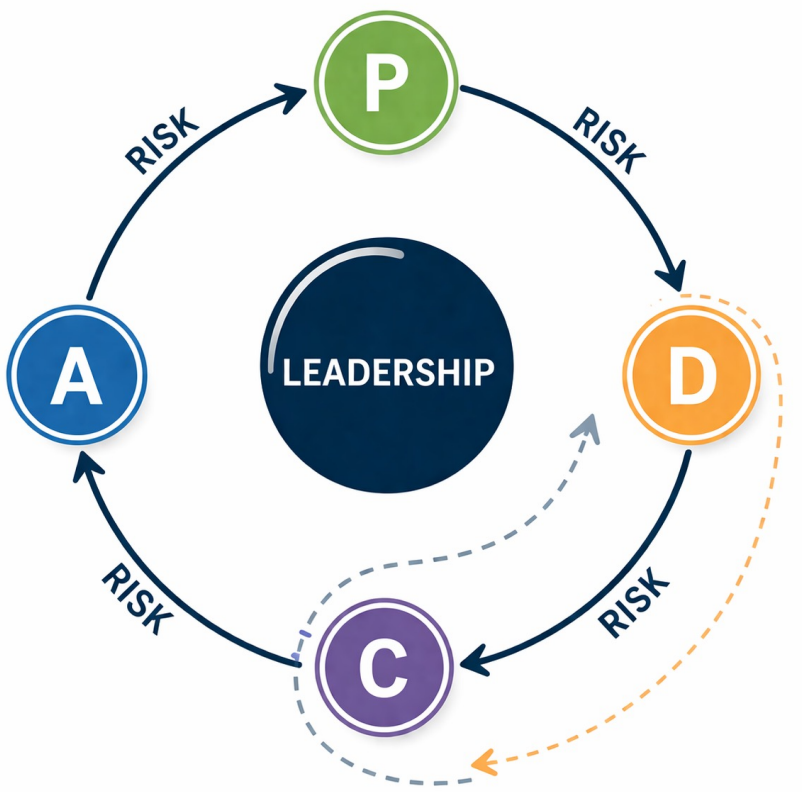
PDCA - Bypassed



WHY?

- Conflicting priorities
- Time pressure
- Siloed problem solving
- Lack of training in RCA tools
- Non-conformities seen as negative
- Performance initiative?

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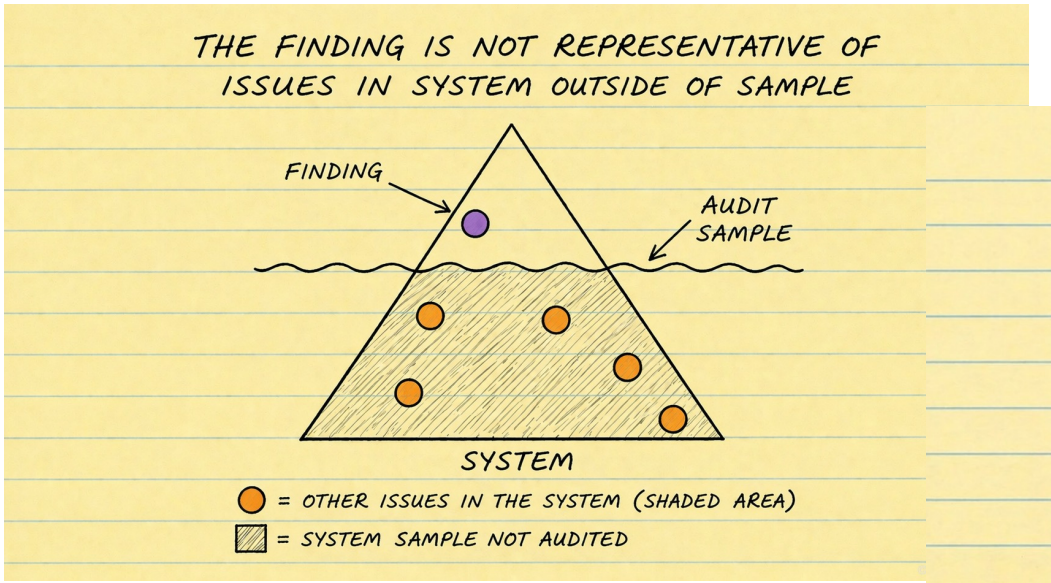
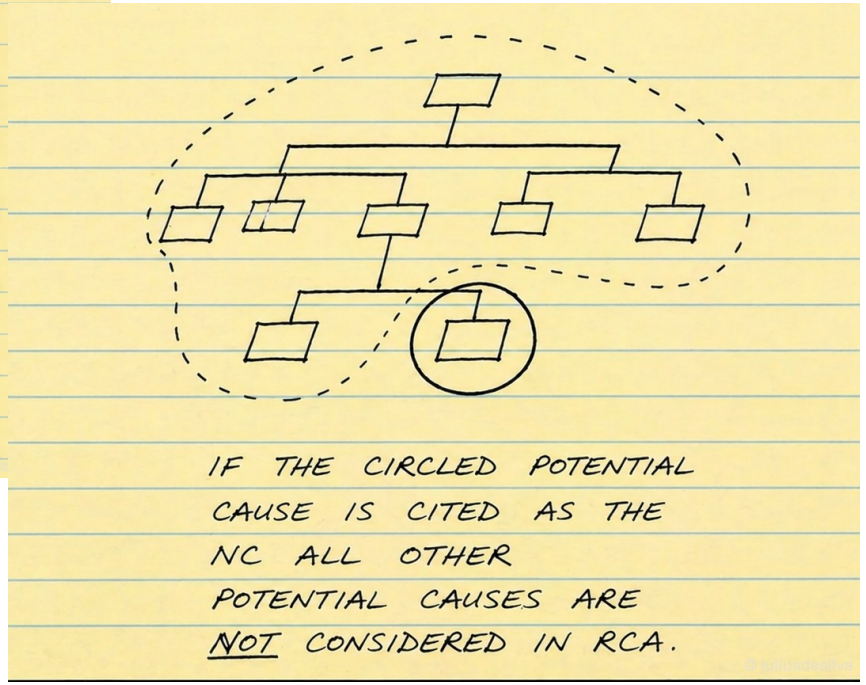
The Audit Iceberg





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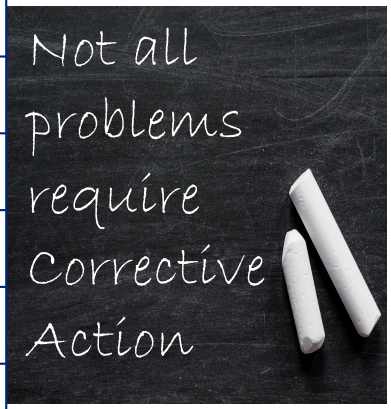
The Decision to Act

Decision Question	If Answer Is…	Recommended Level of Action	What This Means in Practice
1. What is the risk if this happens again?	Low impact / low risk	Correction	Fix the issue and move on
	High impact / safety, compliance, or major cost risk	System Redesign	Redesign process or controls to prevent recurrence
2. Is this isolated or part of a pattern?	One-off event	Correction	No deeper action needed beyond fixing
	Repeated or trending issue	Corrective Action	Investigate cause and address process weakness
3. Did a control fail—or was there no control?	Control worked, issue was incidental	Correction	No systemic change required
	Control failed	Corrective Action	Fix or improve the control
	No control existed	System Redesign	Design and implement new controls
4. Did the system make the error likely?	No (truly random / unavoidable)	Correction	Address locally
	Yes (confusing process, pressure, unclear expectations)	System Redesign	Change system conditions, not just behavior



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What actually happened … in plain English?

OR - Define the Problem from a system perspective

We often proceed to fixing the local issue –

- Without carefully defining the system problem
- Without determining the extent of the non-conformity
- Without identifying if it can occur or recur elsewhere

Then if needed set to gather further evidence from those involved in the non-conformity

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Where was it supposed to be caught?

- Non-Conformities occur in a chain
- Consider failed preventive controls based on risks
- Consider effectiveness of detection controls
- Examine decisions made in the moment and the context that made them appear reasonable

Ask "How do we stop the failure travelling?"

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Why did a good person do a 'bad' thing?

- The system found them competent at the start of the task.
- No system survives contact with human behavior unchanged. What changed?
- Dive into what caused the non-conformity to happen:
  - Was the work rushed?
  - Were directions unclear?
  - Was it harder to do it right than wrong?
- How did the system fail the individual?



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What did the system *reward*?

- Behavior follows incentives/objectives
- If speed is rewarded – accuracy becomes optional, or
- Caution is penalized while output is rewarded
- OTD- on time delivery pressures.
- Even with new controls the operational environment may push people to by-pass it.

A well-designed system delivers on the planned results



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What step is relying on memory or 'experience'?

- If the outcome depends on someone 'just knowing what to do'… then performance will vary.
- It will vary with fatigue… workload… distractions… who's on shift.
- "Competent" personnel compensate for unclear instructions, missing details, inconsistent methods

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What did we assume?

- We assume things are in place… without checking
- Problems happen when “we thought” replaces “we looked”
- We fix what went wrong… but miss what we assumed
- Strong systems don’t rely on assumptions—they make things easy to check

"Risk is not a one-time exercise"



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One-off… or pattern?

- Small issues often mask larger recurring patterns
- Similar failures get separated by wording, owner, or location
- Without trending, the same weakness is “fixed” repeatedly
- Seeing the pattern shifts action from fixing events to redesigning the system

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Could this happen again tomorrow?

- While the likelihood & probability of occurrence may reduce, we cannot reduce the severity of the non-conformity without a redesign.
- Language creates the illusion of control.
- Training is the most easily reversible corrective action.

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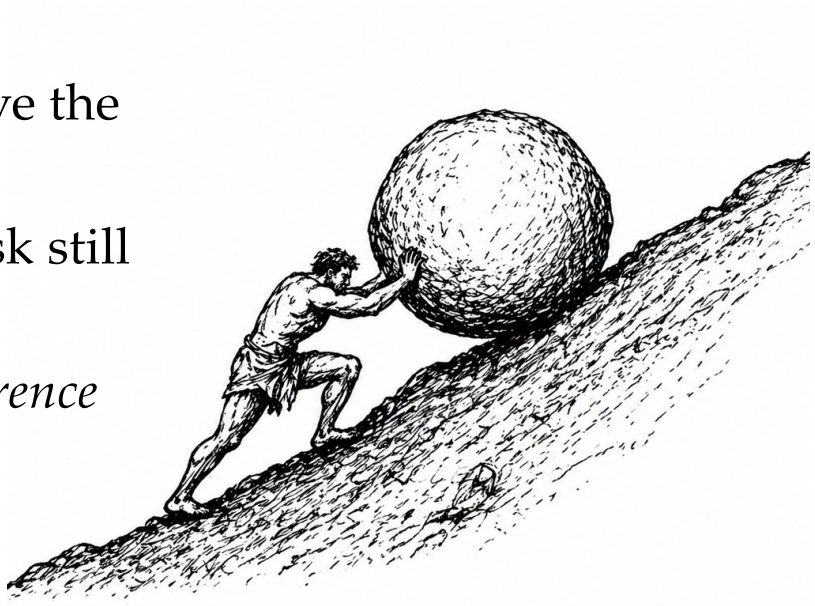
Are we fixing the problem .. Or just hiding it?

- We reward closure… not effectiveness
- "Quick fixes" are often highly visible—and largely ineffective
- Most actions increase awareness but leave the system unchanged
- If nothing in the process changed, the risk still exists

"Completion shows activity. Absence of recurrence shows effectiveness."



Is the Corrective Action measurable?

- What changed in the system?
- How will we measure success?
- Over what time period will we verify it?
- What evidence will prove recurrence risk is reduced?

If you reviewed your last 10 corrective actions
how many changed the system?

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An industry example

- Define the system problem (not the event).
- Map the failure pathway.
- Identify control breakdowns.
- Redesign controls (not behavior).
- Define measurable effectiveness.
- Verify over time.



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In Conclusion

- Your system is a proactive & a preventative tool
- Systems reflect priorities
- Corrective Action is about redesigning the system, so failure is less likely
- Always consider the reversibility of your corrective action

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Procurement Options

GSA MAS: 47QTCA20D0050
SAM UEI: E8KYQBSFJ6V6
CAGE: 1GFC9
STARS 8(a) III

SDVOSB Partners
WOSB Partners
HUBZONE Partners
Other Vehicles

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Thank You!!!



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