Nonprofit Risk Management Center

Clearing the Air: How to Find Powerful Lessons After a Loss or Near Miss

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Resource Type: Risk eNews

Topic: General

The hindsight bias, also known as the "I-knew-it-all-along" effect, is the tendency to believe that past events were predictable. In the risk realm, an important part of a risk leader's responsibility is reflecting on mistakes, losses, near misses and situations that didn't go as planned or hoped. The NRMC team strongly recommends that risk teams pause, and take time to undertake an After-Action Review, or ponder the root causes of a loss, in the wake of a serious loss or near miss. Resolving to do so is fundamental to improving the quality, consistency, and reliability of the services your nonprofit delivers.

An important aspect of these pause-and-reflect moments is to consider whether there were signs, signals, or indicators that can be added to the risk team's watch list, to interrupt or otherwise mitigate future risk events. We offer the following tips to maximize learning and make these reflective moments memorable and truly useful.

Sign Spotting

- *Begin with the basics: what you believe you know*. Begin the process of debriefing with what your team believes it knows about possible underlying conditions, factors, or circumstances that contributed to the incident or near miss.
- *Continue with humility.* Ask, "What don't we know about the conditions that led to this risk event?"
- *Consider actions, policies, protocols that fortified your response*. For example: "What did we do or have in place that proved helpful in this instance?"
- *Brainstorm possible changes that could reduce the recurrence or severity of the risk event*. Remember that by following the four rules of basic brainstorming you'll reduce the social inhibitions that sometimes occur in groups, and increase the creative quotient of the process. The four rules are:

1. focus on quantity
2. no criticism
3. encourage wild ideas
4. combine and improve ideas

- *Sort and stress test the team's best ideas.* Start with the best combined and improved ideas from the brainstorming session; use a simple filter to take your concepts on a test-run. Possible stress-test filters include:

  - *Practicality:* Is the new process, policy, or training requirement one that your nonprofit can practically implement in a reasonable time frame?
  - *Payoff:* What is the investment required to adopt the new policy or approach? Is the investment one that will pay dividends by reducing the likelihood of a similar incident or substantially reducing the cost or other consequences?
  - *Pushback:* What resistance to the proposed new protocol does your team expect? What incentives, supports, or other strategies can be employed to anticipate, counter, and overcome pushback?
  - *Process:* What process does your team recommend to finalize its preferred strategies? Are there sequential steps in the process? What timetable is reasonable to fully implement the changes in practice or policy?

- *Capture lessons learned*. Before wrapping up a debrief, remember to recap and document the potent lessons learned from the incident or near miss. To maximize learning, ask:
  - What do we know now that we didn't fully understand or appreciate before the incident?
  - What are the most compelling lessons learned from the experience of the incident, and our discussions during the debriefing?
  - How can we apply what we have learned in this instance to other functions or operations?
  - How will this organization be more effective as a result of experiencing this risk?

Risk Reminders: Avoid the Traps and Smokescreens

A number of post-incident traps can easily divert the attention of teams resolved to fix the factors that gave rise to the incident. Aim to avoid these three snares as you reflect on what happened and how your organization will evolve to avoid a recurrence of the incident.

- *Hastily assigning blame*. Joseph T. Hallinan describes the tendency to blame in his book,*Why We Make Mistakes: How We Look Without Seeing, Forget Things in Seconds, and Are All Pretty Sure We Are Way Above Average*. According to Hallinan, the vast majority of errors, from workplace accidents to airplane crashes, are quickly and almost universally attributed to human error. Blaming people for making mistakes is arguably second nature, if not an element of the human condition, but distracts us from taking a closer look at errors that occur in the life of the organization we serve. In some cases, a closer look might reveal cultural, systemic, technological, or process barriers that lead to human error. Learn more about mistakes, multitasking and the blame game.
- *Choosing overly simplistic solutions.* Just as it's human nature to look for culprits when something goes wrong, many risk leaders are drawn to simple solutions. And why not? If a simple solution will do the trick, why choose an over-engineered one? The challenge is that risks rarely if ever behave. Few significant risk events will follow the path imagined by your team. Although a quick answer may seem efficient, the most creative and durable solutions usually result from healthy dialogue and the patience necessary to ponder the probing questions. Learn more about a reluctance to simplify and the power of healthy skepticism.
- *Tidying up too soon.* Anytime your nonprofit adopts a brand-new policy, protocol or requirement, it's impossible to predict its long-term benefits and downsides. Yet many risk leaders believe that a policy should be buttoned up and bulletproof before release. Resist the urge to plaster FINAL or PERMANENT watermarks over your newly minted policy. Keep in mind that it may be necessary to act on changes in the future that are impossible to identify now. Enlist the entire workforce in identifying worthwhile changes in the policy by including language such as this in every new policy:

  > *We invite and welcome your comments, suggestions, and possible changes to this new policy. Your help making this policy meet our goals is needed and appreciated!*

If you've ever chastised yourself for failing to sense, spot, or signal others about a smoldering situation that later erupted into a risk event, you're not alone. Even with keen awareness of what could go wrong, a risk leader's clearest line of sight is always in the aftermath of a risk event, not the lead-up. But in risk's wake we often miss the opportunity to understand and document learning. Use the tips in this article to make sure that these fruitful opportunities don't go to waste.

Melanie Herman is Executive Director of the Nonprofit Risk Management Center. She welcomes your stories about incident debriefs and after-action reviews, and ah-ha moments from experiencing risk at Melanie@nonprofitrisk.org or 703.777.3504.