DEVOPS CULTURE AND MINDSET

Using Incident Reviews to Your Advantage



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Slide 1: What Strikes Dread in the Hearts of Developers?



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Slide 2: Learning Objectives



Learning Objectives

Discuss how software industry evolved

Change mindset around incident reviews

Explain how to use them to your advantage

Describe using incident reviews to improve an organization's processes

Slide 3: It Was a Blame Game



It Was a Blame Game

Software engineer in the **hot seat**

Interrogated for root cause of an incident

Action plan so this "never happens again"

Tasks not followed up or completed

Slide 4: Results of Old School Incident Reviews

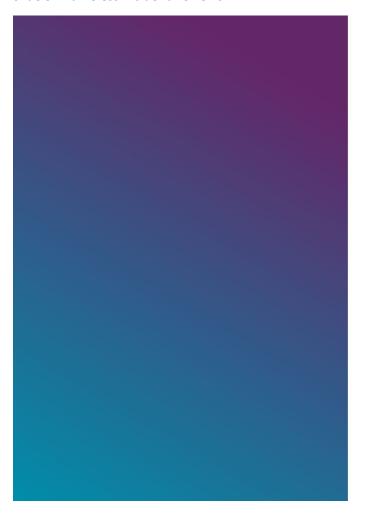


Results of Old School Incident Reviews

Everyone **frustrated**

People were **very apprehensive** when an incident review was scheduled

Slide 5: Blameless Incident Reviews



Blameless Incident Reviews

Shift in the industry

Encourage candor and learning

Perform critical and objective analysis

Plan prevention **strategies** for future

Slide 6: Honoring and Extracting Reality



Honoring and Extracting Reality

Seek discovery of what really happened

It has to be safe for **reality** to surface

If leaders don't want to understand they won't be able to extract reality

Slide 7: Is Your Culture Pathological or Generative?



Is Your Culture Pathological or Generative?

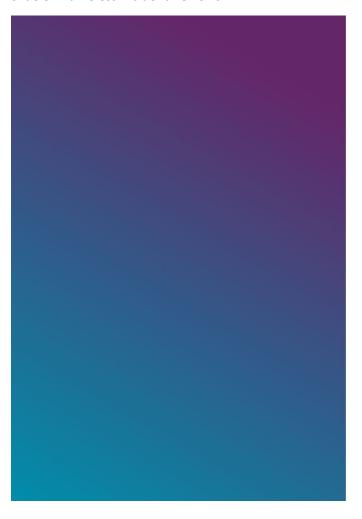
Explore the Westrum Model

Pathological Culture:

Failure > Blame & Scapegoating

Generative Culture: Failure > Inquiry Spirit of learning, blame-free

Slide 8: Blameless Incident Reviews



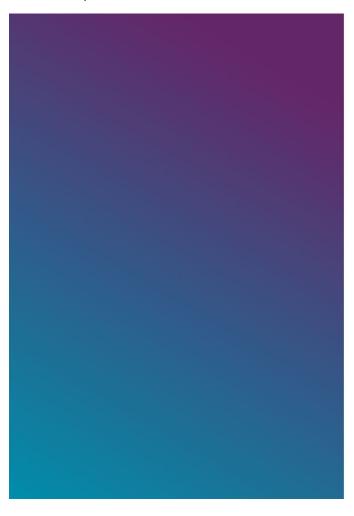
Blameless Incident Reviews

Calls for a good facilitator

Encourages open exploration

Check out Etsy's facilitator guide

Slide 9: Study Successes



Study Successes

What worked?

What can we learn from this success?

What can we apply to other parts of the organization?

Slide 10: Transformation of Root Cause Analysis



Transformation of Root Cause Analysis

Then, we sought single a root cause

Now, thinking has changed

With complex systems we must seek multiple contributing factors

Slide 11: The Myth of Human Errors as the Root Cause



The Myth of Human Errors as the Root Cause

Human errors are **never** the root cause!

Something in the system **broke down**

Usually it's a process failure

Slide 12: An Example of Why Human Errors are NOT Root Cause



An Example of Why Human Errors are NOT Root Cause

Conducted blameless inquiry

What was assumed to be human error ended up reinterpreted as management failure

Slide 13: Benefits of a Blameless Incident Review



Benefits of a Blameless Incident Review

Focus shifted from blame to improvement

Able to identify better **leading indicators**

Multiple contributing factors managed



Software industry has evolved with regard to incident management

Shift from seeking a single root cause to multiple contributing factors

High-performing organizations use incidents as opportunities to learn

Focus on what broke down in the system, **NOT** human error