



WHEN COMPLIANCE IS THE FLOOR, NOT THE FINISH LINE



What in the process empowered the error?

One question has followed me throughout my work in quality: What in the process empowered the error?

Whenever I'm involved in root cause and corrective action, reviewing a nonconformance, challenging a process weakness, or evaluating an undesirable outcome, I resist allowing the investigation to stop with one explanation:

Someone made a mistake.

People make mistakes. We're human. But if our investigation ends with "human error," what have we actually learned?

The more important questions are: What allowed the error to occur? What allowed it to continue? What prevented the system from detecting it? And what allowed it to progress far enough to affect the intended outcome?

That's where root cause analysis stops being about simply identifying who made the error and becomes an opportunity to understand why the system allowed it and how to strengthen the process so it doesn't happen again.

DON'T BUILD SYSTEMS THAT DEPEND ON PERFECT PEOPLE

Human beings make mistakes. We become distracted, misunderstand instructions, make assumptions, receive incomplete information, and occasionally exercise poor judgment.

A robust quality system recognizes this reality and asks an important question:

How do we design the process so that one human error does not automatically become an undesirable outcome?

Training matters. Competency matters.

Accountability matters. But when corrective action ends with "retrain the employee," we should ask whether we've corrected the system or simply reminded one person to be more careful.

A mature quality system doesn't rely on someone remembering to do the right thing. It makes the right thing part of how the work gets done.



Employees should absolutely be empowered to stop, question, challenge, and escalate when something doesn't look right.

But mature quality systems go further.

They don't rely exclusively on someone noticing a problem and having the courage to speak up.

Where risk warrants it, the process itself should help detect problems, prevent unintended progression, and require escalation when defined conditions haven't been satisfied.

PREVENT → DETECT → CONTAIN → ESCALATE → LEARN → IMPROVE.

THE QUALITY OF LEADERSHIP: WHEN THE SYSTEM SPEAKS, DO WE LISTEN?

Robust processes don't eliminate the need for leadership. They reveal the quality of it.

Leadership establishes priorities. Processes translate those priorities into repeatable behaviors. Controls help protect the process from predictable variation and error. Employees contribute knowledge, judgment, experience, and insight into how the process actually performs.

But even the strongest system is only effective when leaders are willing to respond to what it reveals.

When a control stops the process, what happens?

When required evidence is missing, is the requirement protected or is pressure applied to proceed?

When someone escalates a concern that threatens schedule, cost, or delivery, does leadership become curious or frustrated?

That's where the stated commitment to quality meets the experienced quality culture.

REFLECT & CORRECT QUESTIONS FOR LEADERS

Where does our process depend too heavily on human memory or individual heroics?

What prevents work from progressing when required conditions haven't been satisfied?

Can critical controls be bypassed, and if so, how is that detected and escalated?

When we identify "human error," do we continue investigating what enabled it?

Are lessons learned strengthening our systems or simply becoming another reminder to employees?

IF THE SAME MISTAKE WERE MADE TOMORROW BY A DIFFERENT PERSON, WHAT IN OUR PROCESS WOULD PREVENT THE SAME OUTCOME?

If we cannot answer that confidently, the corrective action may not be finished.



BE CAREFUL WHAT YOU REWARD

Metrics such as on-time delivery, productivity, cost, cycle time, closure rates, and reduced findings can all provide valuable information.

But leaders must understand the behaviors those measures may unintentionally encourage.

Consider a goal to reduce audit findings.

A mature quality culture hears:

Strengthen the process so fewer problems exist.

A struggling quality culture may hear:

Make sure fewer problems are found.

Same metric. Very different behavior.

So the leadership question isn't simply: "Did we achieve the metric?"

It is also:

"How did we achieve it?"

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