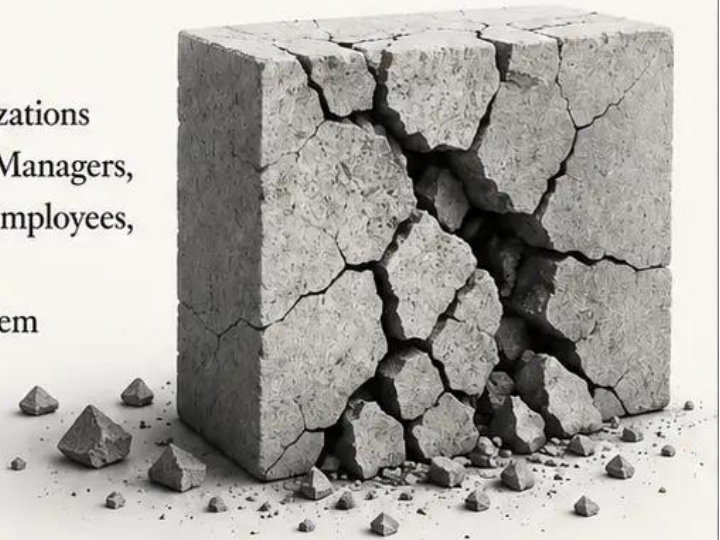


FOR LEADERS TIRED OF SOLVING THE WRONG PROBLEM

DESIGNED TO FAIL

How Organizations
Build Weak Managers,
Lose Good Employees,
and Call It a
People Problem



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DESIGNED TO FAIL

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Designed to Fail: How Organizations Build Weak Managers, Lose Good Employees, and Call It a People Problem

ISBN: 9798184480978

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Examples, scenarios, and organizational details are used for instructional purposes. Identifying details may be altered, combined, or generalized to protect confidentiality while preserving the management and systems issues being discussed.

A Note on This Digital Edition

This digital edition of *Designed to Fail* was built to move.

If this PDF was shared with you, good. Read it. Pass it along. Send it to the leader, manager, HR professional, business owner, board member, or supervisor who keeps watching the same workplace problems return under different names.

And if sending it directly feels politically expensive, send me a note. Tell me where the book needs to land, and I may let it arrive by professional serendipity with a simple message:

“Thought you could use this.”

If you found this book sailing under a flag I did not personally raise, I understand how the seas work. I am not going to clutch pearls or make anyone walk the plank.

Just keep the file intact.

The purpose of this book is not to hide the argument behind a gate. The purpose is to put better diagnostic language into the hands of people who are tired of watching organizations blame employees, managers, culture, attitude, loyalty, or work ethic before examining the system that keeps producing the same failure.

Recurring people problems usually leave a trail.

- Unclear expectations.
- Weak authority.
- Stale policies.
- Unsupported supervisors.
- Poor documentation.
- Overloaded roles.
- Leadership habits that reward reaction over repair.

That is where the real work starts.

If this book helps you name a pattern you have been watching, share it with someone who needs better language for the same problem. If it gives your leadership team a better conversation, use it. If it makes a recurring workplace issue harder to dismiss as “just a people problem,” then it is doing what it was built to do.

Bring Dr. Faulkner to Speak

Dr. Thomas W. Faulkner speaks to HR leaders, executives, managers, business owners, public-sector leaders, and professional associations on recurring workplace problems, weak management conditions, preventable turnover, supervisor accountability, documentation failure, and why organizations keep calling system failures people problems.

Speaking and Conference Booking

<https://faulknerhrsolutions.info/speaking>



Book a Consultation

For employers dealing with recurring HR issues, weak documentation, inconsistent supervision, employee relations concerns, turnover patterns, policy breakdowns, or decisions that need to hold up under pressure.

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About Dr. Thomas W. Faulkner

Dr. Thomas W. Faulkner helps employers stop blaming people for problems their systems keep creating.

As Principal Consultant of [Faulkner HR Solutions](https://faulknerhrsolutions.info), Dr. Faulkner brings more than 15 years of HR, leadership, and operational experience across small business, nonprofit, behavioral health, municipal government, and public-sector environments. He is an SPHR-certified HR practitioner, Lean Six Sigma Black Belt, and organizational leadership scholar known for translating messy workplace problems into clear, fixable system failures.

His core argument is blunt: recurring workplace problems are often the predictable result of unclear expectations, inconsistent authority, untrained supervisors, stale policies, weak documentation, and leadership habits that reward reaction over repair.

Through Faulkner HR Solutions, Dr. Faulkner helps employers reduce risk, strengthen supervisors, improve retention, and make people decisions that hold up. His commentary gives media professionals a sharper lens for stories about workplace conflict, leadership breakdowns, employee relations, small business HR risk, public-sector workforce challenges, supervisor accountability, and why organizations keep reliving the same people problems.

He is a strong source for pieces that need strategic HR opinion with honest grit and conviction. His perspective is practical, direct, and built around a clear thesis:

Recurring people problems are usually system problems leadership has not had the discipline, clarity, or nerve to fix.

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How to Use This Book

Before we get started, I need to ask you something, and I do not mean it in that cutesy, poetic way authors sometimes use when they are trying to seem intimate before immediately becoming abstract with their readers. What I mean to ask sets the work agreement for this book.

Do not come into this experience guarded and only looking for validation for the person or persons who failed you.

That will be the easiest way to read these pages, and I know that because I have been in enough rooms, heard enough stories, reviewed enough files, and watched enough leaders bring the same problem into meetings with me under a different name. One month, the organization is reviewing attendance like some old-time clock morality play where the whole point is whether one employee respected the schedule. The next month, everyone is studying a performance issue that does not really have a clear standard behind it. Then the problem becomes communication, but ask around and no one can say who was supposed to communicate what, when, to whom, or with what authority. Move into documentation and suddenly someone wants the record to become a cathedral after everyone spent six months feeding the file scraps, rumors, half-memories, panic, and whatever else they could scrape together once the damage needed to look like it had a respectable history. Then cue up manager issues, culture issues, retention issues, "nobody wants to work anymore" issues, or whatever label lets the room feel like it has discovered something new.

That is not how I want you to use this book.

I want you to bring one real problem with you. Not the sanitized version you could state publicly in a leadership class where everyone pretends their company is one communication plan away from maturity. Bring the problem that keeps coming back no matter how

many times the organization renames it, the one you are tired of explaining because it has already shown up as attendance, communication, performance, morale, manager failure, culture, and whatever else made the room feel better than admitting the same ugly little machine was still underneath it, grinding out the same result. Bring the resignation everyone keeps calling sudden even though it had been dragging a six-month shadow through the hallway, the manager who keeps dodging hard conversations until the problem starts leaking through the walls, the employee everyone calls difficult even though half the difficulty may be coming from a role nobody built well enough to survive real work, the documentation file strutting into the room with more confidence than evidence, and the policy everybody cites like scripture while no two people follow it the same way twice.

This book is diagnostic, which means I am going to keep asking you the same frustrating, familiar questions from different angles until the habit starts to settle into your bones.

What condition made this specific failure more likely?

What did your organization make easier than the standard?

What did leadership tolerate long enough for people to treat it as normal?

What was never made clear?

Who had responsibility without enough authority to act?

Where did the work really go?

What did the file prove, and what did it fail to prove?

What did people learn when pressure arrived?

I hope some of these questions annoy you. I mean that with the utmost affection, at least in the limited way affection is useful in literary relationships. Good diagnostic questions are supposed to irritate the part of us that wants the problem to become simple before it has earned the right to become simple. They slow us down when the closest person is already emotionally available for blame. They keep the problem in the room longer than we would prefer. They make owners ask whether their involvement has quietly become the workflow, make leaders ask whether their governance is actually governance or just fear wearing a procedure jacket, and make HR ask whether the file proves what happened or only proves that someone tried to make the ending look cleaner than the process ever was.

And I know why readers first think about the person when the circumstances become expensive, embarrassing, emotional, or just

hard to explain. I am not dictating these words from a clean little tower while brushing through golden locks, tucked away from the realities of people who make decisions before all the facts are perfect and before employees give them the courtesy of being obviously wrong. I know the pressure. I know the board does not always calm down after the fourth customer calls about staff acting inside a policy that did not quite match the situation. I know managers wait too long to intervene and then want courage by noon. I know employees sometimes make the easy path impossible. I know executives often want the answer to be less complex than reality has any intention of becoming. I know how it feels to want a simple explanation, not because simplicity is lazy, but because the operation does not pause politely while you try to figure out what broke.

That is why this book exists.

But let me say this plainly before anyone gets too comfortable with system language. If you try to use the word *system* as a broom closet for behavior you do not want to explain, this book is not here to help you hide. I know what happens when system language gets into the hands of people who already know how to dodge a mirror. Suddenly every bad decision is a process issue, and every avoided conversation is a training gap. The manager who ducked, softened, or waited until the whole thing smelled like smoke and everyone wanted to point at the structure and act like the structure reached into their mouth and took the words away.

I am not interested in that game.

If a manager reacted unfairly to the failure of another employee, that manager owns it. If a supervisor watched a problem rot in the corner for six months and then dragged it into HR like someone else was supposed to turn stale recollections, vague emails, missing follow-ups, and undocumented warnings, that supervisor owns it too. If a leader protected the person who kept the revenue coming in, the backlog moving, the schedule covered, or the dashboard green while everyone around them kept absorbing the damage, the protection belongs to that leader and not just the final result. And if an employee knew the standard, understood the expectation, had a fair opportunity to meet it, had access to the tools necessary to do the work, and still decided the rules were written for other people, that decision is theirs.

A weak system may make failure easier to create, hide, or tolerate. It does not wipe away fingerprints.

That is the accountability boundary for this book. We are going to examine the system because recurring failures usually show us something larger than the person standing closest to the mess. But examining the system does not require us to stop examining the people inside it. It requires us to stop accepting blame-shifting from either direction. Do not let the person hide behind the system. Do not let the system hide behind the person.

Accountability gets sharper when we turn on the lights. The light shows who selected the behavior, who enabled it, who ignored it, and who tried to present a long pattern as a sudden surprise.

That is much harder than blame.

Blame feels clean because it gives the room a name. Diagnosis is heavier because it gives the room a condition. And conditions are harder to fire, harder to write up, harder to gossip about, and harder to remove from the meeting with one decisive sentence. A person can be named quickly. A condition has to be understood. It has to be mapped against the work and tested against the role, the authority, the incentives, the capacity, and the quiet lessons people have been receiving from the organization long before the official standard ever opened its mouth.

That is why I am asking you to look past the first person standing nearest to the failure. Not because that person is innocent, and not because leadership is always guilty. The first person you see is often just the person standing closest to the moment when the hidden condition finally became visible.

The employee giving inconsistent answers may be the person the customer hears, but that contradiction may have been born three departments back in a handoff nobody has ever had the stomach to map because a real map would make the defect too visible to keep blaming tone, attitude, common sense, or whatever else lets the room avoid the design problem. By the time the wrong answer reaches the customer, it may have already passed through unclear ownership, half-translated expectations, private workarounds, missing authority, and a long organizational habit of letting people improvise until the improvisation becomes the process.

The resignation letter works the same way. It has a date on it, so leadership can treat that date like the moment the problem arrived. But people usually do not detach in one clean motion. They start pulling themselves out in smaller withdrawals. A question goes unanswered long enough that asking again starts to feel stupid. A public promise

disappears into the same air that swallowed the last promise. A manager says they will follow up and then lets the issue die quietly on the floor. A standard gets announced, ignored, resurrected, and ignored again until employees learn the real rule is whatever survives the shifting weather of leadership mood, personal preference, convenience, and the quiet little discomforts that decide whether anyone with authority is actually going to enforce the thing they said mattered.

By the time the resignation lands, the employee may have already quit believing in the mission, the manager, the promise, or whatever version of the organization they were still trying to respect. The letter only makes the exit official and doesn't often explain the conditions that made leaving start to feel rational.

That is the habit this book is trying to build. Stop treating the visible event as the whole diagnosis and start asking what the organization had been teaching people before the event finally became documentable.

Read for the label, then start looking underneath.

When the room calls something an attendance issue, ask what the schedule, the enforcement pattern, and the supervisor follow-up actually looked like before the violation became convenient to name. If it gets called a communication issue, the question is who owned the communication, what authority attached to it, and what happened the last time someone tried to clarify the same thing. A manager problem is worth testing against whether the manager had enough role clarity, authority, capacity, and support to lead consistently under pressure. And when the room reaches for culture, ask what the organization has been rewarding, tolerating, or quietly teaching people to do.

This book is not the place where I hand you a stack of tools before you understand what those tools are supposed to repair. That work belongs in a field manual, where the diagnostic habit has already been established and the reader is ready to start cutting into the operating condition with something sharper than frustration.

This book has a different job. It is here to establish the worldview, make the misdiagnosis visible, and train the diagnostic eye before the practical repair work begins.

That matters because tools are only useful after the condition has been named honestly. Otherwise, a checklist becomes one more artifact the organization can wave around while the same managers return to the same unclear authority, the same overloaded day, the

same missing rhythm, and the same quiet understanding that nobody is going to force the issue into the open unless the damage becomes too visible to keep managing around.

A tool can make a strong system easier to operate. It can also give a weak system something cleaner to hide behind. The organization can say it rolled out the checklist and HR can pat itself on the back for the guidance it provided while everyone stands close enough to improvement to borrow its language without ever doing the repair. Meanwhile, the same operating condition sits there untouched, warming itself under the paperwork, while the next version of the problem starts walking toward the same room.

That is why this book comes first.

Read it straight through before you try to convert every chapter into a form, worksheet, or training deck. The chapters move from the official workplace to the operating workplace, from blame to managerial fragility, and from cumulative trust debt to the business receipt that arrives after the organization has ignored the pattern long enough.

If the failure is individual, correct the person.

If the failure is structural, redesign the condition.

If the failure is mixed, then the person owns what they controlled and the organization owns what it designed, tolerated, underfunded, or failed to support.

Many organizations are dishonest about mixed failure because mixed failure denies everybody the comfort of a single villain. Mixed failure is where the organization has to stop standing over the body arguing about whose knife went deepest. The person may have cut. The system may have held the door open, dimmed the lights, and made sure nobody stopped it in time. Name both or stop pretending you came for accountability.

That is the discipline this book is here to build.

I know that sounds heavy because the work requires us to lift heavy. People like to soften that with cleaner language, but real leadership work usually starts with staying uncomfortable long enough to admit the problem did not become expensive by accident. There may be a place in this book where you recognize something your organization has been doing, and I am not talking about the safe kind of recognition where you identify another department, another leader, another employee, anyone except you. I am talking about the kind of

recognition where a sentence catches in your throat because the process sounds familiar in a way you were not looking for. That does not make you the main villain in the story, but it does mean you are out of excuses once you see it.

This book is tough on leadership because leaders are responsible for the conditions people are expected to work inside. Authority carries weight, and part of that weight is responsibility for the conditions other people are expected to survive, follow, interpret, and perform inside.

The person with the greatest authority usually has the greatest ability to clarify the standard, fund the support, correct the workaround, stop protecting the exception, or admit that the thing everyone keeps calling a people problem has been living inside the operating system for a long time. That does not mean leadership caused every problem, and it does not mean every employee is a misunderstood victim of poor systems. It means authority has a receipt, too.

The same applies to HR readers, because I do not want HR using this book as permission to become the disappointed narrator of everyone else's failure. HR can fail, too. HR can be too reactive, too slow, too proud of having a form for a problem it does not understand, and too late into the business discussion before the damage solidifies into a file, a resignation, or a manager standing in the doorway needing courage by noon because the situation they avoided for six months has finally become too loud to manage informally.

HR is often where the workplace brings the mess when it can no longer pretend the mess belongs to one person. That is where HR has to be honest about its own part. Processing the wreckage is not the same as diagnosing the road that keeps producing it.

So if you are in HR, do not read this book as permission to judge everyone else from across the table. Read it as a demand to become more diagnostic and more operational, and to move upstream before the damage becomes an unresolved complaint, grievance, or investigation. HR cannot fix every system alone, and every problem that lands on HR's desk does not belong to HR. But the function loses credibility when it can only name the mess after it arrives, file it correctly, advise on the safest language, and then watch the same conditions send the next version of the problem through the same door.

HR has to be more than the place problems go when everyone else is done pretending. It has to help the organization see the pattern

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earlier, name the operating condition underneath it, and refuse to let paperwork become a substitute for repair. Otherwise, HR becomes part of the loop it keeps being asked to clean up.

That is how you use this book.

Read the story. Identify the label. Examine the condition underneath the label. Sort the failure honestly. Decide what belonged to the person, what belonged to the system, and what belonged to both. Then ask what design elements were in place at the time that made the wrong behavior the easier and safer bet, more rational than the standard the organization claimed to have.

Do not read this book to find the villain. Read it to find the condition. Then prove that the system will behave.

Introduction: The Resignation Was Not the Beginning

That is the line leadership rarely wants to hear when a capable employee finally leaves, mainly because by the time the resignation is sitting in front of them, the room has already started reaching for whatever explanation lets the organization keep the story small.

The timing was bad, which is what organizations say when they want the resignation to sound like a scheduling problem instead of evidence that the employee had been loosening their grip for months. The offer must have been better, which may be true, but a better offer only explains where the employee went, and it doesn't address why the idea of staying had lost enough value for leaving to start making sense. The employee changed, and maybe they did, but people usually change after *quiet punishments for caring too much* teach them to stop bringing their full self to work. Somebody in management should have caught it sooner, which, again, may also be true, but that answer gets diluted when the same organization gave the manager unclear authority and every incentive to keep the problem quiet and unofficial. HR should have known, as if HR has some sacred underground listening device that can hear trust breaking through drywall. And don't get me started on the labor market argument, which is useful enough to sound mature in a meeting, but not specific enough to explain why this employee, in this role, under this manager, inside these conditions, finally decided the cost of staying had gotten too high.

A resignation has a date on it, so the organization can treat it like an event. The actual leaving usually starts when the employee stops believing the gap between what the organization says and what the organization does is temporary.

This book is about that earlier chain. It is about how organizations build weak management conditions, then blame employees, managers, HR, or culture when the predictable result finally becomes too expensive to ignore.

Anyone who has actually run an operation, and I mean actually sat inside the pressure of payroll, deadlines, client expectations, compliance, staff shortages, board questions, budget math, and the quiet little panic that starts crawling up your neck when the revenue will not cover the staffing cost, when the caseload outruns the productivity target, when the overtime keeps eating the margin while the schedule only works on paper, and when the report you owe someone with authority keeps asking for a version of reality the workplace is not currently producing, knows there is a gap between what the business needs from people and what the people system is actually built to produce.

That gap should have meant something to a behavioral health agency I know of before it took a profitability problem and renamed it a clinician discipline problem.

I can empathize with the leaders in those seats. I am not playing armchair quarterback with a clean mug of coffee and the benefit of hindsight, pretending I would have floated into the room like some organizational prophet and fixed the place while everyone else made bad decisions. Two consecutive quarters in the red changes the temperature of the rooms and the emotions people wear on their faces. Accounts payable starts looking less like a back-office function and more like a hostage situation with invoices. Vendors want to be paid, payroll still has to clear, the board wants answers, and clients still need care. Somewhere in the middle of all that, somebody says the thing organizations say when the business needs relief: we need more productivity.

Nothing strange about that. A business, even a mission-driven one, does not survive on goodwill, inspirational wall art, and the warm internal glow of meaning. Rent is not impressed by your values statement, and vendors do not accept "we care deeply" as a payment method, which is unfortunate, because some organizations would absolutely try it if they could, sliding mission language across the table like it might clear an invoice. The failure was not that leadership cared about margins. It was that leadership looked at the capacity it desperately needed and treated that need as if it were the same thing the operation could actually produce.

Introduction

So the pressure rolled downhill, the way it does when nobody designs a better place for it to go, and landed on the lowest-standing members of the system. Every service role got a strict billable-hour target, from the peer support specialists to the licensed clinicians and everyone in between. That number got stapled to performance reviews, monthly counseling statements, and supervisor check-ins. The message was starched and simple. Hit the number, or the discipline starts.

From a conference room, I am sure this felt like accountability because it had enough of the visible equipment to pass for it. There was a measurable expectation, a process everyone could describe, a supervisor conversation, a written record, and a consequence clean enough to make the decision feel mature if nobody looked too long at what the process was actually asking people to do. Squint just right and it looked like a performance system.

But that is where the failure hid, in the gap between the accountability leadership thought it had built and the operation it had actually designed.

A clinician started falling behind on projected monthly productivity. They weren't slacking off; they were dealing with three high-acuity cases that required extensive care coordination, plus a sudden spike in client no-shows that left unbillable holes in their schedule. The supervisor responded exactly the way the system trained them to respond, moving from a verbal warning to a written one to a performance improvement plan with the target, the timeline, and the consequence spelled out. When the clinician still could not reach the required hours, the agency terminated them.

Leadership got the tidy little trophy it had been reaching for the whole time. A clean file.

The file said the employee knew the expectation, the supervisor followed up, the employee had a chance to improve, the target was missed, and the next step was reasonable. It sat there looking professional and useful, like a well-dressed witness prepared to tell the organization exactly what it wanted to hear, which is what makes a weak file dangerous when it is clean enough to look credible but not honest enough to explain the conditions underneath the decision.

But process is not proof.

That sentence matters enough that I almost want to laminate it and tape it to the side of every conference room table where leaders gather to convince themselves an employee problem has been solved because

their paperwork process has finally started growing facial hair. A clean execution of discipline can hand you a clean file in exchange for solving the wrong problem. It can make the wrong interpretation easier to defend, which is a different thing from making it correct.

The termination may have been internally justified. The employee may have missed the number, and the supervisor may have followed every step. But none of that answered the question that should have been sitting in the middle of the room making everyone uncomfortable.

Could the target survive the actual workday?

The kind where the 9:00 no-shows, the 10:00 arrives in crisis, the 11:00 turns into care coordination nobody can bill cleanly, the note from yesterday is still open, the supervisor needs a case consult, the payer will not pay for the service the client actually needs, and by 3:00, the clinician is no longer managing a schedule; but rationalizing whether to leave the target short, massage the work until it looks billable, or let the license take a back seat to a number the operation had no honest way to produce.

Leaders usually do not call it maximum capacity when they are making this mistake. You'll hear the phrase aggressive but achievable, which is how a fantasy number gets dressed up for a meeting and allowed to sit at the table like it belongs there. The number works only because it is built around the cleanest possible version of the day: every client shows, every note closes on time, every payer rule behaves, every supervisor somehow supervises without losing production time, and Murphy keeps his hands off our Outlook Calendar. Operating capacity is what remains after the work still has to be legal, ethical, documented, supervised, and human enough to mean something. This agency managed the clinician against the first number that wore the lace dress that made the room feel like it slipped into something comfortable, not the number the job could actually carry.

And yes, somebody in the room could have said what leaders usually say at this point. Plan better. Tighten the schedule. Fill the gaps. Double-book the chronic no-shows. Shift clients to someone else when a clinician falls behind. Use the team more intelligently. On paper, all of that sounds like management finally remembering it has a brain. In practice, those answers only work if the operation has enough staffing, clinical fit, authorization flexibility, supervisory coordination, documentation discipline, and scheduling control to move people around without turning the day into a haunted switchboard. Double-booking is not efficiency when both clients show up and the clinician is suddenly expected to be in two rooms with one license. Reassigning

clients is not capacity planning when the next clinician is already carrying their own impossible math. A tighter schedule does not create billable hours from no-shows, payer limits, crisis work, care coordination, or services that would be clinically inappropriate to stretch just because the monthly target is hungry.

That is the trap. To make the employer's number, the clinician would have had to over-bill, stretch services past the point where they were still clinically appropriate, and conjure billable hours out of thin air while hoping the universe cooperated. To practice ethically and legally, the way their license required, they had to miss the number.

Leadership had built an impossible condition, handed it to the employee as a performance expectation, and then let the file call the miss accountability.

Then comes the part that should have made leadership feel the floor shift. The agency fired that clinician, hired someone with more experience, and landed in the same spot three months later. The new hire was a seasoned professional who had successfully managed large caseloads elsewhere. But within twelve weeks, they were sitting in the exact same supervisor's office, having the exact same conversation about missed targets. A stronger, more seasoned person in the same seat, under the same target, inside the same constraints, failing against the same math.

At that point, the person may still be part of the explanation, but the clean diagnosis has moved upstream.

You can write up one clinician and call it accountability. You can build the file thick enough to lean on if that helps you sleep. But when the stronger replacement fails the same way under the same target, the organization has run out of permission to keep acting surprised. At that point, leadership is no longer discovering weak clinicians, but instead tying people to the same bad number, pushing them into traffic, and letting the police report call it a pedestrian problem.

Now, some leaders hear an argument like this and immediately assume I am trying to let employees off the hook. So let me drag the elephant into the middle of the room before anyone gets comfortable. I am not arguing that employee behavior is imaginary. Sometimes the person really is the problem, the one who knew the standard and ignored it and sometimes the manager had authority and refused to use it. This book is not here to baptize bad behavior in systems language. Systems explain how often a failure shows up. They do not excuse the people who choose it.

But if the same problem keeps returning with different people, in the same role, under the same supervisor, after the same leadership decision, then at some point the organization has to stop acting like it keeps discovering defective humans with a 90-day expiry date. One bad employee may be a person problem. A pattern of people failing in the same conditions is the system waving both arms, asking why leadership keeps staring at the file instead of the machine.

Which brings me to one of my favorite stories to tell when somebody puts me on the spot for leadership advice. The Stupid Chicken Farmer.

Ajahn Brahm, a British-born Buddhist monk, tells it. A farmer walks into his chicken shed with a basket. He is supposed to collect the eggs. Instead, he grabs the manure, carries it into the house, and complains about the smell. His family looks at him and says, in essence, what a stupid chicken farmer you are. You brought us the manure and left the eggs in the shed.

I love this story because the mistake is so obvious. You do not need special training to see what went wrong. The farmer did not just have a rough day; he missed what was valuable right in front of him by taking the easiest thing to grab, bringing it where it did not belong, and then acting surprised when it made everything smell bad and everyone angry.

I have watched leaders do the same thing after a workplace failure. Not literally grabbing manure, though I have worked in enough organizations to say that sentence with less confidence than I would like. When something goes wrong, leaders reach for the most obvious, emotional, portable part of the problem. They collect stories about the bad employee, the weak supervisor, the toxic department, and the broken culture, and start mythologizing the workforce failures into something much larger than they are. People are lazy and not driven enough to want to be accountable anymore. These are the narratives leaders bring into their meetings, performance reviews, and executive discussions, and they even shape how they see themselves as leaders. This, in turn, stifles progress in figuring out the real issue and just shows everyone the problem they are carrying.

They carry those stories into executive meetings, board conversations, closed-door debriefs, and hallway court, and the stories feel useful because they sound close to the truth. They come with faces and names and examples everyone can remember. They give the room something to point at without having to admit yet that the story may be emotionally accurate and still diagnostically incomplete.

A bad employee gives leadership something to point at, and a culture problem lets people sound serious without getting specific. These stories offer closure, because they let leaders say we found it, we addressed it, we held someone accountable. They let the organization carry the mess into the house and gather everyone around to discuss the odor.

Meanwhile the egg is still sitting in the shed.

The egg is the operational truth. It is the useful thing, the part that can actually improve the business if the organization will bend down and pick it up. In the behavioral health agency, the egg was not the clinician's missed number. That was the manure. The egg was the harder question of whether the profitability problem actually lived in staffing, referrals, scheduling, service mix, payer strategy, administrative bloat, or the leadership decision to call an impossible target accountability.

Leaders avoid the egg because the egg does not let the room stay clean. It takes the story away from the employee, away from the written notice, away from the easy little ending everyone wanted, and puts the problem back where it was built.

That is where this book lives.

Designed to Fail is about how organizations create the conditions they later blame on employees, managers, and culture. It is about the gap between the workplace leaders say they built and the workplace people actually live inside, and about the moment a business problem becomes visible through a human being and leadership decides, too quickly and too comfortably, that the human being must be the explanation.

People do not adapt to the handbook. They adapt to the workplace that answers them back. If the policy says supervisors own performance but leadership reverses every correction that becomes inconvenient, employees learn the supervisor is being walked around on a string, jerked between what higher administration wants today and what they need to document tomorrow so the miss does not land entirely on them. If onboarding promises support but new hires enter departments where one person gets explanation, another gets guesswork, and the next gets whatever the busiest employee remembers to say between fires, the organization has created disparity with a welcome packet stapled to it.

This is where a lot of what leaders call culture actually comes from. Culture is the residue the organization leaves on people after enough

decisions, exceptions, silences, and consequences teach them what the place respects and protects. The business pays for that, just not always in a line item honest enough to name the cause. Then someone looks around and asks why the organization keeps having people problems, as if the people are the only place the cost has been collecting.

Because the workplace is already teaching. It teaches through what it makes clear and what it leaves vague, through who gets real authority and who only gets responsibility, and through what leadership protects when pressure shows up. If leaders do not design the lesson, they should not be surprised by what people learn.

So let me be clear about what this book is and is not. It is not about blaming systems instead of people. It is about refusing to let the most visible person become the whole explanation. Sometimes the answer will still be discipline, or termination, or removing the high performer everyone has been afraid to confront. And sometimes it will be redesigning the role, the metric, the authority map, the documentation standard, or the leadership behavior that quietly made the wrong outcome rational.

Accountability is more the breadth of ownership and not the softness of the cushion. A healthy culture of accountability provides a wider safety net where you are allowed to fail and know the team will catch you, but it doesn't provide the padded room where the standards don't exist and your actions have no consequences.

That is the difference between carrying the problem and doing the work. Carrying the problem lets you stay angry. Doing the work means staying with the truth long enough to own the outcome and build something better. The manure tells you why people are frustrated. The egg tells you what to change. Keep ignoring the egg because you are too busy pointing at the mess, and the same failure will happen *again, and again, and again*.

The visible failure was never the beginning. It was the point where the organization finally ran out of ways to keep the condition hidden.

Chapter 1: The Workplace on Paper

The job description said occasional overtime.

That is the kind of phrase organizations love because it sounds honest enough to survive a hiring packet but soft enough not to scare anyone away. It gives the appearance of transparency without the burden of telling the truth. Occasional overtime. Some after-hours work may be required. Other duties as assigned. Must be flexible. We have all seen these phrases, and most of us have used some version of them because they feel safe and familiar and just vague enough to cover whatever leadership has not had the patience to define.

I know this trick because those phrases do real work for organizations who allow their leaders to underdescribe the job without technically lying, which is the sweet spot where a lot of employment stupidity goes to feel professional. Nobody has to say, “We built this role too thin, we need this person to absorb the overflow, and we are hoping they do not understand that until after payroll has already processed them twice.” Nobody has to define whether occasional means once a quarter, twice a month, every Friday, every time someone calls out, or every time the organization underestimates the work and needs an employee to donate their personal life to the scheduling gods. Instead, everybody gets to say occasional overtime, while staring into the void, and the post moves forward.

The problem is that vague language does not stay vague once someone accepts the job it only hardens into an unexpected working condition turned resignation, waiting for the right miserable, inopportune moment when the organization needs coverage most and the employee has finally had enough of being surprised by the job they supposedly agreed to.

A small rural municipality needed to fill a critical seat in its Public Works Department. If you have ever worked around local government,

especially rural local government, you already know that "public works" is a wonderfully clean label for a job family that often means water, wastewater, streets, drainage, angry residents, emergency repairs, weather response, angry residents, busted pipes, half-documented institutional memory, and the occasional mystery problem somebody swears has been handled "that way for years." This was water and wastewater work in a small municipal system with aging infrastructure, lean staffing, licensing requirements, emergency response expectations, and very little room for the work to be misunderstood or improvised. The role touched the kind of service people only think about when something breaks, backs up, leaks, floods, or stops working. That matters because the job was a position to fill where you were wined and dined for playing your part, but a high-stakes pressure point in a department that already had more work lined up for it than margin to see it through.

When a veteran crew member left, the city did what organizations often do when a vacancy opens, and the operation started leaning sideways. It treated the vacancy like a posting problem before it treated it like a role-design problem. HR and the department head pulled the old job description, reviewed it for obvious problems, confirmed it still looked familiar enough to use, and moved forward.

Across the multiple industries where I have reviewed job descriptions, I have learned that the risky ones do not always look risky at first. That is disappointing news for consultants new to the game who think they are going to walk in and immediately find the obvious "a-ha" language, the legal problem glowing in the margins, the ridiculous duty no one should have approved, or the sentence so outdated that the document would be more useful as toilet tissue than as a business record.

Most of the dangerous ones are quieter than that because they look normal enough to keep moving. This one did. It had the usual pieces you would expect: duties, qualifications, physical requirements, reporting relationships, and enough broad language to give the department room to operate. It also had the catchall phrases every organization seems to keep floating around somewhere in its files. But that is where role design gets missed. A job description is not honest just because it has the right sections. It has to tell the truth about the conditions attached to the job: the hours, interruptions, authority, workload, callouts, pressure points, and the parts of the work that only become visible after someone has accepted the position.

That is the part I have learned to pay attention to. Not just whether the job description is technically acceptable, but whether it is operationally honest.

Returning to our story, the job description that was advertised to solicit for candidates stated, “some overtime may occasionally be required.”

That sentence would have been fine if the job occasionally required overtime. It became a problem because the working reality included regularly scheduled long weeks, emergency callouts, on-call rotation, night work, and field conditions that changed with weather, staffing, equipment, and whatever broke next.

Now, I am not saying the city sat around a conference table and plotted to deceive applicants like some cartoon villain in a budget workshop. Most role dishonesty is not that dramatic and is usually just a product of organizational drift or complacency when an old document gets trusted because it is familiar, HR does not have enough field detail to challenge it, and the department knows the job better than it can explain it.

The city filled the seat quickly, which looked like success if all you were measuring was the vacancy. The applicant accepted. The department had a body, the schedule had a name in the blank space, the council could stop asking when the position would be filled, and the remaining crew could believe relief was coming. On paper, the system worked.

Then the person met the real job.

The real job did not care what the document said. It pulled the new hire out of bed at 1:00 a.m. on a Sunday. Its on-call pressure made planning a weekend with family feel like something only people with fully staffed departments get to enjoy, and its average workweek looked nothing like the version implied during hiring. There was mud, a broken main, a clamp that needed to hold, and the kind of repair where nobody has time to narrate the work like a training video because leaks don't stop for tired crew members, and the only acceptable outcome is getting the line back under control.

That is where the new hire started learning the job in the worst possible way: close enough to be blamed for not knowing, but too new to do much besides watch, hand tools, and stay out of the way. The crew expected him to learn by seeing it once, but emergency work is a poor classroom. Too much of the job lived in muscle memory, local

shortcuts, half-said instructions, and field judgment nobody had slowed down long enough to teach.

And the residents still expected water to run and streets to hold, because citizens, for all their many charms, rarely adjust their expectations around your staffing model.

The new hire did what reasonable people do when they realize they bought one thing and received another.

They left.

Then another did.

Then leadership started telling itself the story organizations like to tell when the person is easier to blame than the document. People do not want to work anymore. Nobody has grit. The applicant pool is weak, rural hiring is impossible, and the younger workforce does not understand the importance of earning their dollar through a hard day's work. The council grumbled, the field crew got bitter, administration got frustrated, overtime climbed, and among all those big feelings, the remaining employees were stuck shouldering the weight of staying ahead of the next crisis.

That is what makes this kind of failure so slippery.

The paper existed. The applicant signed something. The job was posted. The process happened. The organization could say, with a straight enough face to pass casual inspection, that the role had been described. But paper does not become truth because it has a signature line, and a hiring process is not transparent just because the applicant was handed a document that vaguely gestured toward difficulty while avoiding the actual working conditions that would determine whether a reasonable person could survive the job.

A bad hire is sometimes just a good person sold the wrong job.

This is where the workplace on paper starts creating problems for the workplace in practice. The workplace on paper is the organization's official story about itself, told through the job description, the handbook, the org chart, the policy, the pay plan, the onboarding checklist, the values statement, and whatever other artifact leadership uses to explain how the place is supposed to work. Documents help the organization hold people accountable because they give the standard a place to live before the conflict, the complaint, the missed expectation, the resignation, or the termination request shows up needing everyone to suddenly remember what was supposedly clear.

Documents matter because they are supposed to make the organization legible. They should help people understand their roles, responsibilities, and the company's expectations. To be truly effective, employee documentation should serve as a comprehensive guide for navigating the workplace to include removing ambiguity and allowing employees to spend less time searching for answers on policy, workflows and procedures, organizational structure, culture, and performance metrics and more time focusing on their actual work.

Let me pull the chair closer for a minute, because this is where a lot of good people lose the thread.

You probably didn't sit down and decide to deliberately mislead someone; more often, we are too damn busy to deceive anyone and are just trying to keep operations afloat. Posting an advertisement to fill the vacant role as quickly as possible while your team is just trying to get through the week feels like you're doing what has to be done.

But that is exactly how the paper falls behind the job.

The problem is not that you are careless or dishonest. The problem is that you can get so buried in the daily work that movement starts to feel like alignment. The department is still functioning, so the job description must be close enough. The policy is still on file, so the standard must still be clear. The org chart still exists, so the authority must still be obvious. Then somebody gets hired, corrected, evaluated, blamed, or pushed out under a document that describes an older version of the work while the real job has already moved on without it.

That is why there is a difference between paper clarity and operating clarity.

Paper clarity is when the document appears to say something. Operating clarity is when a reasonable person can use that information to make the right decision and anticipate the consequences under real conditions. "Some overtime may occasionally be required" is paper clarity. Operating clarity sounds more like this: the role participates in a rotating on-call schedule, emergency response is part of the job, weeks regularly exceed 40 hours during infrastructure failures and seasonal demand, and the physical work includes outdoor excavation, exposure to weather, and after-hours response to water and wastewater emergencies. The first version protects the organization from saying nothing. The second version gives the applicant enough information about the position to decide whether they can actually live inside the job.

DESIGNED TO FAIL

The same gap runs through reporting lines. The chart says the role reports to the Public Works Director. Operating clarity asks whether the director can actually direct the work, enforce standards, deny exceptions, approve discipline, and survive the first political phone call from someone who does not like the answer. When the org chart says authority belongs to one person but the real decision still has to move through someone else before it can hold, the chart has stopped describing the workplace honestly. It may still be administratively correct, but it is no longer operationally useful.

That is not a small issue. In one public works department, the organization hired a qualified outside operations professional as director. The role looked clear on paper. He was responsible for budget control, standardization, overtime reduction, scheduling discipline, vehicle use, and the daily operating habits of the field crew.

None of that was unreasonable. The issue was that the assignment was bigger than the authority attached to it. He was being held responsible for changing practices that were still protected by informal power, old loyalties, political comfort, and the quiet understanding that some people could ignore the new standard longer than others.

The real system lived somewhere else and the crew members not only knew it, they knew which elected official to call when the director told them something they did not like, which personal cell phone could quietly undo a policy, and which relationship mattered more than the chain of command. So when the director tried to enforce fuel logs or equipment standards, the workers did what the operating organization had taught them to do. They bypassed him. The formal workplace said Robert was the director, but the operating workplace said Robert was nothing more than another pillar to navigate around.

Then leadership held his feet to the fire because overtime was still high, standards were still inconsistent, and the department still would not respond cleanly to his direction. They judged him against the formal authority they had placed on paper while continuing to tolerate the informal authority that made his direction optional. The organization wanted the results of a director without protecting the authority of one.

That is the workplace on paper doing what it does best when nobody tests it against reality. It creates the appearance of clarity while hiding the conditions that make execution impossible. The title says responsibility has been placed. But the work knows whether any of that is true.

Employees know too. They may not use the language we use in this book. They may not say "operating organization" or "authority misalignment," because most people are trying to make it to lunch without being trapped in a strategic vocabulary seminar. But they know when a policy is real and when it is ceremonial. They know when a supervisor can make a decision and when the supervisor has a hand up its ass moving its mouth and calling that management. And they know when onboarding teaches them how to survive the job and when it just shoves paperwork across the table, points at a few doors, introduces seven names they will forget by lunch, and waits for the first mistake to pretend training happened.

That last one deserves its own little moment of disrespect.

Organizations love to confuse onboarding with administrative processing. New employees get forms, logins, a handbook acknowledgment, maybe a cheerful first-day tour, a badge photo where they look mildly trapped, and a folder containing information nobody will remember by Wednesday. The organization calls this onboarding because the employee is technically inside the building now and payroll knows what to do with them. But the employee still does not know what success looks like, who owns their training, what their first 30 days should produce, or which mistakes are normal and which are serious.

Later, when the confusion starts looking like performance, leadership usually reaches for the easiest explanation: the employee is not catching on. By then the onboarding checklist is complete, the signatures are in the file, and everyone can point to enough paper to say the person was trained. What the paper cannot show is that the employee was moved through the front door, handed fragments of the job, and left to learn the real system by stepping on every rake the organization forgot to mention. That usually becomes clear when the supervisor is frustrated, the team is tired of answering the same questions, and HR asks for documentation that proves more than a few disappointed messages and everyone's shared memory of what the employee should have known.

Organizations do need formal systems. Without them, every decision becomes a personality contest or an archaeological dig through whatever the last person remembered. The answer is not to throw out the paperwork and let everyone vibe their way through operations like a committee of well-meaning raccoons, each one holding a different shiny object and acting offended when the building catches fire. But the paperwork will only tell half-truths if you let it sit too long without comparing it to the work.

The document is not the system. The work is.

That sounds simple until you run it through an actual organization, because the minute you say the paper has to match the work, somebody has to go look. Not glance. Look. Pull the job description and ask whether the person in that role is doing the work described or carrying three extra jobs nobody wanted to price correctly and pull the org chart and ask who employees really go to when a decision gets uncomfortable. That is where the paper starts sweating, because the question stops being whether the document exists and becomes whether the organization has been using it to tell the truth.

Not dishonest in the dramatic, criminal, "someone call the news" sense. Dishonest in the way organizations become when they keep using language that no longer fits the work. A job posting says flexibility when it means chronic overextension. A leadership team says accountability when it means other people absorbing consequences for decisions they did not control. A compensation plan says fairness while exceptions get made one urgent hire at a time. Most organizations do not intend to lie. They just keep preserving the conditions where the truth has nowhere useful to live.

That is how the organization turns a role design problem into a bad hire story. The employee leaves, the file says the job was explained, and the blame lands on the person who could not survive the seat. HR gets another vacancy. Finance sees another cost. And the crew sees another green laborer coming into the job who is just going to turn and burn into the problem they want to see themselves out of. Everyone sees a different piece of the mess, and the organization gets to call it a hiring issue because hiring is where the pain is easiest to name.

The harder diagnosis is that the organization filled the vacancy without fixing the role.

That is the entire chapter in one sentence, if you want the version small enough to throw at someone across a meeting table.

The city did not need a better applicant pool before it needed a better understanding of the role. It did not need more grit before it needed more honesty about what the seat actually demanded. Once it stopped selling the document and started describing the work, the problem changed. Repaired, the paper can stop hiding the operating truth. It can help candidates select in or out honestly, give supervisors a standard to manage from, help finance understand the labor reality, and give leadership a basis for accountability that does not depend on surprise, memory, or anger.

But when the paper stays disconnected from the work, blame gets easier. Once leadership trusts the document too much, the person standing closest to the failure starts looking like the obvious explanation. The job description said the expectation was disclosed, so the new hire looks weak. The policy said the rule was clear, so the employee looks careless. The org chart said the manager had authority, so the manager looks passive.

The danger is that paper gives leadership confidence before anyone has earned it from the work. Once the document is treated as proof, the person closest to the miss becomes the easiest explanation, and blame starts sounding responsible.

Chapter 2: When Blame Looks Like Accountability

Organizations love a verb.

We coached. We trained. We documented. We disciplined. We terminated. We put someone on a performance improvement plan, which remains one of corporate America's favorite ways of saying, "We are very serious now, and we have a PDF to prove it."

That kind of action gives the room relief because the organization can feel itself moving again. The issue gets pulled into a meeting, HR opens a file, the manager is told to start documenting what everyone already claims they have known for months, and someone reaches for training slides or a PIP template to regain control over a situation.

But response is not always repair.

That is where blame starts becoming useful to the organization because it animates the heaviness of a recurring problem and attaches it to a person, team or department. Once that happens, the organization can look busy, responsible, and serious without having to ask whether it is treating the condition that produced the problem or just managing the person standing closest to where the problem finally became visible.

And yes, blame can be earned. Some people know the standard and choose to shirk, push off their responsibilities, or leave the mess for someone else to carry. But this chapter is about the easier mistake, and the more expensive one: the organization that takes action against the visible person while leaving the operating condition healthy enough to keep producing the same failure.

One place I watched that happen was inside a technology company that had already decided its problem was training. That is an important

detail. By the time the issue reached me, the organization was not asking whether the work had been designed in a way people could actually sustain. It had already translated the mess into cleaner language. Deadlines kept slipping, handoffs arrived with too much urgency and too little clarity, and people's tempers were short and their patience tolerance for each other was even shorter. From the leadership seat, that given scenario starts to sound like a communication problem, or maybe an accountability problem, which is convenient, because those are things you can put people in a room and train.

The harder truth was that the company had grown faster than its operating discipline. The roadmap kept accepting promises the technical side could not honestly carry, project managers were trying to make six priorities behave like one plan, and managers were told to drive accountability inside a system where the priorities shifted faster than their authority could ever stabilize them.

So, training became the respectable answer. It gave leadership something constructive to fund and a way to say it was investing in people, and maybe in some narrow sense it was. But the training was being handed a job that belonged to workload, priority drift, and executive decision-making. People were being trained for a workplace they were not actually being allowed to function inside.

Training is comforting because it lets the organization sound generous without searching for the broken pieces. Nobody has to say the workload is dishonest, the priorities keep moving, the structure is too thin, or the people creating the pressure are now sending everyone else to class to manage it better.

Sometimes training is the right answer; however in this vignette, training existed only to become a cleaner way to ask employees to survive a broken operating system with better manners and time management skills.

The company brought in a leadership and wellness training initiative designed to reduce cognitive fatigue and support sustainable productivity. One of the practices was simple enough that people could remember it without needing a consultant selling you a \$20k marshmallow and toothpick architecture class. The idea was no more radical than employees were encouraged to unplug roughly ten minutes every hour to reset their focus and prepare for what was next to come. This was not workers trying to overthrow capitalism one water break at a time. It was a basic recognition that knowledge-work still

has human limits, and quality drops when people are driven like machines and then blamed for malfunctioning.

Employees adopted the practice.

For about two weeks, it looked like leadership had done what leadership said it wanted to do. People adjusted their rhythm and leadership treated the wellness framework as part of the way the work was supposed to run.

Then visible activity dipped, and leadership treated that like failure.

The work had not meaningfully declined. What changed were the signals leadership could see quickly: Slack presence, minor ticket response time, and the little digital proof points that make people feel like the machine is still moving. Instead of asking whether the short-term dip was part of the adjustment, leadership panicked at the first sign that repair had an operational cost.

The administration looked at the dip and did what anxious organizations do when a new practice starts costing them something they did not emotionally budget for. They yanked it back and they yanked it back hard.

The ten-minute reset was suddenly wasted operational capacity and precious time that employees had been obviously wasting since before the training occurred. The behavior leadership had just paid people to learn became, almost overnight, evidence that employees could not manage their time and needed more support from their managers to dictate how to catalog their days. The same workforce that had been told to unplug briefly for sustainable output was now treated as though it had exploited the company's generosity and needed to be corrected back into seriousness.

And you, my reader, can probably guess how that category-five whiplash landed.

Employees felt baited-and-switched because they were baited-and-switched. They had been told one version of the workplace existed, followed that version, and then got punished by the operating system for following through that leadership vision. Morale dropped, trust collapsed, and discretionary effort started disappearing from the entire fabric of the organization where it had been holding things together. The entire workplace became more transactional because the company had taught people a very clear lesson that when leadership says it wants sustainability, wait to see whether the metric agrees.

I wish I could earnestly report back that when productivity continued to decline, leadership came back to the drawing board with a new strategy in mind. But this case study would not have made it into my book if the organization's own contradiction had not finally produced enough damage to become annoying. There were discussions about PIPs and requests for more training revolving better time-management systems and accountability structures to support employee productivity. Not training to help leadership align the operating system with the initiative it had just launched. Training aimed at the people who had followed the instruction, absorbed the reversal, lost trust, and then started behaving like rational people inside a system that had overturned that trust. Talk about one hell of a way to spit in the face of your staff in the span of a month.

That is the absurdity I want you to sit with for a moment. Leadership trained people to do something. People did it. Leadership panicked and punished the behavior. Then leadership blamed the people for the consequences of the panic.

If that sentence feels too ugly, good. It should.

Training cannot survive a system that punishes people for doing what the training taught.

This is where blame starts looking like accountability, because leadership can build a very respectable-looking response around the wrong interpretation. It can hold meetings about productivity, coach employees on time management, put people on PIPs, and bring in a new training vendor to address the "real issue," which, magically, is still located somewhere below the executive layer. It can do all of that and still be avoiding the only question that matters.

What did the operating system just teach?

It taught employees that the formal training mattered less than executive discomfort, that sustainability was welcome only until it became visible as a cost, and that "people-first" language can disappear quickly when a report shows you don't move your mouse often enough.

This is one of the reasons I have a very, *very* limited tolerance for the way organizations toss around the word accountability. It has become one of those leadership words that can mean something mature and useful, or it can mean "I would like the consequences of my design choices to land on someone with less authority (or in laymen terms, someone who is not me)." It depends entirely on whether the organization is willing to let accountability travel upstream.

Most organizations love downward accountability. Employees own performance, supervisors own correction, HR owns risk, and everyone below the strategic altitude line owns some measurable thing that can be written into a goal, placed on a dashboard, or turned into a corrective conversation. But upward accountability is where the room usually starts coughing into its sleeve. Ask whether leadership created the contradiction, funded the false assumption, protected the damaging person, or measured the wrong thing, and suddenly everyone gets very careful with language.

That is where blame earns its keep. It lets leadership walk into the room and declare accountability with the same misplaced confidence as Michael Scott declaring bankruptcy, as if saying the word loudly enough completed the legal work. Once the problem has a name in the file, a complicated operating failure can be repackaged as performance, coaching, or, my personal favorite, culture, which is often what organizations say when they want the problem to sound deep without naming the machinery underneath it.

That is the problem. Blame can be necessary and still be incomplete.

A performance improvement plan belongs on the table when the person had the standard, the support, the authority, and a real opportunity to correct the issue. But I have also seen a PIP become a little administrative costume the organization puts on after it has already decided the ending and exit of a story.

Training can be powerful by giving people the language, confidence, judgment, and a cleaner way to handle guesswork and assumptions. Training builds capability when the workplace supports the behavior being taught. Without that support, even good training gets ground down by the same conditions that made the training necessary in the first place.

Termination and employee separation are natural processes of the employee life cycle. As owners, managers, and future leaders, it's important to swallow this lesson early on that some situations reach the point where keeping the person in their role causes more damage than removing them. Read that again if you need clarity. But termination becomes something else when the organization uses the person's exit to avoid admitting that the role, metric, manager, workload, or leadership decision still needs to be dealt with after the badge is turned in.

That is why action alone is not accountability. Accountability demands that we ask whether the response matched the failure, or

whether the organization simply found the most documentable person standing near the mess.

Action is not repair; it is motion. Repair can only occur when the conditions inside the organization change.

The difference matters because leaders often reach for the action that gives the room the fastest relief. Document the difficult employee. Train the toxic department. Centralize every approval after an audit scare and call the bottleneck governance because that sounds less embarrassing than admitting we are leveraging panic and fear rather than rebuilding trust and follow-through in the process. The organization gets to feel responsible while the condition stays alive, and because the condition stays alive, the same problem returns wearing a new set of prescription glasses for leadership to pretend it has never seen the thing before. You're not fooling me, Clark.

That is how organizations pay for the same problem twice. They pay first while the system produces the damage, then again through cleanup, turnover, investigations, replacement hiring, morale repair, consultant fees, and every other expensive ritual that becomes necessary after leadership refuses to diagnose the problem when it was still small enough to handle internally.

Now, because I can already hear the objection forming in the cheap seats, let's go ahead and say the part that needs saying.

Some people really do fail and are not helpless victims of unclear systems, weak onboarding, bad metrics, or missing authority. They walk into a perfectly reasonable structure, receive the tools, understand the standard, see the expectations, and then choose to act like a rogue agent who believes that the rules are optional to them.

That was David.

David was a senior sales representative in a B2B commercial services firm who produced roughly 40 percent of the department's revenue. He also behaved like the company was renting space inside his personal kingdom. He refused to log client data in the CRM, hoarded leads, and intimidated junior reps he had been assigned to mentor.

This is where accountability has to stay clean, because when the standard is clear, the tools exist, the person has the capacity to comply, and the individual knowingly violates the system, the organization does not need to wander into the woods looking for a deeper explanation before it acts. It needs to hold the person accountable.

David's behavior belonged to David.

But that is not the only question the organization had to answer. The second question was harder because it pointed upward: how long did leadership tolerate his behavior because the revenue was useful?

That is where the case changes shape. David's conduct was an individual failure, and I ask you dear reader, was leadership's tolerance of David a system failure or a product of culture where employees needed to hop on the train or have David push you off? The organization did not have to choose between those truths. Mature accountability has to be able to (*or should be able to*) hold both without using one to excuse the other.

This is the part many organizations mishandle because the system language is there to soften individual accountability or they use individual accountability to avoid system responsibility. Neither one alone is good leadership, and if David had been allowed to continue, the company would have been choosing one producer's comfort over the entire team's operating integrity. If it pretended his behavior was merely a symptom of the system, it would have insulted the eleven other salespeople who were expected to follow the rules he treated like a buffet. But if leadership only said "David was the problem" and refused to inspect how long it had protected him because the revenue felt too important to challenge, it would miss the second problem entirely.

That is why this book keeps coming back to diagnosis. The conduct may be individual while the tolerance is systemic.

The result was predictable. The other salespeople were trying to compete inside a game David had been allowed to rig. New employees burned out before learning to crawl their way out of orientation and mid-tier performers stopped pushing because effort did not feel like the path to opportunity. The company had convinced itself it could not afford to fire David because his revenue protected the quarter, while refusing to admit that protecting David was helping starve the rest of the team.

That is the math leaders avoid when they protect toxic output. A person can generate revenue while still capping the system, looking indispensable only because leadership has allowed them to hoard information, relationships, and political protection until the business believes it can no longer function without them.

I do not want to flatten this into a clean little romantic story where the toxic high performer exits, and the organization is magically better

by lunch. Toxic high performers are not always easy to remove and the real short-term losses in revenue account knowledge, and client access poses a real threat in maintaining the continuity of business operations. The point is that accountability has to include the full cost of the behavior, not just the visible production of the person behaving badly.

If David had been a lower producer, leadership would have handled him way earlier in the process with a metaphorical performance and attitude check. But because he produced, leadership called the same behavior complexity, personality, or sales culture, or whatever euphemism people use when they are afraid the money might leave if you insult or strangle the precious golden goose. Selective enforcement is the furthest thing from real accountability, and allowing it to take root in your organization teaches people that standards are not standards at all.

This chapter has to hold the line that some leaders would rather avoid: blame can be necessary, justified, and still too incomplete to count as accountability and your response to the issue has to match the failure type.

That sounds obvious until you watch organizations operate. As a consultant, I get the benefit of external eyes and hindsight. I can usually see the tracks after the pattern has already moved through the place. But when you are inside the organization, trying to keep the work moving while the problem is still alive, clarity is harder to reach. The condition doesn't take the shape of a good Samaritan employee, waltz up to your office door, and announce itself as a system failure. It shows up as another hard week, another difficult employee, another frustrated manager, another exception, another decision that had to be made before anyone had time to inspect what was really happening.

That is why diagnosis matters. Until the condition is named, the organization keeps repairing whatever is easiest to see. It trains the employee, pressures the manager, rewrites the policy, adds another approval step, or documents the behavior without changing the thing that keeps producing it. That may create movement, but it does not create repair.

Repair requires the condition to change.

This is where Faulkner's people systems diagnosis starts to separate motion from repair. In the training contradiction case, the failure lived in reinforcement, proof, and support. Leadership punished the behavior it had just trained, treated visible activity as more important

than the longer-term purpose of the training, and never protected the practice long enough to let it become real. That is a very different diagnosis from "employees need time management," and because it is different, it demands a different response.

If leadership wanted that wellness practice to work, it needed to align the operating system around the behavior. That means defining what output would be measured and over what period, preparing managers for the dip in visible busyness that often comes when people change their work rhythm, and giving the new standard enough runway to become more than a two-week experiment leadership abandoned at the first sign of discomfort. It means deciding whether sustainability was a value or just another buzzword the company liked and wanted to share on their socials when nothing *real* was at stake.

The same is true in reverse with David. The correct response was not another training module on CRM usage, as if the man had been tragically unaware that client notes go in the client-note machine. It was not coaching him gently for the eighth time while everyone else learned that standards depend on revenue share. It was accountability and not because we were mad and having big feelings with David, and not because someone needed to be punished so leadership could feel strong, but because the system had a clear standard, David had the capacity to follow it, and he chose not to.

Most workplace failures that survive long enough to become expensive are mixed condition problems. A person may have failed, and the organization may have helped make that failure easier or more likely than it had to be.

That is the line this chapter has been walking toward.

Accountability gets weaker when it stops at the person closest to the mess. Leave the condition untouched, and the organization does not solve the problem. It only resets the trap for the next person. Blame gives the organization a person. Diagnosis gives it a pattern. Repair requires the organization to choose the pattern.

That is why the question is not whether someone should be held accountable. Sometimes they should, *sometimes immediately*, with the kind of clarity that makes everyone else exhale because the standard finally lands on the whole problem and not just the part of the problem that surfaced.

This is the move we have to make before the book can go any further. We have looked at the workplace on paper and how formal systems can hide operating truth. We have looked at blame and how action can

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impersonate repair. Now we have to get underneath both, into the layer where the organization teaches people what actually matters.

Because the policy is not always the system but the invisible hand that guides people when the written version is inconvenient.

Chapter 3: The Organization Underneath

We have already met Robert. He was the public works director from the first chapter, the one with the title that looked solid right up until he had to make and defend a decision that crossed the grain of what the county consensus desired. I want to come back to him, because his situation was much less about the deceptive job description that hid his work and more what happens when the real decision path runs through relationships, habits, and people no one put on the chart. Robert had every formal marker of authority the institution could hand to a person. What he did not have was control over the informal system that decided whether his authority would be respected or bypassed, and the gap between those two is what this chapter is about.

On paper, the organizational chart makes it clear that Robert served as the Director of Public Works for a rural county government in Texas whose departmental responsibilities included road maintenance, emergency repairs, scheduling, and the general ongoing miracle of keeping the county's near fifty-year old public infrastructure from embarrassing everyone at the next board meeting. He reported to the Commissioners Court directly and his crew reported through their department's heads respectfully. Among the structure were policies, a budget, and a fiscally conservative board with extremely high expectations. Robert had a title, a corner office with a large oak desk and a window-view, and the kind of formal authority that looks very impressive on his embossed business cards.

The county hired Robert because he was the MBA guy from the city, the outside operations professional who looked capable of bringing discipline to a department that had become too loose with labor costs, overtime, and the daily field habits everyone had learned to treat as normal.

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Robert's job, according to the formal structure, was to tighten the operation. He was supposed to bring discipline to spending, scheduling, vehicle use, fuel logs, and the daily field habits that had been allowed to wander too long. It was the kind of assignment that sounds clean in a public meeting, especially when elected officials want credit for protecting taxpayer money without yet having to explain to voters why the cleanup requires saying no to people who have gotten comfortable hearing yes. You cannot shake the coin cup in front of the public and then get sentimental when someone finally asks where the money is going.

And to be clear, the goals were not wrong. Public infrastructure does not run on good intentions alone, and taxpayers have a right to expect some level of adult supervision over assets, labor, and service delivery. Nobody gets to hide behind the romance of rural government and pretend a county vehicle is a personal convenience because the driver's cousin knows someone on the court.

So, Robert came in and did what the formal organization told him he had been hired to do. He started enforcing standards and that is when the organization underneath him introduced itself.

You see, the field crews already understood the real chain of command. They knew Robert had the title, but they also knew the title was not where the final answer lived. They knew which elected commissioner had always taken their calls, which precinct relationship mattered, and which personal cell phone could quietly soften a directive or undo a boundary. They knew that if Robert denied questionable overtime, asked for documentation, or tried to bring some order to equipment use, there was an alternative path available to them, and I'm not speaking of grievances or requests for informal resolutions.

One of Robert's crew members didn't have to argue with him for long because when Robert posted a new schedule requiring the crew to log their vehicle mileage at the end of every shift, a senior operator just shook his head, walked out to his truck, and made a telephone call directly to one of the commissioners. Mind you, this call didn't take place through a work order system, not through a documented escalation path, but on a personal cell phone, complaining that Robert was treating them like children and slowing down the real work that needed to be done. And because local politics has a special talent for making the small feel enormous, especially when the person on the other end of the phone is not just an employee but also a voter, a neighbor, a cousin, or someone whose extended family can turn one

scheduling dispute into a precinct weather event, the commissioner would issue the quiet override.

"Don't worry about Robert's new policy."

"Just keep doing what we've always done. I'll talk to him."

And with a sentence or two, Robert's authority evaporated.

Not publicly, of course. Publicly, everyone still expected him to control the department, still treated him as the director, still wanted budget discipline and accountable crews, still pointed to him as the person who had been brought in to fix the problem. But behind the scenes, the same officials asking him to stop the leakage were creating the holes in the bucket.

That is the organization underneath.

There is the formal organization, which is what the organization says. It lives in the org chart, the policy manual, the board minutes, the budget, and all the other places where the institution explains itself as if explanation were the same thing as reality. Then there is the operating organization, which is what the organization reinforces. It lives in what gets tolerated, protected, rewarded, ignored, and repeated when pressure shows up and the room gets uncomfortable.

The formal organization said Robert was the Public Works Director. The operating organization said that didn't mean so much because elected commissioners could privately overrule him without consequence. Guess which one the crews obeyed.

The part leaders miss is that they often confuse permission with power and they believe that titles alone create authority and written artifacts inside of the organization make it hold.

That's adorable, because authority itself is not real until somebody challenges it and the organization backs the person who was supposed to have it. If an employee can ignore a supervisor who is giving a lawful and reasonable directive, circumvent that leader behind their back, and suffer nothing for doing it, then that supervisor never had authority in the first place.

Robert wasn't struggling because of a lack of leadership presence nor was he failing because he needed to communicate better, though I am sure someone probably said that because "better communication" is the all-purpose seasoning of a weak diagnosis. He was being publicly held responsible for outcomes he was privately prevented from controlling.

The consequences Robert was facing weren't philosophical and eventually he burned out because that is what happens when an organization makes someone accountable for a system it refuses to let them govern. This kind of arrangement creates a particular kind of professional exhaustion that is hard to explain to people who only look at structure from the outside. It is not the exhaustion of hard work, though the work may be hard. It is not even the exhaustion of navigating conflict, per se, but rather the exhaustion of being told you own the result while watching the organization quietly remove every tool required to produce it, of being blamed in public by the same system that sabotages you in private, of standing in a meeting while everyone acts confused about budget leakage you can trace directly back to the undocumented exception somebody issued from a cell phone at 7:42 p.m. because a voter was annoyed.

That is why the operating organization matters more than the formal one. The formal organization can tell a beautiful story and still be functionally irrelevant; but the operating organization is the one that determines what happens inside of a work system.

In Robert's department, the crew learned the director only manages unless the commissioner intervenes.

That sentence provides a conceptual definition of an operating organization.

Once that rule is learned, the formal system starts to collapse in people's minds. The fuel policy, the scheduling rules, the equipment standards, the board's expectations, and Robert's title may still sit there on paper, but the workforce has already learned the only rule that matters is enforcement only counts if the person enforcing the standard can survive the override.

And before my private-sector readers get too comfortable, do not let the county label make you smug. Your version may not involve elected officials, precinct politics, or taxpayer money, but the pattern still knows how to find you in your complacency. The actors change. The system does not.

In a family-owned business, the org chart says the operations manager owns scheduling, but everyone knows the founder's spouse can override it with one comment at dinner. In a hospital department, policy says the manager approves exceptions, but high-status clinicians get to ignore the process because nobody wants to lose them *in this market*. In a small business, the supervisor is responsible for performance but cannot approve discipline, adjust workload, or

change pay without the owner, which means the owner is the system and the supervisor is the *toddler with unsupervised email access* who asks for permission before they can act.

I say all of that with this preface. The organization underneath is not always the sinister, curly fingered monster waiting to grab your toes as soon as they poke outside of the covers. Sometimes it grew into what it is simply because people were trying to keep the work moving with the tools they had. Informal channels develop because the formal process is too slow, too disconnected, or too obviously designed by people who have not had to use it under pressure. The workaround saves the day before it becomes the thing slowly draining the organization's blood. Sometimes the person with informal power has it because they know where everything is buried, or because the formal system was empty enough that someone had to become the connective tissue that held the place together while the organization was under duress.

The largest misconception you can take away from this chapter is to recognize that the hidden structure that you find within your organization must be malicious, when often it is sedimentary evidence of organizational adaptation. But adaptation does not mean what you found underneath your organization is conducive for growth. A temporary workaround can help the organization survive the moment and still damage the system when it becomes the normal way work gets done. The question is not whether the operating organization formed for a reason. I can guarantee you that its roots were established in some form of responsive practice to make organization thrive in a moment of doubt. The question we must ask now is whether or not leadership has been honest about what it now controls.

In Robert's case, the operating organization was political access. Somewhere else it might be institutional memory, a founder's approval, or a senior employee everyone is afraid to cross. Sometimes it is HR, not because HR has real authority, but because managers have learned to bring every hard decision there and wait for someone else to absorb the risk. The operating organization is whatever people rely on when the formal system is too weak to carry the work.

This is why one of the most useful diagnostic questions a leader can ask is also one of the most annoying: how does the decision actually get made? Not how is it supposed to get made. Not what does the policy say. Actually. When the customer is angry, the employee pushes back, the board member calls, the high performer threatens to leave, or the supervisor finally says no, who decides? Who can override, who can

block, who can make the exception, and who owns the consequence when the decision goes bad?

That is the real decision path. Map that, and the organization underneath starts showing itself.

Most organizations do not fail only through visible chaos, but vicariously through the mismatch between the structure they claim and the structure they reinforce. The claimed structure gives leadership a sense of order, while the reinforced structure teaches everyone how to behave. When those two disagree, employees follow the one with consequences attached.

That is why Robert's crews followed the commissioners. Not because they had studied governance theory or were naturally resistant to change, but because the organization had taught them where authority lived. Robert could issue a policy and the commissioner could undo it just as quickly.

People do not adapt to the handbook as written, rather they adapt to the workplace that answers them back.

That is the thing about the organization underneath. It does not need permission to operate. It forms wherever the official system fails to carry the pressure. When hiring feels risky and the organization lacks a defensible process, executives become the process. When discipline feels unsafe and managers lack documentation standards, HR becomes the courage substitute. When a director lacks real authority, political relationships become the chain of command.

This is why leaders must stop asking only whether a formal structure exists seek to know whether it maintains its integrity when it is tested. Does the supervisor still have authority when the employee complains? Does the director still own the schedule when the commissioner gets a phone call? Does the policy still matter when the high performer violates it?

So how do we move from identification to repair? I can tell you where it did not start. It did not start with a motivational speech about teamwork, and it did not start with a reminder memo telling employees to respect the chain of command. And now that I have said that somebody reading this is going to want to send the memo even more thinking it will give them something clean and clear to point to that sounds like order being restored. Please, don't.

The repair starts by making the hidden system visible. Every undocumented override had to be connected to a cost. Route deviations, unapproved overtime, fuel usage, missed maintenance,

delayed work. The political exception had to be translated into operational consequence, because until the commissioners could see the price of their informal behavior, the backdoor phone calls would continue to feel like small acts of responsiveness instead of system damage.

Another hard truth leaders must swallow is that your permitted exceptions can be perceived as design decisions. Leadership flexibility, conflict avoidance for the sake of keeping relationships warm, and selective discretion dressed up as “helping out this one time” all teach who can get around the rules and which standards bend. This is an essential part of leadership development that you have to learn to carry and balance for yourself. I am not saying you need to become a rule prude, but you do need to understand that every exception you make teaches something.

In Robert's case, the fix required a formal operating charter that aligned authority with responsibility. Commissioners could not issue direct work orders or policy exemptions to frontline field staff. Precinct requests had to move through a centralized project-intake process. Safety, attendance, equipment tracking, and operational enforcement belonged to the director. If an elected official wanted to override a disciplinary action or operational standard, that decision had to come into the open through a public, recorded process.

That last part is where the temperature changed in the room. The point was not to remove politics from government, which would be a precious little fantasy and probably evidence that someone has never survived a county meeting. The point was simpler and much harder to dodge: stop pretending the political override is harmless when it keeps stripping authority from the person expected to manage the mess afterward.

The same principle applies beyond government. A sales manager has authority only if leadership backs the lead-distribution system when the top producer tries to hijack it. A nonprofit executive has it only if the board refuses to let a fundraising superstar hoard donor data and bully program staff in the name of mission. Without that backing, the formal organization is a wet sock pretending to be a steel-toe boot.

Once you see that, the path toward repair changes. You stop coaching Robert to be more assertive, as if personality can overpower a broken governance structure and you redesign the condition.

That is the discipline this chapter is trying to teach. Map the real decision path before you trust the formal reporting line. Follow the

decision past the org chart and watch what happens when it becomes inconvenient. Who can soften it? Who can stall it? Who can punish the person enforcing it without ever saying they are punishing them? Where does the standard actually die: in a phone call, a side conversation?

That is where the real organization lives, and for reasons I have never fully understood, leaders are often surprised when their employees understand their organization better than they do.

Your employees are professional anthropologists of organizational consequences because they study the workplace like their survival depends on it. They learn who will let them slide in late, who will ask a coworker to “fix” the timecard, who checks the camera and who only threatens to, which one looks away from an extra smoke break, and who can disappear for twenty minutes as long as they come back with the right story. They learn who gets written up for calling in, when policy matters, when relationships matter more, and when the safest career move is to shut up, save screenshots, and start updating the resume. The organization is always teaching. The question is whether leadership is paying attention to the lesson of the day.

The formal organization only matters when it stays connected to the operating one. The job description should tell the truth about the job, the org chart should reflect real authority, the budget has to show leadership more than cost by revealing how labor is being used, strained, wasted, borrowed, or protected, and the technology should support the workflow instead of speeding up confusion.

Here is the part that should bother you, though, because it is the part that turns a bad arrangement into a permanent one. Once the organization underneath keeps repeating, it stops feeling like a workaround and turns into feelings of normalcy. People stop calling the commissioner because it is an exception and start calling because it is how work gets done. The formal system may still be printed, posted, reviewed, and explained in orientation, but the working system has already written better instructions in people’s behavior. That is how the arrangement hardens making the shortcut the route and the exception the expectation.

Eventually, the workaround stops looking like a workaround and starts looking like culture.

Chapter 4: How Workarounds Become Culture

We learned in the previous chapter that workarounds are usually born looking helpful, which is part of why they are so easy to excuse. They do not enter the workplace looking like sabotage; they enter like relief, like a hand pressed against an arterial bleed so the day can keep moving.

That is the danger, because remember that a tourniquet can save you in the moment and still cost you the limb if everyone starts relying on it for circulation. The first workaround you build may be survival-oriented but if you repeat it long enough, it becomes the way the organization functions.

A workaround usually begins when the official system cannot carry the pressure being placed on it. The process is too slow, the authority is unclear, the manager is avoiding the issue, or the structure is not strong enough to support the decision that needs to be made. In that moment, improvisation may be necessary. That is normal because real operations do not pause while leadership draws a cleaner process on a whiteboard.

The danger starts when temporary survival starts becoming permanent design where the shortcut or the exception gets institutionalized into the real system. Everyone knows that this is how workflows, but no one really can point to why it continues to flow this way.

Culture is bigger than workarounds, and I do not want to reduce it to one mechanism just because this chapter is focused there. Culture includes what the organization rewards, protects, repeats, funds, ignores, celebrates, corrects, excuses, and quietly allows to survive.

I am also not talking about the soft-focus version of culture that gets discussed at leadership retreats while someone writes “trust” on a sticky note and reads it off another person’s forehead. Culture is not an extrasensory mist floating through the building and making people act weird. In the way this book uses the word, culture is the pattern of behavior an organization teaches people to treat as normal. Workarounds are one way that pattern gets built, but they are not the whole thing. The larger point is that repeated decisions, exceptions, protections, incentives, silence, and follow-through eventually become the workplace people believe they are living in.

A high-end retail company learned this after one bad termination scared executives so badly that every future employee decision had to drag the old file into the room before anyone was allowed to manage the person standing in front of them. To set the scene for you, the company had multiple store locations, a visible local reputation, and the kind of customer-facing environment where staffing quality mattered because the product was only part of what customers were buying. They were also buying taste, experience, attention, and the strange little performance of being made to feel personally seen while someone persuaded them to spend more of their money.

Retail is not simple work just because outsiders like to treat it as low-complexity labor. Inventory, customers, scheduling, sales pressure, performance issues, and interpersonal drama all share the same oxygen, and when management gets weak, every one of those issues starts breathing on the others. These problems compound exponentially for the business if the value is built around a premium customer experience, one upset customer can absolutely create problems, and one sloppy termination can create even more.

The original termination story was not that impressive to tell. You had a store employee that had become known, at least in management’s language, as someone who liked to “stir the pot.” That phrase should make every HR person in the room sit up a little straighter, not because employees never stir things, because some absolutely do, but because phrases like that have a habit of showing up in personnel conversations when nobody has done the harder work of naming behavior. “Stirring the pot” is not appropriate professional documentation and to call it a spade, is no more than management resorting to gossip to tell you how they feel about the employee. Lazy language like that perfect in literature for us to conjure our own imagination to in the corporate world, it does not tell you what the employee did, when it happened, what standard was violated, who

observed it, or why the final decision should hold up after everyone's emotions leave the room.

That kind of language filled the employee's file, so when the manager came to HR and insisted the complaints were legitimate, the concern had already moved beyond a gut feeling about the guy toward a real problem. Then HR asks the question that puts everyone on the defensive: where is the documentation?

At this point, employers begin to search through memories looking for facts and details. Managers tend to lose track of specific dates, conversations often become classified as coaching sessions instead of actual discussions related to performance issues. Warnings can turn into casual remarks. The next thing you know someone is saying, "Didn't we discuss this with him?", and it is likely the beginning of the end for a poorly maintained personnel file.

The termination happened anyway and the fallout was bad enough to scare the executive team to its core. The terminated employee didn't simply walk away. They threatened the company with a wrongful termination suit stating they were terminated for raising concerns regarding their schedule, and made complaints on social media, tagging the brand and making claims of a hostile work environment. Legal concern, reputational concern, and probably the kind of late-night executive text string that makes everybody into an employment lawyer with a smartphone and a nervous stomach, this company had all the reasons in the world to treat this as serious.

What the company needed was a person willing to slow the room down and separate the employee problem from the management failure sitting underneath it.

The work would have started with the standards. Were expectations clear enough that the employee could reasonably know what success, failure, correction, and continued employment depended on? If the answer was no, then the company needed to prioritize providing clarity over termination.

From there, the next move would have been supervisor support. Managers needed a way to address behavior early, document it plainly, follow up consistently, and escalate before everyone became too tired of the employee to think clearly. That means training, but not the decorative kind we discussed previously where supervisors are handed a slide deck and sent back into the same broken rhythm. Effective training evokes change in the management process and provides them

with actual tools and workflows they can use when the conversation is uncomfortable or the employee is difficult.

Then the file needed to be tested before termination became the emotional destination. A termination readiness process would ask the questions leadership should have been asking all along: What standard was violated? When was it communicated? Who addressed it? What changed after the conversation? Where is the follow-up? Would a neutral person understand this decision without the manager in the room explaining what everyone “knew” but never wrote down?

That is the consulting work. Build the standards, train the managers, install the documentation rhythm, define the escalation point, and pressure-test the file before leadership asks HR to turn a long history of tolerated behavior into a defensible employment decision.

Yeah, leadership didn't build that, here.

Instead, the executive team became so terrified of letting managers make people decisions that the President and Vice President of the organization established centralized control over hiring and began inserting themselves into almost every applicant review and interview decision. Entry-level applicants, floor associates, and senior roles all started moving through the same executive-heavy bottleneck, because leadership no longer trusted the system underneath the decision. And while, in some backwards rationalization of intuitive thought processing, senior involvement has a way of making organizations believe they have strengthened the process when, in reality, all they have really done is move the anxiety closer to the top.

A bottleneck is not governance just because an executive is standing in it waiting to give you a metaphorical thumbs-up as you pass your work through that process.

From an organizational trauma-response, the workaround made emotional sense at first because retaking back control after that bad termination make the process feel safer. If the managers could not be relied on to make and support clean employment decisions, leadership would look at everything itself.

The problem is that fear is very good at making itself sound responsible and the ongoing narrative was that leadership intervention was improving consistency, protecting the brand, and preventing future exposure. Those are not bad goals. Intelligent organizations should care about consistency, reputation, and risk. But when those

goals are not paired with intentional design, they stop functioning as governance and start functioning as avoidance.

As a result, hiring slowed down and with the convoluted hiring practices, candidates would vet themselves out of consideration. Store managers waited on decisions they should have been trusted to make inside a designed system, while good applicants accepted other offers before leadership finished passing resumes around like classified documents. Retail customers do not reschedule their shopping behavior around an executive review bottleneck, so the delay did not stay contained inside hiring. Existing employees carried more shifts, managers spent more time explaining vacancies than leading teams, and executives burned hours reviewing roles that should never have reached their desk in the first place.

The company did not eliminate its risk; it just shifted the position to where the risk was allowed to make a mess. Termination fear moved into hiring drag, thin coverage, burned-out staff, lost candidates, weaker customer experience, and executive time spent babysitting decisions that should have been made with the managers you put in those roles to, *you know*, manage. Instead, the discomfort of trusting managers became a hiring bottleneck that couldn't move without executive permission.

Pay close mind to that last sentence, because through that operational fragility organization kept teaching itself that executive control was the answer to operational weakness, which is a seductive lesson because it makes leaders feel useful on one side, but delimited on the other as most organizations won't scale by routing every decision through the people most removed from the daily work. We teach organizations to scale by designing decision rights, standards, tools, and proof so the right people can make the right decisions at the right level without everyone acting like the building will burst into flames if the President does not personally approve an associate hire.

The company eventually had to redesign the process because of the sheer unsustainability and unavailability of executive presence among the swings of retail staffing patterns. Our redesign process didn't remove the executive team from the loop, but they stayed involved where the risk justified it and helped our team design an actual hiring architecture with risk tiers, role-specific approval levels, structured interview guides, documentation standards, and termination readiness questions that empowered managers to make better decisions. When the decision rights were clarified, managers were able to get the hiring

process moving again without the company treating every applicant like a potential lawsuit wearing shoes.

That is the difference between governance and fear. Governance designs the process so decisions can move cleanly without pretending risk does not exist while fear grabs the decision, holds it at the top, and carries the movement in a swaddled, nurtured rear naked choke.

That same pattern shows up when the workaround is not executive control, but a new piece of technology. Leaders feel the disorder, buy a tool, and then skip the design work that would have made the tool useful in the first place.

A construction firm I worked with bought a field-management platform because a vendor in shining armor sold them the narrative that they could improve their jobsite communication with a \$15k investment. The organization was experiencing real operational challenges with unplanned and undocumented schedule changes, punch-order lists that only existed in conversations that nobody could track down, and daily reports with detailed field notes that only exist in text messages.

Leadership called the software implementation a process improvement project, but the company skipped all the common questions that would have made it one. Who had authority to update the schedule? Who owned the handoff from field to office? What counted as a complete update? What happened when supervisors kept bypassing the system because calling someone was faster than using the tool?

So the platform did what tools usually do when they are dropped onto weak design: it took the confusion, gave it a branded dashboard, and distributed the same broken process with more confidence.

The issue matters because culture is not just a statement of values. Culture is the set of acceptable norms produced by the system, and I don't categorize that through the motivational sense, but more diagnostically.

You can usually tell what the culture has become by simply people watching in moment of decision. The manager gets bypassed, and nobody even looks up anymore because if you're that employee that raises a valid concern, you get polished copy of handbook language handed back to you, and learn that reporting a problem is often just a slower way of being asked to solve it yourself or ignore it harder.

Those lessons do not come from the values posted on the wall between the "Hang in there" kitten and the framed mission statement

nobody has read since orientation. They come from the battle tested realities of operational function of what gets protected with pressure squeezes and what gets avoided when shit gets thrown around, and what people learn the organization will do once the room stops spinning.

At some point, employees stop avoiding these realities and start learning how to adjust, route around them, and function inside the system as it actually exists. Regardless of how well intended leadership wanted the culture to be, culture eventually stops being what you hoped people would believe and starts becoming the survival instincts they learned from working under the conditions you allowed.

Leaders should be very careful when they say, “That’s just our culture,” because they may be saying more than they realize. Sometimes that sentence means our family culture of poor planning is now being used as an excuse to underpay, overextend, emotionally obligate, and guilt people into silence.

This is where I need to be clear before someone mistakes diagnosis for my fervent cynicism toward contemporary organizational design, or decides this whole book is just evidence of an undiagnosed need for me to work through something in counseling. I am not standing here as some scorned little professional throwing rocks at every contemporary culture practice because a trust fall hurt my feelings. *I’m looking at you Javi, you were supposed to catch me.* Some cultural patterns are genuinely strong because the system keeps reinforcing behavior worth repeating. Good cultures make the right thing easier to do, while those weaker options usually do not become weak because everyone woke up one day and chose dysfunction. It’s a product of making sense of the world around you.

That is why the practical question is not, “How do we fix the culture?” At least not first.

The better question I ask is: what has been allowed to become normal?

What approval step exists because leadership does not trust the system underneath it? What fear is being disguised as oversight? What decision sits too high in the organization because the lower levels were never given the tools, authority, or proof standards to own it? What exception has been repeated enough times that it is no longer really an exception? What behavior does everyone know violates the standard but continues to survive because the person attached to it is useful, difficult, senior, productive, protected, or too exhausting to confront?

Those are the questions we feel matter because they force the organization to inspect the operating conditions underneath the culture language, and yes, they are less glamorous than culture work you see demonstrated in social media reels and keynotes, which is why we believe that they are more useful. Culture work can stay abstract for a long time because abstraction is profitable. If a consultant can keep the problem behind enough hand movements and polished terminology, the organization can be sold a larger, more convoluted solution before anyone has to ask the simpler diagnostic question: what is the system teaching people to do?

In the retail case, the company eventually had to admit that the hiring process was not moving toward a culture of higher standards but one that operated through a fear response. Once the risk-tiered process and the manager tools were built, the bottleneck could relax and the system no longer relied on senior leaders to absorb every ounce of risk.

Leadership involvement is not always value. Sometimes it is necessary, appropriate, and protective. Other times, it is evidence that the system underneath leadership cannot be trusted to hold a decision.

When every decision has to climb to the top before it can move, the organization is usually dealing with a delegation and trust problem. That kind of workaround does not stay contained. The hiring bottleneck strains staffing, thin staffing drags on the customer experience, managers start leading from stress instead of judgment, documentation gets sloppy, and leadership becomes even more convinced that decisions need to be pulled upward. By the time everyone starts calling the culture tense, reactive, and slow, the workaround has already become the environment.

The same pattern shows up in compensation, change, accountability, communication, and performance. One exception creates a condition. The condition creates the opportunity for another workaround. Give that workaround enough time, protection, and leadership avoidance, and eventually it stops sounding temporary and starts calling itself culture.

Once that happens, the origin story stops being the most important part. The question becomes what the workaround is doing now. Is it still protecting the business, or is it protecting leadership discomfort? Is it reducing risk, or moving it into another part of the business? Has it become culture, or has avoidance simply found better lighting?

The retail company had to answer that. So did the family-owned service business and the construction firm that automated a broken

process. Different industries, different symptoms, same underlying warning: the organization kept allowing a temporary response to become the operating pattern. And once that happens, people adapt to a new sense of normalcy and build survival habits around what the system repeatedly proves and how the workplace answers them back.

By the time the workaround has tenure, people have already adjusted themselves around it. The capable employee starts guarding their judgment because initiative has become a liability. The promoted supervisor learns to wait, soften, delay, and route the hard call upward because the organization keeps proving that authority is safest when unused. HR becomes the cleanup crew for decisions that should have been managed before they ever needed a file. Good people get quieter, more documented, and less willing to volunteer for extra work that can be used against them later.

Leadership calls those behaviors attitude, resistance, weakness, or disengagement because those labels keep the diagnosis comfortable. But the workforce usually shows you what the system has taught them to survive.

And nowhere does that lesson do more damage than inside the person expected to manage others without enough authority, protection, or trust to see it through

Chapter 5: Managerial Fragility

I use the phrase managerial fragility to describe the condition where a supervisor gets blamed as the failure point despite the role itself never being built well enough to hold the weight of leadership. For my definition highlighting fiends, managerial fragility:

“...is the condition created when a manager is expected to provide clarity, fairness, follow-through, development, and accountability without the authority, support, role design, cadence, and reinforcement required to do those things consistently under pressure.”

The phrase is deliberate because fragility does not mean the manager is weak as a person, nor does it excuse a supervisor who dodges the job. It describes the instability that surfaces when the relationship between the manager, the role, and the organization cannot carry the weight being set on it. A person can be loyal, hardworking, and technically excellent and still be dropped into a management role that lacks the authority, rhythm, support, and proof structure to function when operations become difficult.

That distinction matters because employees do not experience organizational design in the abstract. They experience the manager who has to explain the decision, hold the standard, handle the conflict, develop the employee, document the concern, and absorb pressure from above while trying to keep the work moving. When the organization's missing structure has nowhere else to go, it becomes that one person's problem to carry.

When the manager cannot hold steady clarity and follow-through, employees rarely name the deeper condition and identify the spade in their eyes. They call the manager weak. They decide nothing ever changes here, that leadership doesn't care, that HR only shows up once

the damage is done. Eventually some of them stop asking for clarity at all and start finding ways to survive around the manager instead.

Those reactions are understandable, but I argue that they are equally incomplete. Managerial fragility is a systems problem that becomes visible through the manager first.

That is why I needed language for it. The usual labels were too easy, and once we started pressing on them, they were not strong enough to hold the diagnosis. Weak supervisor. Poor communication. Lack of confidence. Bad attitude. Culture problem. Leadership gap. Each one sounded plausible, which is why they were useful in the first place. But plausible is not the same thing as true. Those labels may contain a piece of truth, but they often only name the person closest to the visible failure without explaining whether the organization built the role in a way that made failure more likely.

A weak manager may be an individual problem. Plenty of supervisors avoid correction because correction is uncomfortable, unpleasant, and completely un-optional once you accept a management title. Plenty want the pay, the status, and the small authority pleasures of supervision without the conversations, decisions, documentation, and accountability that are supposed to come attached. Some managers should be corrected. Some should be removed. I am not interested in turning every failed supervisor into a misunderstood casualty of structure while Sarah McLachlan stands in the background holding a puppy and serenading me.

But when management keeps failing in the same place, after the same kind of promotion, with unclear authority, overloaded work, weak follow-through, missing documentation, and employee complaints that all rhyme around fairness and confusion, the organization should stop pretending it keeps accidentally selecting the wrong human.

It may be building the wrong role.

Before leadership names the manager as weak, difficult, passive, reactive, inconsistent, or not ready, it needs to ask whether the manager was placed inside a role that could realistically produce clear decisions, timely correction, usable documentation, fair enforcement, and enough credibility for employees to believe the manager's authority mattered.

Tell me if this story sounds familiar.

A strong doer gets promoted. The person was reliable, technically competent, fast, and willing to carry more than their share of the work.

They knew the work inside and out and could untangle a problem nobody else wanted to touch. When a shift ran long, they stayed through it to the end. When something broke, they were the one leadership trusted with the fix, and so leadership handed them the difficult customer, the relationship nobody wanted to manage, the uncovered shift, the irritated employee, the informal training of new staff, and whatever other operational headache it was trying to move off its own plate.

Then the organization promotes them into supervision.

The title changes along with the pay and position classification. Too often, nothing else does.

That is where fragility begins. A fragile manager may be technically strong, loyal, and hard-working. The fragility does not live entirely in the person, but in the management architecture around them, *or rather in its absence*. Did anyone give them a role charter that explains what they now own, what they merely influence, what they must escalate, and what authority travels with the title? Did anyone draw the authority map before expecting them to manage conflict inside it? Did the organization carve out protected time for them to manage, hand them a usable documentation standard, or build a structured way to correct a problem before the problem became an emergency? Did anyone clarify how they are supposed to handle the hardest judgment calls in the job, or did leadership simply promote a strong doer and hope management would appear through exposure?

There may be a need for training, because organizations love training when they have not built a system. The new supervisor may sit through a class on communication, conflict, or leadership style, and everybody involved gets to feel more serious because there were slides and someone said psychological safety without laughing. When the supervisor returns to the workplace, the same operating conditions are waiting at the door like a dog that knows it owns the house. The employees push back, the schedule stays overloaded, the senior manager keeps reversing decisions, and the policy remains vague in the exact places where the supervisor needs it to be firm. On top of that, the old technical work is still sitting there because the organization promoted the person without removing enough of the previous job to make room for management.

Then leadership wonders why the supervisor is struggling.

The origin story usually starts with responsibility handed over without architecture. Then the organization calls the manager weak

when they behave exactly like a person trying not to get crushed by the ambiguity of the role. They hesitate because nobody has told them whether leadership will stand behind a firm decision or fold the moment someone complains. They route everything upward because owning a decision alone has already proven to be the riskier bet. Correction gets avoided because no one taught them how to open the conversation early, write it up cleanly, and survive the employee's reaction without being quietly overruled three days later. Through all of it, they keep clinging to the technical work because the spreadsheet gives them immediate proof that they are competent while the management work offers conflict, ambiguity, and the standing opportunity to be blamed for human behavior they were never equipped to shape.

The title may have changed, but the role was mostly built to absorb pressure the organization had not designed a real management system to carry.

There is a particular cruelty in promoting someone into a title and then pretending the title itself created the system they need. The organization acts as if the word "supervisor" should produce confidence, judgment, consistency, documentation, emotional regulation, and clean decision making by magic. It is as if the title were not a role but a spell. Say the word, and the strong doer becomes a leader.

Except they do not.

They become whatever the system teaches them to become.

Reverse them every time an employee complains, and they stop making firm decisions. Criticize the documentation and defer them to HR while giving them no usable way to build one and they learn to delay until the problem is bad enough to hand off. Pile coaching, scheduling, documenting, disciplining, production work, customer issues, coverage gaps, and employee conflict onto the same person without protected management time, and they learn the obvious lesson that supervision is just the old job with more people angry at them.

Then leadership says they are not stepping up, and maybe they aren't. The better diagnosis, I argue, may be that the organization never built that step.

Managerial fragility does not stay theoretical for long. Left alone, it turns into behavior. Employees do not experience the fragility in the same way as managers. They experience the manager who delays,

avoids, overcorrects, disappears, escalates too late, documents too little, or becomes difficult to trust.

That is where subversive management behaviors enter the model.

I use the word subversive carefully too. I do not mean every manager intends harm. Subversive describes the effect, not always the intent. These behaviors undermine clarity, trust, fairness, development, and authority whether the manager meant to cause harm or not.

Subversive management behaviors are recurring managerial patterns that weaken the employee's experience of clarity, fairness, follow-through, development, authority, and proof, regardless of whether the manager intended to create harm.

That is what makes them dangerous.

One missed follow-up can be explained away by a busy season. A vague set of instructions is a communication gap closed by a follow up conversation. An avoided correction gets softened into understandable discomfort. The exception becomes flexibility, the canceled check-in becomes competing priorities, the overloaded reliable employee becomes teamwork, and the undocumented conversation becomes fine because everyone remembers the one offs.

Repetition changes the meaning.

A behavior that looks small in isolation becomes corrosive when it becomes the employee's regular experience of management. The harm is that pattern that teaches people how much or little the system can be trusted.

Clarity failure happens when employees cannot tell what is expected, who owns the decision, which standard applies, what priority comes first, or what the next step is without guessing. The manager may have talked about the work, sent the message, held the meeting, or used enough words to feel finished, but clarity does not exist because information was delivered. Clarity exists when the employee can act correctly without needing to decode what the manager meant.

This failure creates a particular kind of exhaustion because the employee is not simply doing the work. They are doing the work while trying to figure out what the work is supposed to mean *today*. They watch tone, timing, side comments, executive reactions, and whatever informal signal seems more reliable than the formal instruction. In that kind of environment, capable employees become better at reading the room than being more empowered.

Then leadership wonders why people are hesitant.

Follow-through failure happens when the manager does not reliably do what they said they would do. They promise to check on something and forget. They say they will address a concern and let it disappear. They tell an employee the issue matters and then never return to it. They schedule the one-on-one, cancel it twice, and then act confused when the employee stops bringing anything meaningful to the conversation.

Follow-through is how employees decide whether the manager's words carry weight or whether the instruction is just another workplace sound. A manager who repeatedly fails to follow through teaches employees that raising issues is mostly unpaid emotional labor. The employee has to explain the problem, relive the frustration, wait for action, remind the manager, and then eventually realize that the only thing produced by speaking up was another reason to stop doing it in the first place.

Development failure happens when the manager uses employees without growing them. Think of it this way: the capable employee gets the extra work because they can handle it, while the new employee gets corrected but not taught. The ambitious employee asks what it takes to move forward and receives the familiar soapbox speech about hard work, dedication, and patience, which usually sounds better to the person giving it than to the person still waiting for an actual path.

This is where organizations confuse dependence with appreciation. The best employees are given more responsibility because they are competent, but that competence starts feeling like punishment when trust and reliability become more of a ball and chain than a professional development investment.

Fairness failure happens when employees learn that standards depend on who is involved. One person gets grace because they are liked, useful, loud, protected, hard to replace, or politically expensive to correct. Another person gets the full weight of the rule because they are easier to confront.

Employees do not need perfect sameness. Most adults understand that context matters, but the nuances that they cannot sustain for long is watching the organization pretend inconsistency is judgment. They can tell the difference between a thoughtful exception and a convenient double standard. They can tell when the rule is flexible because the situation is unique, and when the rule is flexible because the person violating it has leverage.

Fairness failure teaches employees that the written rules are only part of the system. The rest of the system lives in usefulness, access, politics, production, fear, and whoever leadership does not want to confront.

Proof failure happens when the manager cannot make the work, decision, correction, or concern explainable after the fact. Expectations were verbal. Feedback was informal. Exceptions were remembered but not documented. Coaching happened, allegedly, but there is no follow-up. The employee was told there was a problem, but nobody can reconstruct when, how, or against what standard the problem was measured against.

Proof failure is one of the most compelling reasons managers look weaker than they may actually be, because it shows that they may have seen the issue and talked about the issue, but cannot prove the issue in a way that holds without standing in the room to narrate the emotion, context, and history behind it.

These subversive management behaviors are not always overt signals that alert you to the challenge while it is happening. They often hide inside busy days, staffing shortages, customer pressure, production demands, awkward conversations, and the daily compromises people make so the work can keep moving. The manager does not always wake up and choose to undermine trust. Sometimes the manager simply delays, softens, forgets, avoids, protects themselves, and does whatever necessary to make it to Friday.

The employee still learns from it.

People learn from that architecture. People learn whether the title is real. They observe whether leadership backs the manager or merely lets the manager absorb discomfort until someone louder gets involved. The workforce figures out whether documentation matters before termination or only after HR squints at the file and asks why it reads like it was assembled post-hoc. Employees notice whether consistency is actually expected or just praised in theory while exceptions keep getting handed out to whoever complains the loudest, produces the most, or simply has the best timing.

The organization does not have to announce the real rules. People learn them from the pattern, and once they do, the behavior follows. Supervisors start delaying the hard conversation, employees start documenting every interaction in case they need it later, and managers route decisions upward rather than own them alone. The reliable people quietly stop volunteering, the difficult ones test where the

boundary actually sits, and HR settles into protecting the organization from its own timing. Everyone figures out who really has authority and who is just carrying a title. Then leadership looks out over all that adaptation and calls it culture, as if it arrived uninvited instead of being taught one consequence at a time.

Those behaviors damage teams even when they were produced by bad structure. Simply explaining fragility does not erase the effects experienced by the system. Regardless of impact, the manager's intent does not cancel the employee's experience.

This is why structural diagnosis cannot become sentimental, or turn into a rescue mission for every manager who struggles. Some fragility is a capability gap: the manager wants to lead well but lacks the skill, and what they need is coaching, practice, observation, and repetition. Other times it is behavioral neglect. The manager had the authority, the clarity, the time, and the support to act and chose not to, and that calls for accountability, sometimes including removal. And some fragility is structural impossibility, where the role is built in a way that makes consistent management unrealistic no matter who sits in it. That one requires redesign, not another speech about ownership.

Most real cases are mixed. A supervisor may lack skill and authority at the same time. A manager may avoid conflict because no one ever trained him to handle it and because leadership keeps reversing him the moment the conflict reaches the executive office. The department head who overcontrols may genuinely enjoy the control while also being held accountable for outcomes he cannot actually govern. That is what makes the first label so dangerous. "Weak manager" may be true. It may also be incomplete enough to become a lie.

The work is knowing the difference.

When the role is weak, the manager may become unstable, and from that position of instability the team starts adjusting. The adjustments look small at first. People ask for things in writing, get more cautious with their words, and stop volunteering for anything that isn't already theirs. Candor thins out, questions dry up, and bypassing quietly becomes the norm until a kind of silence settles over the place. None of that is necessarily a bad attitude. Sometimes it is just what it looks like when employees start building protection in the spot where the organization failed to build trust.

That is the danger of managerial fragility. It does not stay inside the supervisor. It moves through the team, settles into the daily experience of the work, and turns into the private calculation each employee runs

about whether the effort is still worth it. It is the first quiet withdrawal from a trust account the organization may not even realize it is draining.

The practical takeaway is simple, but not easy. Before naming the behavior, ask what the organization has been teaching that person to do. Not because the answer will excuse them, but because the answer will tell you what kind of accountability is required.

If the supervisor truly had authority, support, clarity, time, standards, and backing, and still avoided correction, then hold the supervisor accountable. If the manager lacked the skill, build the skill and inspect whether it transfers into behavior. If leadership created the contradiction, reversed the authority, protected the exception, ignored the workload, or funded the structure that made weak management predictable, then leadership does not get to step quietly behind the person closest to the mess and let them take it.

Real accountability traces back to the initial condition that made the failure exist in the first place. Sometimes that condition is individual neglect, sometimes it is a capability gap, and sometimes it is a role no reasonable person could sustain well for long. Often, it is some ugly combination of all three.

That is why managerial fragility matters. It gives the organization a more honest diagnostic question before the blame hardens into a story.

Not why is this manager weak.

A better question is what has this role been built to produce under pressure.

If the answer is avoidance, inconsistency, over-escalation, technical retreat, delayed correction, vague clarity, failed follow-through, unfair application of standards, missing development, weak authority, and proof that only appears once everyone is already frustrated, then the organization should be careful before acting shocked. It may be looking directly at the manager it designed.

And once employees experience that design long enough, they start keeping their own account of what the organization can be trusted to do.

Chapter 6: Leadership Designs Twice

Leadership designs the workplace twice. We covered this extensively in a previous chapter.

The first design is the one everyone can see and shows up in the budget, the org chart, the job descriptions, the staffing model, the compensation plan, the software, the policies, the training calendar, the strategic plan, and the carefully worded values statement that somehow manages to say accountability without making anyone with authority sweat. This is the formal design. It is the design leaders like to point at because it makes the organization look intentional. It gives the room something to review, approve, fund, and file. It creates the impression that the workplace has been built by adults with a plan, or at least adults with access to Microsoft Word and enough confidence to use headings.

The second design is the one leadership creates through what it tolerates.

That design is quieter, more durable, and usually more honest. It is built through exceptions, silence, delay, selective enforcement, political protection, fear, urgency, avoidance, overrides, informal access, and the behaviors leaders decide are too useful, too profitable, too politically sensitive, or too uncomfortable to confront. It is built every time leadership says the standard matters but protects the person violating it. The same process happens when executives tell a manager to own the result while removing the authority to produce it. The system learns when leadership calls an exception business reality and then acts surprised when employees figure out that reality is the real policy.

The first design tells people what leadership wants to believe. The second design tells people what leadership is willing to protect. If you

were paying attention in the previous chapter, it won't be difficult for you to guess what design your employees are most attuned to.

This is why executive accountability cannot be separated from people systems design. Leaders do not only shape organizations when they make formal decisions. They shape them when they refuse to make them. The workplace gets built when correction is delayed because the person is useful, when a high performer is protected because the number feels too important, or when staff concerns are called drama because the alternative would require confronting someone they have allowed to become dangerous. Organizations take shape by letting the workaround survive, letting the exception repeat, letting the toxic person keep producing, letting the file stay empty, letting the donor relationship sit inside one person's private notebook, and letting everyone else pay the tax of working around it.

Then they call the result culture.

A regional nonprofit gave one of the clearest examples of this because the moral language around the work made the avoidance sound almost noble. The organization served youth development programs and depended heavily on municipal support, grants, and private fundraising to keep its services alive. The work mattered, and because the work mattered, effective fundraising was not some decorative business function sitting off to the side. It was part of how the organization kept the doors open, the programs running, and the mission from becoming a nice idea nobody could afford to deliver. In a nonprofit, revenue is not just a growth lever; it is often the difference between serving the community and explaining to needy families why a program is closing why eligibility has tightened, or why the help they were counting on no longer has enough money behind it. That pressure deserves to be taken seriously.

So does the fear that comes with it.

The organization's Director of Development, Rachel, was the kind of fundraiser who made leadership nervous to imagine losing. She had deep donor relationships, wrote strong grants, knew how to speak the language of funders, and secured a large share of the organization's operating budget. She could walk into rooms other people could not enter and walk out with commitments the organization badly needed. On paper, she was a star. In board packets and revenue conversations, she probably looked less like an employee and more like the person leadership believed the organization could not afford to lose.

That is where leadership lost its nerve.

Rachel used her value to the organization as a shield. She bullied program staff, the people actually delivering the youth services the organization existed to provide. If a program coordinator asked her for an update on a grant timeline, she wouldn't just ignore the email; she would walk out of her office, stand in the middle of the bullpen, and loudly ask the coordinator if they wanted to start raising their *own god damn salary*. She demeaned coordinators publicly and talked to program managers like they were administrative inconveniences living off the money she brought in. She refused to use the donor CRM because the donor data was safer, for her purposes, if it remained inside her personal notes and private habits. When finance asked for her expense receipts, she would toss a crumpled pile of restaurant receipts on a desk and tell them to figure it out. She ignored fiscal tracking requirements because process compliance was apparently for people with less leverage. She made promises to donors about program changes without checking with operations, which meant the staff doing the work had to scramble, rearrange schedules, absorb the fallout, and then smile through the mission language while being treated like props in someone else's fundraising performance.

The Executive Director knew.

This was not a hidden problem buried so deep in the organization that leadership had no reasonable way to see it. Complaints had been made, morale was sliding, and the program managers were burning out while coordinators quietly updated their resumes and left. The tension was visible enough to name. Leadership just kept minimizing Rachel's behavior because her funding production made courage feel expensive.

Staff were told, in one form or another, to endure it for the mission.

That sentence deserves to be handled carefully, because mission is one of the most powerful and most abused words in nonprofit leadership. Used well, it focuses people and sustains them through difficult work, reminding them why the discomfort matters and creating meaning when the pay is not competitive and the workload keeps expanding like a haunted accordion. Used the other way, mission becomes a beautiful little hostage note slipped under the door of every employee who is expected to absorb dysfunction because the work is important.

Do it for the mission can mean sacrifice. It can also mean leadership has decided your suffering is cheaper than their confrontation.

In Rachel's case, leadership chose to police the people being harmed rather than correct the person doing the harm. Program staff were told to be patient, be professional, develop thicker skin, understand the pressure, appreciate what Rachel brought in, and avoid making things harder than they needed to be. That is how leadership language starts laundering avoidance. The person creating the damage gets framed as complicated but necessary. The people reacting to the damage get framed as emotional, negative, resistant, or insufficiently mission-centered.

This is where leadership designs the workplace the second time. The formal design said the organization valued collaboration, youth service, accountability, and stewardship. The tolerated design said revenue protects behavior. The formal design said data belonged in the CRM; the tolerated design said Rachel's private donor notes were acceptable because the organization was afraid of forcing the issue. The formal design said fiscal protocols mattered, and program staff mattered. The tolerated design said both of those things mattered right up until they interfered with the person leadership did not want to confront.

The protected employee became the real policy.

This is why leadership does not get to separate mission, money, and culture from the behavior it protects. Culture is not what leadership says during the annual report, but what it allows people to experience while still claiming the annual report is true. If leadership protects a person who humiliates staff, the culture is humiliation. Read that again.

Cost doesn't stay theoretical when you can quantify it. Program staff turnover climbed to a level no serious organization should be able to wave off as personality conflict. The people delivering the mission were leaving because the system kept asking them to absorb the behavior of the person funding it, and the work showed it: delivery quality slipped, and scheduling turned unstable as donor promises kept getting made with no operational coordination behind them. Internal trust eroded because everyone could see the double standard, and everyone could see leadership pretending not to. The CRM, which should have been organizational infrastructure, had quietly become a private leverage point, because one person's refusal to use it was tolerated long enough to harden into dependency.

When one person hoards the relationships, the client history, the donor pipelines, and the undocumented institutional memory, they are not creating an inconvenience. They are creating organizational

captivity. The organization becomes dependent on that person, not because they are irreplaceable by nature, but because leadership has let the system become replaceable only through them. Then leadership calls the person indispensable. No. Leadership allowed the person to become structurally dangerous.

Rachel's production was centralized and visible, but her costs were dispersed. That is one reason toxic high performers survive. Their value is easy to name because it sits in revenue, grants, sales, output, client relationships, or closed deals, whatever number leadership already knows how to read. Their damage spreads through turnover, silence, burnout, rework, guarded employees, missed handoffs, lost trust, inconsistent processes, leadership credibility loss, and the slow cultural drift of everyone learning that standards are negotiable if the output is high enough. If the spreadsheet sees the money, it's easy to miss what everyone else has to pay for her to keep producing.

That was the necessary shift in Rachel's case. The conversation could not stay at the level of whether she was valuable. Of course she was valuable. That is why the problem had survived for so long. Low-value toxic employees usually do not become philosophical questions turned pillow thoughts. They become performance documentation. The real question was whether the organization was measuring her net value or merely worshiping her gross production.

There is a difference. If Rachel brings in funding but causes program staff turnover, program disruption, donor data risk, fiscal noncompliance, burnout, reputation damage, and mission delivery errors, then the organization has to stop saying she generates revenue as if that sentence ends the analysis. Revenue is part of the equation. It is not the whole equation. The work is not mature until the organization measures the toxic tax attached to the production.

That toxic tax had to be quantified. Turnover and the recruiting and training behind it. The institutional knowledge that walked out the door with every coordinator who quit. The donor promises that sent staff into an operational scramble, the hours burned managing around her, the fiscal gaps and the risk of donor data living outside any system the organization controlled. And underneath all of it, the emotional and operational drag carried by everyone who had to keep the mission moving while leadership protected the person making it harder to deliver.

Once leadership had to look at the cost, the moral fog started thinning. The organization was not choosing between Rachel and the mission. It was choosing between Rachel's immunity and the

infrastructure required for the mission to survive without being held hostage by one person. That is a very different decision.

The repair required leadership to do what it should have done earlier: make the system more important than the superstar. Donor data moved into the CRM, no exceptions, and the fiscal protocols that had always applied to everyone else finally applied to her too. Program commitments now had to clear an operational review before anyone promised them to a funder. Staff got a real escalation path, one that did not let executive leadership quietly bury a complaint for the sake of fundraising comfort. And the board had to understand that oversight is not meddling when leadership has spent years protecting a risk in the name of revenue.

Rachel was given clear boundaries. She refused to comply. Then she left.

That part always makes leaders nervous because it proves the fear was real enough to have a consequence. Sometimes, when you finally hold the protected person accountable, they test the system. They issue ultimatums, threaten to leave and remind everyone of the value of what they bring in, while subtly implying that YOUR organization won't survive without them. They have learned, often because leadership taught them, that the fear of their departure is the lever.

The organization expected a funding collapse. And to everyone's surprise, it didn't happen, because the donor data had been captured, the pipelines were visible, and donor relationships were not as emotionally attached to Rachel's volatility as leadership had imagined. With some operational shifting the organization was able to transition key relationships to more stable hands. Some donors were relieved, which is one of those details that leadership should tattoo somewhere discreet because it reveals how often internal fear exaggerates external dependency. The program teams stabilized. Turnover dropped sharply. Mission delivery improved. The donor base grew over time because the organization was no longer forcing the whole mission through one protected personality.

No one is indispensable if their performance depends on making everyone else weaker.

That does not mean removing a toxic high performer is always clean. I am not interested in selling fairy tales where leaders finally do the right thing and the organization heals on the spot while string music plays over the company intercom. Sometimes the exit genuinely hurts, and the revenue dips. Sometimes the transition is messy because

leadership lets the dependency get old enough to grow roots, branches, and maybe a small ecosystem.

Rachel's behavior mattered, but the larger diagnosis sat with the leadership design that kept protecting her production while making everyone else pay the operating cost.

David's case carries the same doubling. His refusal to follow the CRM and lead-routing rules was individual failure. Leadership's tolerance of him because of his revenue was systemic failure. When leadership finally removed his immunity, the team's output expanded, which told leadership something it should have measured years earlier: it had been counting David's production without ever counting how his presence capped everyone else's.

That is why this chapter has to be hard. Not because leaders are villains. Most aren't. Most are just making decisions under pressure, with partial information, competing priorities, real financial constraints, political realities, and the constant threat that whatever they do will create a different problem next week. Leadership is difficult, and anyone who says otherwise is probably selling a keynote with too many mountains in the slide deck, too much synergy in the workbook, and some recycled nonsense about unlocking potential that will eventually be pressed down your throat as a leadership program. Difficulty does not erase responsibility. It only explains why the responsibility has to be designed well enough for a real person to carry it.

The higher your authority, the more your tolerance teaches. When a frontline employee violates a standard, the damage usually stays close to the person. When a supervisor avoids a hard conversation, one team absorbs it. But when leadership protects the violation, or keeps avoiding the person everyone is afraid of, the lesson travels the whole building, and people learn what power means around here.

This is not a call for leaders to become rigid, joyless rule machines, roaming the workplace in search of flexibility to punish. Exceptions can be necessary. Judgment matters. Context matters. A human organization requires discretion because not every situation fits cleanly inside a policy, and any leader who tries to manage entirely by rulebook will eventually create a workplace where compliance survives and judgment dies.

Discretion without design is just favoritism with better manners, and an exception nobody writes down eventually hardens into culture.

The issue is not whether leaders can make exceptions. The issue is whether the exception is governed or hidden.

If Rachel needed temporary flexibility because donor negotiations required urgency, that could have been designed. If David had a unique sales method worth learning from, it could have been captured into the CRM and shared.

The practical takeaway is simple enough to say and irritating enough to do: measure the cost of what leadership protects, not just what the protected person produces.

That is what makes this chapter uncomfortable. Leadership likes accountability as long as it points somewhere else, and likes culture as long as the fix is everyone else's behavior. Mission stays useful right up until the moment it would require looking at what the system itself rewards and protects. People systems do not care what leadership prefers to examine. They teach what leadership actually does.

In Rachel's nonprofit, the system taught staff that money mattered more than dignity until leadership stopped protecting Rachel. In David's sales department, the system taught the team that production bought immunity until leadership removed the immunity. In the tech company, the system taught employees that wellness was real only until the metric got nervous. Different settings, same doctrine. Leadership designs through structure and through tolerance, and the second design is usually the one people trust.

This is where the chapter has to land, because everything after this becomes impossible to discuss honestly if leadership remains outside the frame. The organization cannot keep saying culture matters while protecting the behavior that destroys it. Accountability loses its meaning while creating exceptions for the people leadership fears. Treating people as the greatest asset rings hollow while allowing one asset to depreciate everyone else. Mission language should not be used to silence the staff delivering it. Systems need repair, but pretending tolerance is not a design choice makes that repair impossible.

When the protected pattern finally breaks something, the organization usually looks for the nearest person to blame. After leadership has tolerated the exception, protected the high performer, ignored the warning signs, softened the behavior, delayed the hard conversation, or let the workaround become normal, eventually something visible happens. A resignation arrives. A complaint gets filed. An audit threat emerges. A bad termination occurs. A department collapses. A file breaks. Then everyone wants to know who caused it.

Chapter 7: When Trust Debt Comes Due

Cumulative trust debt is the accumulated cost of repeated unreliability, inconsistency, ambiguity, and unfairness that reduces a person's willingness to keep investing effort.

I put special weight on the word debt because the organization borrows trust from the employee long before it realizes there is a balance to settle. It borrows when it asks for patience after the third unanswered question, and again when a manager promises to follow up and then forgets. It borrows every time the reliable employee absorbs one more urgent assignment because the unreliable one cannot be counted on, and leadership calls that teamwork instead of what it is, which is extraction. The balance deepens each time the rules are treated as serious right up until the useful person breaks them.

At first, the employee may not leave. They may even look more responsible, documenting everything now, asking for written confirmation, no longer filling the gaps informally the way they used to but protecting the record instead. A lazy diagnosis calls that difficult. The better question is what taught a capable person that protection was safer than trust.

The retail termination we looked at earlier carries the same warning in a smaller file. The employee was described as someone who liked to stir the pot, and maybe that felt true to the people saying it. That phrase is not documentation. A file full of labels, toxic, not a team player, negative, drama, poor fit, may feel like a record to the people who lived through the frustration, but it will not carry the decision when the decision has to stand on its own. What happened? When? Who observed it? What standard applied? What was said to the employee, and what changed after? If the file cannot answer those questions, the organization does not have proof or evidence of events.

The pattern that followed was the one a blame event always produces. The visible event was the termination fallout, and the nearest explanation was manager judgment, so the fast fix became executive control over hiring while the actual condition, the absence of a defensible decision system, went untouched. That control did not solve the original problem. It just moved the fear into a different workflow. The organization felt safer and the business got slower, and underneath both, the condition survived.

The Rational Exit Chain Reaction case shows how brutal this gets when the blame event is a resignation, and it is worth more time here because the part that resonates, the slow progression before the exit, is the part leadership never captured.

Mark, the Lead Logistics Coordinator, resigned with zero notice at the beginning of peak season.

The timing made the resignation feel like the whole problem. That is what visible damage does. It walks into the room loud, expensive, and easy to personalize, and suddenly the organization wants a name, a reason, a fix, and preferably something that can be said in one sentence so nobody has to stay too long with the uglier possibility that the resignation was not the beginning of anything.

Leadership had its story ready because leadership usually does. He must have gotten a better offer. It was probably money. His attitude had changed. He had become difficult. Maybe he was never as committed as everyone thought. The story had enough truth around the edges to feel believable, which is the most dangerous kind of wrong explanation. Maybe Mark did get another offer. Maybe his attitude had changed. People do not usually leave after eighteen months of frustration with the same warmth they had walking into the organization on orientation day.

Treating the resignation as the whole event missed the account that had been building long before he left.

Mark had been paying attention before leadership was.

At first, he tried to clarify the work. How should route overrides work? What happens when the Operations Director changes an assignment verbally? Who owns fuel budget control if delivery commitments are being shifted outside the routing plan? Where is the written standard? Those questions were not rebellion. They were an employee trying to make the role workable before the role made him look irresponsible.

That is the first thing trust debt steals from the organization: the ability to recognize clarification as commitment.

A capable employee asking process questions is usually still invested in making the role work. They give the organization the benefit of the doubt. They assume there is a standard somewhere, even if it has to be dug out of hallway conversations, old emails, verbal exceptions, and whatever leadership meant last Tuesday when it said the route plan mattered unless operations needed flexibility.

Then clarification turned into friction.

The overrides kept breaking the schedule. The fuel budget still did not match his actual authority. The role was accountable for deadlines without enough control over the people and decisions that shaped them. So Mark started saying the uncomfortable part more directly. The process was not working. The role could not be held responsible for outcomes it did not control. The organization had built accountability on top of ambiguity and then seemed irritated that the ambiguity kept producing consequences.

That is where organizations start mislabeling the employee.

The question gets heard as pushback now, the concern as negativity, the process warning as just attitude. The person still trying to keep the work from collapsing starts getting treated like the problem, because they have gotten less polite about naming the condition everyone else is busy surviving around.

Then friction turned into guarding.

Emails. Follow-ups. Written confirmation. Careful language. Fewer verbal agreements. Less trust in side conversations. More records. The kind of communication that looks professional if you do not know the backstory and looks like self-defense if you do.

This is where cumulative trust debt becomes visible, but only if leadership knows how to read it. The person who suddenly documents everything may not be difficult at all; they may be trying to survive a danger they have learned to see coming. Asking for written confirmation is not always rigidity. Often it is what is left after someone discovered that flexibility without proof becomes a personal encounter with the guilty until proven innocent trope. And when a person stops trading on informal agreements, the cold, political read is usually wrong. They are answering the cost of having trusted too much in a system that could not explain itself when the pressure arrived.

The organization often misses that shift because guarding can look like professionalism from a distance. The emails are cleaner. The employee is less emotionally expressive. The conversations are more careful. The person may even seem calmer.

Calm is not always repair.

Sometimes calm is the sound of an employee lowering their investment to a level the organization has taught them is safer.

After guarding came withdrawal.

Mark asked fewer questions and offered less candor, and he quietly stopped trying to fix the larger pattern. He did enough to keep things moving, but the extra effort started disappearing from the edges. He no longer took unpaid ownership of broken processes or burned energy trying to make leadership's verbal contradictions add up. He was done spending himself on a role that kept asking him to carry the responsibility without the control.

This is where leadership made its most expensive mistake. It confused the reduction in friction with improvement.

That happens often. The employee stops pushing and leadership assumes the issue is settled. The supervisor, hearing fewer complaints, decides the relationship has stabilized, and the whole team goes quieter, and everyone enjoys the easier room without asking why it got easier. But the employee has not necessarily become more aligned. Sometimes they have just stopped believing alignment is on the table.

Silence can take the form of stability or serve as the last stand for employees no longer investing in repair.

By the time Mark resigned, the decision had been rehearsed privately for months. Intuitively, we can rationalize the letter was not the start of the problem, but the point where his private diagnosis finally became visible to the people above him. The exit was the last step in a sequence that had been running quietly the whole time: he clarified, hit friction, started guarding himself, and withdrew long before he ever left.

That movement is the Rational Exit Progression.

The Rational Exit Progression is the staged process by which a capable employee moves from trying to make the job work to deciding that leaving is the most rational option. It does not replace the idea of cumulative trust debt but instead, operates symbiotically to demonstrate what people do once the debt gets high enough. Trust

debt is the balance. Rational exit is the path employees begin walking when the balance becomes too expensive to keep carrying.

Good employees usually try before they quit. They clarify because they still want the role to work, push until it creates friction because the condition keeps resisting repair, and start guarding themselves once trust has gotten too expensive to spend casually. Then they withdraw, having learned that more investment is unlikely to change the outcome, and eventually they exit. Leadership calls it sudden because it never counted the stages that came before the letter.

In the same breath, I'm also not arguing that every resignation deserves this kind of forensic treatment. People leave for ordinary reasons: better pay, better hours, a family that needs them closer, a career change, a burnout that has more to do with life than with leadership. When the exit is abrupt, high-impact, role-specific, preceded by friction, or followed by similar failure, leadership should slow down before comforting itself with the first convenient story.

Mark's organization did not slow down.

It filled the seat.

A junior dispatcher named Elena was promoted in. She got the title, the pressure, and the salary. What she did not get was a redesigned role. The verbal overrides kept coming, the authority gap stayed exactly where it was, and the same broken architecture that drove Mark out was still there, freshly painted by the optimism that follows a promotion.

Forty-five days later, Elena walked out.

That was the moment the organization should have stopped pretending the individual was the variable. Mark leaving could be explained away if leadership worked hard enough at its own comfort. Elena leaving the same seat inside 45 days, under the same conditions, made that a much harder story to keep telling. Nothing about the role had changed between the two of them. The same authority gap, the same overrides, the same broken architecture had simply been handed to someone new, and now leadership had to strain to keep the person at the center of the explanation.

The company lost \$150,000 in a single quarter because leadership treated the first resignation like an isolated employee event instead of a system receipt.

That is what happens when trust debt comes due. The organization pays for what it would not diagnose earlier, and it pays on every front

at once: the vacancy, the scramble to replace and the rushed promotion to fill the gap, the overtime and customer delays and broken handoffs while the seat sits unstable. It pays in lost credibility. And it pays in the quiet demoralization of everyone still standing there, watching the same role chew up the next person.

And still, the first instinct is often blame.

This is where the blame event takes over. A blame event is the visible moment when a deeper condition finally produces enough damage that leadership has to respond. The event may be a resignation, complaint, termination failure, audit threat, customer escalation, department collapse, or public mistake. The organization feels pressure, and under pressure incomplete explanations start to feel complete.

Pressure makes organizations hungry for explanations they can act on quickly. Replace the employee, discipline the staff, clamp down on approvals, send the frontline to training. Tell HR to fix the file, announce tighter expectations, pull the decisions upward and bolt on one more approval step, put a senior leader over the process, and move on.

Some of those actions may be necessary. A business still has to stabilize after damage, get the routes covered and the customers answered and the funders shown enough proof to stay, and point its people in a direction. Leaders do not get to sit in philosophical reflection while the operation catches fire.

Action is not diagnosis, and be it so that fast action attached to a shallow explanation can become another way the system avoids being seen.

That is why micromanagement so often follows a blame event. Leadership gets scared and pulls decisions upward, and the centralizing always gets called control when often it is just a symptom of not trusting the system.

Control creates capacity, while fear consumes it. A controlled process protects the business; a fearful one merely protects leadership from feeling exposed.

That difference matters because panic decisions teach too. Respond to an audit threat by approving every expense yourself, and the staff learn that judgment is dangerous and a bottleneck is safer than authority. Take over hiring after one bad termination, and managers learn that a single weak file can cost them their decision rights for years. Fill a seat without redesigning the role, and employees learn that continuity matters to leadership more than cause ever did. The system

keeps teaching during the cleanup, and sometimes it teaches the wrong lesson harder than the original failure ever did.

That is how trust debt spreads beyond the first employee.

Mark's trust debt became Elena's operating condition. The retail manager's weak file became executive control over hiring. A customer complaint becomes customer service training when the real failure is a handoff no one owns. The organization keeps reacting to the receipt instead of tracing what produced the charge.

This is the hinge of the chapter: cumulative trust debt is not just an employee feeling. It becomes an organizational pattern once leadership responds to the visible event without correcting the underlying condition.

The better question is not simply why did Mark leave but what had the organization borrowed from Mark before he decided the balance was too high.

His patience. His judgment. His willingness to clarify. His tolerance for ambiguity. His emotional energy. His belief that someone would eventually fix the authority gap. His willingness to keep absorbing responsibility for conditions he did not control.

By the time he left, the organization had already spent those things.

Elena inherited the bill.

This is where leadership has to become more disciplined. When a high-trust employee goes guarded, the question is what changed. If the reliable one has stopped volunteering, look at how much extra work got handed over disguised as recognition. People confirming every conversation in writing are telling you something about what memory failed to protect them from last time, and a manager who escalates everything is usually telling you that authority has become too risky to use. And when a role burns through two capable people under identical conditions, stop calling the second one a bad fit.

A resignation is not automatically proof of organizational failure.

In Mark's case, the organization had to cover the role. That was unavoidable. Before promoting Elena into the same architecture, leadership needed to inspect the authority gap, the override process, the route ownership, the fuel budget control, the verbal decision pattern, and the trust signals that showed Mark had been leaving in stages. Without that work, the promotion was not a repair. It was a transfer of debt.

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That is why cumulative trust debt and the Rational Exit Progression belong in the same chapter. One explains the account while the other explains the movement. Together, they show why preventable attrition rarely begins at resignation and how the business pays for what the system had been teaching all along.

That is how trust debt comes due.

Chapter 8: The Business Gets the Receipt

The customer usually finds the system before leadership does.

That is one of those truths organizations do not like, because it suggests the business has been performing its internal confusion in public longer than anyone wanted to admit. Customers, patients, residents, donors, and whoever else has the misfortune of standing at the receiving end of a broken handoff do not experience your org chart. They don't care that billing reports to one director and logistics reports to another, or that HR has spent six months trying to explain that the employee onboarding specialist is teaching company culture while answering every "How are you doing?" question with a "tape and glue" response.

They experience the system, and the system they experience is not the one leadership meant to build. It is the one that answers them.

A regional medical equipment distribution company gave me one of the cleaner examples of this because the customer pain became loud enough to drag the internal problem into the open. The company had expanded quickly, growing from a single location into a regional provider with multiple branches, more patients, more routes, and a bigger operational footprint than its original structure had ever been designed to carry. The founders were moving fast. Sales were strong. The business had momentum, and momentum has a way of making leaders confuse speed with readiness, because strong sales feel like proof the operation is sound when all they really prove is that people are buying faster than the company has figured out how to deliver.

Then the customers started telling a different one.

Patients and families began complaining about delayed equipment deliveries. A mother would call asking where her son's oxygen concentrator was, only to be told it was out for delivery, and an hour later she would call back to hear from someone else that the clinical

paperwork was missing. Supplies arrived late or incomplete, leaving families scrambling over the weekend, and intake files disappeared somewhere between the first call and fulfillment. Invoices came out wrong, billing for equipment that had not arrived. One department told the customer one thing while another told them something different, and the family on the other end of the phone was left trying to reconcile a business process they had no reason to understand and every reason to resent.

If you have ever been the customer inside that kind of system, you know the feeling. You call because something matters to you, and it does not matter as a workflow or a ticket or a line item in someone else's internal dashboard. It matters because it is attached to your actual life. You explain the problem to one person, then another, then another and each employee you talk to sounds almost helpful enough to keep you from losing your mind, but not powerful enough to actually resolve the issue you are experiencing. Eventually you stop hearing individual voices and start hearing the organization underneath them.

That is what was happening here.

Leadership reached for the easiest label first: customer service problem. Of course they did. The complaints were arriving through customer service, the calls sounded bad, and frustrated customers were getting inconsistent answers from frontline staff who had no better answer to give. From the outside it looked like a customer service issue because customer service was where the pain was most audible.

That is how receipts work. They do not always arrive at the department that created them.

Customer service did not design the intake flow. It did not own billing rules, control warehouse readiness, manage delivery routes, decide which clinical information had to be verified before a shipment could go out, or build the escalation path when an order got stuck between departments. Customer service answered the phone, and answering the phone made them the face of everyone else's confusion. That is a terrible place to put people, *out-of-the-loop*, and it is also a common one.

The internal system had outgrown its ownership structure. Billing, logistics, clinical, customer service, and operations were all touching the same customer experience, but no one owned the full path from intake to delivery to billing correction to follow-up. Each department could explain its own piece, produce its own little island of truth, and offer a defensible reason the delay was not entirely theirs. That is the

fascinating part of a broken system: everyone gets to be partially right while the customer absorbs the full consequence.

Every link in the chain was waiting on the link before it. Billing wanted documentation before it could cleanly process the account, clinical wanted verification before equipment could be released, and logistics would not route an incomplete order. Customer service had nothing reliable to tell anyone until somebody upstream moved, and the supervisors who owned pieces of the problem lacked the authority across the whole chain to force a resolution. Everyone waited on someone else, the customer waited on the company, and the process kept feeding itself from the tail.

Customer pain is often the internal system with the curtain pulled back. That sentence is the diagnostic move. When a customer experiences delay, contradiction, or repeated handoff failure, the organization should resist the urge to start with why the frontline employee sounded tired on the phone, even if they did, and ask instead what the customer had to travel through to reach that tired employee in the first place. What did the order need? Who owned the first decision? Where did the information stop, who had the authority to unstick it, and what standard told employees what to do when the answers conflicted?

If the answer is shrugging, side conversations, private habits, and "it depends," then the business has an internal ownership problem that the customer was kind enough, or angry enough, to expose.

The appropriate response is contingent upon the answer received. Customer service training may improve tone and de-escalation, and there is nothing wrong with that. There are few things more frustrating to me as a consumer than finally reaching an inconvenienced customer service representative after I have shouted "representative" fourteen times into the phone and beaten the "o" button on the dial pad like it personally designed the automated menu. Sometimes frontline staff genuinely need better tools for conversations with customers who are scared or exhausted or just completely out of patience. But no amount of phone etiquette can repair a broken handoff between billing and logistics, or hand an employee authority the organization never gave them, or make a lost intake file reappear. Training the person who answers the phone may make the receipt sound nicer or fancy up the operational language behind how you disguise the phrase "I don't know. Why are you calling me," but doesn't change what the business is charging itself.

This is the part of workforce system failure leaders often miss. They assume people problems stay inside people channels, that an HR issue stays in HR and a culture issue stays parked in the same foggy little room where leaders store all the words they are tired of defining. People systems do not sit politely inside HR like a file cabinet waiting to be cataloged.

Sometimes the cost lands in customer experience, like the medical equipment company. Sometimes it shows up in finance, where a water department's overtime started telling a story payroll could not diagnose on its own. The department was averaging roughly fourteen hours of overtime per week per person. That is well past a rounding error or a seasonal bump. That is the kind of overtime that walks into budget conversations with muddy boots and a staffing problem.

Leadership saw payroll pressure because payroll was the receipt in front of them. Overtime was high, labor cost was up, and the immediate temptation was to treat it like a wage problem, a scheduling problem, maybe even an employee effort problem, depending on who was in the room and how much patience they had left. Overtime was the invoice.

The actual condition lived underneath the payroll report. The team structure was weak. Several employees were green and still learning, and two experienced operators, both with more than fifteen years of field knowledge, were carrying the primary work because they were the only ones leadership and the crew trusted to do it right. When a main broke at 3:00 a.m., the newer employees would show up, but showing up and owning the work are not the same thing. They stood near the trench holding flashlights while the two veterans climbed down into the mud to fix the pipe.

The newer workers while present, were not yet useful enough to reduce dependency, and that distinction matters, because passive watching without action is the slow and expensive way organizations mistake for training because an experienced person is nearby and words are being spoken somewhere in the general direction of competence. If that is the training being delivered, I want to know who approved the invoice, who nodded along like this was professional development, and why, as a taxpayer, I am apparently helping fund something that is not worth mud stuck to the boots of the crew standing in that trench.

There are moments when shadowing makes sense. Nobody should pretend water infrastructure work can be learned from a binder in a conference room while someone points at a valve on a slide. *Righty-tighty, lefty-loosie. Write it down...* Field work requires exposure,

repetition, and the vocational judgment that develops when someone who knows the sound of failure teaches you what to hear before the problem becomes visible. But if the organization never moves from passive watching to a structured transfer of ownership, the experienced workers become the permanent operating system. Everyone else orbits them, the overtime grows around them, and the confidence never transfers. The department keeps paying experienced people to carry work that newer employees should gradually be trained to own.

The finance department sees the overtime while operations sees people standing around. The experienced workers feel buried, the newer ones feel underused and embarrassed, and leadership sees a payroll line and starts wondering why the department costs so damn much.

That is where business leaders have to be careful with financial data. Numbers are useful, but they are not omniscient. Payroll can tell you what labor costs, but it is limited in expounding further as to why paid time is turning into overtime, idle observation, rework, or dependency on two people who have become the human version of infrastructure. A payroll report shows you the receipt without ever explaining the system that printed it.

That is the first discipline of this chapter: do not stop diagnosis at the place where the pain appears. The receipt rarely sits in the same place as the cause.

HR knows this better than almost anyone, though HR often gets accused of making things complicated when it is just pointing out that the complication has been living rent-free in the business for months. A manager avoids a performance issue for half a year. No timely feedback, no clean documentation, no clarified standard the employee was ever measured against. What exists instead is a few vague emails, a disappointed message or two, and a frustrated note that says the employee has attitude, which is not documentation so much as a mood that learned how to use a keyboard.

Then the manager arrives in HR with urgency demanding that the employee has to be terminated. Today, ideally. Before lunch, if we are really respecting the business need.

HR asks for the file, and the file looks like it was assembled during a power outage by someone trying to remember six months of frustration in one sitting. Dates are missing and standards are vague. There is a sticky note from February that says attitude again, and an

email from April complaining about a missed deadline with no follow-up attached to it. The employee's explanation was never captured. The manager has examples, plenty of them, and can talk for twenty minutes about how difficult the employee is. What they do not have is a record capable of standing without them in the room narrating the frustration. Everyone knew the person was a problem, which is always the sentence people use right before they discover that everyone knew is not an employment record.

Leadership calls it an HR problem. HR is slowing us down. HR is protecting bad employees. HR is being too cautious, as usual.

No. The business is getting the receipt for management avoidance. HR may be the department left holding the paper when the music stops, but HR did not create the months of silence, vague correction, and emotional waiting that hollowed out the decision. Asking to see the file did not make the file useless. It revealed that the file could not defend the decision on its own.

This is usually the moment somebody at the table reaches for at-will employment like it is a loaded sidearm. We can fire for any reason or no reason, they say, as if the phrase were a force field instead of a doctrine with a dozen exceptions carved into it by statute, case law, and every protected category an angry former employee can name on the way to an attorney's office. I spend a fair amount of time on this, because I built a whole session around it, "Firing Is Not a Strategy: Risk-Ready Employment Systems for Public Sector Entities," which I have delivered as a general session at the 2025 Texas PRIMA in Galveston and as the closing keynote at the 2026 TMHRA Conference in Round Rock, and the title is the entire argument. At-will tells you that you do not need cause. It does not tell you that you do not have risk. Firing without cause and firing without consequence are two very different things, and the gunslinger who confuses them tends to find that out in a deposition, where "everyone knew the person was a problem" sounds even thinner than it did in the conference room. A termination is not a strategy. It is the last visible step in a long chain of system failure, and pulling the trigger at the end of that chain does not repair a single link behind it. It just makes the failure official.

The same receipt shows up when the manager role itself starts turning over. A supervisor burns out, steps down, or becomes so cautious that every decision moves upward like it needs a chaperone. Leadership tells the story as a leadership-fit problem because that is the tidiest version of events. The person was not ready. They lacked confidence. They could not handle conflict. Maybe. But then the

replacement starts avoiding the same conversations, escalating the same decisions, and building the same weak files. At that point the business is not paying for one manager who could not hold the role. It is paying for a management seat built like a trap, where every person placed inside it inherits responsibility without enough authority, time, rhythm, or backing to make the role behave.

That receipt is expensive because it does not arrive as one clean line item. It shows up in employee churn, HR cleanup, inconsistent customer experience, senior leadership rework, and the quiet operational drag of everyone learning that the supervisor title is real only until the work gets uncomfortable. That is managerial fragility with a business cost attached, and it does not stay in the manager's office. It moves through the whole operation. Employees learn who can make decisions and who is the corporate scarecrow, which standards survive a complaint, and whether the supervisor can correct a problem or merely carry it until someone above them gets annoyed enough to intervene. Once they learn those things, their behavior changes, and the human resources department becomes the emergency room for decisions that should have had a primary care physician months earlier.

Compliance works the same way. A nonprofit distributing emergency assistance learned this when a funder began questioning whether allocation decisions were consistent. The organization relied heavily on staff intuition and unwritten rules, and when the audit threat appeared, leadership's first instinct was to blame staff judgment and tighten control by pushing approvals upward. The instinct was understandable, but it was also incomplete.

A family walks in at 4:45 p.m. on a Friday. Their electricity is scheduled to be shut off Monday morning. There is a utility bill due, and the staff member knows them because they have been in the program for a year. The required intake form is incomplete only because the mother could not get her pay stubs printed in time. The executive director is stuck in a meeting, the need is sitting right there in front of everyone, obvious and urgent, and the staff member does what mission-driven people often do when a vague system meets a real human being with a deadline. They make a small exception. They verbally approve the voucher, hand it over, and plan to collect the pay stubs next week.

Then the start of the next day brings another exception, and after that a verbal approval over the phone, and after that a follow-up note scribbled on a legal pad. A staff member uses judgment because that is

what the mission seems to require, and over time the organization develops an operating rhythm built on trust, urgency, memory, and the shared belief that everyone is doing their best. That may feel humane in the moment. It becomes a problem when the decision cannot be reviewed later.

Blaming staff judgment and yanking every approval upward may make leadership feel safer, the way panic feels useful when smoke enters a room. But panic is not governance. Requiring executive approval for everything may create the appearance of control, but if leadership does not also build eligibility standards, authority bands, documentation requirements, and a reviewable file, then the organization has only relocated the bottleneck to someone with a higher title.

Compliance risk is often proof failure. Not because people are careless by nature, but because the system never required decisions to become explainable. The nonprofit did not need less mission. It needed a way to protect the mission from decisions that could not tell their own story. A file should be able to explain why help was approved, what standard applied, what was reviewed, who had the authority, and why the decision was consistent with the organization's obligations. If the file cannot do that, then the organization is asking trust and good intent to perform the work of governance, which is unfair to the staff and risky for the organization. The integrity of a system is measured by how well it protects the people trying to do the right thing under pressure.

That protection matters because good people make risky decisions inside vague systems all the time. They care, they move fast, and they bend toward the need standing in front of them, filling gaps with judgment and relationships and urgency because nobody gave them anything sturdier to use. Then a funder, auditor, attorney, customer, or angry former employee asks the organization to explain itself, and everyone discovers in the same miserable moment that good intent is not an audit trail.

This is where leaders have to abandon the fantasy that people-system failure is soft. There is nothing soft about lost margin, emergency couriers, audit exposure, legal risk, angry families, or an executive losing an entire week to a problem the system had been warning them about for months. The language may begin with people. The cost does not stay there.

That is also why this chapter should not be read as HR defending HR. HR is not the hero here, and it can fail in plenty of ways. It can be

late, narrow, disconnected from operations, too cautious one week and too reactive the next, or too proud of having a form for a problem it never actually understood. This is not an argument that every business receipt proves HR was ignored and would have saved the day if only the mortals had listened. The argument is less convenient than that. People systems are business systems, and the cost of a broken one always lands somewhere specific.

The practical habit is simple, though not always easy: when business pain shows up, do not stop at the department where it appears. Before you call a customer complaint a customer service issue, map the work the customer had to travel through before they ever reached the phone. A payroll spike might be an overtime discipline problem, or it might be what shows up when nobody designed the team structure, the training transfer, and the workflow underneath it. The weak termination file is rarely HR caution; it is usually the visible end of months of supervision nobody mapped. And a resignation blamed on the labor market often dissolves the moment you trace what the employee actually experienced of clarity, control, support, and follow-through before deciding to leave. That is how the organization stops paying for symptoms.

The repairs followed the same logic each time, even though the receipts looked nothing alike. The medical equipment company did not need a culture meeting; it needed someone to own the customer's resolution from intake through delivery and billing correction, with a defined handoff between departments and a clear answer to who had the authority to unstick a stalled order. The water department did not need overtime scolding; it needed a real plan for which tasks a newer worker could own by month and by quarter, so that passive observation finally turned into supervised execution and the two veterans stopped being load-bearing walls. The weak-file case did not need a faster termination; it needed a management rhythm that made documentation normal long before anyone said termination out loud, early enough to correct behavior before the whole building had grown tired of the employee and started mistaking exhaustion for another reason to give the person a boot out the door. And the nonprofit did not need less judgment in its mission work; it needed enough decision architecture that judgment was never stranded without proof. Different receipts, same discipline. Trace the pain back to the condition.

There is no such thing as just an HR problem when the condition affects how the business makes decisions, serves customers, spends

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labor, manages risk, or proves its actions. HR may be where the issue gets processed. It is rarely the only place the issue was produced. The business gets the receipt because the business created the conditions, funded them, tolerated them, or failed to notice that the conditions had changed.

By the time the receipt shows up, the system has usually been teaching the wrong lesson for a while, and everyone has been a diligent student. Customers learned that the company contradicts itself, employees learned that documentation is self-defense, and finance learned that labor is expensive without ever being shown why. Leadership learned, or should have by now, that the place where pain appears is not always the place where failure was built.

That is the receipt. It is the delayed proof that the condition was never as contained as leadership wanted it to be.

This is where Designed to Fail has been moving the whole time. The workplace on paper gave the organization a story to tell, and blame gave it a single person to pin the story on. Underneath both, the operating organization showed where authority lived, and the workarounds that grew in the gaps eventually hardened into something everyone agreed to call culture. Managerial fragility turned weak role design into the daily texture of the job, and trust debt built up quietly, one unanswered question and one unsupported manager at a time, until the exit or the complaint or the audit threat or the payroll spike finally arrived looking sudden, only because nobody had been counting the balance.

The receipt does not prove where the failure began. It proves where the business finally had to pay for it.

Conclusion: The Black Book Begins Where This Book Ends

This is where the Black Book becomes necessary.

Designed to Fail should not try to solve every HR touchpoint. The moment it does, the argument starts dragging a tool cart behind it, and the reader loses the bigger thing this book is built to do, which is make the worldview hard to unsee. These pages exist to explain why blame keeps getting mistaken for accountability, how weak management conditions get built, and how a capable employee moves through a rational exit while leadership rehearses its surprise.

The Black Book owns the next job. It is where the diagnostic questions, the repair scripts, and the field-use checklists live, sorted by the specific touchpoint where the failure showed up. Designed to Fail is the book that makes you stop trusting the first label. The Black Book is the manual you reach for after that loss of innocence, when you have a hiring failure or a manager-avoidance pattern or a termination risk sitting on your desk and you need somewhere to start.

If this book has done its job, you leave with a different reflex, and a more demanding one. The first thing you reach for is no longer the name of whoever was standing closest to the mess. You start asking what condition made the failure more likely, what leadership tolerated long enough to make it feel normal, and whether the same seat will hand the same story to the next person who sits in it.

The visible failure was never the beginning. It was the receipt. The Black Book begins where that receipt has to be traced.

DESIGNED TO FAIL

The People Systems Black Book

PART TWO

THE BLACK BOOK

*A Diagnostic Operating System for People-System
Failure*

The label is the doorway, not the diagnosis.

The Black Book Diagnostic System

The first half of this book explained how organizations build weak managers, lose good employees, and call it a people problem. It mapped the distance between the workplace on paper and the organization underneath. This half of the book is where that distance gets repaired.

The Black Book is not a collection of essays. It is a diagnostic operating system. It exists because an organization cannot fix a structural failure by correcting an individual employee, and it cannot fix an individual failure by redesigning a structural condition. If the failure is individual, correct the person. If the failure is structural, redesign the condition. If the failure is mixed, the person owns what they controlled and the organization owns what it designed, tolerated, underfunded, or failed to support.

The discipline of this book is proving which one you are actually dealing with before you act. The label is only the doorway. The diagnosis has to prove the condition before the organization repairs it.

How This System Works

The system has three connected layers. Layer One, the Master Visible Problem Bank, routes you from the symptom you are already complaining about to the correct diagnostic card. Layer Two, the Diagnostic and Repair Cards, walks you through a guided investigation of each problem and a step-by-step repair. Layer Three, the Appendix Tool System, provides the deep, scored instruments the cards route into when a specific condition requires a full audit.

The layers are designed to chain. A card identifies a failing condition; it sends you to the tool that scores that condition; the tool produces a number, an interpretation, and a decision rule; and the decision rule tells you exactly what to repair and which tool to run next. Used together, the layers behave less like a book and more like an operating system for organizational judgment.

HOW TO READ A SCORED TOOL

Every tool in Layer Three is scored. You rate each dimension from 0 (Failing) to 3 (Strong) using the two-sided evidence in the table, total the score, and read the result against the interpretation bands. The Decision Rule then forces the call, including the override condition where a single critical zero can veto an otherwise passing total. The point is not the number itself. The point is that the number makes the diagnosis specific, defensible, and hard to argue away with a feeling.

THE ACCOUNTABILITY BOUNDARY

A weak system can make failure easier to create, hide, tolerate, or reward. It does not erase individual responsibility. If a person breached conduct, that breach is theirs. The purpose of examining the system is not to excuse the person. It is to make sure the repair actually reaches the condition that produced the failure, so the next person in that seat is not set up to repeat it.

Layer One: The Master Visible Problem Bank

Find the label your organization is currently using. The bank routes you to the correct Diagnostic and Repair Card and tells you the depth of the instrument you are about to use.

Reading the Depths

Depth	Built For	What It Produces
Quick Sort · 1	Narrower, contained problems	Fast attribution and a route to the right tool
Full Diagnostic · 2	Major recurring people problems	Full individual, system, and mixed diagnosis
Deep System · 3	Problems exposing the operating model	Structural, multi-department redesign

The Problem Index

If the organization is complaining in the language on the left, go to the card on the right.

The Complaint	Go To	Depth
“We made a bad hire.”	Card 01 · The Bad Hire	2
“They aren’t meeting the standard.”	Card 02 · Poor Performance	2
“The manager isn’t handling their team.”	Card 03 · The Weak Manager	2
“People just don’t care anymore.”	Card 04 · Low Morale	2
“We keep losing our best people.”	Card 05 · Good Employees Leave	2
“There’s no file to act on.”	Card 06 · The Documentation Failure	2
“The customers are angry.”	Card 07 · Customer Complaints	2
“Nobody stays in this department.”	Card 08 · High Turnover	2
“They broke the rule.”	Card 09 · The Policy Violation	2

People Systems Black Book

“Everyone is exhausted.”	Card 10 · Burnout and Overload	2
“They’re always late or absent.”	Card 11 · Chronic Lateness / Attendance	1
“The work is always late.”	Card 12 · Missed Deadlines	1
“They can’t get along.”	Card 13 · Team Conflict / Personality Clash	1
“They won’t do it the new way.”	Card 14 · Resistance to Change	1
“They hit numbers but they’re toxic.”	Card 15 · The Disengaged High Performer	1
“Nobody knows what’s going on.”	Card 16 · Communication Breakdown	1
“That’s not my job.”	Card 17 · Scope Creep / Role Confusion	1
“They just don’t fit in here.”	Card 18 · The “Culture Fit” Complaint	1
“We have a plan but nothing happens.”	Card 19 · Strategy Is Not Executing	3
“We’re growing but breaking.”	Card 20 · The Growth Plan Is Failing	3
“If they leave, we’re in trouble.”	Card 21 · The Work Depends on One Strong Employee	3
“Everyone gets a special deal.”	Card 22 · Pay Exceptions Became the Pay System	3
“That’s the rule, but this is how we do it.”	Card 23 · The Policy Exists but Practice Differs	3
“We can’t defend why we did this.”	Card 24 · The Decision Cannot Survive Review	3
“Three hires for one desk this year.”	Card 25 · Turnover Repeats in the Same Role	3

Layer Two: Diagnostic and Repair Cards

Each card is a working case file. Use the system below once, then let the cards move quickly from label to condition, and from condition to repair.

How Every Card Works

Start with the label. Do not stop there. Each card moves from the visible complaint to the condition underneath it, then from the condition to a repair that can survive the workday.

Use the same operating sequence for every card:

- Identify the visible label.
- Test whether the pattern is isolated, recurring, rewarded, or tolerated.
- Separate individual failure, system failure, and mixed failure.
- Map each failure type back to PSD: Clarity, Control, Flow, Support, Proof, or Reinforcement.
- Write the corrected diagnostic statement before choosing a repair.
- Route into the appendix tool that builds the repair.
- Test the repair under pressure before calling it fixed.

Depth Rules

Depth 1: Quick Sort cards are for contained problems. Use them to attribute the issue quickly and route into the right tool. If more than one system condition appears, escalate to a Full Diagnostic.

Depth 2: Full Diagnostic cards are for recurring people problems. Work the person-side, system-side, and mixed-failure scans before deciding where accountability belongs.

Depth 3: Deep System cards are for operating-model problems. Lead with PSD, include the cross-functional owners, and do not let one department solve a multi-department failure alone.

PSD Failure Nesting

- Clarity contains expectation failure, role-design failure, standard failure, and unclear success criteria.
- Control contains authority failure, decision-rights failure, escalation failure, and override failure.
- Flow contains workflow failure, handoff failure, bottleneck failure, and process drift.

- Support contains capacity failure, training-transfer failure, tool failure, staffing failure, and supervisor-support failure.
- Proof contains documentation failure, evidence failure, file-sufficiency failure, and unverifiable decision logic.
- Reinforcement contains tolerated failure, rewarded failure, protected exceptions, and behavior the organization keeps teaching under pressure.

Diagnostic Statement Builder

Every card should produce a meeting-ready diagnostic statement before a repair is selected:

This appears to be a [individual / system / mixed] failure involving [PSD domain and failure type], because [evidence]. The first repair target is [repair target], and the proof standard is [what must change in the work].

If the reader cannot complete that sentence with evidence, the organization is not ready to act as if it knows the cause.

Evidence Source Rule

Every score, attribution, and repair choice needs an evidence source. Name the document, record, observation, interview, report, or data point that supports the finding. If the evidence source does not exist, the gap is itself a finding.

Field Case Note

The cases in this manual illustrate patterns, not miracle fixes. In real work, repair is often partial. A good intervention may reduce the failure, expose the next condition, or give leadership enough proof to make a cleaner decision.

◆ FULL DIAGNOSTIC CARD · DEPTH 2
CARD 01

The Bad Hire

1 LABEL IN USE: BAD HIRE

Use this card when the organization has already decided the new employee was the problem. Test whether the role, selection process, and onboarding created the failure before assigning it to the person.

2 WHAT THIS USUALLY GETS BLAMED ON

- The candidate fooled us.
- Nobody wants to work.
- HR rushed the process.
- The hiring manager picked wrong.
- They are not a culture fit.

3 WHY THAT DIAGNOSIS MAY BE TOO THIN

The story writes itself: the organization knew exactly what it needed, communicated it perfectly, and was simply deceived. That diagnosis is too thin because it skips the distance between the job description and the actual daily pressure of the role. If the selection process tested for a theoretical job, the organization did not make a bad hire. It made a blind one. And if a competent person arrived and unraveled within ninety days, the question is not only who they are, but what the organization did to them after they walked in the door.

4 SYMPTOM PATTERN SCAN

Use this scan to decide whether the problem is isolated or patterned before you go further.

Question	Answer	What It May Indicate
Has this happened before?		Pattern issue
With more than one person?		System recurrence
Under the same supervisor?		Supervision issue
In the same role?		Role design / selection
During high workload?		Capacity issue
Does it vanish when one strong employee carries it?		Hidden dependency
Did leadership know before acting?		Tolerated failure
Did the organization benefit from the behavior?		Rewarded failure

5 INDIVIDUAL FAILURE SCAN

Mark only what the evidence supports.

Failure Type	Present?	Diagnostic Question
Capability failure	Yes / No / Unknown	Can the person perform the actual work at the required level?
Judgment failure	Yes / No / Unknown	Do they make poor decisions even when trying?
Reliability failure	Yes / No / Unknown	Can the organization count on them consistently?
Fit failure	Yes / No / Unknown	Is the role asking for a version of the person they do not reliably become?
Adaptability failure	Yes / No / Unknown	Can they adjust when work, expectations, tools, or priorities change?

DESIGNED TO FAIL

Learning-Transfer failure	Yes / No / Unknown	Do they receive instruction but fail to convert it into practice?
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6 SYSTEM FAILURE SCAN

Inspect the conditions that may be creating, hiding, protecting, or worsening the visible problem.

Failure Type	Present?	Diagnostic Question
Selection failure	Yes / No / Unknown	Did the hiring process test for the actual role?
Onboarding failure	Yes / No / Unknown	Did the organization convert the hire into a functioning employee?
Expectation failure	Yes / No / Unknown	Was the standard clear before the person was judged against it?
Role Design failure	Yes / No / Unknown	Is the job built in a way a real person can perform?
Supervision failure	Yes / No / Unknown	Did the supervisor clarify, coach, correct, document, and escalate properly?
Training-Transfer failure	Yes / No / Unknown	Did training become behavior, or just attendance?

7 MIXED FAILURE SCAN

Use this scan when the honest answer may be both person and system.

Mixed Failure Type	Present?	What It Means
System-Created Individual Failure	Yes / No / Unknown	The system produced the behavior it later condemned.
System-Hidden Individual Failure	Yes / No / Unknown	Weak metrics, supervision, or documentation kept the issue invisible.
Individual-Revealed System Failure	Yes / No / Unknown	The person did not create the broken system, but exposed it.

8 EVIDENCE REQUIRED

Separate evidence from assumption before you act.

If the Finding Is...	Evidence Needed	If Missing...
Primarily individual	The person misrepresented credentials or could not perform after clear expectations, support, and a fair runway	If onboarding never happened, you cannot yet call it an individual failure
Primarily system	The role was unclear, selection tested the wrong things, and onboarding never converted the hire	If selection and onboarding were sound and the person still failed, look individually
Mixed	A weak selection process met a candidate who oversold, then a thin onboarding finished the job	You likely need to repair selection and address the specific capability gap

9 GUIDED DIAGNOSTIC PATH

Follow the sequence. Each answer narrows the diagnosis.

Can the organization show exactly what this person was hired to do and that the posting matched the real role?

If yes → The posting was accurate. Proceed to test selection.

If no → The posting was idealized fiction. You hired for a job that doesn't exist.
Establishes Role Reality.

Did the selection process test the actual work instead of only interview skill?

If yes → A work sample or simulation was used.

If no → Conversational interviews only. You hired for charisma.
Establishes Selection Integrity.

Was there a structured 30/60/90-day onboarding ramp with verified milestones?

If yes → A structured, verified ramp to productivity.

If no → An orientation day followed by abandonment. The hire was not converted.
Establishes Onboarding Conversion.

Was the standard for success made explicit before performance was judged?

If yes → Yes, in writing.

If no → No, it was assumed. You are judging against a secret standard.

Establishes Expectation Clarity.

Was a named supervisor actively coaching, observing, and documenting the ramp?

If coaching was active and documented → Proceed to test individual capability.

If coaching did not occur until failure → The manager avoided the work.

Establishes Supervision Strength.

10 ATTRIBUTION FINDING

Force the sort. Mark one. Do not act as if you know more than the evidence proves.

- Primarily individual failure
- Primarily system failure
- Mixed failure (name the type below)
- Insufficient evidence to act as if you know

CORRECTED DIAGNOSTIC STATEMENT

Instead of: “This is a bad hire.”

The better diagnosis: “This appears to be a selection-and-onboarding failure, involving a role that was never clearly defined, because the process tested for interview performance and the organization never converted the hire into a functioning employee.”

11 REPAIR TARGET

Once the attribution is clear, identify where the fix belongs. Mixed failure may require two sequenced targets.

Target	Needed?	Likely Repair Move
Selection	Yes / No	Redesign selection to test the real work, not the interview
Onboarding	Yes / No	Build a real 30/60/90 conversion plan with verified milestones
Role	Yes / No	Define the role and its standard before the next hire
Person	Yes / No	If the gap is genuine and supported, address the specific capability or fit issue

12 GUIDED REPAIR WALKTHROUGH

Follow the path from finding to repair. Each step names the move, the tool, and the proof that the step is done.

Step 1. If the interview tested the wrong things...

Run The Selection Integrity Test (Tool 10). Require a work sample for all future hires in this role.

Step 2. If the hire was abandoned after week one...

Run The Onboarding Conversion Test (Tool 11). Assign a dedicated owner to the 30/60/90 ramp.

Step 3. If the standard was never clear...

Run The Expectation Clarity Test (Tool 12). Define what 'good' looks like before taking disciplinary action.

Record the concrete plan. Name owners and dates, or the repair will not happen.

DESIGNED TO FAIL

Action	Owner	Deadline	Evidence of Completion
Clarify the standard			
Align authority to accountability			
Correct the person-side issue			
Repair the system condition			
Document the follow-up			
Review under pressure			

13 PROOF UNDER PRESSURE

Test the repair against the real workday.

Pressure Test	Holds?	What Failed?
Understaffed day	Yes / No	
High workload	Yes / No	
Supervisor absent	Yes / No	
Leadership wants an exception	Yes / No	
Employee pushes back	Yes / No	
Customer pressure / overtime rises	Yes / No	
Documentation requested months later	Yes / No	

14 TOOL ROUTING

Carry the finding into the matching appendix tool.

If the Card Reveals...	Use This Tool
Selection failure	The Selection Integrity Test (Tool 10)
Onboarding failure	The Onboarding Conversion Test (Tool 11)
Role design failure	The Role Reality Test (Tool 01)
Expectation failure	The Expectation Clarity Test (Tool 12)
Any mixed finding	The Mixed Failure Map (Tool 07)
Before acting on anyone	The Evidence Standard / Proof-File Builder (Tool 15)
To close the diagnosis	The Attribution Decision Protocol (Tool 17)

15 THE AUTHORITY MOVE

A hire fails before the first day far more often than the organization admits. Before you write off the person, prove the role was real, the test was honest, and the onboarding actually happened.

16 SEEN IN THE FIELD

A CASE IN PRACTICE

A marketing agency was ready to fire a copywriter around day 60 for “missing the brand voice.”

The manager was not inventing the problem. Some of the work was flat. A few captions sounded like they belonged to a different company. The employee was also frustrated because every round of feedback seemed to move the target. One draft was “too corporate.” The next was “trying too hard.”

The agency had treated brand voice like shared knowledge, but it mostly lived in the heads of people who had been there long enough to absorb it. The interview had been heavy on culture fit and creative chemistry. There was no writing test, no sample review, and no real discussion of tone, audience, client expectations, or revision standards. Onboarding was a laptop, a login, a few folders, and a quiet assumption that a capable writer would figure it out.

This was not a clean employee failure. The copywriter had work to improve. The agency also had a standard it had never made usable.

The firing was paused. The manager and leadership built what should have existed before the hire started: approved samples, rejected samples, tone rules, client-specific guidance, revision expectations, and a weekly review cadence. The writer was given thirty days against the actual standard instead of sixty days against managerial taste.

The writer improved enough to stay and the agency lost the ability to blame the next person for missing a standard it had never built.

◆ FULL DIAGNOSTIC CARD · DEPTH 2
CARD 02

Poor Performance

1 LABEL IN USE: POOR PERFORMANCE

Use this card when performance has fallen below expectation and the organization is ready to call it effort, attitude, or capability. Test whether the standard, workload, tools, supervision, and proof were strong enough to make that conclusion fair.

2 WHAT THIS USUALLY GETS BLAMED ON

- They don't care.
- They are lazy.
- They lack initiative.
- They aren't trying hard enough.

3 WHY THAT DIAGNOSIS MAY BE TOO THIN

Performance gets read as pure willpower, which is convenient because willpower is the one variable that lets the environment off the hook. That diagnosis is too thin because it treats the workplace as a neutral stage on which character simply expresses itself. It never asks whether the standard was clear, whether the tools functioned, whether the workload was mathematically possible, or whether the manager ever actually corrected the drift before it hardened into a pattern. Effort matters. It is just rarely the whole equation, and almost never the first thing to verify.

4 SYMPTOM PATTERN SCAN

Use this scan to decide whether the problem is isolated or patterned before you go further.

Question	Answer	What It May Indicate
Has this happened before?		Pattern issue
With more than one person?		System recurrence
Under the same supervisor?		Supervision issue
In the same role?		Role design / selection
During high workload?		Capacity issue
Does it vanish when one strong employee carries it?		Hidden dependency
Did leadership know before acting?		Tolerated failure
Did the organization benefit from the behavior?		Rewarded failure

5 INDIVIDUAL FAILURE SCAN

Mark only what the evidence supports.

Failure Type	Present?	Diagnostic Question
Capability failure	Yes / No / Unknown	Can the person perform the actual work at the required level?
Willingness failure	Yes / No / Unknown	Can they do it but choose not to?
Reliability failure	Yes / No / Unknown	Can the organization count on them consistently?
Learning-Transfer failure	Yes / No / Unknown	Do they receive instruction but fail to convert it into practice?
Ownership failure	Yes / No / Unknown	Do they avoid responsibility even when the role is clear?

6 SYSTEM FAILURE SCAN

Inspect the conditions that may be creating, hiding, protecting, or worsening the visible problem.

Failure Type	Present?	Diagnostic Question
Expectation failure	Yes / No / Unknown	Was the standard clear before the person was judged against it?
Capacity failure	Yes / No / Unknown	Is the workload possible under normal operating conditions?
Supervision failure	Yes / No / Unknown	Did the supervisor clarify, coach, correct, document, and escalate properly?
Training-Transfer failure	Yes / No / Unknown	Did training become behavior, or just attendance?
Workflow failure	Yes / No / Unknown	Does the work move cleanly from person to person or department to department?
Technology/Process failure	Yes / No / Unknown	Did software automate confusion instead of fixing workflow?
Role Design failure	Yes / No / Unknown	Is the job built in a way a real person can perform?

7 MIXED FAILURE SCAN

Use this scan when the honest answer may be both person and system.

Mixed Failure Type	Present?	What It Means
System-Created Individual Failure	Yes / No / Unknown	The system produced the behavior it later condemned.
System-Tolerated Individual Failure	Yes / No / Unknown	The individual issue existed, but leadership allowed it to continue.
System-Hidden Individual Failure	Yes / No / Unknown	Weak metrics, supervision, or documentation kept the issue invisible.
Individual-Amplified System Failure	Yes / No / Unknown	The system was weak, and the person made the weakness worse.

8 EVIDENCE REQUIRED

Separate evidence from assumption before you act.

If the Finding Is...	Evidence Needed	If Missing...
Primarily individual	Clear standard, adequate tools and capacity, real coaching, and continued failure afterward	If the standard was never clear, you are judging against a target the person never had
Primarily system	Unclear standard, impossible capacity, broken tools, or absent supervision	If conditions were sound and the person still failed, look individually
Mixed	A real capability gap met an environment that never clarified, supported, or corrected it	You will likely need coaching for the person and repair for the condition

9 GUIDED DIAGNOSTIC PATH

Follow the sequence. Each answer narrows the diagnosis.

Was the performance standard explicit before the performance was judged?

If yes → Standard was explicit and dated. Proceed to test capacity.

If no → Standard was implied or retroactive. The measurement is invalid.

Establishes Expectation Clarity.

Is the workload achievable under normal operating conditions based on tested math?

If yes → The math works. Proceed to test tools and flow.

If no → The workload is mathematically impossible. Burnout and failure are guaranteed.

Establishes Mathematical Capacity.

Do the tools and workflow let a competent person succeed?

If yes → Tools function normally.

If no → Broken handoffs or tech create massive rework. The system is failing the person.

Establishes Support/Workflow.

Did specific coaching and feedback occur early enough to matter?

If documented coaching happened early → Proceed to test individual capability.

If feedback waited until the annual review → The manager avoided the work.

Establishes Supervision Strength.

Has the person ever performed well under stable conditions?

If the person always struggled → Likely capability or selection gap.

If the person used to perform well → Trace the change in role, boss, tools, volume, or conditions.

Establishes Pattern and Cause.

10 ATTRIBUTION FINDING

Force the sort. Mark one. Do not act as if you know more than the evidence proves.

- Primarily individual failure
- Primarily system failure
- Mixed failure (name the type below)
- Insufficient evidence to act as if you know

CORRECTED DIAGNOSTIC STATEMENT

Instead of: “This is a performance and attitude problem.”

The better diagnosis: “This appears to be a mixed failure, involving a real capability gap inside an unclear standard, because the target was never made explicit, the workload was untested, and the drift was never corrected before it became a pattern.”

11 REPAIR TARGET

Once the attribution is clear, identify where the fix belongs. Mixed failure may require two sequenced targets.

Target	Needed?	Likely Repair Move
Expectation	Yes / No	Make the standard explicit, measurable, and dated
Supervisor	Yes / No	Establish a real coaching and correction rhythm with documentation
Capacity	Yes / No	Confirm the workload is possible; adjust if it is not
Person	Yes / No	Address the specific, supported, and still-unmet capability gap

12 GUIDED REPAIR WALKTHROUGH

Follow the path from finding to repair. Each step names the move, the tool, and the proof that the step is done.

Step 1. If the standard was vague...

Run The Expectation Clarity Test (Tool 12). Write the standard down and restart the clock.

Step 2. If the workload is untested...

Run The Capacity Reality Test (Tool 03). Prove the math works before putting the employee on a PIP.

Step 3. If the manager never coached...

Run The Supervision Strength Test (Tool 04). Coach the manager on early intervention before allowing them to fire the employee.

Record the concrete plan. Name owners and dates, or the repair will not happen.

Action	Owner	Deadline	Evidence of Completion
Clarify the standard			
Align authority to accountability			
Correct the person-side issue			
Repair the system condition			
Document the follow-up			
Review under pressure			

13 PROOF UNDER PRESSURE

Test the repair against the real workday.

Pressure Test	Holds?	What Failed?
Understaffed day	Yes / No	
High workload	Yes / No	
Supervisor absent	Yes / No	
Leadership wants an exception	Yes / No	
Employee pushes back	Yes / No	
Customer pressure / overtime rises	Yes / No	
Documentation requested months later	Yes / No	

14 TOOL ROUTING

Carry the finding into the matching appendix tool.

If the Card Reveals...	Use This Tool
Expectation failure	The Expectation Clarity Test (Tool 12)
Capacity failure	The Capacity Reality Test (Tool 03)
Supervision failure	The Supervision Strength Test (Tool 04)
Documentation failure	The Documentation Sufficiency Test (Tool 05)
Any mixed finding	The Mixed Failure Map (Tool 07)
Before acting on anyone	The Evidence Standard / Proof-File Builder (Tool 15)
To close the diagnosis	The Attribution Decision Protocol (Tool 17)

15 THE AUTHORITY MOVE

Before you decide a person will not perform, prove a competent person could. Clarify the standard, confirm the math, supply the support, and document the correction. Then, and only then, is the remaining gap theirs to own.

16 SEEN IN THE FIELD

A CASE IN PRACTICE

A sales rep was placed on a PIP for missing quota. The rep argued the territory was too large to cover. The quota itself was clear. The problem was the work required to reach it. The CRM required nearly two hours of manual entry a day, and no one had tested how that burden affected actual selling time. The manager had also never done a ride-along, so the coaching was based on dashboard activity instead of field reality. The PIP was revised, the organization cleaned up the CRM process, required the manager to observe the work in the field, and reset the plan around activity the rep could control.

◆ FULL DIAGNOSTIC CARD · DEPTH 2
CARD 03

The Weak Manager

1 LABEL IN USE: WEAK MANAGER

Use this card when a manager is being labeled avoidant, soft, inconsistent, or ineffective. Test whether the manager had clear authority, training, decision support, and organizational backing before making the person the whole diagnosis.

2 WHAT THIS USUALLY GETS BLAMED ON

- They avoid conflict.
- They want to be everyone's friend.
- They lack leadership skills.
- They are too soft.

3 WHY THAT DIAGNOSIS MAY BE TOO THIN

Managerial courage gets diagnosed as a personality defect, which keeps the spotlight off the architecture the manager is standing inside. That diagnosis is too thin because managers learn what the organization actually rewards and punishes. A manager will avoid conflict if the organization has a habit of reversing their decisions, leaving them exposed in HR, or demanding accountability while withholding the authority to enforce it. Sometimes the manager is genuinely weak. Often the manager is rational, and the system trained the very avoidance it now resents.

4 SYMPTOM PATTERN SCAN

Use this scan to decide whether the problem is isolated or patterned before you go further.

Question	Answer	What It May Indicate
Has this happened before?		Pattern issue
With more than one person?		System recurrence
Under the same supervisor?		Supervision issue
In the same role?		Role design / selection
During high workload?		Capacity issue
Does it vanish when one strong employee carries it?		Hidden dependency
Did leadership know before acting?		Tolerated failure
Did the organization benefit from the behavior?		Rewarded failure

5 INDIVIDUAL FAILURE SCAN

Mark only what the evidence supports.

Failure Type	Present?	Diagnostic Question
Capability failure	Yes / No / Unknown	Can the person perform the actual work at the required level?
Judgment failure	Yes / No / Unknown	Do they make poor decisions even when trying?
Willingness failure	Yes / No / Unknown	Can they do it but choose not to?
Communication failure	Yes / No / Unknown	Do they fail to share, clarify, escalate, or receive information effectively?
Ownership failure	Yes / No / Unknown	Do they avoid responsibility even when the role is clear?

6 SYSTEM FAILURE SCAN

Inspect the conditions that may be creating, hiding, protecting, or worsening the visible problem.

Failure Type	Present?	Diagnostic Question
Authority failure	Yes / No / Unknown	Does the person being blamed control the outcome?
Expectation failure	Yes / No / Unknown	Was the standard clear before the person was judged against it?
Supervision failure	Yes / No / Unknown	Did the supervisor clarify, coach, correct, document, and escalate properly?
Training-Transfer failure	Yes / No / Unknown	Did training become behavior, or just attendance?
Reinforcement failure	Yes / No / Unknown	What behavior does the organization actually reward, tolerate, punish, or protect?
Role Design failure	Yes / No / Unknown	Is the job built in a way a real person can perform?
Leadership Decision failure	Yes / No / Unknown	Did leadership create the condition but blame the downstream employee?

7 MIXED FAILURE SCAN

Use this scan when the honest answer may be both person and system.

Mixed Failure Type	Present?	What It Means
System-Created Individual Failure	Yes / No / Unknown	The system produced the behavior it later condemned.
System-Tolerated Individual Failure	Yes / No / Unknown	The individual issue existed, but leadership allowed it to continue.
Individual-Revealed System Failure	Yes / No / Unknown	The person did not create the broken system, but exposed it.
Individual-Amplified System Failure	Yes / No / Unknown	The system was weak, and the person made the weakness worse.

8 EVIDENCE REQUIRED

Separate evidence from assumption before you act.

If the Finding Is...	Evidence Needed	If Missing...
Primarily individual	Real authority and support exist, yet the manager still will not clarify, coach, correct, or document	If the org undercuts the manager's authority, the avoidance may be rational
Primarily system	Decisions get reversed, authority is withheld, and the manager was never developed	If authority and backing exist and the manager still fails, look individually
Mixed	An underdeveloped manager met an organization that withholds backing and authority	You must restore authority and develop the manager at the same time

9 GUIDED DIAGNOSTIC PATH

Follow the sequence. Each answer narrows the diagnosis.

Does this manager actually hold the authority their accountability implies?

If yes → Yes, full decision rights. Proceed to test backing.

If no → No, they must escalate everything. They are a messenger, not a manager.

Establishes Authority Alignment.

When they have made hard calls, did the organization back them or reverse them?

If leadership backed the manager fully → The manager may be genuinely avoiding conflict.

If leadership reversed the manager when staff complained → The organization trained the avoidance.

Establishes Reinforcement/Backing.

Were they ever trained to clarify, coach, correct, document, and escalate?

If yes → Yes, concrete management training was provided.

If no → No, they were promoted for being a good individual contributor and left alone.

Establishes Training Transfer.

What does the organization reward managers for, and does it quietly reward harmony over standards?

If yes → Rewards holding the standard.

If no → Rewards zero complaints to HR. The manager is protecting their own bonus.

Establishes Real Incentives.

Is the manager's span and role realistically manageable?

If yes → Span of control is reasonable (e.g., 6-10 direct reports).

If no → Span is 25+. They cannot manage; they can only react.

Establishes Capacity.

10 ATTRIBUTION FINDING

Force the sort. Mark one. Do not act as if you know more than the evidence proves.

- Primarily individual failure
- Primarily system failure
- Mixed failure (name the type below)
- Insufficient evidence to act as if you know

CORRECTED DIAGNOSTIC STATEMENT

Instead of: “This is a weak manager.”

The better diagnosis: “This appears to be an authority-and-development failure, involving accountability without backing, because the organization withheld decision rights, reversed hard calls, and never developed the management skill it now expects.”

11 REPAIR TARGET

Once the attribution is clear, identify where the fix belongs. Mixed failure may require two sequenced targets.

Target	Needed?	Likely Repair Move
Authority	Yes / No	Align the manager's decision rights with their accountability and back their calls
Training	Yes / No	Develop the concrete skills of clarifying, coaching, correcting, and documenting
Reinforcement	Yes / No	Reward standard-holding, not just harmony
Person	Yes / No	If authority and development exist, address the manager's specific avoidance directly

12 GUIDED REPAIR WALKTHROUGH

Follow the path from finding to repair. Each step names the move, the tool, and the proof that the step is done.

Step 1. If authority is missing or reversed...

Run The Authority-to-Accountability Map (Tool 02). Grant the decision rights and commit to backing the manager's calls.

Step 2. If the manager was never trained...

Run The Supervision Strength Test (Tool 04). Build a 60-day coaching plan focused purely on having hard conversations and documenting them.

Step 3. If the span of control is impossible...

Run The Capacity Reality Test (Tool 03). Reduce the direct reports to a manageable number.

Record the concrete plan. Name owners and dates, or the repair will not happen.

Action	Owner	Deadline	Evidence of Completion
Clarify the standard			
Align authority to accountability			
Correct the person-side issue			
Repair the system condition			
Document the follow-up			
Review under pressure			

13 PROOF UNDER PRESSURE

Test the repair against the real workday.

Pressure Test	Holds?	What Failed?
Understaffed day	Yes / No	
High workload	Yes / No	
Supervisor absent	Yes / No	
Leadership wants an exception	Yes / No	
Employee pushes back	Yes / No	
Customer pressure / overtime rises	Yes / No	
Documentation requested months later	Yes / No	

14 TOOL ROUTING

Carry the finding into the matching appendix tool.

If the Card Reveals...	Use This Tool
Authority failure	The Authority-to-Accountability Map (Tool 02)
Supervision failure	The Supervision Strength Test (Tool 04)
Reinforcement failure	The Reinforcement Audit (Tool 06)
Leadership decision failure	The Leadership Decision Impact Review (Tool 09)
Any mixed finding	The Mixed Failure Map (Tool 07)
Before acting on anyone	The Evidence Standard / Proof-File Builder (Tool 15)
To close the diagnosis	The Attribution Decision Protocol (Tool 17)

15 THE AUTHORITY MOVE

Authority and accountability must travel together. A manager held responsible for outcomes they cannot control will manage the only thing they can: the conflict. Restore the authority before you judge the courage.

16 SEEN IN THE FIELD

A CASE IN PRACTICE

A retail manager was accused of being 'too soft' on late employees, and the regional director demanded they be fired for weak leadership. The diagnostic showed that HR had overturned the manager's last two write-ups for lateness because the documentation wasn't perfect (Backing), and the manager had 30 direct reports (Capacity). The manager wasn't soft; they were exhausted and unsupported. The org reduced the span of control to 15, trained the manager on the exact proof standard HR required, and backed the next write-up.

◆ FULL DIAGNOSTIC CARD • DEPTH 2
CARD 04

Low Morale

1 LABEL IN USE: LOW MORALE

Use this card when the organization is calling the workforce negative, disengaged, or unwilling. Test whether morale is actually the residue of workload, inconsistency, unfairness, poor supervision, or tolerated contradiction.

2 WHAT THIS USUALLY GETS BLAMED ON

- People are just negative.
- It's a generational issue.
- We need more team-building.
- A few toxic people are ruining it.

3 WHY THAT DIAGNOSIS MAY BE TOO THIN

Morale gets treated like weather, something to be cheered up with an event and a slogan. That diagnosis is too thin because morale is almost always a lagging indicator of an operational reality. People rarely burn out from hard work. They burn out from futile work, broken handoffs, missing tools, protected underperformers, and decisions that make their daily survival harder for no reason they can see. Branded swag with a company logo on it does not fix a workflow. The mood is the receipt for conditions the organization has not addressed.

4 SYMPTOM PATTERN SCAN

Use this scan to decide whether the problem is isolated or patterned before you go further.

Question	Answer	What It May Indicate
Has this happened before?		Pattern issue
With more than one person?		System recurrence
Under the same supervisor?		Supervision issue
In the same role?		Role design / selection
During high workload?		Capacity issue
Does it vanish when one strong employee carries it?		Hidden dependency
Did leadership know before acting?		Tolerated failure
Did the organization benefit from the behavior?		Rewarded failure

5 INDIVIDUAL FAILURE SCAN

Mark only what the evidence supports.

Failure Type	Present?	Diagnostic Question
Willingness failure	Yes / No / Unknown	Can they do it but choose not to?
Adaptability failure	Yes / No / Unknown	Can they adjust when work, expectations, tools, or priorities change?
Communication failure	Yes / No / Unknown	Do they fail to share, clarify, escalate, or receive information effectively?
Conduct failure	Yes / No / Unknown	Did they breach behavioral, ethical, legal, safety, or professional standards?

6 SYSTEM FAILURE SCAN

Inspect the conditions that may be creating, hiding, protecting, or worsening the visible problem.

Failure Type	Present?	Diagnostic Question
Workflow failure	Yes / No / Unknown	Does the work move cleanly from person to person or department to department?
Capacity failure	Yes / No / Unknown	Is the workload possible under normal operating conditions?
Reinforcement failure	Yes / No / Unknown	What behavior does the organization actually reward, tolerate, punish, or protect?
Supervision failure	Yes / No / Unknown	Did the supervisor clarify, coach, correct, document, and escalate properly?
Expectation failure	Yes / No / Unknown	Was the standard clear before the person was judged against it?
Compensation failure	Yes / No / Unknown	Is pay creating distrust, distortion, resentment, or retention risk?
Leadership Decision failure	Yes / No / Unknown	Did leadership create the condition but blame the downstream employee?
Technology/Process failure	Yes / No / Unknown	Did software automate confusion instead of fixing workflow?

7 MIXED FAILURE SCAN

Use this scan when the honest answer may be both person and system.

Mixed Failure Type	Present?	What It Means
System-Created Individual Failure	Yes / No / Unknown	The system produced the behavior it later condemned.
System-Tolerated Individual Failure	Yes / No / Unknown	The individual issue existed, but leadership allowed it to continue.
Individual-Amplified System Failure	Yes / No / Unknown	The system was weak, and the person made the weakness worse.
System-Hidden Individual Failure	Yes / No / Unknown	Weak metrics, supervision, or documentation kept the issue invisible.

8 EVIDENCE REQUIRED

Separate evidence from assumption before you act.

If the Finding Is...	Evidence Needed	If Missing...
Primarily individual	A small number of genuinely disruptive people degrade an otherwise sound environment	If morale is broad and conditions are poor, the cause is the conditions
Primarily system	Broken workflows, impossible capacity, protected underperformers, and unheard feedback	If conditions are sound and only a few are negative, address those individuals
Mixed	Poor conditions amplified by a few people who give the mood its voice	You must repair conditions and address the genuinely toxic behavior

9 GUIDED DIAGNOSTIC PATH

Follow the sequence. Each answer narrows the diagnosis.

Is the low morale broad, or concentrated in specific teams, shifts, or supervisors?

If yes → Broad across the organization. Look at systemic leadership decisions.

If no → Concentrated. The failure is localized to that supervisor or workflow.
Establishes Scope of Failure.

Can employees name the daily friction specifically when asked?

If yes → They name a specific broken tool or handoff. Fix it.

If no → They give vague answers. Dig deeper into trust and safety.
Establishes Workflow Friction.

Does the organization protect or excuse underperformers at the expense of the committed?

If accountability is even → Proceed to inspect workload and reinforcement.

If accountability is uneven → Top performers may be carrying the dead weight.

Establishes Reinforcement/Tolerance.

Has feedback been gathered, and did anything visibly change because of it?

If yes → Yes, changes were made.

If no → Surveys are sent, but nothing ever changes. You have taught them futility.
Establishes Feedback Loop Integrity.

Are the tools and workflows letting people do good work, or fighting them?

If yes → Tools work.

If no → The tech stack requires constant workarounds. The work itself is punishing.
Establishes Support/Technology.

10 ATTRIBUTION FINDING

Force the sort. Mark one. Do not act as if you know more than the evidence proves.

- Primarily individual failure
- Primarily system failure
- Mixed failure (name the type below)
- Insufficient evidence to act as if you know

CORRECTED DIAGNOSTIC STATEMENT

Instead of: “This is a morale and attitude problem.”

The better diagnosis: “This appears to be a systemic conditions failure, involving futile work and protected underperformance, because broken workflows and unheard feedback taught committed people that effort here is not worth it.”

11 REPAIR TARGET

Once the attribution is clear, identify where the fix belongs. Mixed failure may require two sequenced targets.

Target	Needed?	Likely Repair Move
Workflow	Yes / No	Fix the daily friction employees actually name
Reinforcement	Yes / No	Stop protecting underperformers at the expense of the committed
Supervisor	Yes / No	Close the loop on feedback so people see that speaking up changes something
Capacity	Yes / No	Address the overload driving the futility

12 GUIDED REPAIR WALKTHROUGH

Follow the path from finding to repair. Each step names the move, the tool, and the proof that the step is done.

Step 1. If underperformers are protected...

Run The Reinforcement Audit (Tool 06). Begin active performance management on the lowest performers dragging the team down.

Step 2. If a specific workflow is cited as friction...

Run The Workflow Handoff Map (Tool 13). Remove the bottleneck the team has been complaining about for a year.

Step 3. If feedback is ignored...

Run The Leadership Decision Impact Review (Tool 09). Pick one piece of frontline feedback, fix it visibly within 14 days, and announce it.

Record the concrete plan. Name owners and dates, or the repair will not happen.

Action	Owner	Deadline	Evidence of Completion
Clarify the standard			
Align authority to accountability			
Correct the person-side issue			
Repair the system condition			
Document the follow-up			
Review under pressure			

13 PROOF UNDER PRESSURE

Test the repair against the real workday.

Pressure Test	Holds?	What Failed?
Understaffed day	Yes / No	
High workload	Yes / No	
Supervisor absent	Yes / No	
Leadership wants an exception	Yes / No	
Employee pushes back	Yes / No	
Customer pressure / overtime rises	Yes / No	
Documentation requested months later	Yes / No	

14 TOOL ROUTING

Carry the finding into the matching appendix tool.

If the Card Reveals...	Use This Tool
Workflow failure	The Workflow Handoff Map (Tool 13)
Reinforcement failure	The Reinforcement Audit (Tool 06)
Capacity failure	The Capacity Reality Test (Tool 03)
Supervision failure	The Supervision Strength Test (Tool 04)
Any mixed finding	The Mixed Failure Map (Tool 07)
Before acting on anyone	The Evidence Standard / Proof-File Builder (Tool 15)
To close the diagnosis	The Attribution Decision Protocol (Tool 17)

15 THE AUTHORITY MOVE

Morale is not a feeling to be managed. It is a measurement to be read. When good people stop caring, they are usually telling you something true about the conditions before they tell you with their resignation.

16 SEEN IN THE FIELD

A CASE IN PRACTICE

An engineering team had poor morale scores, and HR's first recommendation was a team-building retreat. The diagnostic showed the team was burned out because they were losing patience with an outdated deployment tool and the lazy work of one engineer who missed miss deadlines and pushed work back onto others. Leadership paused the retreat and dealt with the operating conditions instead. The manager was required to address the performance issue directly, the deployment process was reviewed, and the tool problem evaluated as an escalated operational problem. Employee morale started to improve because they could see that leadership had stopped treating frustration as attitude and started addressing the conditions producing it.

◆ FULL DIAGNOSTIC CARD • DEPTH 2
CARD 05

Good Employees Leave

1 LABEL IN USE: GOOD EMPLOYEES LEAVE

Use this card when strong employees keep exiting and leadership is tempted to blame the market. Test whether the organization has been extracting from its most reliable people while under-repairing the conditions that made leaving rational.

2 WHAT THIS USUALLY GETS BLAMED ON

- They got a better offer.
- You can't compete with that salary.
- They wanted a different career path.
- It was just timing.

3 WHY THAT DIAGNOSIS MAY BE TOO THIN

The departure gets filed as an inevitable market force, which is the explanation that requires the organization to change nothing. That diagnosis is too thin because it ignores the internal push factors that made the external pull irresistible. Good employees rarely abandon a functioning, supportive environment for a marginal raise. They leave when the organization forces them to carry the weight of broken systems, protects the people who do less, and ignores the warnings they raised long before they updated their resume.

4 SYMPTOM PATTERN SCAN

Use this scan to decide whether the problem is isolated or patterned before you go further.

Question	Answer	What It May Indicate
Has this happened before?		Pattern issue
With more than one person?		System recurrence
Under the same supervisor?		Supervision issue
In the same role?		Role design / selection
During high workload?		Capacity issue
Does it vanish when one strong employee carries it?		Hidden dependency
Did leadership know before acting?		Tolerated failure
Did the organization benefit from the behavior?		Rewarded failure

5 INDIVIDUAL FAILURE SCAN

Mark only what the evidence supports.

Failure Type	Present?	Diagnostic Question
Willingness failure	Yes / No / Unknown	Can they do it but choose not to?
Adaptability failure	Yes / No / Unknown	Can they adjust when work, expectations, tools, or priorities change?
Ownership failure	Yes / No / Unknown	Do they avoid responsibility even when the role is clear?

6 SYSTEM FAILURE SCAN

Inspect the conditions that may be creating, hiding, protecting, or worsening the visible problem.

Failure Type	Present?	Diagnostic Question
Reinforcement failure	Yes / No / Unknown	What behavior does the organization actually reward, tolerate, punish, or protect?
Capacity failure	Yes / No / Unknown	Is the workload possible under normal operating conditions?
Compensation failure	Yes / No / Unknown	Is pay creating distrust, distortion, resentment, or retention risk?
Supervision failure	Yes / No / Unknown	Did the supervisor clarify, coach, correct, document, and escalate properly?
Role Design failure	Yes / No / Unknown	Is the job built in a way a real person can perform?
Workflow failure	Yes / No / Unknown	Does the work move cleanly from person to person or department to department?
Leadership Decision failure	Yes / No / Unknown	Did leadership create the condition but blame the downstream employee?

7 MIXED FAILURE SCAN

Use this scan when the honest answer may be both person and system.

Mixed Failure Type	Present?	What It Means
System-Created Individual Failure	Yes / No / Unknown	The system produced the behavior it later condemned.
System-Tolerated Individual Failure	Yes / No / Unknown	The individual issue existed, but leadership allowed it to continue.
Individual-Revealed System Failure	Yes / No / Unknown	The person did not create the broken system, but exposed it.
System-Converted Individual Failure into Organizational Damage	Yes / No / Unknown	A person-side issue became broader damage because leadership mishandled the response.

8 EVIDENCE REQUIRED

Separate evidence from assumption before you act.

If the Finding Is...	Evidence Needed	If Missing...
Primarily individual	Genuinely personal, idiosyncratic reasons unrelated to conditions, across unrelated leavers	If leavers share a common complaint, the cause is structural, not personal
Primarily system	Departures cluster around the same conditions, supervisors, or unaddressed overload	If conditions are sound and exits are random, the cause may truly be external
Mixed	Real external offers that were only attractive because internal conditions had already eroded loyalty	You must repair the push factors, not just match the pull

9 GUIDED DIAGNOSTIC PATH

Follow the sequence. Each answer narrows the diagnosis.

Do the exits share a common theme, supervisor, or breaking point?

If departures are random → Proceed to inspect market and role-specific pressure.

If departures cluster under the same manager or project → Inspect that local condition.

Establishes Pattern Integrity.

Did the strongest leavers carry responsibilities or pressure that others did not?

If they carried a normal workload → Proceed to test compensation and supervision.

If they carried the weight of three people → The organization punished competence with overload.

Establishes Capacity and Burden Shifting.

Did they raise concerns before leaving, and what happened to those concerns?

If yes → They never spoke up.

If no → They warned leadership six months ago, and nothing changed.

Establishes Feedback Loop Failure.

Does the organization reward the committed or quietly punish them with more work?

If yes → Rewards them with pay and promotion.

If no → Rewards them with the hardest projects and no extra pay.

Establishes Reinforcement.

Is compensation actually uncompetitive, or is that the convenient story?

If yes → Market data shows we pay well.

If no → We pay below market and refuse to adjust until they have an offer.

Establishes Compensation Reality.

10 ATTRIBUTION FINDING

Force the sort. Mark one. Do not act as if you know more than the evidence proves.

- Primarily individual failure
- Primarily system failure
- Mixed failure (name the type below)
- Insufficient evidence to act as if you know

CORRECTED DIAGNOSTIC STATEMENT

Instead of: “This is a compensation and market problem.”

The better diagnosis: “This appears to be a reinforcement and capacity failure, involving committed people overloaded and unrewarded, because the organization let its best carry its worst and ignored the warnings until the resignation arrived.”

11 REPAIR TARGET

Once the attribution is clear, identify where the fix belongs. Mixed failure may require two sequenced targets.

Target	Needed?	Likely Repair Move
Reinforcement	Yes / No	Stop overloading the committed to compensate for the tolerated
Capacity	Yes / No	Rebalance the workload your best people are silently absorbing
Supervisor	Yes / No	Act on concerns before they become exits
Compensation	Yes / No	Address genuine pay gaps where they actually exist

12 GUIDED REPAIR WALKTHROUGH

Follow the path from finding to repair. Each step names the move, the tool, and the proof that the step is done.

Step 1. If top performers are carrying the dead weight...

Run The Reinforcement Audit (Tool 06). Force managers to distribute work fairly and manage out the bottom 10%.

Step 2. If pay is actually the issue...

Run The Compensation Distortion Test (Tool 14). Do an equity true-up before the next person gets a competing offer.

Step 3. If a specific supervisor is bleeding talent...

Run The Supervision Strength Test (Tool 04). Intervene with the manager immediately.

Record the concrete plan. Name owners and dates, or the repair will not happen.

Action	Owner	Deadline	Evidence of Completion
Clarify the standard			
Align authority to accountability			
Correct the person-side issue			
Repair the system condition			
Document the follow-up			
Review under pressure			

13 PROOF UNDER PRESSURE

Test the repair against the real workday.

Pressure Test	Holds?	What Failed?
Understaffed day	Yes / No	
High workload	Yes / No	
Supervisor absent	Yes / No	
Leadership wants an exception	Yes / No	
Employee pushes back	Yes / No	
Customer pressure / overtime rises	Yes / No	
Documentation requested months later	Yes / No	

14 TOOL ROUTING

Carry the finding into the matching appendix tool.

If the Card Reveals...	Use This Tool
Reinforcement failure	The Reinforcement Audit (Tool 06)
Capacity failure	The Capacity Reality Test (Tool 03)
Compensation failure	The Compensation Distortion Test (Tool 14)
Supervision failure	The Supervision Strength Test (Tool 04)
Any mixed finding	The Mixed Failure Map (Tool 07)
Before acting on anyone	The Evidence Standard / Proof-File Builder (Tool 15)
To close the diagnosis	The Attribution Decision Protocol (Tool 17)

15 THE AUTHORITY MOVE

By the time the resignation lands, the employee has usually already quit the mission and is simply finalizing the paperwork. The departure is not the beginning. It is the receipt for everything the organization decided not to fix.

16 SEEN IN THE FIELD

A CASE IN PRACTICE

A hospital lost four of its best charge nurses to a competitor offering \$2 more an hour. The CNO blamed the budget. The diagnostic showed that the competitor's ratio was 1:4, while the hospital's was 1:6 (Capacity), and the CNO routinely ignored complaints about a toxic scheduling coordinator (Supervision). They didn't leave for \$2; they left for survival. The hospital replaced the scheduler and capped the ratio at 1:5 and turnover steadied.

◆ FULL DIAGNOSTIC CARD · DEPTH 2
CARD 06

The Documentation Failure

1 LABEL IN USE: DOCUMENTATION FAILURE

Use this card when the organization wants action but the file cannot carry the decision. Test whether the problem is missing paperwork, weak supervision, unclear standards, delayed correction, or a failure to build proof as the work unfolded.

2 WHAT THIS USUALLY GETS BLAMED ON

- Managers are too busy to write things down.
- HR makes the forms too complicated.
- It's too much red tape.
- We'll deal with it if we have to.

3 WHY THAT DIAGNOSIS MAY BE TOO THIN

Documentation gets framed as an administrative chore competing with real work, which quietly excuses the absence. That diagnosis is too thin because documentation is not separate from managing; it is the proof that managing happened. An empty file rarely means a busy manager. It usually means the hard conversation never occurred, the standard was never set in writing, or the correction was avoided. The blank file is not a clerical gap. It is a record of avoidance, and it surfaces at the exact moment the organization can least afford it.

4 SYMPTOM PATTERN SCAN

Use this scan to decide whether the problem is isolated or patterned before you go further.

Question	Answer	What It May Indicate
Has this happened before?		Pattern issue
With more than one person?		System recurrence
Under the same supervisor?		Supervision issue
In the same role?		Role design / selection
During high workload?		Capacity issue
Does it vanish when one strong employee carries it?		Hidden dependency
Did leadership know before acting?		Tolerated failure
Did the organization benefit from the behavior?		Rewarded failure

5 INDIVIDUAL FAILURE SCAN

Mark only what the evidence supports.

Failure Type	Present?	Diagnostic Question
Reliability failure	Yes / No / Unknown	Can the organization count on them consistently?
Ownership failure	Yes / No / Unknown	Do they avoid responsibility even when the role is clear?
Communication failure	Yes / No / Unknown	Do they fail to share, clarify, escalate, or receive information effectively?
Conduct failure	Yes / No / Unknown	Did they breach behavioral, ethical, legal, safety, or professional standards?

6 SYSTEM FAILURE SCAN

Inspect the conditions that may be creating, hiding, protecting, or worsening the visible problem.

Failure Type	Present?	Diagnostic Question
Documentation failure	Yes / No / Unknown	Does the file show the standard, pattern, support, response, and reason for action?
Supervision failure	Yes / No / Unknown	Did the supervisor clarify, coach, correct, document, and escalate properly?
Expectation failure	Yes / No / Unknown	Was the standard clear before the person was judged against it?
Training-Transfer failure	Yes / No / Unknown	Did training become behavior, or just attendance?
Policy-to-Practice failure	Yes / No / Unknown	Is the written rule different from the working rule?
Reinforcement failure	Yes / No / Unknown	What behavior does the organization actually reward, tolerate, punish, or protect?

7 MIXED FAILURE SCAN

Use this scan when the honest answer may be both person and system.

Mixed Failure Type	Present?	What It Means
System-Hidden Individual Failure	Yes / No / Unknown	Weak metrics, supervision, or documentation kept the issue invisible.
System-Tolerated Individual Failure	Yes / No / Unknown	The individual issue existed, but leadership allowed it to continue.
Individual-Revealed System Failure	Yes / No / Unknown	The person did not create the broken system, but exposed it.
System-Converted Individual Failure into Organizational Damage	Yes / No / Unknown	A person-side issue became broader damage because leadership mishandled the response.

8 EVIDENCE REQUIRED

Separate evidence from assumption before you act.

If the Finding Is...	Evidence Needed	If Missing...
Primarily individual	A specific manager was trained, had time, and still refused to document	If no standard or training existed, the gap belongs to the system
Primarily system	No documentation standard, no training, no time built into the role, no verification	If the standard existed and was ignored, address the individual
Mixed	A weak documentation culture met a manager avoiding the underlying conversation	You must build the standard and address the avoidance behind the blank file

9 GUIDED DIAGNOSTIC PATH

Follow the sequence. Each answer narrows the diagnosis.

Does the file show the standard, the pattern, the support, the response, and the reason?

If yes → Yes, it is complete.

If no → No, it is empty or vague.

Establishes Proof Reality.

Was there ever a documentation standard, and was anyone trained on it?

If yes → Yes, managers were trained.

If no → No, HR just expects them to know what to write.

Establishes Expectation/Training.

Is documentation time built into the manager's role, or assumed to happen for free?

If yes → They have administrative time.

If no → They are 100% scheduled on the floor. Writing requires unpaid overtime.

Establishes Capacity.

Does the empty file hide an avoided conversation?

If the conversation happened but was not logged → Repair documentation before acting.

DESIGNED TO FAIL

If the employee was never told they were failing → Repair supervision and expectation clarity.

Establishes Supervision Avoidance.

Does the organization correct managers when they fail to document?

If yes → Rejects their requests for termination.

If no → Approves the firing anyway, assuming the risk. The rule is dead.

Establishes Reinforcement.

10 ATTRIBUTION FINDING

Force the sort. Mark one. Do not act as if you know more than the evidence proves.

- Primarily individual failure
- Primarily system failure
- Mixed failure (name the type below)
- Insufficient evidence to act as if you know

CORRECTED DIAGNOSTIC STATEMENT

Instead of: “This is a busy-manager problem.”

The better diagnosis: “This appears to be a documentation and supervision failure, masking conversation avoidance, because no standard was set, no training was provided, and the empty file is hiding corrections that never happened.”

11 REPAIR TARGET

Once the attribution is clear, identify where the fix belongs. Mixed failure may require two sequenced targets.

Target	Needed?	Likely Repair Move
Documentation	Yes / No	Set a clear, usable documentation standard and verify its use
Supervisor	Yes / No	Train managers to document the standard, pattern, support, and response
Reinforcement	Yes / No	Make documentation part of how managers are evaluated
Person	Yes / No	Address the avoidance the blank file is concealing

12 GUIDED REPAIR WALKTHROUGH

Follow the path from finding to repair. Each step names the move, the tool, and the proof that the step is done.

Step 1. If the manager is avoiding conflict...

Run The Supervision Strength Test (Tool 04). Force the manager to have the hard conversation and log it today.

Step 2. If the organization accepts empty files...

Run The Evidence Standard Builder (Tool 15). HR must formally reject any disciplinary request that lacks the 5-part proof standard.

Step 3. If the manager has no time to write...

Run The Capacity Reality Test (Tool 03). Build 2 hours of admin time into their weekly schedule.

DESIGNED TO FAIL

Record the concrete plan. Name owners and dates, or the repair will not happen.

Action	Owner	Deadline	Evidence of Completion
Clarify the standard			
Align authority to accountability			
Correct the person-side issue			
Repair the system condition			
Document the follow-up			
Review under pressure			

13 PROOF UNDER PRESSURE

Test the repair against the real workday.

Pressure Test	Holds?	What Failed?
Understaffed day	Yes / No	
High workload	Yes / No	
Supervisor absent	Yes / No	
Leadership wants an exception	Yes / No	
Employee pushes back	Yes / No	
Customer pressure / overtime rises	Yes / No	
Documentation requested months later	Yes / No	

14 TOOL ROUTING

Carry the finding into the matching appendix tool.

If the Card Reveals...	Use This Tool
Documentation failure	The Documentation Sufficiency Test (Tool 05)
Proof failure	The Evidence Standard / Proof-File Builder (Tool 15)
Supervision failure	The Supervision Strength Test (Tool 04)
Expectation failure	The Expectation Clarity Test (Tool 12)
Any mixed finding	The Mixed Failure Map (Tool 07)
Before acting on anyone	The Evidence Standard / Proof-File Builder (Tool 15)
To close the diagnosis	The Attribution Decision Protocol (Tool 17)

15 THE AUTHORITY MOVE

An empty file almost never means there was nothing to write. It means no one was willing to write it. Documentation is not paperwork about the work. It is the proof the work was managed at all.

16 SEEN IN THE FIELD

A CASE IN PRACTICE

A warehouse manager wanted to fire a forklift driver for “constant safety violations.” The concern was serious, but the file was empty. No dates, no written warnings, no witness notes, no retraining record, and no proof that the safety standard had ever been restated after the first concern. The manager said he was “too busy moving freight to do HR’s paperwork,” but the diagnostic showed the real issue was supervision avoidance. The driver was removed from forklift duties pending review, the manager was required to address the safety standard in writing.

◆ FULL DIAGNOSTIC CARD · DEPTH 2
CARD 07

Customer Complaints

1 LABEL IN USE: CUSTOMER COMPLAINTS

Use this card when customer frustration is being blamed on frontline behavior. Test whether the complaint was produced by staffing, training, workflow, authority, technology, or decisions made several steps upstream.

2 WHAT THIS USUALLY GETS BLAMED ON

- The frontline needs customer service training.
- The employee was rude.
- The customer is just difficult.
- One bad interaction.
- Bad day at the desk.

3 WHY THAT DIAGNOSIS MAY BE TOO THIN

The complaint gets read as a single bad interaction by a single employee, which keeps the diagnosis at the desk where the pain was loudest. That diagnosis is too thin because the customer usually experiences the system, not the person. Angry customers are typically reacting to broken handoffs, conflicting answers from different departments, and internal workflows the organization never integrated. The frontline employee is simply the most audible point of a failure that started several steps upstream, in rooms the customer never sees.

4 SYMPTOM PATTERN SCAN

Use this scan to decide whether the problem is isolated or patterned before you go further.

Question	Answer	What It May Indicate
Has this happened before?		Pattern issue
With more than one person?		System recurrence
Under the same supervisor?		Supervision issue
In the same role?		Role design / selection
During high workload?		Capacity issue
Does it vanish when one strong employee carries it?		Hidden dependency
Did leadership know before acting?		Tolerated failure
Did the organization benefit from the behavior?		Rewarded failure

5 INDIVIDUAL FAILURE SCAN

Mark only what the evidence supports.

Failure Type	Present?	Diagnostic Question
Communication failure	Yes / No / Unknown	Do they fail to share, clarify, escalate, or receive information effectively?
Judgment failure	Yes / No / Unknown	Do they make poor decisions even when trying?
Reliability failure	Yes / No / Unknown	Can the organization count on them consistently?
Conduct failure	Yes / No / Unknown	Did they breach behavioral, ethical, legal, safety, or professional standards?

6 SYSTEM FAILURE SCAN

Inspect the conditions that may be creating, hiding, protecting, or worsening the visible problem.

Failure Type	Present?	Diagnostic Question
Workflow failure	Yes / No / Unknown	Does the work move cleanly from person to person or department to department?
Authority failure	Yes / No / Unknown	Does the person being blamed control the outcome?
Capacity failure	Yes / No / Unknown	Is the workload possible under normal operating conditions?
Expectation failure	Yes / No / Unknown	Was the standard clear before the person was judged against it?
Technology/Process failure	Yes / No / Unknown	Did software automate confusion instead of fixing workflow?
Training-Transfer failure	Yes / No / Unknown	Did training become behavior, or just attendance?
Leadership Decision failure	Yes / No / Unknown	Did leadership create the condition but blame the downstream employee?

7 MIXED FAILURE SCAN

Use this scan when the honest answer may be both person and system.

Mixed Failure Type	Present?	What It Means
System-Created Individual Failure	Yes / No / Unknown	The system produced the behavior it later condemned.
System-Hidden Individual Failure	Yes / No / Unknown	Weak metrics, supervision, or documentation kept the issue invisible.
Individual-Revealed System Failure	Yes / No / Unknown	The person did not create the broken system, but exposed it.
System-Converted Individual Failure into Organizational Damage	Yes / No / Unknown	A person-side issue became broader damage because leadership mishandled the response.

8 EVIDENCE REQUIRED

Separate evidence from assumption before you act.

If the Finding Is...	Evidence Needed	If Missing...
Primarily individual	One employee generates complaints others in the same role and system do not	If complaints span many employees, the system is producing them
Primarily system	Complaints cluster around handoffs, conflicting answers, and processes no one owns	If the workflow is clean and one person fails, address that person
Mixed	A broken handoff handed to an employee without the authority or tools to resolve it	You must fix the workflow and equip the frontline to resolve

9 GUIDED DIAGNOSTIC PATH

Follow the sequence. Each answer narrows the diagnosis.

Can the organization identify where the complaint originates, not just where it surfaces?

If yes → It originates at the desk. The employee made an error.

If no → It originates upstream (billing, shipping) and surfaces at the desk.

Establishes Source of Failure.

Does the frontline have the authority and information to resolve what they are blamed for?

If yes → Yes, they have full system access and override authority.

If no → No, they must tell the customer 'I have to ask my manager.'

Establishes Authority Alignment.

Do all departments that touch the customer tell a consistent story?

If yes → One department owns the journey.

If no → Three departments touch them, and none talk to each other.

Establishes Workflow Integration.

What does the technology force the customer or employee to endure?

If the technology is seamless → Test workflow and individual handling.

If the system drops data or forces rework → The employee is absorbing a technology/process failure.

Establishes Technology Support.

Did a leadership decision upstream create the condition the customer is feeling?

If yes → No.

If leadership changed the refund window or service rule → Trace the customer complaint back to that decision.

Establishes Leadership Decision Impact.

10 ATTRIBUTION FINDING

Force the sort. Mark one. Do not act as if you know more than the evidence proves.

- Primarily individual failure
- Primarily system failure
- Mixed failure (name the type below)
- Insufficient evidence to act as if you know

CORRECTED DIAGNOSTIC STATEMENT

Instead of: “This is a customer service problem.”

The better diagnosis: “This appears to be a workflow and authority failure, surfacing at the frontline, because broken handoffs and inconsistent answers reach the customer through an employee who lacks the authority to fix them.”

11 REPAIR TARGET

Once the attribution is clear, identify where the fix belongs. Mixed failure may require two sequenced targets.

Target	Needed?	Likely Repair Move
Workflow	Yes / No	Integrate the handoffs that generate the inconsistent experience
Authority	Yes / No	Give the frontline the authority and information to resolve issues
Technology	Yes / No	Fix the tools forcing the bad experience
Person	Yes / No	Coach genuine individual interaction gaps where they are real

12 GUIDED REPAIR WALKTHROUGH

Follow the path from finding to repair. Each step names the move, the tool, and the proof that the step is done.

Step 1. If the frontline lacks power to fix the issue...

Run The Authority-to-Accountability Map (Tool 02). Grant them the \$50 override or the system access they need to resolve it instantly.

Step 2. If departments are giving conflicting answers...

Run The Workflow Handoff Map (Tool 13). Map the customer journey and assign a single owner to the transition points.

Step 3. If the employee is genuinely rude...

Run The Expectation Clarity Test (Tool 12). Set the behavioral standard and hold them accountable.

DESIGNED TO FAIL

Record the concrete plan. Name owners and dates, or the repair will not happen.

Action	Owner	Deadline	Evidence of Completion
Clarify the standard			
Align authority to accountability			
Correct the person-side issue			
Repair the system condition			
Document the follow-up			
Review under pressure			

13 PROOF UNDER PRESSURE

Test the repair against the real workday.

Pressure Test	Holds?	What Failed?
Understaffed day	Yes / No	
High workload	Yes / No	
Supervisor absent	Yes / No	
Leadership wants an exception	Yes / No	
Employee pushes back	Yes / No	
Customer pressure / overtime rises	Yes / No	
Documentation requested months later	Yes / No	

14 TOOL ROUTING

Carry the finding into the matching appendix tool.

If the Card Reveals...	Use This Tool
Workflow failure	The Workflow Handoff Map (Tool 13)
Authority failure	The Authority-to-Accountability Map (Tool 02)
Capacity failure	The Capacity Reality Test (Tool 03)
Leadership decision failure	The Leadership Decision Impact Review (Tool 09)
Any mixed finding	The Mixed Failure Map (Tool 07)
Before acting on anyone	The Evidence Standard / Proof-File Builder (Tool 15)
To close the diagnosis	The Attribution Decision Protocol (Tool 17)

15 THE AUTHORITY MOVE

The customer does not experience your org chart. They experience the system your org chart produced. When the complaint lands at the desk, trace it back to the room where the handoff actually broke.

16 SEEN IN THE FIELD

A CASE IN PRACTICE

A telecom provider saw a spike in complaints about 'rude call center reps.' The VP ordered empathy training. The diagnostic showed that a recent billing software update was double-charging customers (Technology), and the reps had been stripped of their authority to issue refunds (Authority). The reps weren't rude; they were trapped in a loop of apologizing for a system they couldn't fix.

◆ FULL DIAGNOSTIC CARD · DEPTH 2
CARD 08

High Turnover

1 LABEL IN USE: HIGH TURNOVER

Use this card when the organization keeps replacing people without changing the seat. Test whether turnover is tied to role design, supervision, workload, pay, onboarding, or a condition the organization keeps feeding new people into.

2 WHAT THIS USUALLY GETS BLAMED ON

- It's the nature of the industry.
- Turnover is high everywhere.
- People use us as a stepping stone.
- It's the labor market.

3 WHY THAT DIAGNOSIS MAY BE TOO THIN

Turnover gets accepted as an external weather system the organization must simply endure, which excuses it from examining anything. That diagnosis is too thin because it averages away the signal. If departures concentrate under specific supervisors, on specific shifts, in specific roles, or at a specific tenure mark, this is not an industry condition. It is a localized design failure the organization keeps declining to redesign. The benchmark is a comfort. The pattern underneath it is the actual finding.

4 SYMPTOM PATTERN SCAN

Use this scan to decide whether the problem is isolated or patterned before you go further.

Question	Answer	What It May Indicate
Has this happened before?		Pattern issue
With more than one person?		System recurrence
Under the same supervisor?		Supervision issue
In the same role?		Role design / selection
During high workload?		Capacity issue
Does it vanish when one strong employee carries it?		Hidden dependency
Did leadership know before acting?		Tolerated failure
Did the organization benefit from the behavior?		Rewarded failure

5 INDIVIDUAL FAILURE SCAN

Mark only what the evidence supports.

Failure Type	Present?	Diagnostic Question
Fit failure	Yes / No / Unknown	Is the role asking for a version of the person they do not reliably become?
Reliability failure	Yes / No / Unknown	Can the organization count on them consistently?
Adaptability failure	Yes / No / Unknown	Can they adjust when work, expectations, tools, or priorities change?

6 SYSTEM FAILURE SCAN

Inspect the conditions that may be creating, hiding, protecting, or worsening the visible problem.

Failure Type	Present?	Diagnostic Question
Role Design failure	Yes / No / Unknown	Is the job built in a way a real person can perform?
Supervision failure	Yes / No / Unknown	Did the supervisor clarify, coach, correct, document, and escalate properly?
Capacity failure	Yes / No / Unknown	Is the workload possible under normal operating conditions?
Compensation failure	Yes / No / Unknown	Is pay creating distrust, distortion, resentment, or retention risk?
Onboarding failure	Yes / No / Unknown	Did the organization convert the hire into a functioning employee?
Reinforcement failure	Yes / No / Unknown	What behavior does the organization actually reward, tolerate, punish, or protect?
Selection failure	Yes / No / Unknown	Did the hiring process test for the actual role?
Leadership Decision failure	Yes / No / Unknown	Did leadership create the condition but blame the downstream employee?

7 MIXED FAILURE SCAN

Use this scan when the honest answer may be both person and system.

Mixed Failure Type	Present?	What It Means
System-Created Individual Failure	Yes / No / Unknown	The system produced the behavior it later condemned.
System-Tolerated Individual Failure	Yes / No / Unknown	The individual issue existed, but leadership allowed it to continue.
Individual-Revealed System Failure	Yes / No / Unknown	The person did not create the broken system, but exposed it.
System-Hidden Individual Failure	Yes / No / Unknown	Weak metrics, supervision, or documentation kept the issue invisible.

8 EVIDENCE REQUIRED

Separate evidence from assumption before you act.

If the Finding Is...	Evidence Needed	If Missing...
Primarily individual	Random, idiosyncratic exits with no shared condition, supervisor, role, or timing	If exits cluster, the cause is structural regardless of the industry average
Primarily system	Departures concentrate by supervisor, shift, role, or tenure mark	If exits are genuinely random and benchmark-normal, monitor rather than redesign
Mixed	Predictable churn the organization has normalized rather than diagnosed	You must locate the cluster and redesign the condition producing it

9 GUIDED DIAGNOSTIC PATH

Follow the sequence. Each answer narrows the diagnosis.

Can the organization show where turnover concentrates by supervisor, shift, role, and tenure?

If yes → It is evenly distributed.

If no → It spikes at 90 days, or specifically under Manager X.

Establishes Pattern and Cluster.

Can the organization identify when people typically leave and what happens just before?

If yes → They leave after 3 years for career growth.

If no → They leave at 45 days, right after training ends.

Establishes Onboarding vs. Development Failure.

Does a specific supervisor sit above a disproportionate share of exits?

If yes → No.

If one manager loses a disproportionate share of the team → Inspect the supervisor condition.

Establishes Supervision Failure.

Is the role itself sustainable at the funded capacity?

If yes → Yes.

If no → No, the math requires 60 hours a week.

Establishes Capacity Reality.

Do exit conversations reveal a consistent condition or breaking point?

If exit conversations reveal nothing actionable → The exits may be market-driven.

If exit conversations name the same broken process or leader → The organization is ignoring the signal.

Establishes Known Ignored Data.

10 ATTRIBUTION FINDING

Force the sort. Mark one. Do not act as if you know more than the evidence proves.

- Primarily individual failure
- Primarily system failure
- Mixed failure (name the type below)
- Insufficient evidence to act as if you know

CORRECTED DIAGNOSTIC STATEMENT

Instead of: “This is an industry turnover problem.”

The better diagnosis: “This appears to be a localized design failure, concentrated in a specific role and supervisor, because the organization averaged the pattern into a benchmark instead of redesigning the condition producing the exits.”

11 REPAIR TARGET

Once the attribution is clear, identify where the fix belongs. Mixed failure may require two sequenced targets.

Target	Needed?	Likely Repair Move
Role	Yes / No	Redesign the specific role driving the cluster
Supervisor	Yes / No	Examine and repair supervision where exits concentrate
Onboarding	Yes / No	Fix the conversion gap if exits cluster early in tenure
Capacity	Yes / No	Make the role sustainable at funded levels

12 GUIDED REPAIR WALKTHROUGH

Follow the path from finding to repair. Each step names the move, the tool, and the proof that the step is done.

Step 1. If turnover clusters under one manager...

Run The Supervision Strength Test (Tool 04). Intervene with the manager; do not feed them another hire until they improve.

Step 2. If turnover spikes right after training...

Run The Onboarding Conversion Test (Tool 11). Bridge the gap between the classroom and the floor with a 30-day nesting period.

Step 3. If the role is simply burning people out...

Run The Capacity Reality Test (Tool 03). Right-size the workload or increase the headcount.

DESIGNED TO FAIL

Record the concrete plan. Name owners and dates, or the repair will not happen.

Action	Owner	Deadline	Evidence of Completion
Clarify the standard			
Align authority to accountability			
Correct the person-side issue			
Repair the system condition			
Document the follow-up			
Review under pressure			

13 PROOF UNDER PRESSURE

Test the repair against the real workday.

Pressure Test	Holds?	What Failed?
Understaffed day	Yes / No	
High workload	Yes / No	
Supervisor absent	Yes / No	
Leadership wants an exception	Yes / No	
Employee pushes back	Yes / No	
Customer pressure / overtime rises	Yes / No	
Documentation requested months later	Yes / No	

14 TOOL ROUTING

Carry the finding into the matching appendix tool.

If the Card Reveals...	Use This Tool
Role design failure	The Role Reality Test (Tool 01)
Supervision failure	The Supervision Strength Test (Tool 04)
Onboarding failure	The Onboarding Conversion Test (Tool 11)
Capacity failure	The Capacity Reality Test (Tool 03)
Any mixed finding	The Mixed Failure Map (Tool 07)
Before acting on anyone	The Evidence Standard / Proof-File Builder (Tool 15)
To close the diagnosis	The Attribution Decision Protocol (Tool 17)

15 THE AUTHORITY MOVE

Industry-average turnover is the explanation organizations reach for when they would rather not look. Disaggregate the number. The cluster underneath it is almost always a condition you can name and fix.

16 SEEN IN THE FIELD

A CASE IN PRACTICE

A hotel chain accepted 50% annual turnover at the front desk, with HR blaming 'the transient labor market.' The diagnostic disaggregated the data and found that 80% of the turnover happened on the night shift at three specific properties. The problem wasn't the industry; it was a night-audit procedure that forced staff to stay two hours past their shift without overtime pay (Capacity/Policy). The chain ran the Capacity Reality Test, fully automated the audit procedure to remove the overload, and turnover dropped to 23%.

◆ FULL DIAGNOSTIC CARD · DEPTH 2
CARD 09

The Policy Violation

1 LABEL IN USE: POLICY VIOLATION

Use this card when someone broke a rule and the organization is ready to discipline. Test whether the rule was clear, trained, enforced, realistic, and consistently protected before treating the violation as purely individual.

2 WHAT THIS USUALLY GETS BLAMED ON

- They knew the rule and broke it.
- They lack integrity.
- They are insubordinate.
- They cut corners.

3 WHY THAT DIAGNOSIS MAY BE TOO THIN

The written rule is treated as the only rule, which makes the violation look like a simple character failure. That diagnosis is too thin because it ignores the working rule. If the organization wrote a strict policy but routinely praised, promoted, or quietly tolerated the people who bypassed it to hit their numbers, the employee did not violate the culture. They followed the actual reinforcement system, right up until the moment it became a liability and the written rule was suddenly remembered. Real conduct violations exist. So do violations the system invited.

4 SYMPTOM PATTERN SCAN

Use this scan to decide whether the problem is isolated or patterned before you go further.

Question	Answer	What It May Indicate
Has this happened before?		Pattern issue
With more than one person?		System recurrence
Under the same supervisor?		Supervision issue
In the same role?		Role design / selection
During high workload?		Capacity issue
Does it vanish when one strong employee carries it?		Hidden dependency
Did leadership know before acting?		Tolerated failure
Did the organization benefit from the behavior?		Rewarded failure

5 INDIVIDUAL FAILURE SCAN

Mark only what the evidence supports.

Failure Type	Present?	Diagnostic Question
Conduct failure	Yes / No / Unknown	Did they breach behavioral, ethical, legal, safety, or professional standards?
Judgment failure	Yes / No / Unknown	Do they make poor decisions even when trying?
Willingness failure	Yes / No / Unknown	Can they do it but choose not to?
Reliability failure	Yes / No / Unknown	Can the organization count on them consistently?
Ownership failure	Yes / No / Unknown	Do they avoid responsibility even when the role is clear?

6 SYSTEM FAILURE SCAN

Inspect the conditions that may be creating, hiding, protecting, or worsening the visible problem.

Failure Type	Present?	Diagnostic Question
Policy-to-Practice failure	Yes / No / Unknown	Is the written rule different from the working rule?
Reinforcement failure	Yes / No / Unknown	What behavior does the organization actually reward, tolerate, punish, or protect?
Expectation failure	Yes / No / Unknown	Was the standard clear before the person was judged against it?
Supervision failure	Yes / No / Unknown	Did the supervisor clarify, coach, correct, document, and escalate properly?
Capacity failure	Yes / No / Unknown	Is the workload possible under normal operating conditions?
Training-Transfer failure	Yes / No / Unknown	Did training become behavior, or just attendance?

7 MIXED FAILURE SCAN

Use this scan when the honest answer may be both person and system.

Mixed Failure Type	Present?	What It Means
System-Created Individual Failure	Yes / No / Unknown	The system produced the behavior it later condemned.
System-Tolerated Individual Failure	Yes / No / Unknown	The individual issue existed, but leadership allowed it to continue.
System-Rewarded Individual Failure	Yes / No / Unknown	The organization benefited from the behavior before calling it a problem.
Individual-Exploited System Failure	Yes / No / Unknown	The person used unclear standards or weak enforcement to avoid accountability.

8 EVIDENCE REQUIRED

Separate evidence from assumption before you act.

If the Finding Is...	Evidence Needed	If Missing...
Primarily individual	A clear, enforced, well-understood rule deliberately broken for personal gain	If the rule was routinely bypassed and rewarded, the violation was invited
Primarily system	The shortcut was the norm, tolerated and even rewarded until it became visible	If the rule was genuinely enforced and one person broke it, address the conduct
Mixed	A real choice made inside a system that rewarded the very behavior it now condemns	You must address the conduct and close the contradiction that invited it

9 GUIDED DIAGNOSTIC PATH

Follow the sequence. Each answer narrows the diagnosis.

Was the rule clear, trained, and genuinely enforced before this violation?

If yes → Yes, strictly enforced.

If no → No, it was in the handbook but never mentioned.

Establishes Expectation Clarity.

Did others bypass the same rule without consequence?

If this is isolated → Address the individual conduct and still document the standard.

If everyone does it → The real problem is tolerated practice, not one violation.

Establishes Policy-to-Practice Gap.

Did the organization reward the outcome the shortcut produced?

If yes → No.

If the shortcut saves time and speed is rewarded → The system is reinforcing the violation.

Establishes Reinforcement Alignment.

Could the rule be followed under the real workload and time pressure?

If yes → Yes, easily.

If no → No, following the rule makes hitting the quota impossible.

Establishes Mathematical Capacity.

Did supervisors respond when they saw the workaround before the violation became formal?

If the organization corrected it immediately → The rule is being enforced; address the individual conduct.

If leaders looked the other way → The rule is dead; the violation was invited.

Establishes Supervisory Tolerance.

10 ATTRIBUTION FINDING

Force the sort. Mark one. Do not act as if you know more than the evidence proves.

- Primarily individual failure
- Primarily system failure
- Mixed failure (name the type below)
- Insufficient evidence to act as if you know

CORRECTED DIAGNOSTIC STATEMENT

Instead of: “This is a clear policy violation.”

The better diagnosis: “This appears to be a system-rewarded conduct failure, involving a tolerated shortcut, because the organization rewarded the result the bypass produced and only enforced the rule once it became a liability.”

11 REPAIR TARGET

Once the attribution is clear, identify where the fix belongs. Mixed failure may require two sequenced targets.

Target	Needed?	Likely Repair Move
Reinforcement	Yes / No	Stop rewarding the outcome the violation produces
Policy	Yes / No	Make the rule workable and consistently enforced for everyone
Supervisor	Yes / No	Enforce consistently before, not only after, the liability appears
Person	Yes / No	Address genuine, deliberate conduct where the rule was clear and enforced

12 GUIDED REPAIR WALKTHROUGH

Follow the path from finding to repair. Each step names the move, the tool, and the proof that the step is done.

Step 1. If everyone breaks the rule...

Run The Policy-to-Practice Gap Test (Tool 08). Rewrite the rule to match reality, or enforce it strictly and accept the resulting slowdown.

Step 2. If the organization rewards the shortcut...

Run The Reinforcement Audit (Tool 06). Tie performance bonuses to compliance, not just speed.

Step 3. If the rule is sound and the person simply broke it...

Run The Evidence Standard Builder (Tool 15). Document the violation and proceed with formal discipline.

DESIGNED TO FAIL

Record the concrete plan. Name owners and dates, or the repair will not happen.

Action	Owner	Deadline	Evidence of Completion
Clarify the standard			
Align authority to accountability			
Correct the person-side issue			
Repair the system condition			
Document the follow-up			
Review under pressure			

13 PROOF UNDER PRESSURE

Test the repair against the real workday.

Pressure Test	Holds?	What Failed?
Understaffed day	Yes / No	
High workload	Yes / No	
Supervisor absent	Yes / No	
Leadership wants an exception	Yes / No	
Employee pushes back	Yes / No	
Customer pressure / overtime rises	Yes / No	
Documentation requested months later	Yes / No	

14 TOOL ROUTING

Carry the finding into the matching appendix tool.

If the Card Reveals...	Use This Tool
Policy-to-practice failure	The Policy-to-Practice Gap Test (Tool 08)
Reinforcement failure	The Reinforcement Audit (Tool 06)
Documentation failure	The Documentation Sufficiency Test (Tool 05)
Supervision failure	The Supervision Strength Test (Tool 04)
Any mixed finding	The Mixed Failure Map (Tool 07)
Before acting on anyone	The Evidence Standard / Proof-File Builder (Tool 15)
To close the diagnosis	The Attribution Decision Protocol (Tool 17)

15 THE AUTHORITY MOVE

Before you discipline the person who broke the rule, ask who else broke it and got promoted. A rule the organization rewards people for ignoring is not a standard. It is a trap with a signature line.

◆ FULL DIAGNOSTIC CARD · DEPTH 2
CARD 10

Burnout and Overload

1 LABEL IN USE: BURNOUT AND OVERLOAD

Use this card when exhaustion is being treated as resilience failure. Test whether the work, staffing, workflow, expectations, and supervisor capacity are built for operating capacity or only for the fantasy version of a perfect week.

2 WHAT THIS USUALLY GETS BLAMED ON

- They need better time management.
- They need to practice self-care.
- They need to build resilience.
- They can't handle pressure.

3 WHY THAT DIAGNOSIS MAY BE TOO THIN

Capacity is treated as infinite and the inability to cope is filed under personal wellness, which is how an organization avoids discussing arithmetic. That diagnosis is too thin because it weaponizes resilience to dodge a math problem. If a role requires fifty hours of clean execution and the organization funds forty, no amount of time management or self-care closes the gap. The burnout is simply the arithmetic resolving itself on the employee's back, and the wellness language is the anesthetic the organization applies so it does not have to feel the cost it created.

4 SYMPTOM PATTERN SCAN

Use this scan to decide whether the problem is isolated or patterned before you go further.

Question	Answer	What It May Indicate
Has this happened before?		Pattern issue
With more than one person?		System recurrence
Under the same supervisor?		Supervision issue
In the same role?		Role design / selection
During high workload?		Capacity issue
Does it vanish when one strong employee carries it?		Hidden dependency
Did leadership know before acting?		Tolerated failure
Did the organization benefit from the behavior?		Rewarded failure

5 INDIVIDUAL FAILURE SCAN

Mark only what the evidence supports.

Failure Type	Present?	Diagnostic Question
Capability failure	Yes / No / Unknown	Can the person perform the actual work at the required level?
Adaptability failure	Yes / No / Unknown	Can they adjust when work, expectations, tools, or priorities change?
Reliability failure	Yes / No / Unknown	Can the organization count on them consistently?
Ownership failure	Yes / No / Unknown	Do they avoid responsibility even when the role is clear?

6 SYSTEM FAILURE SCAN

Inspect the conditions that may be creating, hiding, protecting, or worsening the visible problem.

Failure Type	Present?	Diagnostic Question
Capacity failure	Yes / No / Unknown	Is the workload possible under normal operating conditions?
Role Design failure	Yes / No / Unknown	Is the job built in a way a real person can perform?
Workflow failure	Yes / No / Unknown	Does the work move cleanly from person to person or department to department?
Reinforcement failure	Yes / No / Unknown	What behavior does the organization actually reward, tolerate, punish, or protect?
Supervision failure	Yes / No / Unknown	Did the supervisor clarify, coach, correct, document, and escalate properly?
Technology/Process failure	Yes / No / Unknown	Did software automate confusion instead of fixing workflow?
Leadership Decision failure	Yes / No / Unknown	Did leadership create the condition but blame the downstream employee?

7 MIXED FAILURE SCAN

Use this scan when the honest answer may be both person and system.

Mixed Failure Type	Present?	What It Means
System-Created Individual Failure	Yes / No / Unknown	The system produced the behavior it later condemned.
System-Tolerated Individual Failure	Yes / No / Unknown	The individual issue existed, but leadership allowed it to continue.
Individual-Amplified System Failure	Yes / No / Unknown	The system was weak, and the person made the weakness worse.
System-Converted Individual Failure into Organizational Damage	Yes / No / Unknown	A person-side issue became broader damage because leadership mishandled the response.

8 EVIDENCE REQUIRED

Separate evidence from assumption before you act.

If the Finding Is...	Evidence Needed	If Missing...
Primarily individual	A sustainable workload that one person, uniquely, cannot organize despite real support	If the workload is impossible for anyone, the failure is the design, not the person
Primarily system	The role's demands exceed funded capacity for everyone who holds it	If others manage the same load comfortably, examine the individual's methods
Mixed	An overloaded role made worse by inefficient individual habits	You must fund the capacity and coach the methods together

9 GUIDED DIAGNOSTIC PATH

Follow the sequence. Each answer narrows the diagnosis.

Can the organization show what the role actually requires in hours and what has been funded?

If yes → Math balances. Look at workflow or individual efficiency.

If no → Math is broken. 60 hours of work, 40 hours funded.

Establishes Mathematical Capacity.

Is the overload affecting everyone in the role, or one person?

If yes → Just one person. They may need coaching.

If no → Everyone is drowning.

Establishes Systemic Scope.

Was work added without anything being removed?

If nothing recent was added → The baseline capacity may already be flawed.

If new initiatives were launched with zero tasks retired → The overload is a mathematical certainty.

Establishes Addition without Subtraction.

Do the tools and workflow create avoidable rework?

If yes → Tools are fine.

If no → The software crashes daily, adding 2 hours of manual entry.

Establishes Friction/Rework.

Does the organization reward overwork and quietly punish boundaries?

If boundaries are respected → Inspect individual workload habits and role expectations.

If leaving on time is treated as lacking commitment → The organization is rewarding overextension.

Establishes Reinforcement of Exhaustion.

10 ATTRIBUTION FINDING

Force the sort. Mark one. Do not act as if you know more than the evidence proves.

- Primarily individual failure
- Primarily system failure
- Mixed failure (name the type below)
- Insufficient evidence to act as if you know

CORRECTED DIAGNOSTIC STATEMENT

Instead of: “This is a resilience and time-management problem.”

The better diagnosis: “This appears to be a capacity and role-design failure, dressed as a wellness issue, because the role’s funded hours cannot contain its required work and the organization kept adding without removing.”

11 REPAIR TARGET

Once the attribution is clear, identify where the fix belongs. Mixed failure may require two sequenced targets.

Target	Needed?	Likely Repair Move
Capacity	Yes / No	Match funded capacity to the real demands of the role
Role	Yes / No	Redesign the role so its work fits its hours
Workflow	Yes / No	Remove the rework and friction inflating the load
Reinforcement	Yes / No	Stop rewarding overwork as a proxy for commitment

12 GUIDED REPAIR WALKTHROUGH

Follow the path from finding to repair. Each step names the move, the tool, and the proof that the step is done.

Step 1. If the math is broken...

Run The Capacity Reality Test (Tool 03). Immediately pause the lowest-value 20% of the workload to create breathing room.

Step 2. If bad tools are causing the overload...

Run The Workflow Handoff Map (Tool 13). Fix the specific integration that is forcing the manual rework.

Step 3. If the organization punishes boundaries...

Run The Reinforcement Audit (Tool 06). Leaders must visibly leave on time and stop emailing on weekends to reset the culture.

DESIGNED TO FAIL

Record the concrete plan. Name owners and dates, or the repair will not happen.

Action	Owner	Deadline	Evidence of Completion
Clarify the standard			
Align authority to accountability			
Correct the person-side issue			
Repair the system condition			
Document the follow-up			
Review under pressure			

13 PROOF UNDER PRESSURE

Test the repair against the real workday.

Pressure Test	Holds?	What Failed?
Understaffed day	Yes / No	
High workload	Yes / No	
Supervisor absent	Yes / No	
Leadership wants an exception	Yes / No	
Employee pushes back	Yes / No	
Customer pressure / overtime rises	Yes / No	
Documentation requested months later	Yes / No	

14 TOOL ROUTING

Carry the finding into the matching appendix tool.

If the Card Reveals...	Use This Tool
Capacity failure	The Capacity Reality Test (Tool 03)
Role design failure	The Role Reality Test (Tool 01)
Workflow failure	The Workflow Handoff Map (Tool 13)
Reinforcement failure	The Reinforcement Audit (Tool 06)
Any mixed finding	The Mixed Failure Map (Tool 07)
Before acting on anyone	The Evidence Standard / Proof-File Builder (Tool 15)
To close the diagnosis	The Attribution Decision Protocol (Tool 17)

15 THE AUTHORITY MOVE

Resilience is not a substitute for staffing, and self-care is not a substitute for math. When the role demands more than the organization funds, burnout is not a personal failing. It is the budget arriving in human form.

16 SEEN IN THE FIELD

A CASE IN PRACTICE

An accounting team was working 60-hour weeks. HR offered a mindfulness seminar. The diagnostic showed that a recent merger had doubled the vendor count, but headcount was frozen (Capacity), and the new expense software required manual duplicate entry (Technology). The mindfulness seminar would have taught soft skills but doubled the amount of work for the team to return back to. The team returned to 40-hour weeks, and no one quit after leadership hired two temporary staff to help recover backlogged entries and consulted with an IT agency to build an API to automate the software duplication issues.

◆ QUICK SORT CARD • DEPTH 1
CARD 11

Chronic Lateness / Attendance

1 LABEL IN USE: CHRONIC LATENESS / ATTENDANCE

Use this card when attendance is the visible issue. Test whether the schedule, enforcement pattern, supervisor follow-up, accommodation issues, and tolerated history support the conclusion being drawn.

2 WHAT THIS USUALLY GETS BLAMED ON

- They don't respect the schedule.
- They are unreliable.
- They take advantage.

3 WHY THAT DIAGNOSIS MAY BE TOO THIN

Attendance reads as pure self-discipline, and often it is. The diagnosis becomes too thin when the organization has tolerated the lateness for months, enforced the rule unevenly across people, or built a schedule that collides with known structural realities and then treated the predictable result as a character flaw.

4 SYMPTOM PATTERN SCAN

Use this scan to decide whether the problem is isolated or patterned before you go further.

Question	Answer	What It May Indicate
Has this happened before?		Pattern issue
With more than one person?		System recurrence
Under the same supervisor?		Supervision issue
In the same role?		Role design / selection
During high workload?		Capacity issue
Does it vanish when one strong employee carries it?		Hidden dependency
Did leadership know before acting?		Tolerated failure
Did the organization benefit from the behavior?		Rewarded failure

5 GUIDED DIAGNOSTIC PATH

Follow the sequence. Each answer narrows the diagnosis.

Was the attendance expectation explicit and consistently enforced for everyone?

If yes → Yes. Proceed to discipline.

If no → No, it was tolerated or applied selectively.

Establishes Consistency of Expectation.

How long was the lateness tolerated before it became a problem?

If yes → Addressed immediately.

If no → Ignored for six months until the manager got mad.

Establishes Supervisory Tolerance.

Is there a structural cause (shift design, commute, coverage) the schedule ignores?

If timing is workable and reliable → Inspect individual choice and accountability.

If the shift starts before transportation is reasonably available → Inspect schedule design before discipline.

DESIGNED TO FAIL

Establishes Structural Conflict.

6 ATTRIBUTION FINDING

Force the sort. Mark one. Do not act as if you know more than the evidence proves.

- Primarily individual failure
- Primarily system failure
- Mixed failure (name the type below)
- Insufficient evidence to act as if you know

CORRECTED DIAGNOSTIC STATEMENT

Instead of: “This is an attendance and respect problem.”

The better diagnosis: “This appears to be a system-tolerated reliability failure, because the lateness was permitted for months and enforced unevenly before it was suddenly treated as misconduct.”

7 TOOL ROUTING

Carry the finding into the matching appendix tool.

If the Card Reveals...	Use This Tool
Expectation failure	The Expectation Clarity Test (Tool 12)
Supervision failure	The Supervision Strength Test (Tool 04)
Reinforcement failure	The Reinforcement Audit (Tool 06)
Documentation failure	The Documentation Sufficiency Test (Tool 05)
Any mixed finding	The Mixed Failure Map (Tool 07)
Before acting on anyone	The Evidence Standard / Proof-File Builder (Tool 15)
To close the diagnosis	The Attribution Decision Protocol (Tool 17)

8 THE AUTHORITY MOVE

A rule the organization tolerates for six months cannot be enforced like an emergency in the seventh. Restore consistency before you assign blame.

9 SEEN IN THE FIELD

A CASE IN PRACTICE

An employee was 10 minutes late every Tuesday. The manager wanted to fire them. The diagnostic revealed the manager had never written them up (Tolerance) and let another employee leave early on Fridays without penalty (Inconsistent Enforcement). Firing would look like bias. The manager was asked to issue a clear written standard to the whole team.

◆ QUICK SORT CARD · DEPTH 1
CARD 12

Missed Deadlines

1 LABEL IN USE: MISSED DEADLINES

Use this card when work keeps arriving late. Test whether the person controlled the full timeline, whether upstream handoffs were reliable, and whether the deadline was realistic under the actual workload.

2 WHAT THIS USUALLY GETS BLAMED ON

- They procrastinate.
- They can't prioritize.
- They overcommit.

3 WHY THAT DIAGNOSIS MAY BE TOO THIN

The assumption is that the employee controls their own timeline. The diagnosis becomes too thin when upstream delays consume the runway before the work even reaches them, or when leadership injects unplanned emergencies that quietly overwrite the original deadline and then express surprise it was missed.

4 SYMPTOM PATTERN SCAN

Use this scan to decide whether the problem is isolated or patterned before you go further.

Question	Answer	What It May Indicate
Has this happened before?		Pattern issue
With more than one person?		System recurrence

Under the same supervisor?		Supervision issue
In the same role?		Role design / selection
During high workload?		Capacity issue
Does it vanish when one strong employee carries it?		Hidden dependency
Did leadership know before acting?		Tolerated failure
Did the organization benefit from the behavior?		Rewarded failure

5 GUIDED DIAGNOSTIC PATH

Follow the sequence. Each answer narrows the diagnosis.

Did the person control the full timeline, or depend on upstream handoffs?

If yes → Full control.

If no → Upstream delays ate 80% of the timeline.
Establishes Workflow Dependency.

How often is planned work displaced by injected emergencies?

If yes → Rarely.

If no → Daily. Priorities change every morning.
Establishes Expectation Stability.

Was the deadline realistic given the actual capacity?

If yes → Yes, math works.

If no → No, the volume required double the available hours.
Establishes Mathematical Capacity.

6 ATTRIBUTION FINDING

Force the sort. Mark one. Do not act as if you know more than the evidence proves.

- Primarily individual failure
- Primarily system failure
- Mixed failure (name the type below)
- Insufficient evidence to act as if you know

CORRECTED DIAGNOSTIC STATEMENT

Instead of: “This is a procrastination problem.”

The better diagnosis: “This appears to be a workflow and capacity failure, because upstream delays and injected emergencies consumed the runway before the work could be completed on time.”

7 TOOL ROUTING

Carry the finding into the matching appendix tool.

If the Card Reveals...	Use This Tool
Workflow failure	The Workflow Handoff Map (Tool 13)
Capacity failure	The Capacity Reality Test (Tool 03)
Expectation failure	The Expectation Clarity Test (Tool 12)
Authority failure	The Authority-to-Accountability Map (Tool 02)
Any mixed finding	The Mixed Failure Map (Tool 07)
Before acting on anyone	The Evidence Standard / Proof-File Builder (Tool 15)
To close the diagnosis	The Attribution Decision Protocol (Tool 17)

8 THE AUTHORITY MOVE

A missed deadline is the end of a chain, not the start of one. Trace the timeline backward before you blame the person standing at the finish line.

9 SEEN IN THE FIELD

A CASE IN PRACTICE

A designer kept missing Friday deadlines. The diagnostic showed that the copywriters (upstream) routinely delivered their text on Thursday afternoon instead of Tuesday, leaving the designer 24 hours to do 40 hours of work. The designer wasn't slow; they were the final shock absorber for the writers' delays. The deadline was shifted to '72 hours post-copy' after running the and fewer deadlines or reworks were observed.

◆ QUICK SORT CARD · DEPTH 1
CARD 13

Team Conflict / Personality Clash

1 LABEL IN USE: TEAM CONFLICT / PERSONALITY CLASH

Use this card when conflict is being reduced to personalities. Test whether the roles are competing for resources, decisions, credit, authority, or unclear ownership before calling it interpersonal drama.

2 WHAT THIS USUALLY GETS BLAMED ON

- They just don't like each other.
- Different communication styles.
- Personality difference.

3 WHY THAT DIAGNOSIS MAY BE TOO THIN

Friction gets labeled interpersonal, which is the most convenient diagnosis because it requires no structural change. It becomes too thin when the conflict is actually a design collision: two roles competing for the same scarce resource, or accountability and authority misaligned between them, so the system guarantees a fight no amount of mediation will resolve.

4 SYMPTOM PATTERN SCAN

Use this scan to decide whether the problem is isolated or patterned before you go further.

Question	Answer	What It May Indicate
Has this happened before?		Pattern issue
With more than one person?		System recurrence
Under the same supervisor?		Supervision issue
In the same role?		Role design / selection
During high workload?		Capacity issue
Does it vanish when one strong employee carries it?		Hidden dependency
Did leadership know before acting?		Tolerated failure
Did the organization benefit from the behavior?		Rewarded failure

5 GUIDED DIAGNOSTIC PATH

Follow the sequence. Each answer narrows the diagnosis.

Do the two roles compete for the same resource, credit, or decision?

If yes → No.

If shared work has conflicting targets → Repair goal alignment before calling it personality conflict.

Establishes Resource/Goal Conflict.

Is authority clear, or contested between them?

If yes → Clear.

If no → Both believe they have final say over the process.

Establishes Authority Alignment.

Does the conflict track specific tasks, or follow them everywhere?

If yes → Follows them everywhere. It's personal.

If no → Only flares up during the monthly close process.

Establishes Workflow Friction.

6 ATTRIBUTION FINDING

Force the sort. Mark one. Do not act as if you know more than the evidence proves.

- Primarily individual failure
- Primarily system failure
- Mixed failure (name the type below)
- Insufficient evidence to act as if you know

CORRECTED DIAGNOSTIC STATEMENT

Instead of: “This is a personality clash.”

The better diagnosis: “This appears to be a role-design failure, because two roles are structured to compete for the same authority and resources, producing a conflict the design itself guarantees.”

7 TOOL ROUTING

Carry the finding into the matching appendix tool.

If the Card Reveals...	Use This Tool
Role design failure	The Role Reality Test (Tool 01)
Authority failure	The Authority-to-Accountability Map (Tool 02)
Workflow failure	The Workflow Handoff Map (Tool 13)
Reinforcement failure	The Reinforcement Audit (Tool 06)
Any mixed finding	The Mixed Failure Map (Tool 07)
Before acting on anyone	The Evidence Standard / Proof-File Builder (Tool 15)
To close the diagnosis	The Attribution Decision Protocol (Tool 17)

8 THE AUTHORITY MOVE

When two reasonable people keep fighting in the same spot, suspect the spot. Personality is often the last explanation, not the first.

◆ QUICK SORT CARD · DEPTH 1
CARD 14

Resistance to Change

1 LABEL IN USE: RESISTANCE TO CHANGE

Use this card when employees are accused of resisting the new way. Test whether the change was operationalized, supported, reinforced, and made better than the old process before blaming resistance.

2 WHAT THIS USUALLY GETS BLAMED ON

- They are stubborn.
- They are stuck in the past.
- They fear change.

3 WHY THAT DIAGNOSIS MAY BE TOO THIN

The change is assumed to be obviously good and the employee merely rigid. The diagnosis becomes too thin when the new process is genuinely worse, the tools are untested, the rollout was thin, or the organization demands the new behavior while continuing to reward the old one.

4 SYMPTOM PATTERN SCAN

Use this scan to decide whether the problem is isolated or patterned before you go further.

Question	Answer	What It May Indicate
Has this happened before?		Pattern issue
With more than one person?		System recurrence
Under the same supervisor?		Supervision issue
In the same role?		Role design / selection
During high workload?		Capacity issue
Does it vanish when one strong employee carries it?		Hidden dependency
Did leadership know before acting?		Tolerated failure
Did the organization benefit from the behavior?		Rewarded failure

5 GUIDED DIAGNOSTIC PATH

Follow the sequence. Each answer narrows the diagnosis.

Is the new process actually better, or just newer?

If yes → It is measurably better.

If no → It adds 10 steps to their day for no local benefit.

Establishes Operational Reality.

Does the organization still reward the old behavior?

If incentives have been updated → Inspect training, workflow, and reinforcement.

If bonuses still pay out under the old method → The system is rewarding resistance.

Establishes Reinforcement.

Was training real, or just an announcement?

If yes → Supported with practice and coaching.

If no → An email and a PDF manual.

Establishes Support/Training.

6 ATTRIBUTION FINDING

Force the sort. Mark one. Do not act as if you know more than the evidence proves.

- Primarily individual failure
- Primarily system failure
- Mixed failure (name the type below)
- Insufficient evidence to act as if you know

CORRECTED DIAGNOSTIC STATEMENT

Instead of: “This is resistance to change.”

The better diagnosis: “This appears to be a reinforcement and rollout failure, because the organization demanded a new behavior while still rewarding the old one and never proved the change was workable.”

7 TOOL ROUTING

Carry the finding into the matching appendix tool.

If the Card Reveals...	Use This Tool
Reinforcement failure	The Reinforcement Audit (Tool 06)
Training-transfer failure	The Supervision Strength Test (Tool 04)
Technology failure	The Workflow Handoff Map (Tool 13)
Leadership decision failure	The Leadership Decision Impact Review (Tool 09)
Any mixed finding	The Mixed Failure Map (Tool 07)
Before acting on anyone	The Evidence Standard / Proof-File Builder (Tool 15)
To close the diagnosis	The Attribution Decision Protocol (Tool 17)

8 THE AUTHORITY MOVE

Resistance is sometimes wisdom the organization has not slowed down to hear. Before you override it, confirm the change deserves to win.

9 SEEN IN THE FIELD

A CASE IN PRACTICE

A behavioral health startup rolled out a new EHR and told therapists to stop using paper notes. Operations called the therapists “resistant to change.” The diagnostic showed something more practical. The system timed out during session documentation, autosave was unreliable, and the note templates did not match how clinicians captured treatment progress (Technology). At the same time, therapists were still being evaluated on same-day note completion and back-to-back session volume, which the paper process helped them survive (Reinforcement).

◆ QUICK SORT CARD • DEPTH 1
CARD 15

The Disengaged High Performer

1 LABEL IN USE: DISENGAGED HIGH PERFORMER

Use this card when a strong performer has gone cold, sharp, withdrawn, or difficult. Test whether the organization has overused their reliability, protected weaker contributors, or failed to match contribution with support and recognition.

2 WHAT THIS USUALLY GETS BLAMED ON

- They have an attitude problem.
- They think they're untouchable.
- They've gotten complacent.

3 WHY THAT DIAGNOSIS MAY BE TOO THIN

A formerly excellent employee withdrawing is read as ego. The diagnosis becomes too thin when the high performer has simply realized that the reward for excellence is absorbing the workload of the underperformers the organization refuses to manage, and the withdrawal is a rational response to that bargain.

4 SYMPTOM PATTERN SCAN

Use this scan to decide whether the problem is isolated or patterned before you go further.

Question	Answer	What It May Indicate
Has this happened before?		Pattern issue
With more than one person?		System recurrence
Under the same supervisor?		Supervision issue
In the same role?		Role design / selection
During high workload?		Capacity issue
Does it vanish when one strong employee carries it?		Hidden dependency
Did leadership know before acting?		Tolerated failure
Did the organization benefit from the behavior?		Rewarded failure

5 GUIDED DIAGNOSTIC PATH

Follow the sequence. Each answer narrows the diagnosis.

Is this person carrying work the organization should be redistributing?

If the load is fair → Inspect individual standards and performance.

If they carry a disproportionate share of output → The organization has created a dependency.

Establishes Burden Shifting.

Does the organization protect underperformers at this person's expense?

If yes → No.

If the manager avoids correcting weak performance and shifts work here → The dependency is being reinforced.

Establishes Supervisory Tolerance.

Is recognition or pay lagging the contribution?

If yes → They are the highest paid.

If no → They make the same as the person doing half the work.

Establishes Compensation Equity.

6 ATTRIBUTION FINDING

Force the sort. Mark one. Do not act as if you know more than the evidence proves.

- Primarily individual failure
- Primarily system failure
- Mixed failure (name the type below)
- Insufficient evidence to act as if you know

CORRECTED DIAGNOSTIC STATEMENT

Instead of: “This is an attitude problem.”

The better diagnosis: “This appears to be a reinforcement failure, because the organization repaid excellence with the workload of the people it would not manage, and the disengagement is the rational result.”

7 TOOL ROUTING

Carry the finding into the matching appendix tool.

If the Card Reveals...	Use This Tool
Reinforcement failure	The Reinforcement Audit (Tool 06)
Capacity failure	The Capacity Reality Test (Tool 03)
Supervision failure	The Supervision Strength Test (Tool 04)
Compensation failure	The Compensation Distortion Test (Tool 14)
Any mixed finding	The Mixed Failure Map (Tool 07)
Before acting on anyone	The Evidence Standard / Proof-File Builder (Tool 15)
To close the diagnosis	The Attribution Decision Protocol (Tool 17)

8 THE AUTHORITY MOVE

When your best person stops trying, ask what trying earned them. Disengagement is often the most rational response to an unfair bargain.

9 SEEN IN THE FIELD

A CASE IN PRACTICE

A top software engineer stopped volunteering for hard projects and started leaving exactly at 5pm. The manager blamed 'lost passion' and requested a PIP. The diagnostic showed the engineer had spent six months fixing the bugs of a junior dev the manager refused to develop further or coach out of the organization (Supervision/Reinforcement). The engineer had established a boundary and pushed responsibility back on the manager to manage the junior dev, and the senior engineer re-engaged with her work.

◆ QUICK SORT CARD · DEPTH 1
CARD 16

Communication Breakdown

1 LABEL IN USE: COMMUNICATION BREAKDOWN

Use this card when people say nobody knows what is going on. Test whether the issue is actually unclear ownership, broken decision flow, missing escalation, or messages dying in predictable places.

2 WHAT THIS USUALLY GETS BLAMED ON

- People need to talk more.
- We need better emails.
- Nobody listens.

3 WHY THAT DIAGNOSIS MAY BE TOO THIN

Communication failure is treated as a volume problem, so the organization prescribes more meetings and longer emails. The diagnosis becomes too thin when the real issue is architectural: it is unclear who owns the decision, who must be informed, and where the escalation path runs. More talking into a broken structure only produces more noise.

4 SYMPTOM PATTERN SCAN

Use this scan to decide whether the problem is isolated or patterned before you go further.

Question	Answer	What It May Indicate
Has this happened before?		Pattern issue
With more than one person?		System recurrence
Under the same supervisor?		Supervision issue
In the same role?		Role design / selection
During high workload?		Capacity issue
Does it vanish when one strong employee carries it?		Hidden dependency
Did leadership know before acting?		Tolerated failure
Did the organization benefit from the behavior?		Rewarded failure

5 GUIDED DIAGNOSTIC PATH

Follow the sequence. Each answer narrows the diagnosis.

Is it clear who owns each decision and who must be informed?

If yes → Yes, RACI is defined.

If no → No, everyone CCs everyone to avoid blame.

Establishes Authority/Ownership.

Does an escalation path exist, and do people know it?

If yes → Yes.

If no → No, issues bounce laterally until they explode.

Establishes Workflow Architecture.

Can the organization identify where the message dies?

If yes → With one specific individual.

If no → In the handoff between two specific departments.

Establishes Point of Failure.

6 ATTRIBUTION FINDING

Force the sort. Mark one. Do not act as if you know more than the evidence proves.

- Primarily individual failure
- Primarily system failure
- Mixed failure (name the type below)
- Insufficient evidence to act as if you know

CORRECTED DIAGNOSTIC STATEMENT

Instead of: “This is a communication problem.”

The better diagnosis: “This appears to be a workflow and authority failure, because decision ownership and escalation paths were never defined, so more communication only adds noise to an undefined structure.”

7 TOOL ROUTING

Carry the finding into the matching appendix tool.

If the Card Reveals...	Use This Tool
Workflow failure	The Workflow Handoff Map (Tool 13)
Authority failure	The Authority-to-Accountability Map (Tool 02)
Role design failure	The Role Reality Test (Tool 01)
Expectation failure	The Expectation Clarity Test (Tool 12)
Any mixed finding	The Mixed Failure Map (Tool 07)
Before acting on anyone	The Evidence Standard / Proof-File Builder (Tool 15)
To close the diagnosis	The Attribution Decision Protocol (Tool 17)

8 THE AUTHORITY MOVE

Communication does not fail for lack of words. It fails for lack of structure. Fix who owns what before you ask everyone to talk more.

9 SEEN IN THE FIELD

A CASE IN PRACTICE

A marketing team complained of 'poor communication' with Sales, and the VP blamed 'silo mentality.' They instituted a daily 30-minute sync. It changed nothing. The diagnostic revealed that neither team knew who had final approval on pricing discounts (Authority). They didn't need a meeting; they needed a decision-maker. The VP named the Sales Director the sole approver. The daily meeting was cancelled, and the 'communication problems were improved.

◆ QUICK SORT CARD • DEPTH 1
CARD 17

Scope Creep / Role Confusion

1 LABEL IN USE: SCOPE CREEP / ROLE CONFUSION

Use this card when people are arguing over what belongs to whom. Test whether the task was assigned, whether a vacuum pulled someone into it, and whether role boundaries exist anywhere beyond assumption.

2 WHAT THIS USUALLY GETS BLAMED ON

- They're stepping on toes.
- They're not staying in their lane.
- They overreach.

3 WHY THAT DIAGNOSIS MAY BE TOO THIN

The lanes are assumed to be clearly painted. The diagnosis becomes too thin when the organization has left a vacuum: a critical task sits unassigned, someone absorbs it to keep the work moving, and the resulting confusion gets blamed on the person who filled the gap rather than on the design that left it.

4 SYMPTOM PATTERN SCAN

Use this scan to decide whether the problem is isolated or patterned before you go further.

Question	Answer	What It May Indicate
Has this happened before?		Pattern issue
With more than one person?		System recurrence
Under the same supervisor?		Supervision issue
In the same role?		Role design / selection
During high workload?		Capacity issue
Does it vanish when one strong employee carries it?		Hidden dependency
Did leadership know before acting?		Tolerated failure
Did the organization benefit from the behavior?		Rewarded failure

5 GUIDED DIAGNOSTIC PATH

Follow the sequence. Each answer narrows the diagnosis.

Is the disputed task actually assigned to anyone?

If yes → Yes, it clearly belongs to someone else.

If no → No, it fell through the cracks.

Establishes Role Design Gap.

Did a vacuum force someone to absorb it?

If the work was formally assigned → Inspect whether authority and documentation support it.

If they took it over to prevent failure → The workaround is masking a system gap.

Establishes Workflow Necessity.

Are role boundaries explicit, or assumed?

If yes → Written and clear.

If no → Vague historical assumptions.

Establishes Expectation Clarity.

6 ATTRIBUTION FINDING

Force the sort. Mark one. Do not act as if you know more than the evidence proves.

- Primarily individual failure
- Primarily system failure
- Mixed failure (name the type below)
- Insufficient evidence to act as if you know

CORRECTED DIAGNOSTIC STATEMENT

Instead of: “This is a scope and lane problem.”

The better diagnosis: “This appears to be a role-design failure, because a critical task was left unassigned and the person who absorbed it to keep work moving is being blamed for the vacuum the design created.”

7 TOOL ROUTING

Carry the finding into the matching appendix tool.

If the Card Reveals...	Use This Tool
Role design failure	The Role Reality Test (Tool 01)
Authority failure	The Authority-to-Accountability Map (Tool 02)
Expectation failure	The Expectation Clarity Test (Tool 12)
Workflow failure	The Workflow Handoff Map (Tool 13)
Any mixed finding	The Mixed Failure Map (Tool 07)
Before acting on anyone	The Evidence Standard / Proof-File Builder (Tool 15)
To close the diagnosis	The Attribution Decision Protocol (Tool 17)

8 THE AUTHORITY MOVE

People do not usually invade clear lanes. They fill empty ones. Before you accuse someone of overreach, find out whether the work they grabbed was ever assigned at all.

9 SEEN IN THE FIELD

A CASE IN PRACTICE

An Operations Manager was reprimanded for 'overstepping' into HR by handling initial phone screens. The diagnostic showed that HR was taking 14 days to screen candidates, causing Operations to lose applicants to competitors (Workflow). The manager wasn't power-grabbing; they were trying to survive the delay. Leadership ran the diagnosis, established a strict 48-hour SLA for HR screens, and the manager gladly returned the task. Time-to-hire dropped by ten days.

◆ QUICK SORT CARD • DEPTH 1
CARD 18

The "Culture Fit" Complaint

1 LABEL IN USE: CULTURE FIT COMPLAINT

Use this card when culture fit becomes the label. Test whether the organization can name a specific behavior or whether the person is exposing an informal power structure, protected workaround, or preference disguised as culture.

2 WHAT THIS USUALLY GETS BLAMED ON

- They're just not one of us.
- They don't get our vibe.
- They rub people the wrong way.

3 WHY THAT DIAGNOSIS MAY BE TOO THIN

"Culture fit" is treated as an objective, shared standard. The diagnosis becomes too thin because the phrase is often a weaponized, subjective label used to reject someone who challenges the informal power structure, asks uncomfortable questions, or refuses to participate in the organization's preferred workarounds. Sometimes fit is real. Often it is a polite word for "inconvenient."

4 SYMPTOM PATTERN SCAN

Use this scan to decide whether the problem is isolated or patterned before you go further.

Question	Answer	What It May Indicate
Has this happened before?		Pattern issue
With more than one person?		System recurrence
Under the same supervisor?		Supervision issue
In the same role?		Role design / selection
During high workload?		Capacity issue
Does it vanish when one strong employee carries it?		Hidden dependency
Did leadership know before acting?		Tolerated failure
Did the organization benefit from the behavior?		Rewarded failure

5 GUIDED DIAGNOSTIC PATH

Follow the sequence. Each answer narrows the diagnosis.

Can anyone name the specific behavior, or only a vague feeling?

If yes → Yes, they interrupt clients and use profanity.

If no → No, 'they just don't gel with us.'

Establishes Objective Conduct vs. Subjective Bias.

Does the person challenge an informal power structure or a protected workaround?

If yes → No.

If they keep asking why the safety manual is ignored → Treat the 'fit' complaint as compliance data.

Establishes Systemic Protection.

Would the same behavior be tolerated from a favored employee?

If the standard is even → Inspect individual conduct and coaching history.

DESIGNED TO FAIL

If a protected top performer acts the same way → The culture fit complaint is selective enforcement.

Establishes Reinforcement/Tolerance.

6 ATTRIBUTION FINDING

Force the sort. Mark one. Do not act as if you know more than the evidence proves.

- Primarily individual failure
- Primarily system failure
- Mixed failure (name the type below)
- Insufficient evidence to act as if you know

CORRECTED DIAGNOSTIC STATEMENT

Instead of: “This is a culture-fit problem.”

The better diagnosis: “This appears to be a reinforcement and expectation failure, because ‘fit’ is being used to reject someone who exposed a protected workaround, rather than naming any concrete conduct issue.”

7 TOOL ROUTING

Carry the finding into the matching appendix tool.

If the Card Reveals...	Use This Tool
Expectation failure	The Expectation Clarity Test (Tool 12)
Reinforcement failure	The Reinforcement Audit (Tool 06)
Policy-to-practice failure	The Policy-to-Practice Gap Test (Tool 08)
Supervision failure	The Supervision Strength Test (Tool 04)
Any mixed finding	The Mixed Failure Map (Tool 07)
Before acting on anyone	The Evidence Standard / Proof-File Builder (Tool 15)
To close the diagnosis	The Attribution Decision Protocol (Tool 17)

8 THE AUTHORITY MOVE

"They don't fit" is the easiest sentence in the building to say and the hardest to defend. Make the organization name the behavior. If it cannot, the problem may be the mirror, not the hire.

9 SEEN IN THE FIELD

A CASE IN PRACTICE

A new analyst was flagged for termination at 60 days for 'poor culture fit.' HR pressed for details. The manager admitted the analyst kept pointing out errors in the team's monthly reporting model (Protection). The analyst didn't lack fit; they lacked compliance with the team's comfortable mediocrity. HR blocked the termination and proved the 'fit' issue was actually the analyst exposing a broken reporting process. HR forced the manager to address the reporting errors instead of firing the messenger.

◆ DEEP SYSTEM CARD • DEPTH 3
CARD 19

Strategy Is Not Executing

1 LABEL IN USE: STRATEGY IS NOT EXECUTING

Use this card when the plan exists but the work has not changed. Test whether the strategy was translated into roles, authority, workflow, capacity, proof, and reinforcement before calling it execution failure.

2 WHAT THIS USUALLY GETS BLAMED ON

- The frontline doesn't get it.
- Middle management failed to cascade the vision.
- We lack execution discipline.
- People are resistant to the new direction.

3 WHY THAT DIAGNOSIS MAY BE TOO THIN

The comfortable diagnosis blames the people asked to carry the plan and protects the people who wrote it. That diagnosis is too thin because a strategy that cannot be executed by the actual workforce, using the actual tools, inside the actual budget, is not a strategy. It is a wish with a deadline attached. When execution fails everywhere at once, the problem is rarely a thousand individual failures of will. It is one upstream design failure replicated across the organization. The plan was built for a company that does not exist.

4 SYMPTOM PATTERN SCAN

Use this scan to decide whether the problem is isolated or patterned before you go further.

Question	Answer	What It May Indicate
Has this happened before?		Pattern issue
With more than one person?		System recurrence
Under the same supervisor?		Supervision issue
In the same role?		Role design / selection
During high workload?		Capacity issue
Does it vanish when one strong employee carries it?		Hidden dependency
Did leadership know before acting?		Tolerated failure
Did the organization benefit from the behavior?		Rewarded failure

5 INDIVIDUAL FAILURE SCAN

Mark only what the evidence supports.

Failure Type	Present?	Diagnostic Question
Capability failure	Yes / No / Unknown	Can the person perform the actual work at the required level?
Willingness failure	Yes / No / Unknown	Can they do it but choose not to?
Ownership failure	Yes / No / Unknown	Do they avoid responsibility even when the role is clear?
Adaptability failure	Yes / No / Unknown	Can they adjust when work, expectations, tools, or priorities change?

6 SYSTEM FAILURE SCAN

Inspect the conditions that may be creating, hiding, protecting, or worsening the visible problem.

Failure Type	Present?	Diagnostic Question
Expectation failure	Yes / No / Unknown	Was the standard clear before the person was judged against it?
Role Design failure	Yes / No / Unknown	Is the job built in a way a real person can perform?
Authority failure	Yes / No / Unknown	Does the person being blamed control the outcome?
Capacity failure	Yes / No / Unknown	Is the workload possible under normal operating conditions?
Workflow failure	Yes / No / Unknown	Does the work move cleanly from person to person or department to department?
Reinforcement failure	Yes / No / Unknown	What behavior does the organization actually reward, tolerate, punish, or protect?
Leadership Decision failure	Yes / No / Unknown	Did leadership create the condition but blame the downstream employee?
Technology/Process failure	Yes / No / Unknown	Did software automate confusion instead of fixing workflow?

7 MIXED FAILURE SCAN

Use this scan when the honest answer may be both person and system.

Mixed Failure Type	Present?	What It Means
System-Created Individual Failure	Yes / No / Unknown	The system produced the behavior it later condemned.
System-Hidden Individual Failure	Yes / No / Unknown	Weak metrics, supervision, or documentation kept the issue invisible.
Individual-Revealed System Failure	Yes / No / Unknown	The person did not create the broken system, but exposed it.
System-Converted Individual Failure into Organizational Damage	Yes / No / Unknown	A person-side issue became broader damage because leadership mishandled the response.

8 EVIDENCE REQUIRED

Separate evidence from assumption before you act.

If the Finding Is...	Evidence Needed	If Missing...
Primarily individual	Specific roles given clear targets, authority, and capacity, who still refused to act after coaching	If most roles never received clear targets, you are blaming people for an unfunded plan
Primarily system	The same stall appears across teams, functions, and managers regardless of who is in the seat	If only one team stalls, the failure may be local, not strategic
Mixed	A weak rollout met a workforce that quietly preferred the old way and was never required to change	You likely need to fix the plan and require the behavior, not one or the other

9 GUIDED DIAGNOSTIC PATH

Follow the sequence. Each answer narrows the diagnosis.

Can a frontline employee state the strategy and name what changed in their daily work?

If yes → Proceed to test capacity and authority.

If no → The strategy is a boardroom secret. Stop blaming the frontline for missing a target they cannot see.

Establishes Clarity of Expectation.

Which existing activities were stopped to make room for the new ones?

If yes → Capacity was managed. Proceed to test incentives.

If no → The strategy is an unfunded mandate. You have added work without adding time.

Establishes Mathematical Capacity.

Does the reward system pay people to execute the new strategy?

If yes → Incentives are aligned. Proceed to test workflow.

If no → You are demanding the new way but paying for the old way. People will follow the money.

Establishes Reinforcement Alignment.

Does anyone own each strategic outcome with the authority and budget to deliver it?

If yes → Ownership is clean. Examine specific execution gaps.

If no → Accountability exists without authority. The strategy will stall in committee.

Establishes Authority Control.

When pressure rose, did people revert to the old way, and did anyone correct it?

If yes → Supervision is active. The failure is likely individual resistance.

If no → The organization tolerated the reversion. The strategy is dead.

Establishes System Tolerance.

10 ATTRIBUTION FINDING

Force the sort. Mark one. Do not act as if you know more than the evidence proves.

- Primarily individual failure
- Primarily system failure
- Mixed failure (name the type below)
- Insufficient evidence to act as if you know

CORRECTED DIAGNOSTIC STATEMENT

Instead of: “This is an execution discipline problem.”

The better diagnosis: “This appears to be a leadership-design failure, involving an unfunded plan layered onto unchanged incentives, because no role was given the capacity, authority, or reward alignment the strategy required.”

11 REPAIR TARGET

Once the attribution is clear, identify where the fix belongs. Mixed failure may require two sequenced targets.

Target	Needed?	Likely Repair Move
Leadership Decision	Yes / No	Rebuild the plan against real capacity, tooling, and budget before re-launching
Reinforcement	Yes / No	Align incentives and recognition to the strategic behavior, not the legacy behavior
Authority	Yes / No	Assign a single accountable owner with decision rights to each outcome
Role	Yes / No	Stop legacy activities to create the capacity the plan assumed

12 GUIDED REPAIR WALKTHROUGH

Follow the path from finding to repair. Each step names the move, the tool, and the proof that the step is done.

Step 1. If the plan assumed capacity that does not exist...

Run The Capacity Reality Test (Tool 03). Pause the rollout until legacy work is removed to make room.

Step 2. If the incentives still reward the old behavior...

Run The Reinforcement Audit (Tool 06). Rewrite the bonus and promotion criteria to match the new strategy.

Step 3. If accountability is diffuse...

Run The Authority-to-Accountability Map (Tool 02). Assign single owners with budget control.

DESIGNED TO FAIL

Record the concrete plan. Name owners and dates, or the repair will not happen.

Action	Owner	Deadline	Evidence of Completion
Clarify the standard			
Align authority to accountability			
Correct the person-side issue			
Repair the system condition			
Document the follow-up			
Review under pressure			

13 PROOF UNDER PRESSURE

Test the repair against the real workday.

Pressure Test	Holds?	What Failed?
Understaffed day	Yes / No	
High workload	Yes / No	
Supervisor absent	Yes / No	
Leadership wants an exception	Yes / No	
Employee pushes back	Yes / No	
Customer pressure / overtime rises	Yes / No	
Documentation requested months later	Yes / No	

14 TOOL ROUTING

Carry the finding into the matching appendix tool.

If the Card Reveals...	Use This Tool
Leadership decision failure	The Leadership Decision Impact Review (Tool 09)
Reinforcement failure	The Reinforcement Audit (Tool 06)
Capacity failure	The Capacity Reality Test (Tool 03)
Authority failure	The Authority-to-Accountability Map (Tool 02)
Any mixed finding	The Mixed Failure Map (Tool 07)
Before acting on anyone	The Evidence Standard / Proof-File Builder (Tool 15)
To close the diagnosis	The Attribution Decision Protocol (Tool 17)

15 THE AUTHORITY MOVE

Strategy does not fail in the field. It fails in the design, and then performs that failure in the field where everyone can watch. Repair the plan against reality before you correct the people executing it.

16 SEEN IN THE FIELD

A CASE IN PRACTICE

A healthcare network launched a 'patient-first' strategy, but wait times worsened. Leadership blamed clinic managers for 'lacking urgency.' The diagnostic revealed that while the strategy demanded longer patient consultations (Capacity), the bonus structure still paid doctors strictly on patient volume (Reinforcement). The managers were caught in a system-created failure. Leadership stopped disciplining the managers, changed the physician compensation model to weight patient satisfaction equally with volume, and wait times dropped.

◆ DEEP SYSTEM CARD • DEPTH 3
CARD 20

The Growth Plan Is Failing

1 LABEL IN USE: GROWTH PLAN IS FAILING

Use this card when growth is creating fragility instead of strength. Test whether the organization built the staffing, onboarding, workflow, supervision, and infrastructure required before volume increased.

2 WHAT THIS USUALLY GETS BLAMED ON

- Sales isn't pushing hard enough.
- Operations can't keep up.
- The market shifted.
- We just need to hire faster.

3 WHY THAT DIAGNOSIS MAY BE TOO THIN

Growth is treated as an effort problem, so leadership applies more pressure to the parts of the system already breaking. That diagnosis is too thin because most growth failures are infrastructure failures wearing a sales costume. The organization sold capacity it had not yet built, then asked the existing system to stretch until the handoffs snapped. The receipt arrives as customer complaints, missed deliveries, and the quiet departure of the people who held the strain together.

4 SYMPTOM PATTERN SCAN

Use this scan to decide whether the problem is isolated or patterned before you go further.

Question	Answer	What It May Indicate
Has this happened before?		Pattern issue
With more than one person?		System recurrence
Under the same supervisor?		Supervision issue
In the same role?		Role design / selection
During high workload?		Capacity issue
Does it vanish when one strong employee carries it?		Hidden dependency
Did leadership know before acting?		Tolerated failure
Did the organization benefit from the behavior?		Rewarded failure

5 INDIVIDUAL FAILURE SCAN

Mark only what the evidence supports.

Failure Type	Present?	Diagnostic Question
Capability failure	Yes / No / Unknown	Can the person perform the actual work at the required level?
Reliability failure	Yes / No / Unknown	Can the organization count on them consistently?
Ownership failure	Yes / No / Unknown	Do they avoid responsibility even when the role is clear?
Adaptability failure	Yes / No / Unknown	Can they adjust when work, expectations, tools, or priorities change?

6 SYSTEM FAILURE SCAN

Inspect the conditions that may be creating, hiding, protecting, or worsening the visible problem.

Failure Type	Present?	Diagnostic Question
Capacity failure	Yes / No / Unknown	Is the workload possible under normal operating conditions?
Workflow failure	Yes / No / Unknown	Does the work move cleanly from person to person or department to department?
Role Design failure	Yes / No / Unknown	Is the job built in a way a real person can perform?
Onboarding failure	Yes / No / Unknown	Did the organization convert the hire into a functioning employee?
Technology/Process failure	Yes / No / Unknown	Did software automate confusion instead of fixing workflow?
Leadership Decision failure	Yes / No / Unknown	Did leadership create the condition but blame the downstream employee?
Selection failure	Yes / No / Unknown	Did the hiring process test for the actual role?

7 MIXED FAILURE SCAN

Use this scan when the honest answer may be both person and system.

Mixed Failure Type	Present?	What It Means
System-Created Individual Failure	Yes / No / Unknown	The system produced the behavior it later condemned.
Individual-Revealed System Failure	Yes / No / Unknown	The person did not create the broken system, but exposed it.
Individual-Amplified System Failure	Yes / No / Unknown	The system was weak, and the person made the weakness worse.
System-Converted Individual Failure into Organizational Damage	Yes / No / Unknown	A person-side issue became broader damage because leadership mishandled the response.

8 EVIDENCE REQUIRED

Separate evidence from assumption before you act.

If the Finding Is...	Evidence Needed	If Missing...
Primarily individual	Specific leaders with adequate resources who failed to build or hire to plan	If resourcing lagged the plan, the failure is upstream of the people executing
Primarily system	Volume outran the infrastructure, breaking handoffs the org never redesigned for scale	If the system held and only one node failed, look locally first
Mixed	Under-built infrastructure met thin management of the strain it created	You likely need to fund the infrastructure and strengthen the management of it

9 GUIDED DIAGNOSTIC PATH

Follow the sequence. Each answer narrows the diagnosis.

Was the capacity assumed by the growth plan actually built before the sales were booked?

If yes → Infrastructure was staged. Proceed to test workflow and handoffs.

If no → The organization sold unbuilt capacity. The strain on operations is mathematically guaranteed.

Establishes Leadership Decision Reality.

Can the organization identify where volume currently breaks the handoff?

If yes → The bottleneck is isolated. Map it and resize it.

If no → The workflow is breaking everywhere. The architecture cannot handle the scale.

Establishes Workflow Integrity.

Does the time required to make a new hire productive match the hiring pace?

If yes → Conversion is fast enough to support growth. Examine retention.

If no → Onboarding is too slow. You are pouring volume into an empty bucket.

Establishes Onboarding Conversion.

Is a manual process now load-bearing at a volume it was never designed to carry?

If yes → Manual processes have been automated. Test individual execution.

If no → A process built for 10 units is trying to process 100. It will fail.

Establishes Technology/Process Readiness.

Can the organization calculate the cost of rework, expedites, and recovery created by the growth plan?

If yes → Rework is tracked and low. The growth is clean.

If no → Rework is consuming the margin the growth was supposed to create.

Establishes True Cost of Growth.

10 ATTRIBUTION FINDING

Force the sort. Mark one. Do not act as if you know more than the evidence proves.

- Primarily individual failure
- Primarily system failure
- Mixed failure (name the type below)
- Insufficient evidence to act as if you know

CORRECTED DIAGNOSTIC STATEMENT

Instead of: “This is a sales and operations performance problem.”

The better diagnosis: “This appears to be a leadership-design failure, involving revenue scaled ahead of infrastructure, because the organization booked capacity it had not built and forced the existing workflow to absorb the gap.”

11 REPAIR TARGET

Once the attribution is clear, identify where the fix belongs. Mixed failure may require two sequenced targets.

Target	Needed?	Likely Repair Move
Leadership Decision	Yes / No	Sequence growth to infrastructure readiness; stop selling unbuilt capacity
Capacity	Yes / No	Fund and stage the capacity the plan assumed before the next push
Workflow	Yes / No	Redesign the handoffs that break under volume
Onboarding	Yes / No	Compress time-to-productivity so hiring can keep pace

12 GUIDED REPAIR WALKTHROUGH

Follow the path from finding to repair. Each step names the move, the tool, and the proof that the step is done.

Step 1. If operations is failing due to volume...

Run The Capacity Reality Test (Tool 03). Halt new sales until the operational math balances.

Step 2. If handoffs are breaking...

Run The Workflow Handoff Map (Tool 13). Redesign the specific bottleneck before adding more volume.

Step 3. If new hires are not helping fast enough...

Run The Onboarding Conversion Test (Tool 11). Build a rigid 30-day ramp to productivity.

DESIGNED TO FAIL

Record the concrete plan. Name owners and dates, or the repair will not happen.

Action	Owner	Deadline	Evidence of Completion
Clarify the standard			
Align authority to accountability			
Correct the person-side issue			
Repair the system condition			
Document the follow-up			
Review under pressure			

13 PROOF UNDER PRESSURE

Test the repair against the real workday.

Pressure Test	Holds?	What Failed?
Understaffed day	Yes / No	
High workload	Yes / No	
Supervisor absent	Yes / No	
Leadership wants an exception	Yes / No	
Employee pushes back	Yes / No	
Customer pressure / overtime rises	Yes / No	
Documentation requested months later	Yes / No	

14 TOOL ROUTING

Carry the finding into the matching appendix tool.

If the Card Reveals...	Use This Tool
Capacity failure	The Capacity Reality Test (Tool 03)
Workflow failure	The Workflow Handoff Map (Tool 13)
Leadership decision failure	The Leadership Decision Impact Review (Tool 09)
Onboarding failure	The Onboarding Conversion Test (Tool 11)
Any mixed finding	The Mixed Failure Map (Tool 07)
Before acting on anyone	The Evidence Standard / Proof-File Builder (Tool 15)
To close the diagnosis	The Attribution Decision Protocol (Tool 17)

15 THE AUTHORITY MOVE

Growth does not reward the company that sells the fastest. It rewards the company that can deliver what it sold. If the infrastructure cannot carry the promise, the promise becomes the liability.

16 SEEN IN THE FIELD

A CASE IN PRACTICE

A logistics company expanded rapidly, but delivery times plummeted. The CEO blamed the warehouse director. The diagnostic proved that while sales grew 40%, warehouse headcount was frozen 'until revenue stabilized' (Capacity), and the routing software crashed above 500 orders/day (Technology). The director was failing because the system demanded it. The CEO paused the sales incentive program for 60 days to fund warehouse hiring and a software patch.

◆ DEEP SYSTEM CARD • DEPTH 3
CARD 21

The Work Depends on One Strong Employee

1 LABEL IN USE: WORK DEPENDS ON ONE STRONG EMPLOYEE

Use this card when the operation is quietly dependent on one person. Test whether knowledge, workflow, authority, and backup capacity live in the system or only inside a reliable employee the business cannot afford to lose.

2 WHAT THIS USUALLY GETS BLAMED ON

- They're our rockstar.
- They're just uniquely talented.
- Nobody else steps up.
- We're lucky to have them.

3 WHY THAT DIAGNOSIS MAY BE TOO THIN

The organization tells itself a flattering story about a heroic employee, because the story is more comfortable than the truth underneath it. That diagnosis is too thin because heroism is not a scalable operating model. When an entire function survives on one person's institutional memory, excessive hours, and informal workarounds, the organization does not have a workflow. It has a single point of failure it has chosen to celebrate instead of resolve. The dependency is not a talent fact. It is a design decision the organization keeps re-making.

4 SYMPTOM PATTERN SCAN

Use this scan to decide whether the problem is isolated or patterned before you go further.

Question	Answer	What It May Indicate
Has this happened before?		Pattern issue
With more than one person?		System recurrence
Under the same supervisor?		Supervision issue
In the same role?		Role design / selection
During high workload?		Capacity issue
Does it vanish when one strong employee carries it?		Hidden dependency
Did leadership know before acting?		Tolerated failure
Did the organization benefit from the behavior?		Rewarded failure

5 INDIVIDUAL FAILURE SCAN

Mark only what the evidence supports.

Failure Type	Present?	Diagnostic Question
Capability failure	Yes / No / Unknown	Can the person perform the actual work at the required level?
Reliability failure	Yes / No / Unknown	Can the organization count on them consistently?
Ownership failure	Yes / No / Unknown	Do they avoid responsibility even when the role is clear?
Communication failure	Yes / No / Unknown	Do they fail to share, clarify, escalate, or receive information effectively?

6 SYSTEM FAILURE SCAN

Inspect the conditions that may be creating, hiding, protecting, or worsening the visible problem.

Failure Type	Present?	Diagnostic Question
Role Design failure	Yes / No / Unknown	Is the job built in a way a real person can perform?
Documentation failure	Yes / No / Unknown	Does the file show the standard, pattern, support, response, and reason for action?
Workflow failure	Yes / No / Unknown	Does the work move cleanly from person to person or department to department?
Capacity failure	Yes / No / Unknown	Is the workload possible under normal operating conditions?
Training-Transfer failure	Yes / No / Unknown	Did training become behavior, or just attendance?
Reinforcement failure	Yes / No / Unknown	What behavior does the organization actually reward, tolerate, punish, or protect?
Leadership Decision failure	Yes / No / Unknown	Did leadership create the condition but blame the downstream employee?

7 MIXED FAILURE SCAN

Use this scan when the honest answer may be both person and system.

Mixed Failure Type	Present?	What It Means
System-Hidden Individual Failure	Yes / No / Unknown	Weak metrics, supervision, or documentation kept the issue invisible.
System-Tolerated Individual Failure	Yes / No / Unknown	The individual issue existed, but leadership allowed it to continue.
Individual-Amplified System Failure	Yes / No / Unknown	The system was weak, and the person made the weakness worse.
System-Created Individual Failure	Yes / No / Unknown	The system produced the behavior it later condemned.

8 EVIDENCE REQUIRED

Separate evidence from assumption before you act.

If the Finding Is...	Evidence Needed	If Missing...
Primarily individual	The person actively hoards knowledge or blocks documentation to protect their indispensability	If the person has asked for help and been denied, the hoarding is structural
Primarily system	No documented process exists, no cross-training was funded, and the dependency was never designed out	If process exists and is simply ignored, look at reinforcement
Mixed	The person quietly enjoys being indispensable while the organization quietly enjoys not paying to fix it	You must remove the dependency by design and address any deliberate gatekeeping

9 GUIDED DIAGNOSTIC PATH

Follow the sequence. Each answer narrows the diagnosis.

If this person resigned today, which specific outputs would stop, and for how long?

If yes → The outputs are known and recoverable. The risk is moderate.

If no → The organization would halt. The dependency is critical.

Establishes Scope of Risk.

Does this person's knowledge live somewhere a competent successor could recover it from the file?

If yes → The process is documented. Test why others aren't doing it.

If no → The process lives entirely in their head. You have no institutional memory.

Establishes Documentation Failure.

Has cross-training ever been funded and scheduled, or only discussed?

If yes → Training occurred but failed. Test the training transfer.

If no → The organization refused to pay for the overlap time. The dependency is a budget choice.

Establishes Support/Funding.

DESIGNED TO FAIL

Does the organization reward this person for carrying the gap while also rewarding their indispensability?

If yes → They are rewarded for sharing knowledge. The dependency may be their own hoarding.

If no → They are treated as a hero for saving the day. The organization is paying for the bottleneck.

Establishes Reinforcement.

Does the workflow route around the official process and through this individual?

If yes → The official process is broken, and this person is the workaroud.

If no → The official process works, but people are lazy. Enforce the process.

Establishes Workflow Integrity.

10 ATTRIBUTION FINDING

Force the sort. Mark one. Do not act as if you know more than the evidence proves.

- Primarily individual failure
- Primarily system failure
- Mixed failure (name the type below)
- Insufficient evidence to act as if you know

CORRECTED DIAGNOSTIC STATEMENT

Instead of: “This is a talent and bench-strength problem.”

The better diagnosis: “This appears to be a role-design and documentation failure, involving an undesigned single point of failure, because the organization never funded the cross-training, documentation, or workflow redundancy the function requires.”

11 REPAIR TARGET

Once the attribution is clear, identify where the fix belongs. Mixed failure may require two sequenced targets.

Target	Needed?	Likely Repair Move
Documentation	Yes / No	Capture the process and knowledge in a recoverable, owned artifact
Role	Yes / No	Redesign the workflow so no single role is structurally load-bearing
Training	Yes / No	Fund and schedule real cross-training with verified transfer
Reinforcement	Yes / No	Stop rewarding indispensability; reward documented, transferable work

12 GUIDED REPAIR WALKTHROUGH

Follow the path from finding to repair. Each step names the move, the tool, and the proof that the step is done.

Step 1. If the knowledge is undocumented...

Run The Documentation Sufficiency Test (Tool 05). Require the employee to document one core process per week as part of their performance goal.

Step 2. If the organization rewards the heroism...

Run The Reinforcement Audit (Tool 06). Shift their bonus structure to reward cross-training others, not just personal output.

Step 3. If the person is hoarding knowledge...

Run The Mixed Failure Map (Tool 07). Address the conduct while forcing the structural redundancy.

DESIGNED TO FAIL

Record the concrete plan. Name owners and dates, or the repair will not happen.

Action	Owner	Deadline	Evidence of Completion
Clarify the standard			
Align authority to accountability			
Correct the person-side issue			
Repair the system condition			
Document the follow-up			
Review under pressure			

13 PROOF UNDER PRESSURE

Test the repair against the real workday.

Pressure Test	Holds?	What Failed?
Understaffed day	Yes / No	
High workload	Yes / No	
Supervisor absent	Yes / No	
Leadership wants an exception	Yes / No	
Employee pushes back	Yes / No	
Customer pressure / overtime rises	Yes / No	
Documentation requested months later	Yes / No	

14 TOOL ROUTING

Carry the finding into the matching appendix tool.

If the Card Reveals...	Use This Tool
Role design failure	The Role Reality Test (Tool 01)
Documentation failure	The Documentation Sufficiency Test (Tool 05)
Training-transfer failure	The Supervision Strength Test (Tool 04)
Mixed failure	The Mixed Failure Map (Tool 07)
Any mixed finding	The Mixed Failure Map (Tool 07)
Before acting on anyone	The Evidence Standard / Proof-File Builder (Tool 15)
To close the diagnosis	The Attribution Decision Protocol (Tool 17)

15 THE AUTHORITY MOVE

A person who cannot take a vacation without the work stopping is not a strength. They are a warning the organization has decided to applaud. Design the dependency out before it leaves on its own terms.

16 SEEN IN THE FIELD

A CASE IN PRACTICE

A senior IT engineer was celebrated for working weekends to fix server crashes. Leadership called him a rockstar and blamed the junior engineers for not keeping up. The diagnostic showed that he was the only one with the root passwords (Documentation) and that leadership praised his weekend saves while ignoring his refusal to train juniors (Reinforcement). The 'rockstar' was actually a bottleneck. Leadership required him to document the architecture and share access within 30 days. He threatened to quit, revealing the hoarding. The org held the line, the knowledge was shared, and the weekend crashes stopped.

◆ DEEP SYSTEM CARD • DEPTH 3
CARD 22

Pay Exceptions Became the Pay System

1 LABEL IN USE: PAY EXCEPTIONS BECAME THE PAY SYSTEM

Use this card when compensation is being governed by urgency, negotiation, exceptions, or threats to leave. Test whether pay decisions still follow a structure the organization can explain and defend.

2 WHAT THIS USUALLY GETS BLAMED ON

- We had to do it to save the deal.
- It was a one-time market adjustment.
- HR's bands are too rigid.
- That hire was special.

3 WHY THAT DIAGNOSIS MAY BE TOO THIN

Each exception was defended as a rational, isolated necessity, which is exactly how a compensation system quietly dies. That diagnosis is too thin because when exceptions outnumber the rule, the exception is the rule. The organization has allowed the loudest negotiators, the most panicked managers, and the most aggressive external offers to redesign its pay architecture by accident. Internal equity erodes, the structure stops predicting anything, and the people who never negotiated become the people who subsidize those who did.

4 SYMPTOM PATTERN SCAN

Use this scan to decide whether the problem is isolated or patterned before you go further.

Question	Answer	What It May Indicate
Has this happened before?		Pattern issue
With more than one person?		System recurrence
Under the same supervisor?		Supervision issue
In the same role?		Role design / selection
During high workload?		Capacity issue
Does it vanish when one strong employee carries it?		Hidden dependency
Did leadership know before acting?		Tolerated failure
Did the organization benefit from the behavior?		Rewarded failure

5 INDIVIDUAL FAILURE SCAN

Mark only what the evidence supports.

Failure Type	Present?	Diagnostic Question
Judgment failure	Yes / No / Unknown	Do they make poor decisions even when trying?
Conduct failure	Yes / No / Unknown	Did they breach behavioral, ethical, legal, safety, or professional standards?

6 SYSTEM FAILURE SCAN

Inspect the conditions that may be creating, hiding, protecting, or worsening the visible problem.

Failure Type	Present?	Diagnostic Question
Compensation failure	Yes / No / Unknown	Is pay creating distrust, distortion, resentment, or retention risk?
Reinforcement failure	Yes / No / Unknown	What behavior does the organization actually reward, tolerate, punish, or protect?
Authority failure	Yes / No / Unknown	Does the person being blamed control the outcome?
Documentation failure	Yes / No / Unknown	Does the file show the standard, pattern, support, response, and reason for action?
Policy-to-Practice failure	Yes / No / Unknown	Is the written rule different from the working rule?
Leadership Decision failure	Yes / No / Unknown	Did leadership create the condition but blame the downstream employee?

7 MIXED FAILURE SCAN

Use this scan when the honest answer may be both person and system.

Mixed Failure Type	Present?	What It Means
System-Tolerated Individual Failure	Yes / No / Unknown	The individual issue existed, but leadership allowed it to continue.
System-Rewarded Individual Failure	Yes / No / Unknown	The organization benefited from the behavior before calling it a problem.
Individual-Exploited System Failure	Yes / No / Unknown	The person used unclear standards or weak enforcement to avoid accountability.
System-Converted Individual Failure into Organizational Damage	Yes / No / Unknown	A person-side issue became broader damage because leadership mishandled the response.

8 EVIDENCE REQUIRED

Separate evidence from assumption before you act.

If the Finding Is...	Evidence Needed	If Missing...
Primarily individual	A specific manager repeatedly granted off-band pay without authority or business case	If the structure invited exceptions and no one enforced the band, the failure is systemic
Primarily system	No enforced band, no exception governance, and no record of why exceptions were granted	If the band is enforced and one person broke it, address that decision
Mixed	Aggressive negotiators exploited a structure leadership refused to govern	You must rebuild the structure and close the exception pathway

9 GUIDED DIAGNOSTIC PATH

Follow the sequence. Each answer narrows the diagnosis.

Can the organization identify what percentage of current pay decisions fall outside the official band?

If yes → Under 10%. The band is holding. Review the specific exceptions.

If no → Over 30%. The band is a fiction. The exception is the system.

Establishes System Integrity.

Is authority to grant pay exceptions documented and limited?

If yes → Authority is restricted to the executive level. The failure is a leadership choice.

If no → Frontline managers can override. You have no governance.

Establishes Authority Control.

Is there a written, retained business case behind each exception?

If yes → The logic is documented and defensible. The exceptions may be valid market adjustments.

If no → Decisions were verbal, panicked, or unrecorded. You cannot defend the payroll.

Establishes Proof and Documentation.

Do internal employees doing the same work at the same level earn materially different pay?

If yes → Internal equity is maintained. The risk is low.

If no → Massive gaps exist based purely on negotiation. You have a ticking retention bomb.

Establishes Internal Equity.

Does the organization reward negotiation over performance without intending to?

If yes → Pay correlates to performance.

If no → The loudest complainers get the money. You are incentivizing threats.

Establishes Reinforcement.

10 ATTRIBUTION FINDING

Force the sort. Mark one. Do not act as if you know more than the evidence proves.

- Primarily individual failure
- Primarily system failure
- Mixed failure (name the type below)
- Insufficient evidence to act as if you know

CORRECTED DIAGNOSTIC STATEMENT

Instead of: “This is a compensation-band rigidity problem.”

The better diagnosis: “This appears to be a compensation-governance failure, involving ungoverned exceptions that overwrote the structure, because no one held authority over the band and every exception was treated as a one-time event.”

11 REPAIR TARGET

Once the attribution is clear, identify where the fix belongs. Mixed failure may require two sequenced targets.

Target	Needed?	Likely Repair Move
Compensation	Yes / No	Rebuild the structure and re-anchor roles to defensible bands
Authority	Yes / No	Restrict and document who may grant exceptions and on what basis
Documentation	Yes / No	Require a retained business case for every exception
Reinforcement	Yes / No	Stop letting negotiation outrank performance in pay outcomes

12 GUIDED REPAIR WALKTHROUGH

Follow the path from finding to repair. Each step names the move, the tool, and the proof that the step is done.

Step 1. If the bands are ignored...

Run The Compensation Distortion Test (Tool 14). Freeze all frontline manager authority to grant off-band pay.

Step 2. If internal equity is broken...

Run The Leadership Decision Impact Review (Tool 09). Budget for a true-up cycle to pay the quiet, loyal performers what they are worth.

Step 3. If exceptions lack proof...

Run The Evidence Standard Builder (Tool 15). Require a formal business case for any future override.

DESIGNED TO FAIL

Record the concrete plan. Name owners and dates, or the repair will not happen.

Action	Owner	Deadline	Evidence of Completion
Clarify the standard			
Align authority to accountability			
Correct the person-side issue			
Repair the system condition			
Document the follow-up			
Review under pressure			

13 PROOF UNDER PRESSURE

Test the repair against the real workday.

Pressure Test	Holds?	What Failed?
Understaffed day	Yes / No	
High workload	Yes / No	
Supervisor absent	Yes / No	
Leadership wants an exception	Yes / No	
Employee pushes back	Yes / No	
Customer pressure / overtime rises	Yes / No	
Documentation requested months later	Yes / No	

14 TOOL ROUTING

Carry the finding into the matching appendix tool.

If the Card Reveals...	Use This Tool
Compensation failure	The Compensation Distortion Test (Tool 14)
Reinforcement failure	The Reinforcement Audit (Tool 06)
Authority failure	The Authority-to-Accountability Map (Tool 02)
Policy-to-practice failure	The Policy-to-Practice Gap Test (Tool 08)
Any mixed finding	The Mixed Failure Map (Tool 07)
Before acting on anyone	The Evidence Standard / Proof-File Builder (Tool 15)
To close the diagnosis	The Attribution Decision Protocol (Tool 17)

15 THE AUTHORITY MOVE

A pay structure that bends for everyone who pushes is not a structure. It is a negotiation surface. Re-establish the rule, govern the exception, and pay for the work rather than the willingness to argue about it.

16 SEEN IN THE FIELD

A CASE IN PRACTICE

A mid-sized firm was losing its best senior engineers while paying new, less-experienced hires 20% more. HR sourced wage compression but couldn't perform a tactical redirect. The diagnostic showed that any director could authorize a sign-on bonus to close a candidate, but annual raises for existing staff were capped at 3% (Compensation Failure). The firm was actively punishing loyalty. The CEO ran the Compensation Distortion Test, froze director-level pay authority, and initiated a \$200k internal equity true-up for the senior engineers.

◆ DEEP SYSTEM CARD • DEPTH 3
CARD 23

The Policy Exists but Practice Differs

1 LABEL IN USE: POLICY EXISTS BUT PRACTICE DIFFERS

Use this card when the handbook says one thing and the work says another. Test whether the policy can survive the actual workflow, time pressure, supervisor behavior, and technology the organization built around it.

2 WHAT THIS USUALLY GETS BLAMED ON

- People are taking shortcuts.
- We need to retrain everyone on the manual.
- Compliance isn't auditing hard enough.
- Staff are careless.

3 WHY THAT DIAGNOSIS MAY BE TOO THIN

Leadership treats the written policy as sacred and the workforce as rogue, which is the most flattering possible reading for the people who wrote the policy. That diagnosis is too thin because a widespread deviation is rarely a mass mutiny. It is an adaptation. The workforce has discovered that the written rule is impossible to follow under real time constraints, or that leadership actually rewards the speed of the shortcut more than the safety of the rule. The gap between policy and practice is a message. Read it before you retrain people on the thing they already know.

4 SYMPTOM PATTERN SCAN

Use this scan to decide whether the problem is isolated or patterned before you go further.

Question	Answer	What It May Indicate
Has this happened before?		Pattern issue
With more than one person?		System recurrence
Under the same supervisor?		Supervision issue
In the same role?		Role design / selection
During high workload?		Capacity issue
Does it vanish when one strong employee carries it?		Hidden dependency
Did leadership know before acting?		Tolerated failure
Did the organization benefit from the behavior?		Rewarded failure

5 INDIVIDUAL FAILURE SCAN

Mark only what the evidence supports.

Failure Type	Present?	Diagnostic Question
Judgment failure	Yes / No / Unknown	Do they make poor decisions even when trying?
Reliability failure	Yes / No / Unknown	Can the organization count on them consistently?
Conduct failure	Yes / No / Unknown	Did they breach behavioral, ethical, legal, safety, or professional standards?
Willingness failure	Yes / No / Unknown	Can they do it but choose not to?

6 SYSTEM FAILURE SCAN

Inspect the conditions that may be creating, hiding, protecting, or worsening the visible problem.

Failure Type	Present?	Diagnostic Question
Policy-to-Practice failure	Yes / No / Unknown	Is the written rule different from the working rule?
Expectation failure	Yes / No / Unknown	Was the standard clear before the person was judged against it?
Capacity failure	Yes / No / Unknown	Is the workload possible under normal operating conditions?
Reinforcement failure	Yes / No / Unknown	What behavior does the organization actually reward, tolerate, punish, or protect?
Supervision failure	Yes / No / Unknown	Did the supervisor clarify, coach, correct, document, and escalate properly?
Technology/Process failure	Yes / No / Unknown	Did software automate confusion instead of fixing workflow?
Leadership Decision failure	Yes / No / Unknown	Did leadership create the condition but blame the downstream employee?

7 MIXED FAILURE SCAN

Use this scan when the honest answer may be both person and system.

Mixed Failure Type	Present?	What It Means
System-Created Individual Failure	Yes / No / Unknown	The system produced the behavior it later condemned.
System-Tolerated Individual Failure	Yes / No / Unknown	The individual issue existed, but leadership allowed it to continue.
System-Rewarded Individual Failure	Yes / No / Unknown	The organization benefited from the behavior before calling it a problem.
Individual-Exploited System Failure	Yes / No / Unknown	The person used unclear standards or weak enforcement to avoid accountability.

8 EVIDENCE REQUIRED

Separate evidence from assumption before you act.

If the Finding Is...	Evidence Needed	If Missing...
Primarily individual	A few people deviate while the majority follow the workable rule	If almost everyone deviates, the rule, not the people, is the problem
Primarily system	The written rule cannot be executed in the available time or with the available tools	If the rule is workable and ignored anyway, examine reinforcement and supervision
Mixed	An unworkable rule met a culture that rewards the shortcut and tolerates the risk	You must rewrite the rule to be executable and re-establish enforcement

9 GUIDED DIAGNOSTIC PATH

Follow the sequence. Each answer narrows the diagnosis.

Can the policy actually be followed in the time the work allows? Have you timed it?

If yes → The math works. Proceed to test enforcement.

If no → The policy takes 10 minutes; the workflow allows 5. The rule is fiction.
Establishes Mathematical Capacity.

What does the organization reward when policy and speed collide?

If yes → It rewards safety and compliance, even if it slows down.

If no → It pays bonuses for speed and looks the other way on the shortcut. The deviation is rewarded.
Establishes Reinforcement.

How many people deviate, and is the deviation consistent enough to be the real process?

If yes → Only a few outliers. This is an individual conduct issue.

If no → Nearly everyone. The workaround is the actual company process.
Establishes Systemic Prevalence.

Did supervisors ever enforce the written rule, or did they quietly endorse the workaround?

If yes → Supervisors enforce it. The breakdown is at the frontline.

If no → Supervisors teach the workaround to new hires. The rule is dead.

Establishes Supervisory Tolerance.

Does the technology support the policy or fight it?

If yes → The tech makes compliance easy.

If no → The tech requires 14 clicks to follow the rule. People will always bypass it.

Establishes Technology/Process Alignment.

10 ATTRIBUTION FINDING

Force the sort. Mark one. Do not act as if you know more than the evidence proves.

- Primarily individual failure
- Primarily system failure
- Mixed failure (name the type below)
- Insufficient evidence to act as if you know

CORRECTED DIAGNOSTIC STATEMENT

Instead of: “This is a staff compliance problem.”

The better diagnosis: “This appears to be a policy-to-practice failure, involving a rule the work cannot accommodate, because the organization rewards the shortcut, never timed the policy against reality, and allowed the workaround to become the standard.”

11 REPAIR TARGET

Once the attribution is clear, identify where the fix belongs. Mixed failure may require two sequenced targets.

Target	Needed?	Likely Repair Move
Policy	Yes / No	Rewrite the rule so it is executable under real conditions, or fund the conditions it requires
Reinforcement	Yes / No	Stop rewarding the shortcut; align recognition with the rule you intend to keep
Supervision	Yes / No	Re-establish consistent enforcement once the rule is workable
Technology	Yes / No	Make the compliant path the easiest path

12 GUIDED REPAIR WALKTHROUGH

Follow the path from finding to repair. Each step names the move, the tool, and the proof that the step is done.

Step 1. If the rule is mathematically impossible...

Run The Capacity Reality Test (Tool 03). Rewrite the policy to fit the time, or slow the line down to fit the policy.

Step 2. If the workaround is universal...

Run The Policy-to-Practice Gap Test (Tool 08). Declare amnesty for the past, adopt the workaround if it is safe, or strictly enforce the rule if it is not.

Step 3. If the shortcut is rewarded...

Run The Reinforcement Audit (Tool 06). Tie bonuses to compliance gates, not just speed.

DESIGNED TO FAIL

Record the concrete plan. Name owners and dates, or the repair will not happen.

Action	Owner	Deadline	Evidence of Completion
Clarify the standard			
Align authority to accountability			
Correct the person-side issue			
Repair the system condition			
Document the follow-up			
Review under pressure			

13 PROOF UNDER PRESSURE

Test the repair against the real workday.

Pressure Test	Holds?	What Failed?
Understaffed day	Yes / No	
High workload	Yes / No	
Supervisor absent	Yes / No	
Leadership wants an exception	Yes / No	
Employee pushes back	Yes / No	
Customer pressure / overtime rises	Yes / No	
Documentation requested months later	Yes / No	

14 TOOL ROUTING

Carry the finding into the matching appendix tool.

If the Card Reveals...	Use This Tool
Policy-to-practice failure	The Policy-to-Practice Gap Test (Tool 08)
Reinforcement failure	The Reinforcement Audit (Tool 06)
Capacity failure	The Capacity Reality Test (Tool 03)
Supervision failure	The Supervision Strength Test (Tool 04)
Any mixed finding	The Mixed Failure Map (Tool 07)
Before acting on anyone	The Evidence Standard / Proof-File Builder (Tool 15)
To close the diagnosis	The Attribution Decision Protocol (Tool 17)

15 THE AUTHORITY MOVE

When the whole department breaks the same rule the same way, that is not indiscipline. That is the real process revealing itself. Fix the rule to fit the work, or fund the work to fit the rule, then enforce what remains.

16 SEEN IN THE FIELD

A CASE IN PRACTICE

A hospital cited nurses for failing to complete hourly rounding logs, with administration blaming 'careless frontline staff' and demanding write-ups. The diagnostic revealed that patient ratios made hourly rounding mathematically impossible (Capacity), and charge nurses actively taught new hires to batch the logs at the end of the shift to save time (Supervision).

◆ DEEP SYSTEM CARD • DEPTH 3
CARD 24

The Decision Cannot Survive Review

1 LABEL IN USE: DECISION CANNOT SURVIVE REVIEW

Use this card when the organization cannot defend a decision after the fact. Test whether the standard, authority, facts, consistency, rationale, and record were strong enough before action was taken.

2 WHAT THIS USUALLY GETS BLAMED ON

- The auditor doesn't understand our business.
- It's just a paperwork issue.
- We made the right call at the time.
- The reviewer is being difficult.

3 WHY THAT DIAGNOSIS MAY BE TOO THIN

The organization insists the logic was sound even though the file is empty, which is the exact reasoning that collapses under scrutiny. That diagnosis is too thin because in any regulated, audited, or litigated environment, if it is not in the file, it did not happen. When a decision cannot survive review, the failure is rarely the reviewer. It is a culture of informal authority operating without the discipline of proof. The decision may have been correct. Correct and defensible are not the same thing, and only one of them survives the room you are not in.

4 SYMPTOM PATTERN SCAN

Use this scan to decide whether the problem is isolated or patterned before you go further.

Question	Answer	What It May Indicate
Has this happened before?		Pattern issue
With more than one person?		System recurrence
Under the same supervisor?		Supervision issue
In the same role?		Role design / selection
During high workload?		Capacity issue
Does it vanish when one strong employee carries it?		Hidden dependency
Did leadership know before acting?		Tolerated failure
Did the organization benefit from the behavior?		Rewarded failure

5 INDIVIDUAL FAILURE SCAN

Mark only what the evidence supports.

Failure Type	Present?	Diagnostic Question
Judgment failure	Yes / No / Unknown	Do they make poor decisions even when trying?
Conduct failure	Yes / No / Unknown	Did they breach behavioral, ethical, legal, safety, or professional standards?
Reliability failure	Yes / No / Unknown	Can the organization count on them consistently?
Communication failure	Yes / No / Unknown	Do they fail to share, clarify, escalate, or receive information effectively?

6 SYSTEM FAILURE SCAN

Inspect the conditions that may be creating, hiding, protecting, or worsening the visible problem.

Failure Type	Present?	Diagnostic Question
Documentation failure	Yes / No / Unknown	Does the file show the standard, pattern, support, response, and reason for action?
Authority failure	Yes / No / Unknown	Does the person being blamed control the outcome?
Expectation failure	Yes / No / Unknown	Was the standard clear before the person was judged against it?
Supervision failure	Yes / No / Unknown	Did the supervisor clarify, coach, correct, document, and escalate properly?
Policy-to-Practice failure	Yes / No / Unknown	Is the written rule different from the working rule?
Leadership Decision failure	Yes / No / Unknown	Did leadership create the condition but blame the downstream employee?

7 MIXED FAILURE SCAN

Use this scan when the honest answer may be both person and system.

Mixed Failure Type	Present?	What It Means
System-Hidden Individual Failure	Yes / No / Unknown	Weak metrics, supervision, or documentation kept the issue invisible.
System-Tolerated Individual Failure	Yes / No / Unknown	The individual issue existed, but leadership allowed it to continue.
Individual-Revealed System Failure	Yes / No / Unknown	The person did not create the broken system, but exposed it.
System-Converted Individual Failure into Organizational Damage	Yes / No / Unknown	A person-side issue became broader damage because leadership mishandled the response.

8 EVIDENCE REQUIRED

Separate evidence from assumption before you act.

If the Finding Is...	Evidence Needed	If Missing...
Primarily individual	One decision-maker ignored a known, required documentation standard	If no standard existed, the failure belongs to the system that never set it
Primarily system	No required proof standard, no review discipline, no record of reasoning anywhere	If the standard existed and one person ignored it, address that conduct
Mixed	A weak proof culture met a decision-maker who relied on informal authority	You must build the proof standard and correct the individual reliance on memory

9 GUIDED DIAGNOSTIC PATH

Follow the sequence. Each answer narrows the diagnosis.

Does the file show the standard, the pattern, the support, the response, and the reason?

If yes → The file is complete. The reviewer may be wrong.

If no → The file is empty or subjective. You have an opinion, not a case.
Establishes Proof/Documentation.

Was there a required documentation standard, and was anyone responsible for verifying it?

If yes → The standard existed and was ignored. Address the individual.

If no → No standard was ever set. The organization failed to require proof.
Establishes Clarity of Expectation.

Who held the authority to make this decision, and is that authority documented?

If yes → Authority is clean and documented.

If no → Authority was assumed or informal. The decision was illegitimate.
Establishes Authority Alignment.

What was decided informally that was never written down?

If nothing material was left unwritten → The file may be sound.

DESIGNED TO FAIL

If the core business rationale lived only in memory → The decision is legally and operationally weak.

Establishes Systemic Tolerance of Informality.

Can the organization identify where this decision would break first if challenged externally?

If yes → It would hold up in court.

If no → It would collapse on the first document request.

Establishes Real Risk.

10 ATTRIBUTION FINDING

Force the sort. Mark one. Do not act as if you know more than the evidence proves.

- Primarily individual failure
- Primarily system failure
- Mixed failure (name the type below)
- Insufficient evidence to act as if you know

CORRECTED DIAGNOSTIC STATEMENT

Instead of: “This is a paperwork problem.”

The better diagnosis: “This appears to be a documentation and proof failure, involving decisions made on informal authority, because the organization never required, verified, or retained the evidence a neutral reviewer would need.”

11 REPAIR TARGET

Once the attribution is clear, identify where the fix belongs. Mixed failure may require two sequenced targets.

Target	Needed?	Likely Repair Move
Documentation	Yes / No	Establish and enforce a proof standard for consequential decisions
Authority	Yes / No	Document who may decide what, and require the record before action
Supervision	Yes / No	Make proof verification part of the manager's job, not an afterthought
Policy	Yes / No	Align the working decision process with the reviewable standard

12 GUIDED REPAIR WALKTHROUGH

Follow the path from finding to repair. Each step names the move, the tool, and the proof that the step is done.

Step 1. If the file is empty...

Run The Evidence Standard Builder (Tool 15). Halt the decision until the record can be reconstructed or newly established.

Step 2. If the standard was never set...

Run The Documentation Sufficiency Test (Tool 05). Write the explicit standard for what a defensible file looks like in this department.

Step 3. If authority was informal...

Run The Authority-to-Accountability Map (Tool 02). Formalize who has the right to make the call, and attach the documentation requirement to that right.

DESIGNED TO FAIL

Record the concrete plan. Name owners and dates, or the repair will not happen.

Action	Owner	Deadline	Evidence of Completion
Clarify the standard			
Align authority to accountability			
Correct the person-side issue			
Repair the system condition			
Document the follow-up			
Review under pressure			

13 PROOF UNDER PRESSURE

Test the repair against the real workday.

Pressure Test	Holds?	What Failed?
Understaffed day	Yes / No	
High workload	Yes / No	
Supervisor absent	Yes / No	
Leadership wants an exception	Yes / No	
Employee pushes back	Yes / No	
Customer pressure / overtime rises	Yes / No	
Documentation requested months later	Yes / No	

14 TOOL ROUTING

Carry the finding into the matching appendix tool.

If the Card Reveals...	Use This Tool
Documentation failure	The Documentation Sufficiency Test (Tool 05)
Proof failure	The Evidence Standard / Proof-File Builder (Tool 15)
Authority failure	The Authority-to-Accountability Map (Tool 02)
Leadership decision failure	The Leadership Decision Impact Review (Tool 09)
Any mixed finding	The Mixed Failure Map (Tool 07)
Before acting on anyone	The Evidence Standard / Proof-File Builder (Tool 15)
To close the diagnosis	The Attribution Decision Protocol (Tool 17)

15 THE AUTHORITY MOVE

Process is not proof. A decision that lives only in someone's memory and good intentions is a decision the organization cannot defend. Build the file before you need it, because by the time you need it, it is already too late to build.

16 SEEN IN THE FIELD

A CASE IN PRACTICE

A director fired a vendor for 'poor service,' but the vendor sued for breach of contract. Leadership called it a frivolous lawsuit and blamed the vendor's lawyers. The diagnostic revealed that while the vendor was indeed terrible, the director had never sent a single written notice of defect (Documentation Failure). The file was empty and the organization had to settle the lawsuit for \$100,000.

◆ DEEP SYSTEM CARD • DEPTH 3
CARD 25

Turnover Repeats in the Same Role

1 LABEL IN USE: TURNOVER REPEATS IN THE SAME ROLE

Use this card when the same seat keeps losing people. Test whether the role, supervisor, workload, selection process, authority, and onboarding are producing the exit before replacing the person again.

2 WHAT THIS USUALLY GETS BLAMED ON

- We've had a run of bad luck.
- The talent pool is weak right now.
- That manager is hard to work for.
- We keep picking the wrong people.

3 WHY THAT DIAGNOSIS MAY BE TOO THIN

The organization tells itself it simply rolled the dice poorly three times, which conveniently keeps the dice, the table, and the house out of the conversation. That diagnosis is too thin because repeated failure in a single node is a structural alarm, not a hiring coincidence. When several capable people with different backgrounds fail in the exact same chair, the problem is the chair. The role is mathematically impossible, starved of authority, structurally positioned to absorb other departments' failures, or supervised by someone the organization refuses to examine.

4 SYMPTOM PATTERN SCAN

Use this scan to decide whether the problem is isolated or patterned before you go further.

Question	Answer	What It May Indicate
Has this happened before?		Pattern issue
With more than one person?		System recurrence
Under the same supervisor?		Supervision issue
In the same role?		Role design / selection
During high workload?		Capacity issue
Does it vanish when one strong employee carries it?		Hidden dependency
Did leadership know before acting?		Tolerated failure
Did the organization benefit from the behavior?		Rewarded failure

5 INDIVIDUAL FAILURE SCAN

Mark only what the evidence supports.

Failure Type	Present?	Diagnostic Question
Capability failure	Yes / No / Unknown	Can the person perform the actual work at the required level?
Fit failure	Yes / No / Unknown	Is the role asking for a version of the person they do not reliably become?
Reliability failure	Yes / No / Unknown	Can the organization count on them consistently?
Adaptability failure	Yes / No / Unknown	Can they adjust when work, expectations, tools, or priorities change?

6 SYSTEM FAILURE SCAN

Inspect the conditions that may be creating, hiding, protecting, or worsening the visible problem.

Failure Type	Present?	Diagnostic Question
Role Design failure	Yes / No / Unknown	Is the job built in a way a real person can perform?
Authority failure	Yes / No / Unknown	Does the person being blamed control the outcome?
Capacity failure	Yes / No / Unknown	Is the workload possible under normal operating conditions?
Selection failure	Yes / No / Unknown	Did the hiring process test for the actual role?
Onboarding failure	Yes / No / Unknown	Did the organization convert the hire into a functioning employee?
Supervision failure	Yes / No / Unknown	Did the supervisor clarify, coach, correct, document, and escalate properly?
Workflow failure	Yes / No / Unknown	Does the work move cleanly from person to person or department to department?
Leadership Decision failure	Yes / No / Unknown	Did leadership create the condition but blame the downstream employee?

7 MIXED FAILURE SCAN

Use this scan when the honest answer may be both person and system.

Mixed Failure Type	Present?	What It Means
System-Created Individual Failure	Yes / No / Unknown	The system produced the behavior it later condemned.
System-Hidden Individual Failure	Yes / No / Unknown	Weak metrics, supervision, or documentation kept the issue invisible.
Individual-Revealed System Failure	Yes / No / Unknown	The person did not create the broken system, but exposed it.
System-Tolerated Individual Failure	Yes / No / Unknown	The individual issue existed, but leadership allowed it to continue.

8 EVIDENCE REQUIRED

Separate evidence from assumption before you act.

If the Finding Is...	Evidence Needed	If Missing...
Primarily individual	Each hire failed for a genuinely different, person-specific reason after a fair, supported tenure	If they failed the same way, the role produced the failure, not the people
Primarily system	Different people fail in the same way in the same seat regardless of background	If only one of several succeeded, study what protected that one
Mixed	A flawed role under a weak supervisor selected through a flawed process	You must redesign the role, fix selection, and examine the supervisor together

9 GUIDED DIAGNOSTIC PATH

Follow the sequence. Each answer narrows the diagnosis.

Do the exits share a common failure mode?

If yes → They failed differently. This may actually be bad luck or bad selection.

If no → They all burned out or missed the same target. The role is producing the failure.

Establishes Pattern Integrity.

Is the role mathematically possible at the funded headcount and hours?

If yes → The math works. Proceed to test authority and handoffs.

If no → The role requires 60 hours and pays for 40. Turnover is guaranteed.

Establishes Capacity.

Does the role carry accountability without the matching authority?

If yes → Authority matches accountability.

If no → They are blamed for outcomes they cannot control. They leave in frustration.

Establishes Authority Alignment.

Does the selection process test for the real role or a sanitized version of it?

If yes → Selection is rigorous and realistic.

If no → You are selling a strategy job and delivering an admin job. They quit when they find out.

Establishes Selection Honesty.

Does the same supervisor sit above every failed tenure?

If turnover spans multiple managers → Inspect role design, workload, pay, onboarding, and career path.

If turnover sits under the same supervisor → The common denominator is the boss, not the chair.

Establishes Supervision Quality.

10 ATTRIBUTION FINDING

Force the sort. Mark one. Do not act as if you know more than the evidence proves.

- Primarily individual failure
- Primarily system failure
- Mixed failure (name the type below)
- Insufficient evidence to act as if you know

CORRECTED DIAGNOSTIC STATEMENT

Instead of: “This is a recruiting and bad-luck problem.”

The better diagnosis: “This appears to be a role-design failure, involving accountability without authority at an impossible capacity, because multiple capable people failed the same way in the same seat under the same conditions.”

11 REPAIR TARGET

Once the attribution is clear, identify where the fix belongs. Mixed failure may require two sequenced targets.

Target	Needed?	Likely Repair Move
Role	Yes / No	Rebuild the role to be possible, with matched authority and realistic capacity
Supervisor	Yes / No	Examine and, if needed, repair the supervision above the role
Selection	Yes / No	Redesign selection to test the real demands of the seat
Authority	Yes / No	Align decision rights with the accountability the role carries

12 GUIDED REPAIR WALKTHROUGH

Follow the path from finding to repair. Each step names the move, the tool, and the proof that the step is done.

Step 1. If the role is overloaded...

Run The Role Reality Test (Tool 01). Strip away the accumulated informal duties and right-size the scope before hiring again.

Step 2. If the supervisor is the common denominator...

Run The Supervision Strength Test (Tool 04). Intervene with the manager; do not sacrifice another hire to them.

Step 3. If the interview is selling a lie...

Run The Selection Integrity Test (Tool 10). Rewrite the job description to reflect the unvarnished reality of the daily work.

DESIGNED TO FAIL

Record the concrete plan. Name owners and dates, or the repair will not happen.

Action	Owner	Deadline	Evidence of Completion
Clarify the standard			
Align authority to accountability			
Correct the person-side issue			
Repair the system condition			
Document the follow-up			
Review under pressure			

13 PROOF UNDER PRESSURE

Test the repair against the real workday.

Pressure Test	Holds?	What Failed?
Understaffed day	Yes / No	
High workload	Yes / No	
Supervisor absent	Yes / No	
Leadership wants an exception	Yes / No	
Employee pushes back	Yes / No	
Customer pressure / overtime rises	Yes / No	
Documentation requested months later	Yes / No	

14 TOOL ROUTING

Carry the finding into the matching appendix tool.

If the Card Reveals...	Use This Tool
Role design failure	The Role Reality Test (Tool 01)
Authority failure	The Authority-to-Accountability Map (Tool 02)
Selection failure	The Selection Integrity Test (Tool 10)
Supervision failure	The Supervision Strength Test (Tool 04)
Any mixed finding	The Mixed Failure Map (Tool 07)
Before acting on anyone	The Evidence Standard / Proof-File Builder (Tool 15)
To close the diagnosis	The Attribution Decision Protocol (Tool 17)

15 THE AUTHORITY MOVE

If one person fails in a chair, study the person. If three people fail in the same chair, study the chair. The organization that keeps re-hiring for a broken role is not unlucky. It is avoiding the redesign the role has been demanding all along.

16 SEEN IN THE FIELD

A CASE IN PRACTICE

A nonprofit hired three Directors of Development in two years; all quit. The board blamed the 'flaky talent pool.' The diagnostic showed that while the Director was accountable for raising \$2M, the board refused to share their donor contacts (Authority) and the Director had to do their own data entry (Capacity). The role was a setup. The board paused hiring, hired an admin to handle the data, and formally committed to opening their networks. The fourth hire stayed for longer than two years.

DESIGNED TO FAIL

PART THREE

THE APPENDIX TOOL SYSTEM

*Scored Field Instruments for Moving From Diagnosis
to Repair*

Layer Three: The Appendix Tool System

These tools move an organization from diagnosis to intervention. A tool used correctly produces a scored profile, a defensible finding, a named owner, a selected repair, and evidence that the repair reached the work. A tool used incorrectly produces a conversation that ends without a decision.

Each tool is scored. Rate every dimension from 0 to 3 against the two-sided evidence, record the evidence source, total the score, and read it against the interpretation bands. The Decision Rule converts the number into an action, including the override where a single critical zero vetoes an otherwise passing total. The tools are built to chain: each one names what it feeds and what feeds it, so the system works as a connected whole.

HOW TO USE EVERY TOOL

Gather the required inputs before the session; answers built from memory produce opinion, not diagnosis. Bring the people who connect HR, finance, operations, leadership, and the work. Score each dimension honestly using the evidence columns. Total the score, read the band, and apply the Decision Rule. Then sequence the repair across 30, 60, and 90 days, name owners, and follow the chain to the next tool. A blank field is not neutral. A blank field is itself a finding.

TOOL 01

The Role Reality Test

REPAIR TARGET **Role Design Failure**

• **PURPOSE**

Determine whether a job is built so that a competent, normally-resourced person can actually perform it. Separates a person who is failing from a role that produces failure.

• **WHEN TO USE**

Use when turnover repeats in the same role, when several people miss the same standard, when accountability appears to exceed authority, or whenever a card returns a Role Design finding.

• **WHAT YOU WILL PRODUCE**

A scored reality profile of the role, exposing specific design gaps (capacity, authority, workflow) and a decision on whether to redesign before replacing.

• **REQUIRED INPUTS**

-
- The current job description
 - Real workload and volume data for the role
 - A map of every handoff into and out of the role
 - The funded hours and headcount versus the actual demand

• **THE SCORED INSTRUMENT**

Score each dimension from 0 (Failing) to 3 (Strong) using the evidence columns. A score without an evidence source is not a finding; record the source before interpreting the total.

Dimension & Question	Strong (3)	At Risk (1-2)	Failing (0)	Score
Clarity of Scope <i>Is the full scope written down, or has it accreted informally?</i>	Scope is explicit, bounded, and matches the daily work.	Scope is mostly known but includes informal duties.	Scope is vague; the role absorbs whatever falls to it.	
Mathematical Capacity <i>Can the role's required work be completed within its funded hours?</i>	Required work fits comfortably within funded hours.	Work fits only if everything goes perfectly; no slack.	Required work mathematically exceeds funded hours.	
Authority Alignment <i>Does the role hold the authority needed to deliver what it is accountable for?</i>	Decision rights match accountability exactly.	Authority exists but is slow or contested.	Held accountable for outcomes they cannot control.	
Handoff Independence <i>Does the role depend on handoffs it cannot control?</i>	Inputs arrive cleanly and on time.	Inputs are often late or flawed, requiring some rework.	Role chronically absorbs and fixes other departments' failures.	
Historical Viability <i>Has more than one capable person succeeded in this role recently?</i>	Multiple people have succeeded without heroic effort.	Only one exceptional person has succeeded.	Multiple capable people have failed the same way.	

Total Score: _____ / 15

Evidence Source Summary:

DESIGNED TO FAIL

• **INTERPRETATION BANDS**

Score	State	What It Means
12–15	Sound	The role is viable. A failure here is more likely individual.
8–11	Strained	The role requires partial redesign (usually authority or handoffs) to be sustainable.
0–7	Impossible	The role is broken by design. Do not discipline the person; redesign the seat.

THE DECISION RULE

If Mathematical Capacity scores 0, the role is impossible regardless of the total score. Do not replace the person until the math is fixed.

→ **Redesign capacity first.**

• **REPAIR SEQUENCING • 30 / 60 / 90**

Typical first moves are seeded below. Assign owners and dates.

Repair Move (seeded)	Owner	30 Days	60/90 Days
Immediate correction: Stop disciplining for outcomes the role cannot control.			
Structural redesign: Realign authority or reduce scope to fit capacity.			
Proof verification: Document the new boundaries and train the adjacent teams.			

• **HOW THIS TOOL CHAINS**

FEEDS INTO: The Capacity Reality Test (Tool 03) if capacity scores 0 ·
The Authority-to-Accountability Map (Tool 02) if authority scores 0
FED BY: Any Deep System Card · Turnover Repeats in the Same Role
(Card 25)

• **THE STANDARD**

A role is not a list of hopes. It is a contract a real person must be able to honor. If the role cannot be performed as designed, redesign it before you replace anyone in it.

TOOL 02

The Authority-to-Accountability Map

REPAIR TARGET **Authority Failure**

• **PURPOSE**

Map whether the person held accountable actually controls the people, resources, and decisions required to succeed. Exposes the most common hidden injustice in organizations: responsibility without authority.

• **WHEN TO USE**

Use when a manager is blamed for team outcomes they cannot enforce, when a frontline employee is blamed for a delay another function controls, or whenever a card returns an Authority finding.

• **WHAT YOU WILL PRODUCE**

An authority gap analysis showing exactly where accountability exceeds control, and a mandate to either grant the power or remove the responsibility.

• **REQUIRED INPUTS**

- The accountability statement for the role
- The actual decision rights the role holds
- The approval and escalation matrix
- A recent failure the person is being blamed for

• **THE SCORED INSTRUMENT**

Score each dimension from 0 (Failing) to 3 (Strong) using the evidence columns. A score without an evidence source is not a finding; record the source before interpreting the total.

Dimension & Question	Strong (3)	At Risk (1-2)	Failing (0)	Score
Resource Control <i>Do they control the budget, tools, and time the outcome requires?</i>	Full control over necessary resources.	Must request resources with unpredictable success.	Zero control; dependent on others' budgets.	
People Control <i>Can they direct or correct the people whose work they depend on?</i>	Direct authority to assign and correct.	Influence only; must persuade peers.	No authority; cannot even escalate effectively.	
Decision Speed <i>Which decisions required to deliver can they make alone?</i>	Can make all operational decisions locally.	Must escalate major decisions; moderate delay.	Must escalate almost everything; chronic delay.	
Backing <i>When they make a hard call, does the organization back them?</i>	Leadership consistently supports their calls.	Backing is inconsistent or politically dependent.	Decisions are routinely reversed upon complaint.	
Consequence Control <i>Can they enforce consequences for failure?</i>	Full authority to document and discipline.	Can document, but HR/leadership stalls action.	Cannot enforce any standard.	

Total Score: _____ / 15

Evidence Source Summary:

DESIGNED TO FAIL

• INTERPRETATION BANDS

Score	State	What It Means
12–15	Aligned	Authority matches accountability. Failure is likely individual.
8–11	Misaligned	The person must rely too heavily on influence and escalation. Grant more local control.
0–7	Setup	Accountability vastly exceeds authority. The person is a scapegoat, not an owner.

THE DECISION RULE

If Backing scores 0, the organization has taught the system to bypass this person. No amount of formal authority will work until leadership stops reversing their decisions.

→ **Restore backing before demanding accountability.**

• REPAIR SEQUENCING • 30 / 60 / 90

Typical first moves are seeded below. Assign owners and dates.

Repair Move (seeded)	Owner	30 Days	60/90 Days
Immediate correction: Halt discipline for outcomes outside the person's control.			
Structural redesign: Rewrite the approval matrix to push decisions down to the accountable role.			
Proof verification: Document the new decision rights and communicate them to the team.			

• **HOW THIS TOOL CHAINS**

FEEDS INTO: The Supervision Strength Test (Tool 04) to ensure they know how to use the new authority · The Leadership Decision Impact Review (Tool 09) if the VP refuses to delegate

FED BY: The Weak Manager (Card 03) · The Role Reality Test (Tool 01)

• **THE STANDARD**

Accountability without authority is not a job. It is a setup. Before you hold someone responsible for an outcome, confirm they were ever given the power to produce it.

TOOL 03

The Capacity Reality Test

REPAIR TARGET Capacity Failure

• **PURPOSE**

Separate a time-management problem from a mathematical impossibility. Converts 'they can't keep up' into a number the organization can no longer ignore.

• **WHEN TO USE**

Use when a team chronically misses deadlines, when burnout is rising, when new work is added without removing old work, or whenever a card returns a Capacity finding.

• **WHAT YOU WILL PRODUCE**

A mathematical proof of the gap between required work and funded hours, forcing a decision to fund, cut, or automate.

• **REQUIRED INPUTS**

- A realistic time estimate for each recurring task
- The volume of each task per period
- Funded hours and headcount
- A record of work added in the last 12 months

• **THE SCORED INSTRUMENT**

Score each dimension from 0 (Failing) to 3 (Strong) using the evidence columns. A score without an evidence source is not a finding; record the source before interpreting the total.

Dimension & Question	Strong (3)	At Risk (1-2)	Failing (0)	Score
Core Workload <i>How many hours does the role's required work actually take?</i>	Takes <80% of funded time, leaving slack.	Takes 90-100% of funded time; tight but doable.	Takes >100% of funded time; mathematically impossible.	
Volume Stability <i>Is the volume predictable or highly volatile?</i>	Stable and predictable.	Occasional spikes that require brief overtime.	Wildly volatile; impossible to staff efficiently.	
Addition vs. Subtraction <i>What work was added recently, and what was removed?</i>	Additions are matched by subtractions or funding.	Additions happen, subtractions are rare.	Constant additions; nothing is ever removed.	
Friction / Rework <i>How much time is lost to broken tools or bad handoffs?</i>	Minimal friction; tools work.	Noticeable friction; moderate time lost.	High friction; rework consumes hours daily.	
Distribution <i>Is the overload affecting everyone, or just one person?</i>	Everyone is at a sustainable pace.	A few top performers carry most of the load.	Everyone is overloaded and failing.	

Total Score: _____ / 15

Evidence Source Summary:

DESIGNED TO FAIL

• **INTERPRETATION BANDS**

Score	State	What It Means
12–15	Sustainable	Capacity is sufficient. Misses are likely individual time-management issues.
8–11	Strained	The system runs hot. A single absence or spike will cause failure. Add slack.
0–7	Impossible	The math is broken. Burnout and failure are guaranteed by design.

THE DECISION RULE

If Core Workload scores 0, the role is mathematically impossible. No amount of resilience, self-care, or time-management coaching will close a math gap.

→ **Fund the hours or cut the scope immediately.**

• **REPAIR SEQUENCING • 30 / 60 / 90**

Typical first moves are seeded below. Assign owners and dates.

Repair Move (seeded)	Owner	30 Days	60/90 Days
Immediate correction: Stop the lowest-value tasks immediately to create breathing room.			
Structural redesign: Re-baseline the headcount model against actual timed volume.			
Proof verification: Track overtime and rework hours to prove the new baseline holds.			

• **HOW THIS TOOL CHAINS**

FEEDS INTO: The Workflow Handoff Map (Tool 13) if friction is high · The Reinforcement Audit (Tool 06) if top performers are carrying the load
FED BY: Burnout and Overload (Card 10) · Missed Deadlines (Card 12)

• **THE STANDARD**

When required hours exceed funded hours, the conversation is over. The role is impossible, and resilience language is just the anesthetic. Fix the math before you coach the person.

TOOL 04

The Supervision Strength Test

REPAIR TARGET **Supervision Failure**

• **PURPOSE**

Audit whether a manager is actually managing the work or merely narrating its failure after the fact. Tests the supervisory chain that should have caught the problem early.

• **WHEN TO USE**

Use when an employee fails and the manager says 'they should have known,' when a termination is requested with no record of coaching, or whenever a card returns a Supervision finding.

• **WHAT YOU WILL PRODUCE**

A profile of the manager's actual intervention rhythm, revealing whether they manage performance or avoid conflict.

• **REQUIRED INPUTS**

- Performance review and feedback history
- One-on-one meeting cadence and notes
- The escalation and correction record
- The dates the standard was communicated

• **THE SCORED INSTRUMENT**

Score each dimension from 0 (Failing) to 3 (Strong) using the evidence columns. A score without an evidence source is not a finding; record the source before interpreting the total.

Dimension & Question	Strong (3)	At Risk (1-2)	Failing (0)	Score
Standard Setting <i>Did the supervisor communicate the standard clearly and early?</i>	Standard was explicit, written, and confirmed early.	Standard was verbal or vague.	Standard was assumed; 'they should have known.'	
Coaching Cadence <i>Is there a real cadence of coaching, or only annual reviews?</i>	Weekly/bi-weekly 1-on-1s focused on the work.	Irregular meetings, mostly status updates.	No regular meetings; feedback only at annual review.	
Early Correction <i>Was drift corrected when it first appeared?</i>	Addressed immediately when the pattern started.	Addressed only after several months of frustration.	Ignored until it became a crisis or PIP.	
Documentation <i>Did the supervisor document the support and response?</i>	Clear, contemporaneous notes of all corrections.	Vague notes ('discussed performance').	No documentation; an empty file.	
Escalation <i>Did the supervisor escalate appropriately?</i>	Escalated to HR/leadership at the right time with proof.	Escalated late, demanding immediate firing.	Never escalated; hid the problem.	

Total Score: _____ / 15

Evidence Source Summary:

DESIGNED TO FAIL

• INTERPRETATION BANDS

Score	State	What It Means
12–15	Active	Supervision is sound. The manager did their job; the failure belongs to the employee.
8–11	Reactive	The manager manages after the fact. Train them on early intervention and documentation.
0–7	Absent	The manager is avoiding the work of management. Do not fire the employee yet; manage the manager.

THE DECISION RULE

If Early Correction scores 0, the manager allowed the behavior to normalize. You cannot fire an employee for a pattern the manager watched and tolerated for six months.

→ **Correct the manager's avoidance first.**

• REPAIR SEQUENCING • 30 / 60 / 90

Typical first moves are seeded below. Assign owners and dates.

Repair Move (seeded)	Owner	30 Days	60/90 Days
Immediate correction: Require the manager to set the explicit standard with the employee today.			
Structural redesign: Install a mandatory, documented 1-on-1 cadence for this manager.			
Proof verification: HR reviews the manager's coaching notes weekly for 60 days.			

• **HOW THIS TOOL CHAINS**

FEEDS INTO: The Documentation Sufficiency Test (Tool 05) if the file is empty · The Authority-to-Accountability Map (Tool 02) if the manager lacks authority to correct

FED BY: The Weak Manager (Card 03) · Poor Performance (Card 02)

• **THE STANDARD**

Supervision is not the act of noticing failure after it arrives. It is the work of preventing it before it does. A manager who only narrates the collapse was never actually managing the work.

TOOL 05

The Documentation Sufficiency Test

REPAIR TARGET **Documentation / Proof Failure**

• **PURPOSE**

Determine whether a file can survive external, legal, or audit review. Tests whether the record proves what the organization believes it knows.

• **WHEN TO USE**

Use before any termination, before placing someone on a PIP, when HR inherits a thin file, or whenever a card returns a Documentation finding.

• **WHAT YOU WILL PRODUCE**

A defensibility score for the file, and a precise list of what must be built before action can be taken.

• **REQUIRED INPUTS**

-
- The complete employee or decision file
 - The applicable written standard or policy
 - The manager's account of the timeline
 - Any prior warnings, plans, or correspondence

• **THE SCORED INSTRUMENT**

Score each dimension from 0 (Failing) to 3 (Strong) using the evidence columns. A score without an evidence source is not a finding; record the source before interpreting the total.

Dimension & Question	Strong (3)	At Risk (1-2)	Failing (0)	Score
The Standard <i>Does the file show the explicit standard that applied?</i>	Standard is written, dated, and acknowledged.	Standard is referenced but not explicitly defined.	No written standard exists in the record.	
The Pattern <i>Does it show a pattern with dates, not a single moment?</i>	Multiple dated instances establishing a clear trend.	Two instances, or vague 'always does this' notes.	A single incident, or no dates at all.	
The Support <i>Does it show the support and correction provided?</i>	Clear record of coaching, tools, or training offered.	Vague mention of 'we talked about this.'	No record of any help or correction provided.	
The Response <i>Does it show the person's response to that correction?</i>	Documents whether the person improved, stalled, or refused.	Notes the person's reaction but not the follow-through.	No record of what happened after the warning.	
The Reason <i>Does it show the business reason for the action?</i>	Clear, objective impact on the business or team.	Subjective impact ('frustrates me').	No business reason stated.	

Total Score: _____ / 15

Evidence Source Summary:

• **INTERPRETATION BANDS**

Score	State	What It Means
12–15	Defensible	The file is complete. The action will survive review. Proceed.
8–11	Vulnerable	The file relies too heavily on manager memory. Document the missing pieces before final action.
0–7	Indefensible	The file is empty or entirely subjective. Do not act. You have an opinion, not a case.

THE DECISION RULE

If The Standard scores 0, you cannot prove what the person was supposed to do. A reviewer will conclude the target was moving.

→ **Establish and date the standard before beginning any discipline.**

• **REPAIR SEQUENCING • 30 / 60 / 90**

Typical first moves are seeded below. Assign owners and dates.

Repair Move (seeded)	Owner	30 Days	60/90 Days
Immediate correction: Halt the adverse action until the file is built.			
Structural redesign: Issue the explicit standard in writing today and require acknowledgment.			
Proof verification: Manager must document the next three infractions contemporaneously.			

• **HOW THIS TOOL CHAINS**

FEEDS INTO: The Evidence Standard Builder (Tool 15) to construct the file · The Supervision Strength Test (Tool 04) to fix the manager

FED BY: The Documentation Failure (Card 06) · The Policy Violation (Card 09)

• **THE STANDARD**

Process is not proof. If the file cannot reconstruct the standard, the pattern, the support, the response, and the reason, the organization does not yet have the right to act, regardless of how certain it feels.

TOOL 06

The Reinforcement Audit

REPAIR TARGET Reinforcement Failure

• **PURPOSE**

Map what the organization actually rewards, tolerates, punishes, and protects, as opposed to what it claims to value. Exposes the real operating incentives behind behavior.

• **WHEN TO USE**

Use when a policy is widely ignored, when a toxic high performer is protected, when good people leave, or whenever a card returns a Reinforcement finding.

• **WHAT YOU WILL PRODUCE**

A map of the shadow incentive system, forcing leadership to see what they are actually paying people to do.

• **REQUIRED INPUTS**

-
- Promotion and recognition history
 - Bonus and incentive criteria
 - A list of known workarounds and who uses them
 - Examples of behavior that was punished vs. protected

• **THE SCORED INSTRUMENT**

Score each dimension from 0 (Failing) to 3 (Strong) using the evidence columns. A score without an evidence source is not a finding; record the source before interpreting the total.

Dimension & Question	Strong (3)	At Risk (1–2)	Failing (0)	Score
Reward Alignment <i>Does the reward system match the stated values?</i>	Rewards perfectly align with stated values and rules.	Rewards mostly align, but occasionally favor speed over rules.	Rewards actively pay for outcomes regardless of how they are achieved.	
Tolerance <i>What behavior is tolerated despite violating the standard?</i>	Violations are addressed quickly and evenly.	Minor violations are ignored if the person is liked.	Major violations are ignored if the person hits their numbers.	
Protection <i>Who is protected from consequences, and why?</i>	No one is above the standard.	Tenured staff get a pass on behavior others would be fired for.	High producers are actively protected from HR/discipline.	
Burden Shifting <i>Are good people punished with the work of underperformers?</i>	Work is distributed fairly; underperformers are managed.	Good people occasionally cover for gaps.	Top performers carry the department while underperformers are ignored.	
Clarity of Consequence <i>What does a rational employee learn to do to get ahead here?</i>	They learn to follow the rules and perform well.	They learn to navigate the politics.	They learn to break the rules, hit the number, and demand protection.	

Total Score: _____ / 15

Evidence Source Summary:

DESIGNED TO FAIL

• INTERPRETATION BANDS

Score	State	What It Means
12–15	Aligned	Incentives match values. Behavior problems are likely individual.
8–11	Drifting	The organization is starting to tolerate workarounds. Tighten enforcement.
0–7	Corrupted	The organization actively rewards the behavior it claims to hate. Fix the incentives, not the employees.

THE DECISION RULE

If Protection scores 0, the organization has a caste system. You cannot discipline a frontline employee for a rule a 'rockstar' is allowed to break.

→ **Remove the protection before enforcing the rule.**

• REPAIR SEQUENCING • 30 / 60 / 90

Typical first moves are seeded below. Assign owners and dates.

Repair Move (seeded)	Owner	30 Days	60/90 Days
Immediate correction: Stop praising or paying bonuses for outcomes achieved via protected workarounds.			
Structural redesign: Rewrite bonus criteria to include conduct and compliance gates.			
Proof verification: Audit the next promotion cycle to ensure no protected violators advance.			

• **HOW THIS TOOL CHAINS**

FEEDS INTO: The Compensation Distortion Test (Tool 14) if pay is driving the behavior · The Policy-to-Practice Gap Test (Tool 08) if workarounds are universal

FED BY: The Disengaged High Performer (Card 15) · The Policy Violation (Card 09)

• **THE STANDARD**

An organization is not what it says it values. It is what it rewards, tolerates, and protects. People read the real incentives perfectly, even when leadership refuses to.

TOOL 07

The Mixed Failure Map

REPAIR TARGET **Mixed Failure**

• **PURPOSE**

Separate precisely what the person owns from what the system designed, tolerated, or rewarded. The authority instrument of the entire book, used when the answer is honestly 'both.'

• **WHEN TO USE**

Use whenever a card returns a Mixed finding, when leadership wants a single villain, or when two repairs are clearly required instead of one.

• **WHAT YOU WILL PRODUCE**

A dual-repair sequence that holds both the individual and the system accountable, preventing the organization from scapegoating.

• **REQUIRED INPUTS**

-
- The completed diagnostic card
 - The person's account of what they controlled
 - The manager's timeline
 - Evidence of system contribution, tolerance, or delay

• **THE SCORED INSTRUMENT**

Score each dimension from 0 (Failing) to 3 (Strong) using the evidence columns. A score without an evidence source is not a finding; record the source before interpreting the total.

Dimension & Question	Strong (3)	At Risk (1–2)	Failing (0)	Score
System Contribution <i>Did the system make the wrong behavior easier or safer?</i>	System actively fought the wrong behavior.	System was neutral or vague.	System actively incentivized or required the wrong behavior.	
System Tolerance <i>Did the system watch the failure and allow it to continue?</i>	System corrected it immediately.	System waited a few weeks before acting.	System tolerated it for months until it became a crisis.	
Individual Control <i>What did the person genuinely control and still get wrong?</i>	Person controlled nothing; purely a victim of design.	Person controlled some choices but was heavily constrained.	Person had full control, clear choices, and chose poorly.	
Individual Exploitation <i>Did the person exploit the system's weakness?</i>	Person tried to do the right thing despite the system.	Person passively accepted the weak system.	Person actively used the weak system to hide or avoid work.	
Proportionality <i>Who owns the majority of the failure?</i>	System drove the failure; person was merely the vehicle.	Shared failure; system enabled it, person chose it.	Person drove the failure; system was mostly a bystander.	

Total Score: _____ / 15

Evidence Source Summary:

DESIGNED TO FAIL

• INTERPRETATION BANDS

Score	State	What It Means
12–15	Individual Heavy	The system is mostly clean. The person exploited or ignored it. Focus repair on the person.
8–11	Truly Mixed	Both contributed heavily. You must sequence two repairs. Usually, fix the system condition first, then hold the person to the new standard.
0–7	System Heavy	The system created or demanded the failure. The person is a symptom. Focus repair entirely on the design.

THE DECISION RULE

If System Tolerance scores 0, the organization forfeited the right to sudden, severe discipline. You cannot fire someone today for something you watched them do all year.

→ **Reset the standard and start a clean clock.**

• REPAIR SEQUENCING • 30 / 60 / 90

Typical first moves are seeded below. Assign owners and dates.

Repair Move (seeded)	Owner	30 Days	60/90 Days
Immediate correction: Acknowledge the system's role to the employee; reset the standard.			
Structural redesign: Fix the workflow, capacity, or incentive that drove the behavior.			
Proof verification: Hold the employee strictly accountable to the newly repaired, fair system.			

• **HOW THIS TOOL CHAINS**

FEEDS INTO: The Reinforcement Audit (Tool 06) if the system rewarded it · The Evidence Standard Builder (Tool 15) to document the reset

FED BY: Any Card returning a Mixed finding

• **THE STANDARD**

Mixed failure denies everyone the comfort of a single villain. The person owns what they controlled. The organization owns what it designed, tolerated, underfunded, or failed to support. Name both.

TOOL 08

The Policy-to-Practice Gap Test

REPAIR TARGET Policy-to-Practice Failure

• **PURPOSE**

Measure the distance between the written rule and the working rule, and decide which one should change. Reads widespread deviation as data, not as mass indiscipline.

• **WHEN TO USE**

Use when compliance fails, when an audit finds a discrepancy, when an employee is disciplined for doing what everyone does, or whenever a card returns a Policy-to-Practice finding.

• **WHAT YOU WILL PRODUCE**

A decision to either rewrite the rule to fit the work, fund the work to fit the rule, or enforce the rule and accept the slowdown.

• **REQUIRED INPUTS**

- The written policy
- A direct observation of the actual workflow
- Interviews with the frontline staff who do the work
- A timing of the policy against real conditions

• **THE SCORED INSTRUMENT**

Score each dimension from 0 (Failing) to 3 (Strong) using the evidence columns. A score without an evidence source is not a finding; record the source before interpreting the total.

Dimension & Question	Strong (3)	At Risk (1-2)	Failing (0)	Score
Executability <i>Can the written policy be completed in the time the work allows?</i>	Easily completed within normal workflow.	Takes extra effort but is possible.	Mathematically impossible under current volume/time constraints.	
Prevalence <i>How many people deviate, and how consistently?</i>	Only one or two outliers.	About half the team, intermittently.	Nearly 100% of the team; the workaround is the real process.	
Supervisory Endorsement <i>Did supervisors endorse or ignore the workaround?</i>	Supervisors strictly enforce the written rule.	Supervisors look the other way.	Supervisors actively teach the workaround to new hires.	
Outcome Reward <i>Does the organization reward the deviation's result?</i>	Organization punishes the deviation regardless of result.	Organization is happy as long as nothing breaks.	Organization pays bonuses based on the speed the workaround provides.	
Risk Profile <i>What is the actual risk of the workaround?</i>	High safety/legal risk; must be stopped.	Moderate risk; quality suffers slightly.	Zero risk; the workaround is actually a better process than the policy.	

Total Score: _____ / 15

Evidence Source Summary:

• **INTERPRETATION BANDS**

Score	State	What It Means
12–15	Rogue Individuals	The rule is workable and enforced. The deviators are the problem. Discipline them.
8–11	Drifting Culture	The rule is slipping due to weak enforcement. Re-establish the standard and train supervisors to hold it.
0–7	Obsolete Policy	The written rule is dead. The workaround is the actual company. Rewrite the rule or fund the capacity to do it right.

THE DECISION RULE

If Executability scores 0, do not discipline the staff. You cannot mandate a 10-minute procedure on a 5-minute assembly line.

→ **Change the line speed or change the procedure.**

• **REPAIR SEQUENCING • 30 / 60 / 90**

Typical first moves are seeded below. Assign owners and dates.

Repair Move (seeded)	Owner	30 Days	60/90 Days
Immediate correction: Amnesty for past workarounds; halt discipline for the impossible rule.			
Structural redesign: Rewrite the policy to match reality, OR fund the headcount required to follow it.			
Proof verification: Audit the new, realistic policy in 30 days to ensure 100% compliance.			

• **HOW THIS TOOL CHAINS**

FEEDS INTO: The Capacity Reality Test (Tool 03) if time is the barrier
· The Leadership Decision Impact Review (Tool 09) if a leader wrote the bad rule

FED BY: The Policy Exists but Practice Differs (Card 23) · The Policy Violation (Card 09)

• **THE STANDARD**

When the whole department breaks the same rule the same way, that is not a discipline problem. It is the real process making itself visible. Fix the rule or fund the conditions, then enforce what remains.

TOOL 09

The Leadership Decision Impact Review

REPAIR TARGET **Leadership Decision Failure**

• **PURPOSE**

Trace a downstream failure back to the upstream leadership choice that created the condition. Holds authority to its own receipt.

• **WHEN TO USE**

Use when a software rollout fails, when a reorganization creates chaos, when a cost cut breaks a workflow, or whenever a card returns a Leadership Decision finding.

• **WHAT YOU WILL PRODUCE**

A documented trace from the frontline pain to the boardroom choice, forcing leadership to revise the decision rather than blame the executors.

• **REQUIRED INPUTS**

-
- The original business case or decision rationale
 - The conditions the decision created downstream
 - The current operational metrics
 - Feedback from the affected departments

• **THE SCORED INSTRUMENT**

Score each dimension from 0 (Failing) to 3 (Strong) using the evidence columns. A score without an evidence source is not a finding; record the source before interpreting the total.

Dimension & Question	Strong (3)	At Risk (1-2)	Failing (0)	Score
Assumption Validity <i>What did the decision assume that proved untrue?</i>	All assumptions held true.	Some friction, but mostly accurate.	Core assumptions about capacity, tech, or customer behavior were entirely false.	
Feedback Loop <i>Was downstream feedback sought before the decision?</i>	Frontline consulted; feedback integrated.	Frontline consulted but feedback ignored.	Decision made in a vacuum; frontline surprised.	
Resource Alignment <i>Were the resources provided to execute the choice?</i>	Fully funded and staffed.	Underfunded, requiring 'stretch'.	Zero new resources; an unfunded mandate.	
Blame Displacement <i>Who is being blamed for the decision's consequences?</i>	Leadership owns the friction.	Shared frustration.	Frontline staff are being disciplined for the system breaking.	
Reversibility <i>What would revising the decision cost versus continuing it?</i>	Cheap to continue, expensive to reverse.	Painful either way.	Cheaper to reverse than to keep paying the daily operational cost.	

Total Score: _____ / 15

Evidence Source Summary:

DESIGNED TO FAIL

• INTERPRETATION BANDS

Score	State	What It Means
12–15	Sound Decision	The choice was reasonable. The failure is likely in downstream execution. Coach the execution.
8–11	Flawed Rollout	The decision is okay, but the resourcing or feedback loop failed. Pause and resource it.
0–7	Architectural Failure	The decision was built on false premises and is destroying the workflow. Reverse or fundamentally revise the decision.

THE DECISION RULE

If Blame Displacement scores 0, leadership is using the frontline as a human shield for a bad strategy.

→ **Move the accountability back to the executive sponsor immediately.**

• REPAIR SEQUENCING • 30 / 60 / 90

Typical first moves are seeded below. Assign owners and dates.

Repair Move (seeded)	Owner	30 Days	60/90 Days
Immediate correction: Stop disciplining downstream staff for the friction the decision created.			
Structural redesign: Revise the original decision based on the actual downstream data.			
Proof verification: Establish a frontline feedback council for the next major rollout.			

• **HOW THIS TOOL CHAINS**

FEEDS INTO: The Workflow Handoff Map (Tool 13) to see what the decision broke · The Capacity Reality Test (Tool 03) if it was an unfunded mandate

FED BY: Strategy Is Not Executing (Card 19) · The Growth Plan Is Failing (Card 20)

• **THE STANDARD**

Authority has a receipt too. When a downstream failure traces cleanly to an upstream decision, the honest move is to follow it upward, even when the person nearest the failure is easier to blame.

TOOL 10

The Selection Integrity Test

REPAIR TARGET Selection Failure

• **PURPOSE**

Determine whether the hiring process actually tested for the real role. Prevents the organization from blaming a candidate for a process that measured the wrong things.

• **WHEN TO USE**

Use after a bad hire, when turnover repeats in a role, or whenever a card returns a Selection finding.

• **WHAT YOU WILL PRODUCE**

An audit of the interview loop, revealing whether it selects for competence or just charisma, and a blueprint for a behavioral redesign.

• **REQUIRED INPUTS**

- The job posting and the real role
- The interview structure and questions
- The criteria used to decide
- The performance of recent hires against the criteria

• THE SCORED INSTRUMENT

Score each dimension from 0 (Failing) to 3 (Strong) using the evidence columns. A score without an evidence source is not a finding; record the source before interpreting the total.

Dimension & Question	Strong (3)	At Risk (1-2)	Failing (0)	Score
Posting Reality <i>Did the posting describe the real role or an idealized one?</i>	Accurate, unvarnished description of the daily work.	Mostly accurate, but glossed over the hard parts.	Fiction; described a strategic role when the job is pure admin.	
Test Validity <i>Did the process test the actual work, or interview performance?</i>	Required a work sample, presentation, or simulation.	Behavioral questions only.	Unstructured conversational interviews ('tell me about yourself').	
Failure Mode Probing <i>Did the process probe the specific ways this role breaks?</i>	Directly tested the known pressures of the seat.	Asked generic adversity questions.	Never mentioned the hard parts of the job.	
Criteria Consistency <i>Were the decision criteria explicit and applied evenly?</i>	Standard rubric scored by all interviewers.	Loose agreement on what to look for.	Decision made entirely on 'gut feel' or 'culture fit.'	
Predictive Value <i>Do successful hires share traits the process never measured?</i>	Process accurately predicts success.	Process is hit-or-miss.	Process selected the last three failures; the criteria are wrong.	

Total Score: _____ / 15

Evidence Source Summary:

• INTERPRETATION BANDS

Score	State	What It Means
12–15	Rigorous	Selection is sound. The bad hire was a genuine anomaly, or the failure happened in onboarding.
8–11	Impressionistic	The process relies too much on conversation. Add a work sample and a scoring rubric.
0–7	Blind	The process tests how well people interview, not how well they work. Redesign from scratch.

THE DECISION RULE

If Test Validity scores 0, you are hiring based on charisma. You cannot blame a candidate for failing at a task you never asked them to demonstrate.

→ **Require a work sample for all future hires in this role.**

• REPAIR SEQUENCING • 30 / 60 / 90

Typical first moves are seeded below. Assign owners and dates.

Repair Move (seeded)	Owner	30 Days	60/90 Days
Immediate correction: Rewrite the job description to include the unvarnished reality of the role.			
Structural redesign: Replace unstructured interviews with a work sample and a scoring rubric.			
Proof verification: Track the 90-day success rate of the next three hires under the new process.			

• **HOW THIS TOOL CHAINS**

FEEDS INTO: The Onboarding Conversion Test (Tool 11) to ensure the hire survives the first 90 days · The Role Reality Test (Tool 01) if the role itself is un-hireable

FED BY: The Bad Hire (Card 01) · Turnover Repeats in the Same Role (Card 25)

• **THE STANDARD**

A process that tests how well someone interviews will reliably hire good interviewers. If you want people who can do the job, the process has to make them do the job.

TOOL 11

The Onboarding Conversion Test

REPAIR TARGET Onboarding Failure

• **PURPOSE**

Determine whether the organization actually converts a hire into a functioning employee, or simply releases them into the work and hopes. Tests the first 90 days as a system.

• **WHEN TO USE**

Use when new hires fail early, when ramp time is long, when turnover clusters in the first months, or whenever a card returns an Onboarding finding.

• **WHAT YOU WILL PRODUCE**

A gap analysis of the first 90 days, moving the organization from 'orientation' to 'conversion.'

• **REQUIRED INPUTS**

-
- The documented onboarding plan, if one exists
 - What the first 30, 60, and 90 days actually contained
 - Who owned the ramp and verified milestones
 - Time-to-productivity data

• **THE SCORED INSTRUMENT**

Score each dimension from 0 (Failing) to 3 (Strong) using the evidence columns. A score without an evidence source is not a finding; record the source before interpreting the total.

Dimension & Question	Strong (3)	At Risk (1-2)	Failing (0)	Score
Plan Existence <i>Is there a real onboarding plan, or an orientation and a desk?</i>	Detailed 90-day plan with weekly milestones.	A one-week schedule, then they are on their own.	No plan; 'shadow Sarah until you figure it out.'	
Accountable Owner <i>Was someone accountable for the hire's ramp, day to day?</i>	A dedicated manager or mentor owns the outcome.	Manager checks in occasionally.	No owner; everyone assumes someone else is training them.	
Milestone Verification <i>Was competence verified, or assumed once orientation ended?</i>	Skills explicitly tested and signed off.	Assumed competent if they didn't ask questions.	No verification; failures only discovered months later.	
Resource Readiness <i>Did the hire have the tools, access, and standard from day one?</i>	Laptop, logins, and desk ready on morning one.	Took a week to get basic access.	Weeks of fighting IT just to start working.	
Time to Productivity <i>How long until a hire is genuinely productive?</i>	Matches the industry/role benchmark.	Takes 50% longer than expected.	Hires are still struggling at 6 months.	

Total Score: _____ / 15

Evidence Source Summary:

• **INTERPRETATION BANDS**

Score	State	What It Means
12–15	Conversion Engine	Onboarding is strong. Early failures are likely selection or individual capability issues.
8–11	Orientation Only	The org does the first week well and the next eleven poorly. Build the 30/60/90 milestones.
0–7	Abandonment	Hires are released into the wild. The org is wasting its recruiting budget. Build a system.

THE DECISION RULE

If Accountable Owner scores 0, onboarding does not exist. 'Shadowing the team' is not a plan; it is an abdication.

→ **Assign a named owner to every new hire's first 90 days.**

• **REPAIR SEQUENCING • 30 / 60 / 90**

Typical first moves are seeded below. Assign owners and dates.

Repair Move (seeded)	Owner	30 Days	60/90 Days
Immediate correction: Assign a dedicated mentor/owner to every person hired in the last 60 days.			
Structural redesign: Build a formal 30/60/90 milestone checklist for the role.			
Proof verification: Manager and hire must both sign off on the 30-day competence check.			

• **HOW THIS TOOL CHAINS**

FEEDS INTO: The Selection Integrity Test (Tool 10) if onboarding is sound but hires still fail · The Expectation Clarity Test (Tool 12) to ensure the standard is taught

FED BY: The Bad Hire (Card 01) · High Turnover (Card 08)

• **THE STANDARD**

Hiring someone is not the same as onboarding them, and onboarding is not the same as orientation. The organization that hands a new hire a login and a hope should not be surprised by the result it built.

TOOL 12

The Expectation Clarity Test

REPAIR TARGET **Expectation Failure**

• **PURPOSE**

Confirm whether the standard was explicit, understood, and dated before the person was judged against it. The first question in nearly every fair diagnosis.

• **WHEN TO USE**

Use at the start of almost any performance or conduct diagnosis, and whenever a card returns an Expectation finding.

• **WHAT YOU WILL PRODUCE**

A definitive ruling on whether the employee actually knew the target, preventing 'secret standard' discipline.

• **REQUIRED INPUTS**

-
- The standard the person is being judged against
 - Evidence of when and how it was communicated
 - The person's understanding of the standard
 - Any written confirmation

• **THE SCORED INSTRUMENT**

Score each dimension from 0 (Failing) to 3 (Strong) using the evidence columns. A score without an evidence source is not a finding; record the source before interpreting the total.

Dimension & Question	Strong (3)	At Risk (1-2)	Failing (0)	Score
Explicitness <i>Is the standard explicit and measurable, or implied?</i>	Written, objective, and measurable.	Verbal but specific.	Vague ('do better', 'be more professional') or entirely implied.	
Timing <i>Was the standard set before the performance was judged?</i>	Set well in advance with time to adjust.	Set right as the discipline started.	Applied retroactively to past behavior.	
Acknowledgment <i>Did the person confirm understanding?</i>	Signed or emailed confirmation of the standard.	Verbal agreement in a meeting.	No proof they ever heard or understood it.	
Stability <i>Was the standard stable, or did it shift without notice?</i>	Remained consistent.	Changed slightly based on manager mood.	Target moved constantly; impossible to hit.	
Universality <i>Would two reasonable people read the standard the same way?</i>	Zero ambiguity.	Some room for interpretation.	Highly subjective; entirely dependent on the manager's opinion.	

Total Score: _____ / 15

Evidence Source Summary:

• **INTERPRETATION BANDS**

Score	State	What It Means
12–15	Clear	The standard was fair and known. Proceed with individual accountability.
8–11	Fuzzy	The standard exists but lacks rigor. Clarify it in writing before escalating discipline.
0–7	Secret	The standard lived only in the manager's head. You cannot discipline the employee. Reset the clock.

THE DECISION RULE

If Explicitness scores 0, the standard is a secret. You cannot hold someone accountable for a target you never painted.

→ **Write the standard, deliver it, and start a new 30-day measurement period.**

• **REPAIR SEQUENCING • 30 / 60 / 90**

Typical first moves are seeded below. Assign owners and dates.

Repair Move (seeded)	Owner	30 Days	60/90 Days
Immediate correction: Remove the retroactive discipline. Draft the explicit standard today.			
Structural redesign: Convert all subjective 'attitude' standards into observable behaviors.			
Proof verification: Employee replies to the standard via email confirming they understand it.			

• **HOW THIS TOOL CHAINS**

FEEDS INTO: The Documentation Sufficiency Test (Tool 05) to ensure the file is built properly · The Supervision Strength Test (Tool 04) to coach the manager on setting expectations

FED BY: Poor Performance (Card 02) · The Policy Violation (Card 09)

• **THE STANDARD**

You cannot hold someone to a standard they were never given. Before any judgment, prove the expectation was explicit, understood, and in place before the work was measured.

TOOL 13

The Workflow Handoff Map

REPAIR TARGET **Workflow Failure**

• **PURPOSE**

Trace how work actually moves across people and departments, and locate where it stalls, doubles back, or breaks. Converts vague 'communication problems' into a precise structural map.

• **WHEN TO USE**

Use when work is chronically late, when departments blame each other, when customers get inconsistent answers, or whenever a card returns a Workflow finding.

• **WHAT YOU WILL PRODUCE**

A visual bottleneck analysis that identifies the exact unowned space or broken loop destroying the timeline.

• **REQUIRED INPUTS**

-
- The real, observed process from start to finish
 - Every handoff point and who owns it
 - The points where work waits, returns, or duplicates
 - The volume and timing through each step

• **THE SCORED INSTRUMENT**

Score each dimension from 0 (Failing) to 3 (Strong) using the evidence columns. A score without an evidence source is not a finding; record the source before interpreting the total.

Dimension & Question	Strong (3)	At Risk (1-2)	Failing (0)	Score
Ownership <i>Does every handoff have a clear owner?</i>	Every step has a named, accountable owner.	Some shared ownership ('the team handles it').	Orphaned steps; work sits in a void until someone yells.	
Velocity <i>Where does work wait, and for how long?</i>	Moves continuously; minimal queue time.	Waits hours/days for batch processing.	Sits in inboxes for weeks awaiting approval.	
Rework Loops <i>Where does work double back or get redone?</i>	Done right the first time >95%.	Occasional kickbacks for missing info.	Chronic rework; downstream constantly fixes upstream errors.	
Visibility <i>Can everyone see where the work is in the flow?</i>	Full tracking; everyone knows the status.	Requires emails/calls to find status.	Total black box; work disappears until it emerges.	
Volume Match <i>Does volume exceed what the bottleneck can absorb?</i>	Flow is balanced.	Occasional pile-ups.	A massive funnel feeds into a tiny pipe; chronic backlog.	

Total Score: _____ / 15

Evidence Source Summary:

• **INTERPRETATION BANDS**

Score	State	What It Means
12–15	Flowing	The workflow is clean. Delays are likely individual execution or capacity issues.
8–11	Friction	The process is slowing down due to rework or batching. Clean up the specific handoff.
0–7	Broken	The architecture is actively fighting the work. Map it on a whiteboard and rebuild it.

THE DECISION RULE

If Ownership scores 0 on a critical step, that step does not exist. Work will drop there 100% of the time.

→ **Assign a single human name to the orphaned handoff before the end of the day.**

• **REPAIR SEQUENCING • 30 / 60 / 90**

Typical first moves are seeded below. Assign owners and dates.

Repair Move (seeded)	Owner	30 Days	60/90 Days
Immediate correction: Assign a single owner to the most broken handoff point.			
Structural redesign: Build a checklist that prevents upstream from passing flawed work downstream.			
Proof verification: Measure the time-in-queue for the bottleneck step over the next 30 days.			

• **HOW THIS TOOL CHAINS**

FEEDS INTO: The Capacity Reality Test (Tool 03) if the bottleneck is purely volume · The Authority-to-Accountability Map (Tool 02) if the owner lacks power to move the work

FED BY: Customer Complaints (Card 07) · Communication Breakdown (Card 16)

• **THE STANDARD**

Most 'people problems' between departments are actually handoff problems no one owns. Map the flow, find the break, and assign it before you mediate another argument about it.

TOOL 14

The Compensation Distortion Test

REPAIR TARGET Compensation Failure

• **PURPOSE**

Detect whether the pay structure is creating distrust, distortion, resentment, or retention risk, and whether exceptions have quietly become the real system.

• **WHEN TO USE**

Use when pay exceptions multiply, when equity complaints rise, when good people leave over fairness, or whenever a card returns a Compensation finding.

• **WHAT YOU WILL PRODUCE**

An equity and governance audit that proves whether the organization is paying for performance or paying for negotiation.

• **REQUIRED INPUTS**

-
- The official pay bands and structure
 - Actual pay for comparable roles and levels
 - The record and rationale of recent exceptions
 - Who holds the authority to grant exceptions

• THE SCORED INSTRUMENT

Score each dimension from 0 (Failing) to 3 (Strong) using the evidence columns. A score without an evidence source is not a finding; record the source before interpreting the total.

Dimension & Question	Strong (3)	At Risk (1-2)	Failing (0)	Score
Band Integrity <i>What share of pay decisions fall outside the official band?</i>	<10% are exceptions.	10-30% are exceptions.	>30% are exceptions; the band is a fiction.	
Internal Equity <i>Do comparable people in comparable roles earn comparable pay?</i>	High parity based on tenure and performance.	Noticeable gaps based on when they were hired.	Massive, indefensible gaps between peers.	
Exception Governance <i>Is there a documented business case behind each exception?</i>	Strict, retained justification for every off-band move.	Vague 'market pressure' notes.	Zero documentation; granted verbally to close a deal.	
Authority Restriction <i>Who can grant exceptions, and is it limited?</i>	Only HR/Execs, with strict limits.	Directors can override with some pushback.	Any panicked manager can promise money to save a hire.	
Behavioral Distortion <i>Does the structure reward negotiation over performance?</i>	Top performers are paid the most.	Average performers who complain get raises.	The loudest, most aggressive negotiators dominate the payroll.	

Total Score: _____ / 15

Evidence Source Summary:

• **INTERPRETATION BANDS**

Score	State	What It Means
12–15	Governed	Compensation is structured and fair. Complaints are likely individual perception issues.
8–11	Drifting	Exceptions are creeping up. Tighten the approval matrix and review the bands.
0–7	Distorted	The system is broken. You are actively incentivizing threats and punishing quiet loyalty. Rebuild.

THE DECISION RULE

If Internal Equity scores 0, you have a ticking time bomb. The moment the payroll becomes public knowledge, you will lose your best people.

→ **Freeze exceptions and initiate an equity true-up immediately.**

• **REPAIR SEQUENCING • 30 / 60 / 90**

Typical first moves are seeded below. Assign owners and dates.

Repair Move (seeded)	Owner	30 Days	60/90 Days
Immediate correction: Revoke frontline manager authority to grant off-band pay exceptions.			
Structural redesign: Conduct an internal equity audit and budget for a true-up cycle.			
Proof verification: Publish the exception governance policy to all leaders.			

• **HOW THIS TOOL CHAINS**

FEEDS INTO: The Reinforcement Audit (Tool 06) to see what else is distorted · The Leadership Decision Impact Review (Tool 09) if an exec broke the bands

FED BY: Pay Exceptions Became the Pay System (Card 22) · Good Employees Leave (Card 05)

• **THE STANDARD**

A pay structure that bends for everyone who pushes is not a structure; it is a negotiation surface. When exceptions outnumber the rule, the exception has already become the system.

TOOL 15

The Evidence Standard (Proof-File) Builder

REPAIR TARGET **Proof Failure**

• **PURPOSE**

Build the record required to support a decision before it is made, not after it is challenged. The master evidence instrument that feeds every consequential action.

• **WHEN TO USE**

Use before any action that may be reviewed, contested, or litigated, and whenever a decision must survive scrutiny.

• **WHAT YOU WILL PRODUCE**

A legally and operationally defensible file, or a hard stop preventing the organization from taking an indefensible risk.

• **REQUIRED INPUTS**

-
- The decision under consideration
 - The applicable standard
 - The factual timeline
 - The support provided and the response received

• **THE SCORED INSTRUMENT**

Score each dimension from 0 (Failing) to 3 (Strong) using the evidence columns. A score without an evidence source is not a finding; record the source before interpreting the total.

Dimension & Question	Strong (3)	At Risk (1–2)	Failing (0)	Score
The Standard <i>What standard applies, and where is it written?</i>	Explicit, written, acknowledged.	Referenced but not documented.	Assumed/unwritten.	
The Pattern <i>What is the dated pattern, not the single incident?</i>	Multiple dates, specific facts, clear trend.	A couple of dates, some vague notes.	One incident or zero dates.	
The Support <i>What support and correction were provided, and when?</i>	Documented coaching, tools, or training.	Verbal warnings only.	No support provided; immediate jump to discipline.	
The Response <i>How did the person respond to that support?</i>	Documented failure to improve after support.	Vague notes on their reaction.	No follow-up on whether they improved.	
The Reason <i>What is the documented business reason for the action?</i>	Objective, measurable business impact.	Subjective team frustration.	No reason documented.	

Total Score: _____ / 15

Evidence Source Summary:

• **INTERPRETATION BANDS**

Score	State	What It Means
12–15	Actionable	The file meets the proof standard. Proceed with the decision.
8–11	Incomplete	The file is weak. Gather the missing documentation before acting.
0–7	Risk	The file is empty. Taking action now is an unforced error. Build the case.

THE DECISION RULE

If The Pattern scores 0, you are firing someone for a bad Tuesday. A reviewer will call it arbitrary.

→ **Unless it is an egregious conduct violation, establish the pattern over 30 days before acting.**

• **REPAIR SEQUENCING • 30 / 60 / 90**

Typical first moves are seeded below. Assign owners and dates.

Repair Move (seeded)	Owner	30 Days	60/90 Days
Immediate correction: Halt the adverse action. Do not proceed on an empty file.			
Structural redesign: Draft the formal warning/PIP detailing the standard and the gap.			
Proof verification: Manager logs weekly progress against the PIP for the next 30 days.			

• **HOW THIS TOOL CHAINS**

FEEDS INTO: The Documentation Sufficiency Test (Tool 05) to audit past files · The Supervision Strength Test (Tool 04) to fix the manager who failed to document

FED BY: The Decision Cannot Survive Review (Card 24) · Any Card before termination

• **THE STANDARD**

Build the file before you need it, because the moment you need it is the moment it is too late to build. A decision that cannot be reconstructed from the record is a decision the organization cannot defend.

TOOL 16

The PSD Diagnostic Master Grid

REPAIR TARGET All Domains

• **PURPOSE**

The six-domain overview that sits beneath every card. Forces each diagnosis to produce a finding across Clarity, Control, Flow, Support, Proof, and Reinforcement.

• **WHEN TO USE**

Use as the spine of any full diagnosis, and to summarize a card's findings into a single defensible view.

• **WHAT YOU WILL PRODUCE**

A comprehensive executive summary of the failure, preventing leadership from cherry-picking the one domain they want to blame.

• **REQUIRED INPUTS**

-
- The completed diagnostic card
 - The evidence gathered
 - The accounts of the people involved

• **THE SCORED INSTRUMENT**

Score each dimension from 0 (Failing) to 3 (Strong) using the evidence columns. A score without an evidence source is not a finding; record the source before interpreting the total.

Dimension & Question	Strong (3)	At Risk (1-2)	Failing (0)	Score
Clarity <i>Was the standard explicit before judgment?</i>	Standard was explicit, written, and acknowledged.	Standard was implied or communicated poorly.	Standard was a secret; applied retroactively.	
Control <i>Did the person control the outcome?</i>	Full authority.	Partial authority.	Zero authority.	
Flow <i>Did the work move cleanly through the system?</i>	Handoffs are clean, owned, and timely.	Handoffs require some rework and chasing.	Handoffs are orphaned, causing chronic delays.	
Support <i>Was real support present?</i>	Tools, time, and coaching provided.	Under-resourced.	Impossible capacity/no tools.	
Proof <i>Does the file prove the failure?</i>	File shows standard, pattern, support, and reason.	File shows incidents but lacks a clear pattern.	File is empty or relies entirely on hearsay.	
Reinforcement <i>What did the organization reward?</i>	Rewarded the right thing.	Tolerated the wrong thing.	Rewarded the wrong thing.	

Total Score: _____ / 18

Evidence Source Summary:

• INTERPRETATION BANDS

Score	State	What It Means
15–18	System Sound	The architecture is clean. The failure is individual. Proceed with discipline.
9–14	System Leaking	The architecture has gaps. Repair the weak domains while holding the person accountable.
0–8	System Broken	The architecture produced the failure. Do not discipline the individual; rebuild the system.

THE DECISION RULE

If Clarity or Control score 0, individual accountability is impossible. You cannot punish someone for missing a secret target or failing at a task they could not control.

→ **Fix Clarity and Control before assessing the person.**

• REPAIR SEQUENCING • 30 / 60 / 90

Typical first moves are seeded below. Assign owners and dates.

Repair Move (seeded)	Owner	30 Days	60/90 Days
Immediate correction: Address the lowest-scoring domain today to stop the bleeding.			
Structural redesign: Map the cross-functional repair for any domain scoring 0 or 1.			
Proof verification: Re-run the PSD Grid in 90 days to prove the system improved.			

- **HOW THIS TOOL CHAINS**

FEEDS INTO: The specific Tool matching the lowest-scoring domain

FED BY: Any Full or Deep Card to summarize findings

- **THE STANDARD**

The PSD grid is the discipline that keeps the organization honest. Each domain must produce a finding. A blank is not neutral. A blank is itself a finding.

TOOL 17

The Attribution Decision Protocol

REPAIR TARGET Attribution Discipline

• **PURPOSE**

Force a single, defensible attribution from the evidence, including the discipline to choose 'insufficient evidence' when that is the truth.

• **WHEN TO USE**

Use to close the diagnostic phase of any card before moving to repair.

• **WHAT YOU WILL PRODUCE**

A final, binding ruling on the nature of the failure (Individual, System, Mixed, or Unknown), locking in the repair direction.

• **REQUIRED INPUTS**

- The completed scans
- The evidence table
- The PSD grid findings

• **THE SCORED INSTRUMENT**

Score each dimension from 0 (Failing) to 3 (Strong) using the evidence columns. A score without an evidence source is not a finding; record the source before interpreting the total.

Dimension & Question	Strong (3)	At Risk (1-2)	Failing (0)	Score
Individual Evidence <i>Does the evidence support primarily individual failure?</i>	Overwhelming proof of capability/con duct gap.	Some evidence, but mixed with system noise.	No evidence; person did everything asked.	
System Evidence <i>Does the evidence support primarily system failure?</i>	Overwhelming proof of broken design/capacity.	Some friction, but workable.	System is perfectly sound.	
Mixed Clarity <i>Can you clearly name the mixed-failure interaction?</i>	Exact dynamic is mapped and proven.	Vague sense of 'both'.	Cannot articulate how they interacted.	
Data Sufficiency <i>Is there enough evidence to act as if you know?</i>	File is complete and verified.	Relying on some assumptions.	Mostly guessing/hear say.	
Reviewer Alignment <i>What would a neutral reviewer conclude?</i>	Would 100% agree with our finding.	Might argue the degree of blame.	Would throw the case out immediately.	

Total Score: _____ / 15

Evidence Source Summary:

• **INTERPRETATION BANDS**

Score	State	What It Means
12–15	Locked	The attribution is proven. Move immediately to the targeted repair.
8–11	Working Hypothesis	You have a strong lean but need to verify one or two assumptions before major structural or personnel moves.
0–7	Insufficient Evidence	You do not know what happened. Stop guessing. Go back and gather the data.

THE DECISION RULE

If Data Sufficiency scores 0, the only acceptable attribution is 'Insufficient Evidence.' Acting without data is how organizations generate lawsuits and lose trust.

→ **Pause the action and build the file.**

• **REPAIR SEQUENCING • 30 / 60 / 90**

Typical first moves are seeded below. Assign owners and dates.

Repair Move (seeded)	Owner	30 Days	60/90 Days
Immediate correction: Lock the attribution and communicate it to the decision-makers.			
Structural redesign: If Mixed or System, initiate the structural repair sequence.			
Proof verification: If Insufficient, assign an owner to gather the specific missing evidence by Friday.			

• **HOW THIS TOOL CHAINS**

<p>FEEDS INTO: The Mixed Failure Map (Tool 07) if the attribution is Mixed · The Evidence Standard Builder (Tool 15) if evidence is insufficient</p> <p>FED BY: The Attribution section of any Card</p>

• **THE STANDARD**

Sometimes the correct finding is that you do not yet have the evidence to act as if you know. Choosing that on purpose is not indecision. It is the difference between diagnosis and blame.

TOOL 18

The Proof-Under-Pressure Protocol

REPAIR TARGET **Repair Durability**

• **PURPOSE**

Stress-test a repair against the real conditions of the workplace. A repair that only works when everyone is calm, staffed, and watched is not a repair. It is a performance.

• **WHEN TO USE**

Use to close every card after a repair is planned, before declaring the problem solved.

• **WHAT YOU WILL PRODUCE**

A durability score for the proposed solution, identifying exactly where it will break when the real workday hits it.

• **REQUIRED INPUTS**

-
- The planned repair
 - The realistic pressure conditions of the operation
 - The people who must sustain the repair when no one is watching

• **THE SCORED INSTRUMENT**

Score each dimension from 0 (Failing) to 3 (Strong) using the evidence columns. A score without an evidence source is not a finding; record the source before interpreting the total.

Dimension & Question	Strong (3)	At Risk (1–2)	Failing (0)	Score
Staffing Pressure <i>Does the repair hold when the department is understaffed?</i>	Built to survive low headcount.	Requires full staff to maintain.	Will collapse the moment one person calls in sick.	
Supervisory Absence <i>Does it hold when the supervisor is absent or busy?</i>	Hardwired into the workflow/tools.	Requires occasional manager nudges.	Relies entirely on the manager constantly watching.	
Exception Pressure <i>Does it hold when leadership wants an exception?</i>	Rule is absolute; leadership respects it.	Leadership occasionally overrides it.	Leadership will break the rule the first time it is inconvenient.	
Pushback Pressure <i>Does it hold when the employee or customer pushes back?</i>	Staff are empowered to hold the line.	Staff waver under pressure.	Staff will cave immediately to avoid conflict.	
Time Pressure <i>Does it hold when volume spikes and overtime rises?</i>	Scales cleanly with volume.	Gets sloppy when busy.	The first thing abandoned when the rush hits.	

Total Score: _____ / 15

Evidence Source Summary:

• **INTERPRETATION BANDS**

Score	State	What It Means
12–15	Structural	The repair is hardened into the system. It will survive the workday. Deploy it.
8–11	Fragile	The repair relies too much on willpower or perfect conditions. Add systemic guardrails (e.g., software locks).
0–7	Performance	This is not a repair; it is a temporary behavioral performance. It will fail by next Tuesday. Redesign it.

THE DECISION RULE

If Supervisory Absence scores 0, you have built a babysitting requirement, not a system repair. A process that only works while the boss is staring at it is a broken process.

→ **Embed the repair into the tool, the checklist, or the incentive.**

• **REPAIR SEQUENCING • 30 / 60 / 90**

Typical first moves are seeded below. Assign owners and dates.

Repair Move (seeded)	Owner	30 Days	60/90 Days
Immediate correction: Identify the lowest-scoring pressure point and add a structural guardrail.			
Structural redesign: Move the repair from 'human memory' into the software, workflow, or physical environment.			
Proof verification: Audit the repair on the busiest day of the month to prove it held.			

• **HOW THIS TOOL CHAINS**

FEEDS INTO: The Workflow Handoff Map (Tool 13) to hardwire the repair · The Reinforcement Audit (Tool 06) to ensure the repair is rewarded

FED BY: The Repair Plan section of any Card

• **THE STANDARD**

If the repair cannot survive an understaffed Tuesday with the supervisor out and a customer waiting, it was never a system repair. It was a temporary performance, and the problem will return the moment the pressure does.

DESIGNED TO FAIL

PART FOUR

THE DIAGNOSTIC ATLAS

*Visual Models, Risk Maps, and Quick References for
Moving from Diagnosis to Repair*

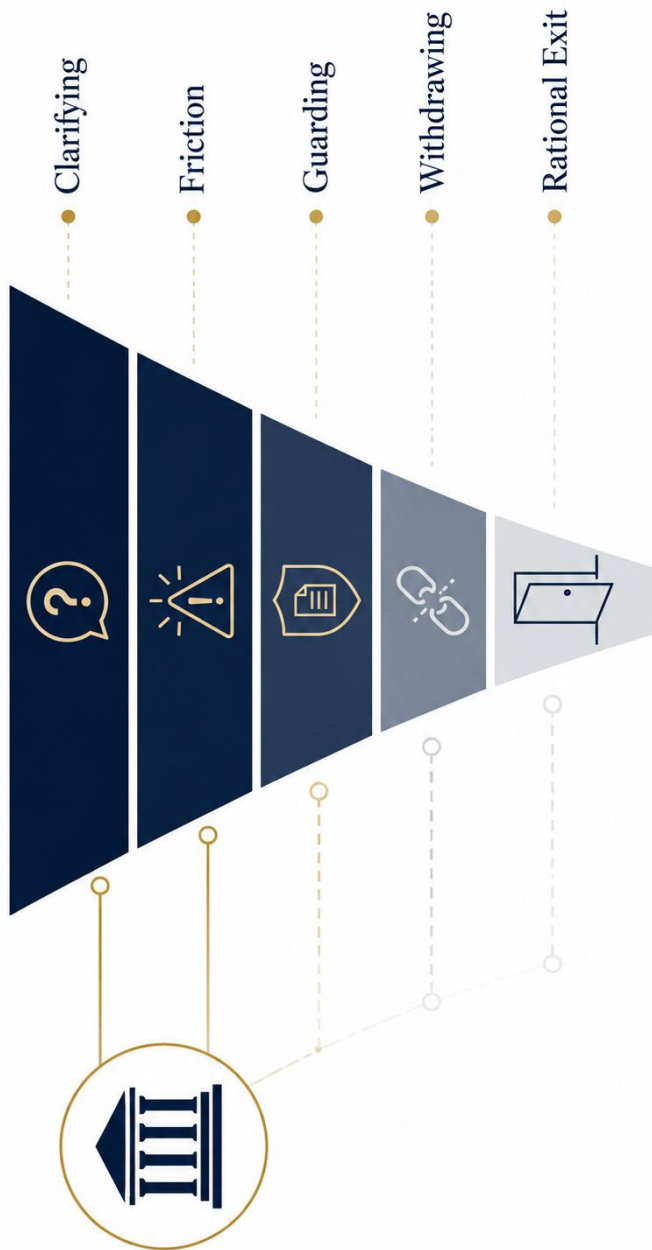
The recurring problem loop is predictable:



The repair loop has to be different:



Rational Exit Progression



Cumulative Trust Debt

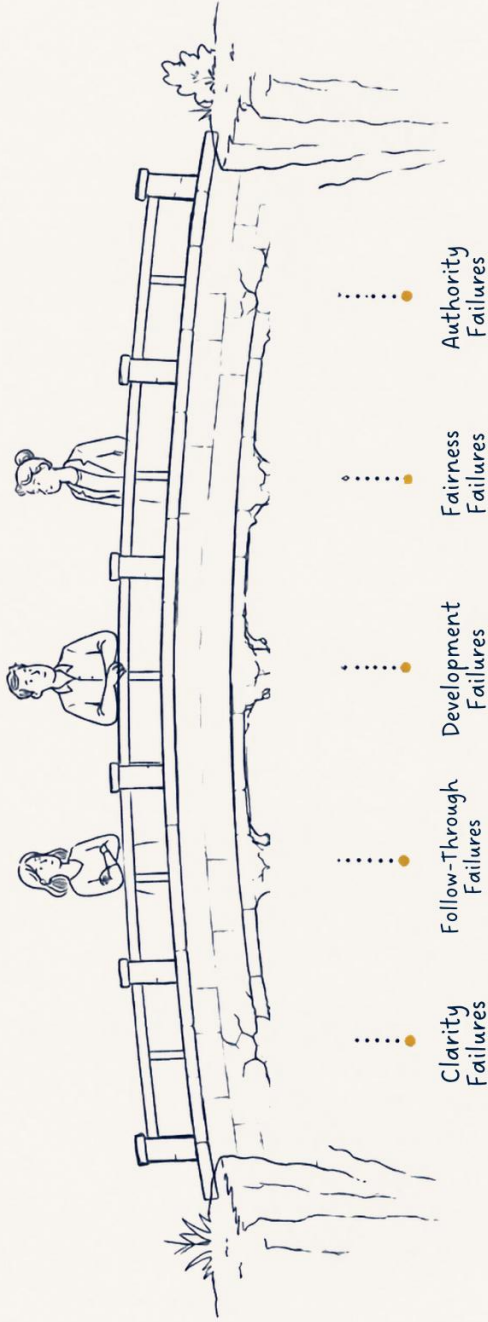
Small failures, repeated often enough.



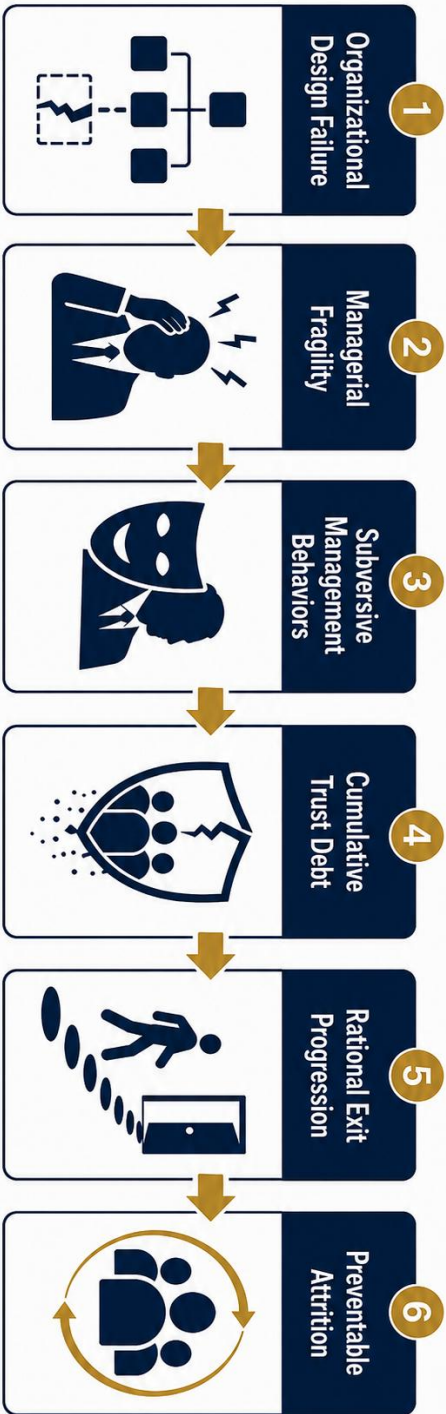
DISCRETIONARY EFFORT



Subversive Management Behaviors



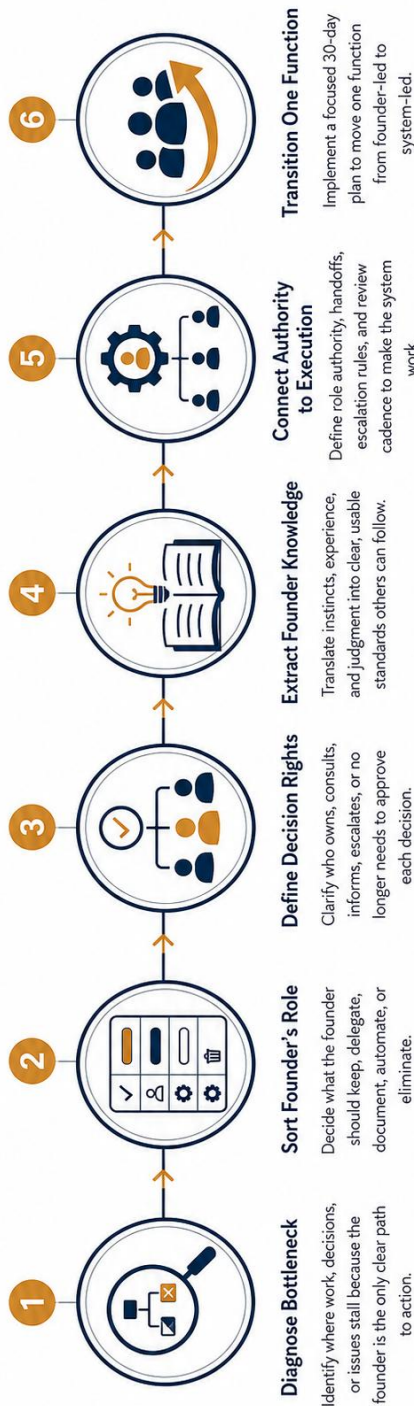
Designed to Fail Chain



A CASCADING CHAIN OF FAILURES. REAL PEOPLE. REAL COSTS. REAL PREVENTABLE.

System-Led Transition Framework

Move decisions, standards, and daily execution out of the founder's head



Outcome: A scalable organization where decisions are clear, authority is defined, and daily execution no longer depends on the founder.

A Simple Framework for Improving HR Processes



Identify the breakdown

Where does the process stall, split, repeat or become inconsistent? Follow the complaints. Where managers call **HR the most**, or where employees express the most **confusion**, the process is usually the weakest.



Map the real workflow

Document what actually happens **o the ground** — **not what the employee handbook** claims happens. Sit with the people who execute the process and ask them to show you what they did the **Last three times**. You will find workarounds, **skipped steps**, and informal systems that have replaced the official ones. You cannot fix a process until you admit how it actually operates.



Remove friction and clarify ownership

Cut redundant steps, define clear roles, and create a standard path. Every step in the process should either add value or **ensure compliance**. If it does neither, cut it. If two people are doing the same check, assign it to one.



Measure whether the fix holds

Track **turnaround time, error rates, compliance misses, manager adherence, and employee experience**. A process is not fixed until the data **proves** it is fixed. Without measurement, you are just hoping the new version works better than the old one.



Preference Is Not Policy

A preference may be reasonable. That does not make it enforceable yet.

 Preference Language	 Standard Language
 <p>“Keep me updated.”</p>	 <p>Send a status update by 3:00 p.m. every Friday.</p>
 <p>“Be more professional.”</p>	 <p>Do not interrupt coworkers during handoff discussions.</p>
 <p>“Stay on top of your work.”</p>	 <p>Complete all intake packets before leaving unless reassigned by the supervisor.</p>
 <p>“Communicate better.”</p>	 <p>Notify the supervisor within 15 minutes if a deadline may be missed.</p>
 <p>“Take ownership.”</p>	 <p>Resolve assigned customer requests or document the barrier before closing the task.</p>

DELEGATION CLARITY CARD

Use this before assigning meaningful work.

<p>1</p>  <p>The outcome is: What needs to be completed?</p>	<p>2</p>  <p>The reason it matters is: Why does this work matter?</p>	<p>3</p>  <p>The standard is: What does acceptable work look like?</p>	<p>4</p>  <p>The deadline is: When is it due?</p>
<p>5</p>  <p>The employee can decide: What authority does the employee have?</p>	<p>6</p>  <p>Check-in will happen: When will progress be reviewed?</p>	<p>7</p>  <p>Escalate if: When should the employee ask for help?</p>	<p>8</p>  <p>Success looks like: How will we know the work was done well?</p>

Delegation should make ownership clear before the work begins.

FACTS FRAMEWORK

Use this to ensure each record holds up under review.



1

Focus on Facts

Capture specific, observable actions and outcomes, not opinions or generalizations.



2

Align with Policies

Reference the exact rule, policy, or expectation that was violated.



3

Clear Expectations

Include what improvement is required, how it will be measured, and timelines.



4

Tone of Professionalism

Keep language respectful and objective, not emotional or punitive.



5

Support and Accountability

Document what support was offered and how progress will be followed up.



Strong documentation should be factual, policy-aligned, clear, professional, and accountable.



The CLEAR Correction Framework™

Correction works better when ambiguity is removed.

C

Clarify the expectation

What standard should have been met?

L

Locate the missed mark

What specifically happened or failed to happen?

E

Explain the impact

Why does the issue matter operationally?

A

Ask for barriers

Is anything preventing the employee from meeting the expectation?

R

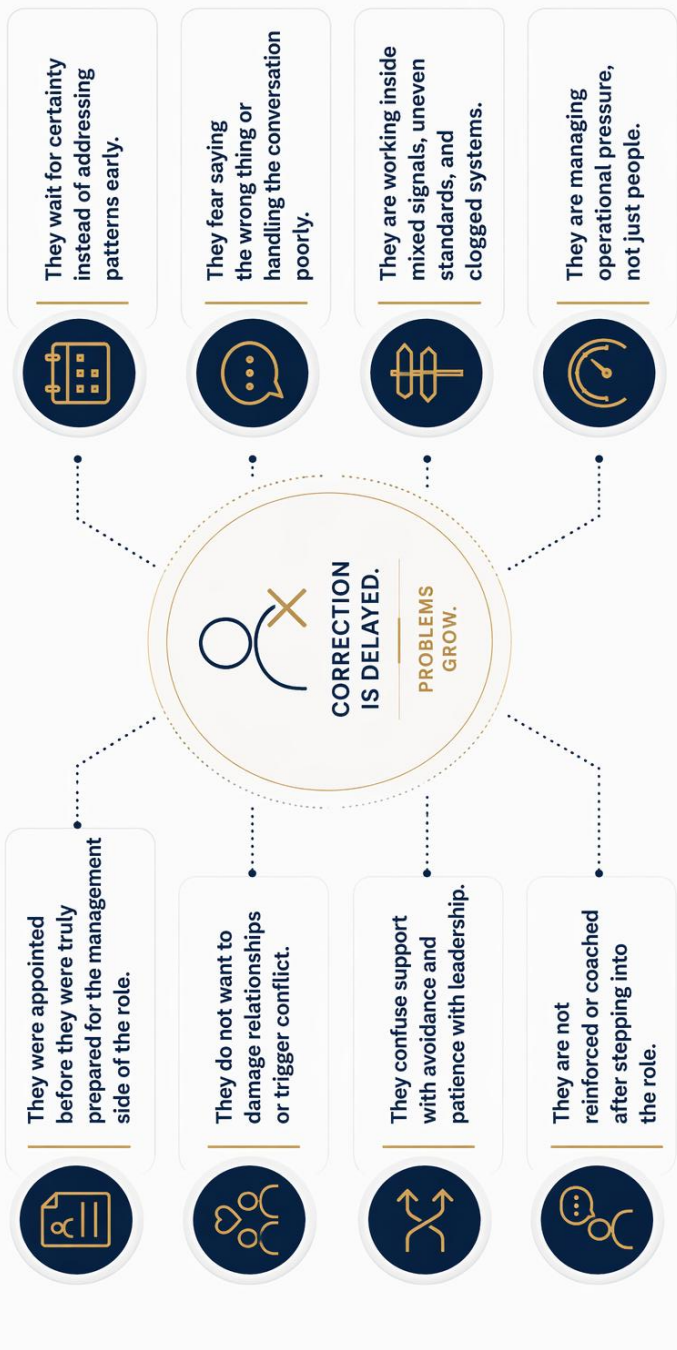
Require the next step

What must change, by when, and when will it be reviewed?



Use correction to define the standard, identify the gap, address barriers, and require a clear next step.

Why Supervisors Avoid the Moment of Correction





FAULKNER HR SOLUTIONS

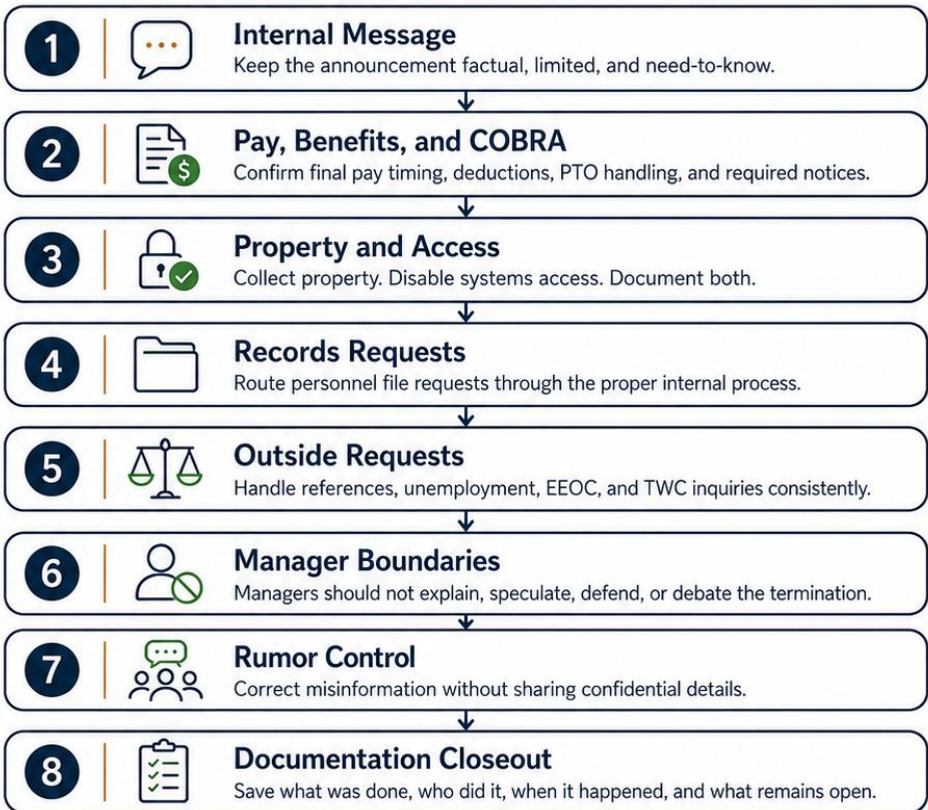
STRATEGY-BACKED. PEOPLE-FIRST.

faulknerhrsolutions.info

After the Termination: Where Employers Create New Risk

CLIENT TOOL | INTERNAL HR CHECKLIST

A practical post-termination flowchart for employers to reduce legal, operational, and reputational risk.



The termination meeting ends one problem.

The follow-through determines whether the employer creates another one.

Employee Issue Intake and Escalation Guide

Quick questions to ask before escalating an employee issue

1



What happened?

Capture the concern in factual terms.

2



When did it happen?

Identify date, time, and frequency.

3



Who was involved?

Identify parties and witnesses.

4



Has this happened before?

Note prior reports or repeated concerns.

5



Is there immediate risk?

Safety, threats, violence, severe misconduct, or urgent operational concern.

6



Are there protected triggers?

Medical, leave, accommodation, harassment, discrimination, retaliation, wage/hour, safety, or protected complaint.

7



What was requested?

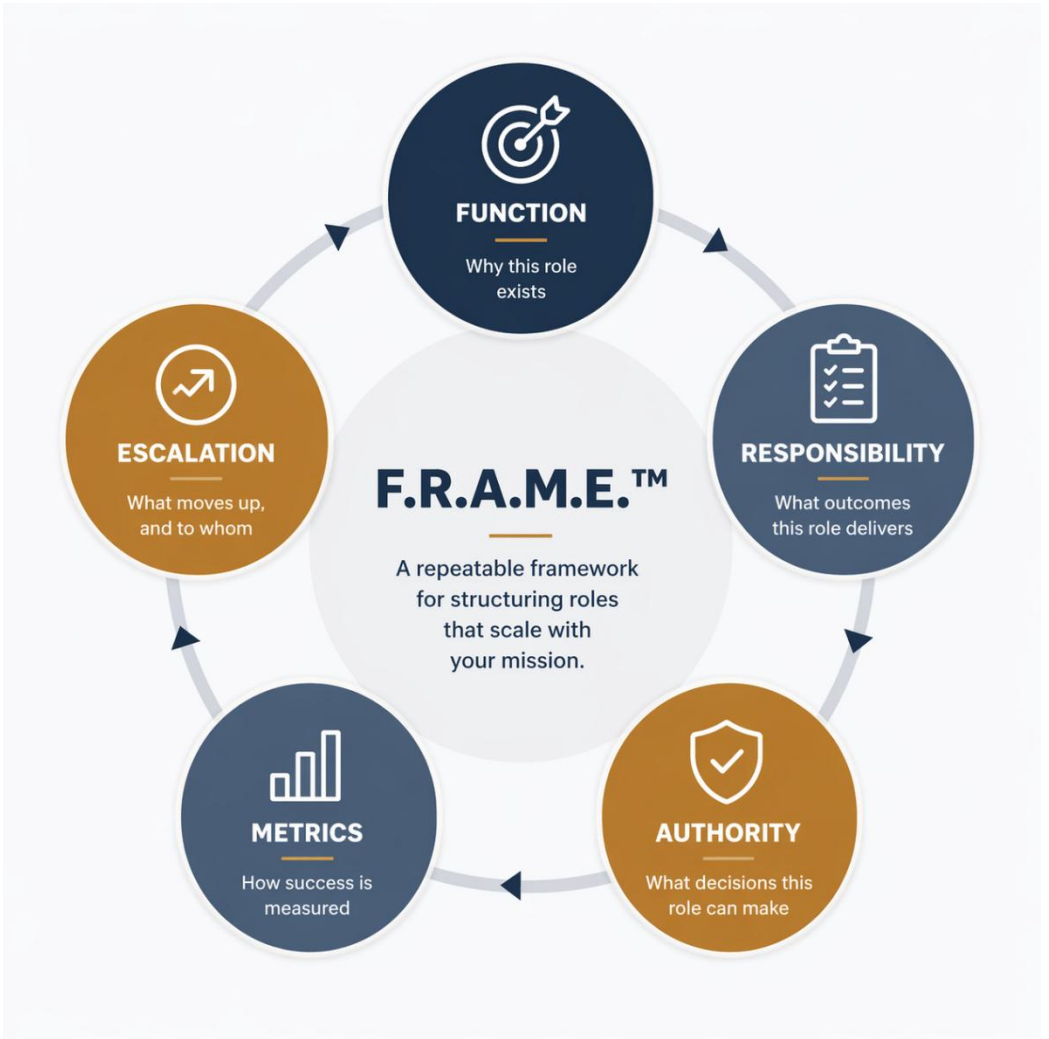
What does the employee say they need or want?

8



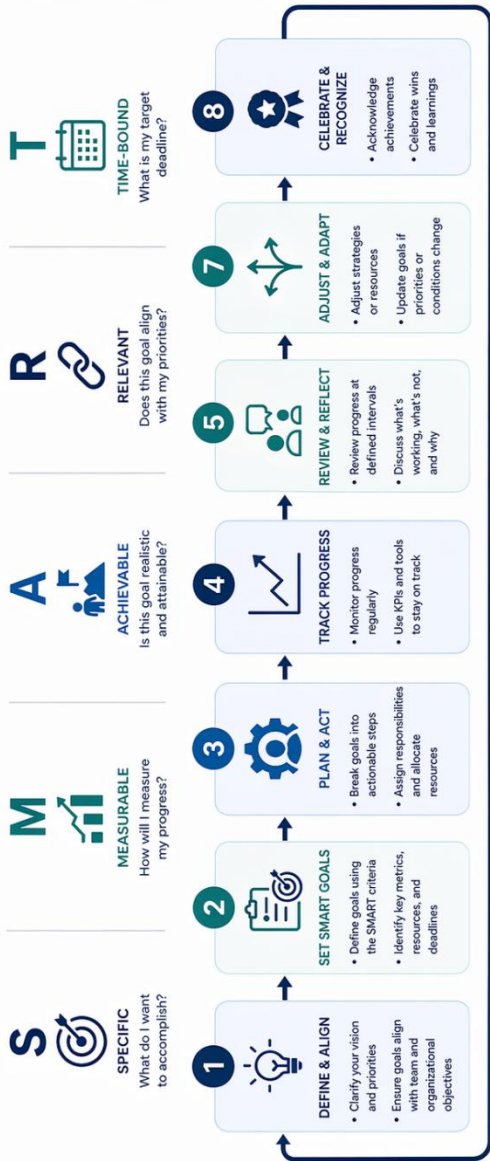
Who needs to be consulted?

HR, leadership, safety, legal, or another proper authority.



SMART GOAL WORKFLOW

A continuous process for setting, achieving, and exceeding goals.



BENEFITS OF THE SMART GOAL WORKFLOW

- ✓ Provides clarity and focus
- ✓ Improves accountability and performance
- ✓ Drives alignment and results
- ✓ Encourages continuous improvement

CONTINUOUS CYCLE.
Better goals.
Better results.
Stronger impact.

Preventive Workforce Architecture

Clarity before consequences.



Strong systems **prevent** problems. Clarity **creates** performance.

Corrective Architecture

— ADDRESS EARLY. CORRECT CLEARLY. STAY CONSISTENT. —



1. BUILD

WHAT IT INCLUDES



Timely coaching conversations



Specific feedback tied to observable behavior



Verbal counseling with clear expectations



Written follow-up when patterns continue



Progressive discipline that escalates with consistency

2. OPERATE

WHAT GOOD LOOKS LIKE



Issues are addressed when they are still small



Employees know what must change and by when



Supervisors correct behavior without overreacting



Accountability feels consistent rather than personal

3. BREAK

WHAT FAILURE LOOKS LIKE



Supervisors avoiding hard conversations



Vague feedback like "fix your attitude"



Long periods of silence followed by sudden escalation



Discipline starting only after patience runs out



Timely correction **builds trust**. Inconsistent correction **destroys it**.

Protective Architecture

CLARITY BEFORE CONSEQUENCES.



1. BUILD

WHAT IT INCLUDES

 Documentation that captures facts, impact, and expectations

 Policy alignment across corrective actions

 Consistency reviews across departments or supervisors

 HR oversight at high-risk decision points

 Records that show support, correction, and follow-up

2. OPERATE

WHAT GOOD LOOKS LIKE

 The file tells a clear story

 Actions are tied to policy and expectation

 Similar issues are handled similarly

 Decisions hold up under review

3. BREAK

WHAT FAILURE LOOKS LIKE

 Documentation created after the decision

 Missing dates, facts, or follow-up

 Different standards applied to different people

 A file that reflects conclusion without showing the process



Strong documentation **protects** people, decisions, and the organization.

Closing the Loop

The Black Book began where the receipt had to be traced. Every card in it refuses to let a label stand in for a diagnosis, because a label only names the discomfort. It never explains the failure, and it cannot repair it.

If this system has done its job, the organization now reaches for a different reflex. When a problem appears, the first move is no longer to find the person nearest the failure. It is to find the condition underneath the label, to walk the guided path one branch at a time, to score the condition instead of feeling it, to sort honestly what belonged to the person and what belonged to the design, and to build a repair that holds when no one is watching.

That is the brand position of this entire book, and the discipline it is trying to install. Senior judgment converted into a diagnostic operating system. The label is only the entry point. The work of this book is everything that comes after it.