**Description:**  Attached is a catalog of video hyperlinks. Each contains a title, hyperlink, duration, description, and possible application to Human Performance Improvement

**Location:**  This document will reside on the EFCOG HPI Task Group webpage in the DLA Catalog Folder. This effort is a supplement to Task 18-5, HPI Dynamic Learning Activity (DLA) Catalog

**Application**: This catalog may be used for any of the following:

1. Personal education: Several of the videos are from HPI thought leaders.
2. Concept clarification: Several of the videos may be used to enhance written or verbal descriptions of HPI concepts, principles, or error reduction tools
3. Humor: Several videos capture human fallibility in humorous method
4. Other applications not listed above

**Restrictions:**  Each row contains a hyperlink and description found at the hyperlinked website. Therefore it is your responsibility to follow all use restrictions and protocols. *This list is simply a tool for you to find HPI related videos.*

**Additions:**  Should you know of a HPI related video that is not contained in this list, please contact the EFCOG HPI Task Group leadership so that it may be considered for addition. Please include a hyperlink to the video or webpage where the video may be found. Also include your perspective on its application to HPI concepts, principles, and or tools.

| Title and Hyperlink | Duration | Description | Uses |
| --- | --- | --- | --- |
| Introduction to Human PerformanceSjb productions<https://www.youtube.com/watch?v=KWYMkvcNYis> | 21:27 | This video explains the basic principles and concepts behind Human Performance. This is the first video of the HPI (Human Performance Improvement) Video Series project.The video is meant to educate the electric utility employees of the introductory concepts and principles of Human Performance | * Reference
 |
| Being Human<https://toolbox.energyinst.org/c/videos/being-human> | 7:28 | Human performance is about understanding and accepting why, as people, we do what we do, why we do it, and the way we do it. In this video we will explore a few key themes of human performance. | * Reference
* Need for HPI
 |
| ISPI Human Performance Improvement Case Studies<https://www.youtube.com/watch?v=UepsI-7MRBg> | 14:21 | **ISPI**Human Performance Improvement (HPI, also called Human Performance Technology, HPT) is a systematic method for analyzing performance problems in organizations, planning coordinated interventions, and measuring results. This video includes interviews with managers who improved their organization's performance by using HPI. Included are military, government, and private sector organizations. See www.ispi.org for further details. Originally titled: Performance Technology Produces Results. Directed by Margo Murray, MMHA The Managers' Mentors, Inc. Produced by Applied Learning International. | * Reference
* Need for HPI
* Anecdotal evidence
 |
| The Field Guide to Understanding Human (Sidney Decker)Part 1<https://www.youtube.com/watch?v=Fw3SwEXc3PU>Part 2<https://www.youtube.com/watch?v=8R8nuAqpq-g>Part 3<https://www.youtube.com/watch?v=rUmnI3Nq3V4>Part 4<https://www.youtube.com/watch?v=crENdW2cGeU>Part 5<https://www.youtube.com/watch?v=CwJePfJYcg8> | 1. 6:37
2. 9:02
3. 7:21
4. 17:06
5. 12:12
 | Sidney Dekker helps you understand a new way of dealing with a perceived 'human error' problem in your organization. | * Reference
 |
| Professor Sidney Dekker on Why Things Go Wrong<https://www.youtube.com/watch?v=pYlIEMNhqM4> | 4:38 | Professor Sidney Dekker of Griffith University speaks about why things go wrong | * Reference
 |
| Safety Differently (Sidney Decker)<https://www.youtube.com/watch?v=nvGyreHrIoM> | 4:25 | Professor Sidney Dekker explains the need for doing safety differently. Watch the full Safety Differently Movie at http://sidneydekker.com/safety-differ... | * Reference
 |
| Prof. James Reason - Error Models<https://www.youtube.com/watch?v=4qnoc5EkFCE> | 18:35 | Total Training Support | * Reference
* Error modes
 |
| Reason explains Swiss Cheese Model<https://www.youtube.com/watch?v=KND5py-z8yI> | 4:08 | Engineering Solutions was produced on behalf of IFA. This short extract covers the James Reason's Swiss Cheese model explained by himself. | * Swiss Cheese Model
 |
| John Nance on Human Error<https://www.youtube.com/watch?v=dyq4SYUtLco> | 2:02 | John Nance explains Human Error at Leapfrog's (Health Care) Annual Meeting on December 6th, 2011 | * Reference
* Need for HPI
 |
| Job Hazard Analysis and Human Performance ImprovementNathan Crutchfield<https://www.youtube.com/watch?v=SXPzHsg_1UY> | 7:13 | An initial overview of how latent errors should be considered when completing the Job Hazard AnalysisPublished on Jan 25, 2011 | * Reference
 |
| Appreciative Inquiry<https://www.youtube.com/watch?v=QzW22wwh1J4&list=PLkQ6H3nH-DonqfrjF57JIwxN525l3QOis> | 3:45 | Creating Positive Change | * Reference
* Performance Improvement
* Management Skills
 |
| We make mistakes in Healthcare<https://www.youtube.com/watch?v=ZP4QRB6H7rY> | 5:31 | We’re human. We make mistakes. Even in healthcare....and we need to get used to that reality in order to better protect our staff and patients from preventable harm. That's the message of this provocative video from staff and leaders at University Health Network, a group of Toronto-based acute care health institutions. UHN continues to lead a national discussion in Canada about preventable medical errors, and the need to move to a Caring Safely culture across the healthcare spectrum. www.uhn.ca | * Reference
* Application of HPI
 |
| Our Kids Say it Best - The How's and Whys of HPI <https://www.youtube.com/watch?v=62jFUmkAuBs&list=PLkzIoxtkDTsPP1huaqzfGCB72H7p0krx->  | 4:13 | **ConEdison**Mario Mattich, Manager – ES&H Program Management (The Excellence Files)This video is about KIDS SAY IT BEST HPI | * Motivational
* Application of HPI
 |
| Human Performance Improvement<https://www.youtube.com/watch?v=bhOOq9BeQHU> | 11:34 | This is a video I produced to celebrate Brooklyn Substations in their 5 years "Operating Error Free" milestone through Human Performance on October 7, 2016. I am very proud of the men and women who made this possible!!! These are real people who do the job correctly day in and day out. Each day, every day! Stay Safe, Stay Focused, and continue to Operate like a PRO! Point, Read, Operate | * Anecdotal evidence
* Application of HPI
 |
| Introduction to Human Performance Improvement (HPI)<https://youtu.be/YoTKvv79q0Q> | 48:04 | Jeff Dalto of *Convergence Training & Vector Solutions* speaks with Joe Estey (Performance Improvement Specialist with *Lucas Engineering Management Solutions*) to get an understanding of what Human Performance Improvement, or HPI is, why to consider implementing it, and how to implement it. | * Reference
 |
| The Betsy Lehman Center for Patient Safety and Medical Error Reduction<https://www.youtube.com/watch?v=wwB88zF4wvU>  | 9:51 | The backstory of the Betsy Lehman Center for Patient Safety and Medical Error Reduction, which was named for a Boston Globe health columnist who died from a massive overdose of chemotherapy, given in error. Go to [http://commonhealth.wbur.org/2014/12/...](https://www.youtube.com/redirect?v=wwB88zF4wvU&redir_token=m5Cy_bOGT0b27-anCD070I6S42x8MTU4MDI1MTMxN0AxNTgwMTY0OTE3&event=video_description&q=http%3A%2F%2Fcommonhealth.wbur.org%2F2014%2F12%2Fmedical-errors-massachusetts-study) to read the full story on the WBUR CommonHealth Blog. Video provided by the Betsy Lehman Center for Patient Safety and Medical Error Reduction. | * Anecdotal evidence
* The need for HPI
 |
| Transparency, Compassion, and Truth in Medical Errors: Leilani Schweitzer at TEDxUniversityofNevadaLeilani Schweitzer: How Can Hospitals Be More Transparent About Medical Errors?<https://youtu.be/qmaY9DEzBzI> | 15:19 | The human element can give us kindness and compassion; it can also give us what we don't want— mistakes and failure. Leilani Schweitzer's son died after a series of medical mistakes. In her talk she discusses the importance and possibilities of transparency in medicine, especially after preventable errors. And how truth and compassion are essential for healing. | * Anecdotal evidence
* Application of HPI
 |
| Best Practice Webinar: Three practical strategies for managing preventable errors in the workplace<https://www.youtube.com/watch?time_continue=2&v=pw3hK5uDaA0> | 57:50 | **Jake Mazulewicz,**Preventable errors on electric utility worksites can end lives, ruin careers and capsize reputations overnight. Some companies manage workplace errors far more effectively than others. What works? What doesn’t? Which methods should you use? Join us to learn the fundamentals of three core error management strategies used by pilots, surgeons, paratroopers, wildland firefighters, and other high reliability teams including those throughout the electric utility industry.► To learn more about Accelix go to https://bit.ly/2ncxyAx ► Follow Accelix on Facebook https://bit.ly/2nWMrae ► Follow Accelix on Instagram https://bit.ly/2mjdOL8 | * Reference
* Application of HPI
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| What is HOPLAB?Southpac International GroupAndy Shone<https://www.youtube.com/watch?v=rRtY2ePoRPg>  | 2:59 | **HOPLAB**The underlying principles of the HOPLAB are to share to collaborate to innovate and to bring people together so they can learn from each other. There’s not that many companies doing this yet. We hope that eventually there will be a lot of companies doing HOP and it will becomes the new social norm. There’s a lot of very large organization trying to do HOP who like the lonely voice in the wilderness. So we want to try and supply them with some support. But also the smaller companies who are doing great but no ones knows about HOP. So one already here this week, I had no idea they were already implementing HOP and were having great results. How do we connect that one small business over here with another small business who are really enthusiastic but in their early stages. So HOPLAB is one way for them to get together and say ‘this has been really good for us and we have had great success with this but we have had challenges with that’ and then this company over here who are in an earlier stage can then bring these ideas together. So that’s one part. But also to try and create a space as role of host thought leaders from all over the world who have been for a very long time and haven’t been recognized. Or breaking out into a space with the people we’re already working with and say ‘this is very similar to what you are doing’ or ‘ this is completely different but can add to the conversation we are having with HOP. People have been doing interesting work around HOP but not quite HOP with the same underlying principles so we can bring them to HOPLAB and add to the conversation through the Masterclass Tour which we are really excited about. Which will people from close to home some from far away who will be coming and talking. That is a well as the stories from everyday people and organizations who are kicking goals and having great success with these ideas. Its for the leaders, the people doing the work, work with organizations who we are working with right now. Its bringing all of these different people into one conversation. We can all learn, collaborate and innovate and when we do that we do that we have better outcomes, better solutions is what we are trying to achieve with the HOPLAB. | * Human and Organizational Performance
 |
| What is HOP?Southpac International GroupBob Edwards<https://www.youtube.com/watch?v=ZoMp5N6AQsc>  | 1:43 | **HOPLAB**Humans and organisational performance or HOP is what we do at work. Its work. Its humans and organisations performing. Its not a separate program. We learn from human performance, we learn from LEAN, from any place that brings value. Lean manufacturing has a lot of cool stuff. But HOP pulls it altogether more comprehensively while throwing out the stuff that’s not very helpful and building on the stuff that is helpful. HOP gives us permission as an organisation or leadership team or operational teams to question more. When we question more what things we are doing that help so lets build on those and what things are we doing that are just a waste of time and start reducing or removing. HOP talks a lot about moving past blame because blame doesn’t seem to fix anything. We can’t stop telling people not to blame, because we blame ourselves when we mess up, but it doesn’t seem to make us any better. So one of the things we use in HOP is moving beyond blame and onto systems that can handle humans. Realising that humans fundamentally come to work to do a good job. So when something bad happens, we really want them to help us how it happened and help us make it better. Contact Southpac International today for innovative HOP courses. |  |
| Explain the five principles of HOPSouthpac International GroupAndy Shone<https://www.youtube.com/watch?v=KWWI8stkOTM>  | 4:53 | **HOPLAB**This video talks about the five principles of HOP. | * HOP principles
 |
| What are the benefits of the HOP approachSouthpac International GroupBob Edwards<https://www.youtube.com/watch?v=0H0pLHiXCes>  | 1:53 | **HOPLAB**The benefits of using the new way of thinking. Maybe its not new, but the benefits who are the employees who are what we call the ‘sharp end of the stick’ are the ones getting things done out there; turning wrenches and making things happen are given a lot of respect in this. We realise they are the ones making this work happen and yes, we need leaders, we need engineers, we need directors and managers, but we also really need the people who are willing to do this hard work to make things happen. One of the biggest benefits that we have been looking at for a long time is how do we get better at engagement and collaboration. As its one thing to ask employees to be more engaged and it’s another to say, “I value you, collaborate with me and see if we can build better work”. So how do you measure this? Well, we don’t know. Because we have so many metrics already what we do say is watch your metrics and see what happens. In some cases, injury rates may go up as people are willing to talk about what’s really happening and they are not hiding injuries. In some cases, we have seen the severity of injuries go way down. In some cases, we have seen organisations with phenomenal numbers but when we peel back that outer layer and looked inside, were quite brittle. So, the value is we’re learning about reality. That’s way, not every organisation doesn’t do this; many of them do not. It's becoming more common to talk about it but it's not the new social norm. We still have plenty of companies that are not comfortable with knowing the way work really gets done. Bob Edwards | Proudly brought to you by Southpac International. | * The benefits of HPI
 |
| What is a Learning Team?Southpac International GroupAndy Shone<https://www.youtube.com/watch?v=TtAaqeCjhys>  | 1:46 | **HOPLAB**Learning Teams are about having a conversation with people who do the work. Often organizations do investigations when things go wrong. They can be useful. Sometimes. But, sometimes they simply confer something we already know. What you look, is what you find. With Learning Teams, we are trying to build a picture by talking to the people who do the work every day. They understand the Blue Line. The real operations. How work really gets done, not how we think work gets done or Work as Imagined (the Black Line). So we want to get them involved. The incredible thing is, and what makes Learning teams so powerful is, as soon as people feel that they are able to speak and be honest. We learn way more than we ever anticipated going into the Learning Team. We might go in wanting to learn about this particular activity or this particular process and we end up learning a lot, lot more. The other great things about Learning Teams is, that we can do them on things that go wrong, but even better to do them on normal activities to find out: "Is this really working how we think it is working?" "Where are the pain points, how can we improve this?" If we can do that, it improves safety, we improve the processes, quality, productivity and so on. So it allows us to have a very real conversation with our front line, about their challenges, their successes. It gives organisations real-live valuable information they probably wouldn't get any other way. | * Learning Team orientation
* Learning Organization
 |
| What are learning teams?Southpac International GroupBob Edwards<https://www.youtube.com/watch?v=vVtLTCpA1GY>  | 1:13 | HOPLABLearning team is about the conversation. Its about bringing people together who do the work, that know the work, that can help us understand how work really gets done. And whether its because something bad happened or almost happened, could be from quality escape, could be an operational upset, maybe even studying successful work, but learning teams are people who know the work helping us understand how the work really gets done. Not how we plan for it to get done, because we always have great plans or so we think. Its like going on a trip, we make plans but as soon as you get on the highway you have to start adapting and adjusting the plan. The learning teams gives us the understanding that we need if we want to get better. What does it really take to get work done, not just what the plan says we were supposed to do. What do we have to actually do to get the work done? | * Learning Team
 |
| When should we use learning teams?Southpac International GroupBob Edwards<https://www.youtube.com/watch?v=nOdHZCRXlDI>  | 1:30 | HOPLABAnytime we want to learn more, whether it was an actual incident, quality escape, could be a near miss, or near hit, good catch, could be an engineering challenge. As an engineer I love using learning teams as I have to the people who build it, maintain it and repair it and the people who are designing it. I like to bring them all together. Because the designers are brilliant, but they don’t know what the manufacturers knows they don’t know about the repairers knows, because they don’t go out and repair or build. So, its really important to study success and successful operations and see if in fact we are as good as we think we are. | * Learning Teams
 |
| How can we learn from human error? | Ivan Pupulidy, PhD | TEDxABQSalon<https://www.youtube.com/watch?v=4wLY_kCNW8k> | 10:31 | Preventable human error is cited as the third leading cause of death in medicine. But error is a common thing in human actions. Dr. Ivan Pupulidy is exploring another way to look at error. He will introduce a concept called the learning review, which asks us to consider the system and the conditions that surround human actions. This path allows us to use error as the starting point for an investigation and places learning ahead of blame. Dr. Pupulidy is the Director of the Office of Learning at the US Forest Service. Over the last decade, he has helped the Forest Service and other organizations accept learning as a principle value. He has also developed a new approach to the review of accidents and incidents, which has been accepted by the US Forest Service and replaced the Serious Accident Investigation Process. Unlike other accident protocols, the “Learning Review” is specifically designed to understand human actions in complex adaptive systems. This talk was given at a TEDx event using the TED conference format but independently organized by a local community. Learn more at https://www.ted.com/tedx | * Reference
* Application of HPI
 |
| Believing in Zero - John Nance<https://www.youtube.com/watch?v=7Eu-5JxTMlg> | 4:45 | A licensed attorney, a decorated Air Force pilot, a Vietnam and Operations Desert Storm/Desert Shield veteran, and an award-winning author, John J. Nance brings a rich diversity of professional training and background to the quest for patient safety and medical practice improvement. A dynamic and deeply dedicated member of the medical community for nearly two decades, Nance was one of the founding members of the National Patient Safety Foundation at the AMA. He has become a trusted and internationally recognized broadcast analyst and advocate for both medical/patient safety and aviation safety and has logged countless appearances on national shows such as Larry King Live, The NewsHour with Jim Lehrer, Oprah, NPR, Nova, The Today Show, and many others. His editorials have been published in newspapers nationwide, including The Los Angeles Times and USA Today. | * Reference material
* inspirational
 |
| Human Performance Improvement<https://www.youtube.com/watch?v=-FiLXoKGiIc> | 11:19 | **Talentrics (2013)**Human Performance Improvement (HPI) is a consultative approach to identifying core performance and opportunity gaps within your business, and provides a framework to develop, implement and measure performance solutions. By using HPI, you will build more strategic partnerships with your clients by focusing on business outcomes more than tracking participation & satisfaction in training delivery. | * Reference
* Application of HPI
 |
| Being Human<https://toolbox.energyinst.org/c/videos/being-human>  | 7:28 | **Toolbox: Putting safety in your hands**Human performance is about understanding and accepting why, as people, we do what we do, why we do it, and the way we do it. In this video we will explore a few key themes of human performance. | * Reference
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| Human Performance – What does it mean?<https://toolbox.energyinst.org/c/videos/human-performance-what-does-it-mean>  | 2:22 | **Toolbox: Putting safety in your hands**Any risk of an incident is one too many. Conversation is the first step for improvement, which is why communication from frontline workers and operations staff is crucial for understanding how processes and tools can be adapted to reduce errors. | * Reference
 |
| Chronic Unease: Recognizing weak signals can help reduce incidents:<https://toolbox.energyinst.org/c/videos/13-chronic-unease> * Part 1: It won’t happen to me
* Part 2: We are all Human
* Part 3: Mind Traps
 | 10:06 | **Toolbox: Putting safety in your hands**Chronic unease is the alertness to weak signals and to mind traps. It is about resetting our tolerance to risk and understanding that small failures are signs that something needs fixing. The video consists of three parts – it stops automatically after each part for an engagement activity. The first part of the video is called “Chronic Unease”. In the first part of the video we see what chronic unease means, using different practical examples in daily life. The second part of the video is called “We are all human.” In this second part of the video we see how our minds work and how this relates to the actions we take or don’t take related to safety. The last part is called “Mind traps.” It explains the biases that we have and how they affect our actions related to safety.[Download the facilitator guidance.](https://toolbox.energyinst.org/__data/assets/pdf_file/0009/1413/Facilitator-guidance-Chronic-unease.pdf) | * Questioning Attitude
* Stop when Unsure
 |
| I keep my barrier strong: <https://toolbox.energyinst.org/c/videos/i-keep-my-barrier-strong> * Part 1: Two incidences – A world apart
* Part 2: When things change
* Part 3: I keep my barrier strong
 | 10:51 | **Toolbox: Putting safety in your hands**In the first process safety reflective learning video we reflected on barrier ownership in general. The key message was about knowing your barrier and ensuring it is strong and healthy. Hardware barriers, human barriers and critical processes were explained. In this second process safety related video, we go in deeper and focus on barriers and critical processes when things change. In the first part of the video we see two scenarios, one about a ship that enters the 500 meter zone, and one about a pigging operation. In part 2, the story develops and we see the situation changing. New threats and hazards appear. The last part of the video explains normalisation of risk and the fact that we are often too optimistic on the outcome of our actions and plans.[Download the facilitator guidance.](https://toolbox.energyinst.org/__data/assets/pdf_file/0009/1422/Facilitator-guidance-I-keep-my-barrier-strong.pdf) | * Controls/Defenses
 |
| I own my barrier: <https://toolbox.energyinst.org/c/videos/i-own-my-barrier> * Part 2: The valve
* Part 3: I own my barrier
 | 11:47 | **Toolbox: Putting safety in your hands**Keeping our product in the pipe or in facilities from the moment we start drilling until the moment we deliver our products to our customers is crucial. In this video we will focus on barrier ownership and put it in context of asset integrity. The first part of the video makes people aware that incidents can happen if barriers are not in place. The Piper Alpha incident is used as an example. In the second part, the bowtie is described. There are hardware- and human barriers, which are supported by critical processes. In the last part of the video we see a petal model appear, a visual representation of asset integrity.[Download the facilitator guidance.](https://toolbox.energyinst.org/__data/assets/pdf_file/0010/1423/Facilitator-guidance-I-own-my-barrier.pdf) | * Controls/Defenses
 |
| Safety Leadership in the field:<https://toolbox.energyinst.org/c/videos/safety-leadership-in-the-field> * Part 1: Open questions
* Part 2: Active Listening
* Part 3: Reframing for problem-solving
* Part 4: What happened next?
 | 5:06 | **Toolbox: Putting safety in your hands**Learn how the use of open questions, active listening and reframing problems as dilemmas can encourage the dialogue between frontline staff and leadership. | * Leadership
* Observations
* Management in the field
* Questioning attitude
* Raising concerns
 |
| Walk thru a task to prevent an incident:<https://toolbox.energyinst.org/c/videos/walk-through-a-task-to-prevent-incidents>  | 3:45 | **Toolbox: Putting safety in your hands**No matter how well we think a task has been planned or designed (work-as-imagined), there are always differences when it comes to execution (work-as-done). Those who do the job will always have to design the last part of it – dealing with local conditions, problem-solving issues they come across, or making the best of the equipment and processes they have. | * Task Preview
* Job site review
 |
| The power of example:<https://toolbox.energyinst.org/c/videos/the-power-of-example>  | 3:16 | **Toolbox: Putting safety in your hands**The example you set influences others. Watch a real life example. A man crosses a railroad crossing, and is followed by his friend. | * Principle #3
 |
| Changing the wrong pressure safety valve:<https://toolbox.energyinst.org/c/videos/changing-the-wrong-pressure-safety-valve>  | 5:53 | **Toolbox: Putting safety in your hands**A potential incident is narrowly avoided when operators replace the wrong pressure safety valve. | * Case study
* Unplanned work
* Emergent work
* Assumptions
* Wrong component
* Near miss
* What is the worst thing that could happen?
 |
| Aviation misfuelling prevention<https://www.youtube.com/watch?v=rrg--s48NrA>  | 4:37 | **Energy Institute**Misfuelling costs lives every year. The EI has developed a new video designed to prevent misfuelling incidents in the aviation industry. Detailing the devastating consequences of a misfuelling incident, this hard-hitting video delivers a powerful message to all operational staff: Stop. Think. Is this the correct fuel for this aircraft? Further support for industry can be found online: <https://publishing.energyinst.org/avi>... in the form of EI good practice guidance, which are produced to assist in the reliable and safe provision of aviation fuel to commercial aircrafts. Specifically, EI Recommended Practice 1597 Procedures for overwing fuelling to ensure delivery of the correct fuel grade to an aircraft provides recommendations for industry provides a system for use by aircraft fuelling ground staff that will prevent aircraft misfuelling and thereby prevent serious incidents. It’s time to act: all misfuelling incidents can be avoided. | * Case Study
* Labeling
* Questioning attitude
* 3-way communications
 |
| The modern view of incident causation<https://toolbox.energyinst.org/c/videos/the-modern-view-of-incident-causation>  | 2:16 | **Toolbox: Putting safety in your hands**We may think that fixing one thing in a chain of events will prevent a bad outcome. This video explains why it’s not that simple. Difficult conditions and error-prone situations are always present in our work. When these combine and increase risk, they can lead to an incident. The good news is that this insight helps us to get ahead of incidents. When we surface and tackle problems, we reduce the likelihood of them interacting together to become an incident. To make these issues visible, it takes leaders and workforce to talk together about how work really happens. | * Event Investigations
* Psychological Safety
* Worker participation
* System weaknesses
 |
| Sleep matters:<https://toolbox.energyinst.org/c/videos/sleep-matters> * Part 1: Sleep matters
* Part 2: Sleep Well
* Part 3: A shared responsibility
 | 10:48 | **Toolbox: Putting safety in your hands**For both individuals and as a work group, it is important to elaborate on how to reduce fatigue risk for the team. This video explains the importance in an interactive way. After seeing this video, participants are able to demonstrate they actively care for each other and can openly discuss fatigue and other safety concerns. and intervene with each other. As part of the session participants are asked what they will do differently to ensure they get enough sleep. In part 1 of the video, the concepts of sleep and fatigue are introduced and where fatigue situations occur in the workplace. It is stressed that one might not be aware of being fatigued. Part 2 gets the audience ready to reflect on their sleeping arrangements, environment and habits and to see how they can improve the quality of sleep for themselves and the whole family. In the last part of the video we look at how recognising fatigue and respecting sleep needs is a shared responsibility, involving the individual, their family and work colleagues. Sleep matters![Download the facilitator guidance.](https://toolbox.energyinst.org/__data/assets/pdf_file/0012/1425/Facilitator-guidance-Sleep-matters.pdf) | * Fatigue
* Sleep
 |
| Prof. Reason - Error types<https://www.youtube.com/watch?v=iHaQjoxQlLs>  | 27:31 | **A fall from grace: Patterns of Human Error Human Error**BBC videoJames Reason explains and demonstrates various types of errors as well an explanation of why these errors occur or do not occur.Several case studies are referenced (Piper Alpha, Tenerife, etc.) | * The value of HPI
* Error theory
 |
| Swiss Cheese<https://www.youtube.com/watch?v=ByQRDuXOgI8>  | 1:12 | **Energy Institute**Managing a business in a successful way is about understanding how the work environment and related hazards can lead to accidents. | * Swiss Cheese
* Failed barriers/controls
 |
| The importance of reflection in learning from incidents<https://www.youtube.com/watch?v=nNyKFeAxmcI>  | 4:43 | **Energy Institute**For learning to happen you must understand why the incident matters to you, you must take time to reflect on the incident and then decide how to take the lessons learned to make your own job safer. Reflection can happen proactively by taking time to think alone, or it can happen reactively when something unexpected happens during a task. This video helps to understand the importance and barriers to reflection, as well as introduces effective strategies to work around those barriers. | * Lessons Learned
* Operating Experience
 |
| Introduction to errors and violations<https://www.youtube.com/watch?v=448MWntGuiE>  | 6:12 | **Energy Institute**There are different types of human error, known as errors and violations. Errors typically refer to slips, lapses or mistakes caused by not paying sufficient attention or failure to solve a problem. On the other hand, violations are intentional actions when people know that they should not be doing something but do it anyway. To find out why people perform workplace violations, watch this video and visit the Hearts and Minds website: <https://heartsandminds.energyinst.org> | * Performance modes
* Violations
 |
| Rule of Three<https://www.youtube.com/watch?v=ASnCtjj_2rA>  | 3:21 | **Energy Institute**The rule of three is a simple technique that can help you develop a good habit for recognising how normal situations can escalate to become serious risks. What are the ambers in your business? How to recognise them as being dangerous? To find out more on how serious risks can be prevented using the Rule of Three, visit the Hearts and Mind website: <https://heartsandminds.energyinst.org>... | * Know when to stop
* Stop when unsure
 |
| Generative Cultures<https://www.youtube.com/watch?v=a7gplNBFEcA>  | 5:41 | **Energy Institute**Generative culture is hard to find and represents the top level of the HSE maturity ladder. This type of organisational culture learns and adapts by focusing on understanding near-miss situations, as well as finding the underlying causes of incidents. Actively seeking out and learning from their failure, generative cultures embrace their errors and use those errors to learn and get better. Is your culture a generative one? If you are interested in finding out more, please visit Hearts and Minds website: https://heartsandminds.energyinst.org. | * Organizational Learning
* HRO: High Risk Organizations
* Safety Culture
 |
| Pre-Accident Investigations (The Podcast)Safety Moment - Is Stop When Unsure a Piece of Bad Advice?<https://www.youtube.com/watch?v=5SdKS24S2sY> Safety FM: <https://www.youtube.com/watch?v=xhk1WkB2_EY> | 3:50 | Todd Conklin turns “Stop when unsure” into “Start when certain” | * Stop when unsure
* Know when to stop
* Start when certain
 |
| What is Human Error | Explained in 2 min<https://www.youtube.com/watch?v=TJdfkmKydyY>  | 2:36 | In this video, we will explore What is Human Error. | * Introduction to Human Error
 |
| Human PerformanceTeresa Waddington <https://www.youtube.com/playlist?list=PLT6ASoWJI68qaHB7d7gBMVH2kng4c0ja7>  | 2:004:224:013:143:37 | **Human Performance - Truth and Power**<https://www.youtube.com/watch?v=aW0O6aevpF0&list=PLT6ASoWJI68qaHB7d7gBMVH2kng4c0ja7&index=1> Speaking truth to power is a game-changing concept in making our workplaces safer; but it’s not easy. It’s not easy to look within ourselves to articulate truth when we’re feeling embarrassed or scared, and it’s not easy to hear truth when we’re feeling embarrassed or scared. This video looks at how speaking - and hearing - truth is the hard way that is always easier in the end.**Human Performance -Set Up for Safety**<https://www.youtube.com/watch?v=7JHFl4BVQvE&list=PLT6ASoWJI68qaHB7d7gBMVH2kng4c0ja7&index=2>What are the structures that help our organisations be set up for safety? This video discusses the 6 key elements that High Reliability Organisations have in place to deliver safety performance.**Human Performance – Learning**<https://www.youtube.com/watch?v=6xasZXRiEeA&list=PLT6ASoWJI68qaHB7d7gBMVH2kng4c0ja7&index=3> Creating a learning organization requires a commitment to change. It calls us to reject the easy answers, to dive into the messy details, and to approach our people with care, curiosity, and a true desire to understand. This video talks about how we can nurture learning in ourselves, our people and our organizations.**Human Performance - Safety Culture**<https://www.youtube.com/watch?v=rlbVNQxqOWA&list=PLT6ASoWJI68qaHB7d7gBMVH2kng4c0ja7&index=4>Creating culture - especially a strong culture of safety - can seem like a difficult task. This video looks at what is responsible for risk in the workplace, and how we can balance risk to create a strong safety culture.**Human Performance - Imperfect People and Models of Failure**<https://www.youtube.com/watch?v=vLmo4a5dnPY&list=PLT6ASoWJI68qaHB7d7gBMVH2kng4c0ja7&index=5>Ever wonder what human performance is? A short video on how we can prevent incidents on our imperfect systems, with imperfect people.Discusses four failure models and where systems like Hierarchy of Control, audits and visible safety leadership, structured risk assessment and barrier health come from. | * Reference
* Concepts
* Theory
 |
| How to handle Human Errors in Pharmaceutical Manufacturing<https://www.youtube.com/watch?v=0C91hpKgj3E>  | 1:45:07 | **Pharma Best Practices Webinars**About the webinar Failure to meet requirements or specifications in Pharmaceutical Manufacturing needs to be addressed by senior management in a compliant manner. An analysis of recent FDA citations reveals that many of the failures are attributed to “human error.” This educational Session will address : What is Human error?How to perform a failure investigation?What Methodology should be followed to determine a root cause?What documentation is required to support a root cause?What are the risks and their impact on the organization?Can only training be an acceptable CAPA?What should be the role of Senior management?Importance of trending Impact of Quality culture Importance of Reward and recognition About the Presenter Dr. M.Damodharan M, Sr. Vice President – Global Quality & Regulatory Affairs – Sai Life Sciences Ltd, has more than 26 years of varied experience in Pharmaceutical Industry in companies like GSK and Ranbaxy. He has implemented self-sustained Quality Management Systems and all time inspection readiness strategies, performed 100 + audits across the globe, successfully handled various regulatory agencies audits including USFDA, implemented integrated electronic systems. He was a contributing author of the ISPE Good Practice Guide: Technology Transfer ( Small molecule case study # 3: Development to commercial at CDMO) | * Webinar
 |
| Human Error Reduction Webinar with Chris Cinieri<https://www.youtube.com/watch?v=7qCkO_dB3qM>  | 39:28 | **Plaris MEP**WHY does "operator error" happen? Find out about tools, tactics and training to reduce "human error" in this fast-moving webinar.Project Manager Chris Cinieri holds a Six Sigma Black Belt from the American Society for Quality. In this webinar, he gives advice on how to reduce human errorTo see more online events for Rhode Island manufacturers, visit <https://polarismep.org/events/> | * Quality Management Systems
* Human Error
 |
| Understanding and managing human error - In a nutshell<https://www.youtube.com/watch?v=eGS5-qs_aZw> | 2:26 | Understanding and managing human error – in a nutshell Humans, all of us, make mistakes. In some industries these mistakes can have really bad consequences – nuclear power, aviation, railways and healthcare for example. In these industries significant effort is spent on eliminating errors, or reducing their consequences. However, errors happen in every business and you will feel the effects of them. A common response to an error is to sanction the person in some way; either through formal discipline, or by sending them for remedial training. Whilst this may be emotionally satisfying for their manager, ultimately it is futile. After all, in most cases, the person will have felt the consequences of their mistake and will have learned from the experience. However, the ‘system’ that they work within – their workplace, the rules they follow, the stresses they feel and the organisation’s culture – will have shaped their behaviour. And this system won’t change unless we try to find out what effect it has on the people working there. This means that other people in similar situations are likely to make similar mistakes, hurting your business (or themselves). So, what things should you look for? Well there are really three areas you need to explore: • the person involved • their workplace and, • the wider organisation. With the person you should find out if they have the skills, personality, attitude, and risk perception to do the job well. In the workplace you should look at how the task has been designed, people’s workloads, their working environment and the procedures they need to follow. In the wider organisation, culture plays a major role in how people behave. For example, how your leaders and managers are seen to behave will have a major effect on the behaviour of the people who work for them. Mistakes provide a real opportunity to learn and improve your business – and there are plenty of simple tools and techniques you can use to uncover these underlying causal factors. Mistakes happen – take the time to learn from them. John Baker Silver Moor Business Consulting LLP john.baker@silvermoorconsulting.co.uk http://www.silvermoorconsulting.co.uk  | * Reference
 |
| NSF International Webinar: Human Error Prevention: The Psychology of Why People Make Mistakes<https://www.youtube.com/watch?v=uO5tjMhWWWc><https://www.youtube.com/user/NSFInternational/videos> | 33:59 | This webinar by Martin Lush focuses on the psychology of human error – why do intelligent and committed people make mistakes? Martin also details best-in-class practices in terms of preventing human error. | * Reference
* Behaviors and decisions
 |
| NSF International: Human Error Reduction<https://www.youtube.com/watch?v=X52ajEoQf-s&t=57s><https://www.youtube.com/user/NSFInternational/videos> | 4:44 | In this video Martin Lush, Global Vice President of Pharma Biotech and Medical Devices, talks about our unique approach to human error reduction within the pharmaceutical industry and explains the program we have designed to help you reduce errors in your organization. | * Reference
* HPI Application
 |
| NSF International: How to reduce repeat deviations, errors and mistakes<https://www.youtube.com/watch?v=XM7rpv1Ya7Y><https://www.youtube.com/user/NSFInternational/videos> | 5:09 | In this video Martin Lush, Global Vice President of Pharma Biotech and Medical Devices, provides invaluable guidance on how to reduce numbers of repeat incidents, their associated costs and your stress levels! | * Error Reduction approach
 |
| NSF International: “Six to Fix” Tips for Repeat Deviation Reduction<https://www.youtube.com/watch?v=w3TqOp9-0L8><https://www.youtube.com/user/NSFInternational/videos> | 5:10 | In this video Martin Lush, Global Vice President of Pharma Biotech and Medical Devices, gives some simple best-in-class deviation practices to help you reduce repeat deviations and the so-called human errors in your organization. | * Error reduction approach
 |
| Sidney Dekker - Just Culture (Full Lecture)<https://www.youtube.com/watch?v=gKqYMpWZbV8> | 41:44 | Sidney has gained worldwide acclaim for his groundbreaking work on human error and safety. He was previously at Lund University in Sweden as Professor where he founded the Leonardo da Vinci Laboratory for Complexity and Systems Thinking, as well as the MSc in Human Factors and System Safety. The program is still running, taking in practitioners from all over the world every year, and Sidney often finds the time to come to Sweden and teach a Learning Lab in the program. He has also been a Senior Fellow at Nanyang Technological University in Singapore, and Visiting Academic in the Department of Epidemiology and Preventive Medicine, Monash University in Melbourne, Australia. He has held an appointment as Professor of Community Health Science at the Faculty of Medicine, University of Manitoba, in Canada.-Source: http://sidneydekker.com/ | * Just Culture
 |
| CAPAssurance: Just Culture: Evaluating Behavioral Choices<https://www.youtube.com/watch?v=Q47jOh0nRJ0> | 9:42 | When determining accountability, Just Culture looks at human behavior and the choices we make. Human behavior is classified according to three different levels of culpability: Human Error, At-Risk Behavior, and Reckless Behavior. Cathy Miller, senior risk management specialist at CAPAssurance, evaluates these behavioral choices in this video. | * Just Culture
* Learning Organizations
 |
| Human Error Fix - Remove Blame | Pharma Biotech<https://www.youtube.com/watch?v=uPT0JbonNW0><https://www.youtube.com/user/NSFInternational/videos> | 1:16 | Start with these 1 minute fixes by NSF International if you want to prevent Human Error. | * Just Culture
* No Blame
 |
| Human Error All The Way<https://www.youtube.com/watch?v=xfl1idVWkUI> | 0:55 | It's always human error, especially when there's no witnesses left.Movie - On Deadly Ground | * Blame culture
 |
| Informa Australia: Reducing Human Error - Safety in Action<https://www.youtube.com/watch?v=g3ovRWpehvg> | 2:46 | We speak to Cristian Sylvestre, Managing Director at SafeStart about reducing human error and building safety culture from the 'bottom up'. http://www.safetyinaction.net.au/ | * Safety Culture
* Look before you move
* Employee Engagement
 |
| NSF International: How to achieve a blame-free culture<https://www.youtube.com/watch?v=z6XjwraVFiU><https://www.youtube.com/user/NSFInternational/videos> | 6:16 | To get the best out of people and drive continuous improvement you must first remove blame. Martin Lush, Global Vice President of Pharma Biotech and Medical Devices, explains how in this short video. | * Just Culture
* No Blame
 |
| Lund University – Human Factors and Systems Safety: Two views on Human Error<https://www.youtube.com/watch?v=rHeukoWWtQ8> | 5:52 | In this video Dr. Johan Bergström introduces two schools of thought on the notion of 'human error': (1) the cognitive psychological school and (2) the joint cognitive school. [www.humanfactors.lth.se](file:///%5C%5Cdcstorage.lanl.gov%5Cdcstorage_eshq_adeshq%24%5Cto%20OSH.HPI%5CHPI%20Practitioners%5CCommunity%20of%20Practice%20Workshop%5C2019-10-22%5Cwww.humanfactors.lth.se) | * Reference
 |
| Innovations in Safety: Understanding Human ErrorRichard A Pollock, CSP<https://www.youtube.com/watch?v=ahLL1iICQKk> | 58:43 | University of Wisconsin – Whitewater – Collage of Business and Economics  | * Reference
 |
| Lifetime Reliability Solutions Global: Human Error: Human error is inevitable, but you can do a lot to prevent mistakes<https://www.youtube.com/watch?v=jAlZWcrLHgs> | 51:53 | LRS Plant Wellness Way Day1 Session 06: Human Error: People are imperfect; we get fatigued, we misread, we lose attention. Human error happens; yet you can use simple strategies and tools to mistake proof and error proof your work procedures.Consultants and companies around the world can get a license to use the Plant and Equipment Wellness Way methodology to Operational Excellence. Send us an email if you want to secure an exclusive PEW License for yourself. | * Reference
 |
| Why Is Reducing Harm — Not Just Error — Important to Patient Safety?<https://www.youtube.com/watch?v=7towBN4PLrI> | 2:09 | Everyone makes mistakes. So how can health care prevent errors from harming patients? In this video, Dr. David W. Bates, Chief Innovation Officer at Brigham and Women’s Hospital, explains why health care is now working to improve patient safety by reducing harm, not just error. Dr. Bates also offers his thoughts on one definition of harm that was used in the Harvard Medical Practice Study, one of the seminal research projects on the epidemiology of medication error. | * Preventing “Harm” not just errors
 |
| Performance Improvement - more than just a change in behavior<https://www.youtube.com/watch?v=vphTQp_nJ9I> | 12:43 | **ISPI****NCODN**Human performance in the workplace can be affected by several factors: one group is about the individual and the other group is about the organization and its environment. Using the framework of Human Performance Technology (HPT), Inge Zegel shares a systems approach to finding better solutions to improve human performance. | * Reference
 |
| Human Performance Improvement<https://www.youtube.com/watch?v=sgU8NhQqSVE&t=61s> |  | **Tim Rooney****PeopleMation**Have you ever had trouble getting good people to do what you wanted them to do? They're "good," so what's the problem? Tim Rooney gives 5 simple areas to assess, that will get you on the way to getting the most from your team and the results you want and expect! | * Organizational Effectiveness
 |
| Medical Mistakes.wmv, 43.6 MB)<https://www.facebook.com/MedicalSimulation/videos/217208851646834/> | 5:46 | This video is of a “simulator” where operating crews can learn from their mistakes | * Value the Prevention of Error - DOE Vol 1 Pg. 4-17
 |
| 3 Human Caused Disasters<https://www.youtube.com/watch?v=vPOrywC0k9I&t=358s> | 8:04 | Think natural disasters are bad? Humans do a pretty good job on our own. Michael Aranda co-hosts this infusion to explain. | * Consequences of human error
 |
| 8 Human Errors That Caused A Major Accident<https://www.youtube.com/watch?v=K2cxSELfprI&t=31s>  | 7:52 | Eight human errors that caused a major accident | * Consequences of human error
 |
| Lund University – Human Factors and System Safety: Was it technical failure or human error?<https://www.youtube.com/watch?v=Ygx2AI2RtkI> | 4:21 | In this video we introduce the roots of the dualistic question whether an accident was caused by either technical failure or human error. We trace it to H.W. Heinrich and his book on Industrial Accident Prevention from 1931 and see how its reasoning has shaped safety research, policy and discourse ever since. In this video we also play around a bit more with animations than we have in our previous videos. Please give us a comment below on how you like it. | * Human Factors
 |
| Human Factors in Industrial Practice - Business Breakfast (Part One)<https://www.youtube.com/watch?v=ZGR_IMbcfo4>  | 19:52 | **University of Aberdeen**On 24 October 2018, Dr. Amy Irwin from the University’s School of Psychology presented a one hour workshop on Human Factors in Industrial Practice. This is part one of the workshop, where Amy provides an overview of the topic. The University is launching a short course on Human Factors in January 2019, which can be studied fully online. For more information visit: <https://www.youtube.com/redirect?event=video_description&redir_token=QUFFLUhqbFNhdjViSTlvaW00bmwtRjJDNHRaclpGMkRlUXxBQ3Jtc0trWm5LeHczalJ4VGlvUTFPSFRWM1hfbmpHUWMtYkprbU13azVvN1dQQTI3cm9YZjdRWGkyeVBrdjBGbk1Jc0h1bHhiMlpSX1FHWnVyaFF0Z2xTUW1nUGsxZEpKaXMxSEpEYWNTbGU3SnVjc3F1MnBEcw&q=https%3A%2F%2Fwww.abdn.ac.uk%2Fstudy%2Fonline%2Fshort-courses%2Findex.php%23human-factors-in-industrial-practice-january> | * Human Factors
* Human Error
* Case Study
 |
| Human Factors: A Quick Guide<https://www.youtube.com/watch?v=aGZz3w5Hy8Y>  | 6:11 | Medisense MedEdWhat happens when we make a mistake? How can we best investigate error in the workplace so as to improve patient safety? Here is a brief guide explaining HUMAN FACTORS, as applied to healthcare in the UK.This video has been produced by Health Education England and Medisense Medical Education, and has been endorsed by the Chartered Institute of Ergonomics and Human Factors. Artwork by Dr Gabriella Petruso. | * Human Factors
 |
| SawStop Hot dog Video - Saw blade retracts within 5 milliseconds of accidental contact<https://www.youtube.com/watch?v=FquL0GG9RGI> | 0:20 | The world's safest saw in action. It won't cut off your finger, or a hotdog!SawStop's 10" cabinet saw was developed from the ground up with a particular focus on safety and quality. It features a revolutionary safety system that stops and retracts the blade (within 5 milliseconds) upon accidental contact, drastically reducing the severity of user injury. The safety system provides invisible protection (doesn't interfere with your work), is always on and performs continuous self tests. The saw also includes a European style riving knife (secured via a quick-change mount) that helps minimize kick-back. | * Error Prevention
* Human Factors
 |
| When Good Alligators Go Bad<https://www.youtube.com/watch?v=cwemXuIHyVM&t=872s>[Alligator Attack Of Kenny Cypress - YouTube](https://urldefense.com/v3/__https%3A/www.youtube.com/watch?v=V-wYAioX4-A__;!!Bt8fGhp8LhKGRg!FNVpCNXSD07fWhymoPbdbW_NIRfG-YtwMH3fZtKNYDmKXlmQZuBiCO6SPHIIE_nOCOrOy8oiF9w7axL7XNGGN88$)  | 3:45 | NOTE: Video is restricted due to graphic content (need to verify age). You’ll need to sign in to YouTube to verify.* An alligator trainer gets his head caught in a gator's mouth during his grand finale.
* Message: There are dangers is your work location that you feel confident working with/around. Your experiences and knowledge are applied in a manner that makes you successful in the dangerous environment. You know the do’s and don’ts. However, sometimes, a mistake happens and a consequence occurs.
 | * Principle #1 - DOE Vol 1 Pg. 1-19
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| Man Caught In Crocodile Death Roll | Untamed & Uncut<https://www.youtube.com/watch?v=6ZhHHVsAnI4> | 1:57 | A crocodile bites down on a man's arm and performs a Death Roll during a routine stunt in this clip from Animal Planet's Untamed & Uncut. | * Principle #1 - DOE Vol 1 Pg. 1-19
 |
| We make mistakes in Healthcare<https://www.youtube.com/watch?v=ZP4QRB6H7rY> | 5:31 | We’re human. We make mistakes. Even in healthcare....and we need to get used to that reality in order to better protect our staff and patients from preventable harm. That's the message of this provocative video from staff and leaders at University Health Network, a group of Toronto-based acute care health institutions. UHN continues to lead a national discussion in Canada about preventable medical errors, and the need to move to a Caring Safely culture across the healthcare spectrum. www.uhn.ca | * Principle #1 - DOE Vol 1 Pg. 1-19
 |
| Why We Make Mistakes and how we can avoid them<https://www.youtube.com/watch?v=oxc0u-C0XEY> | 8:52 | Good message from CBS Sunday Morning | * Principle #1 - DOE Vol 1 Pg. 1-19
 |
| 5 Biggest Mistakes on Live TV<https://www.youtube.com/watch?v=hhQCK_n0BIE> | 7:39 | 5 Biggest Mistakes on Live TV | * Principle #1 - DOE Vol 1 Pg. 1-19
 |
| 2017 Lexus commercial<https://www.youtube.com/watch?v=bp4O_I8Ysos> | 0:30 | Message: Nobody’s perfect. That’s why the Lexus RX comes with our most advanced safety features—standard. Experience it now, at your Lexus dealer.Human behavior (pedestrians) walk in front of vehicles, so Lexus uses pedestrian warning systems and auto-braking to prevent/manage these predictable conditions | * Principle #2 - DOE Vol 1 Pg. 1-19
 |
| A Gator Bite to the Head is No Joke | Gator Boys<https://www.youtube.com/watch?v=0eiORAWH0bc> | 3:50 | Another alligator head chomp video | * Principle #2 - DOE Vol 1 Pg. 1-19
 |
| Prudential: Everybody's Doing It (2:31, Elevator behavior experiment)<https://www.youtube.com/watch?v=BgRoiTWkBHU> | 2:31 | Candid Camera actors in an elevator cause unknowing participants to follow their lead. People will conform to the behaviors of those around them. | * Principle #3 - DOE Vol 1 Pg. 1-19
 |
| Things That Influence Your Everyday Behavior<https://www.youtube.com/watch?v=tbHRoHoZKxE> | 2:24 | Good examples of behavior being influenced | * Principle #3 - DOE Vol 1 Pg. 1-19
 |
| Top motivational speaker Jeff "Odie" Espenship on Leaders Influence behaviors of others<https://www.youtube.com/watch?v=4S0uBqdMbTI> | 1:52 | Value of leadership influence | * Principle #3 - DOE Vol 1 Pg. 1-19
 |
| Peer Influence and Adolescent Behavior (4:04, inherent rewarding of peers changes behaviors – more risk taking)<https://www.youtube.com/watch?v=rt9MyNo65eI> | 4:04 | Inherent rewarding of peers changes behaviors – more risk taking | * Principle #3 - DOE Vol 1 Pg. 1-19
 |
| The Power of Positivity | Brain Games<https://www.youtube.com/watch?v=kO1kgl0p-Hw> | 3:11 | See firsthand how positive and negative reinforcement can affect a player’s game on the court. | * Principle #4 - DOE Vol 1 Pg. 1-19
 |
| Encouragement!<https://www.youtube.com/watch?v=zb8U3l9XHdY> | 0:54 | Kid plays piano with concert pianist | * Principle #4 - DOE Vol 1 Pg. 1-19
 |
| The Death Crawl scene from Facing the Giants<https://www.youtube.com/watch?v=-sUKoKQlEC4> | 5:37 | The Death Crawl scene from Facing the Giants. An amazing inspiration and always worth another viewing! <http://www.facingthegiants.com/buydvd/> | * Principle #4 - DOE Vol 1 Pg. 1-19
 |
| Positive Reinforcement Final.avi<https://www.youtube.com/watch?v=JA96Fba-WHk&t=15s><https://www.youtube.com/watch?v=-63ysqT5nu0><https://www.youtube.com/watch?v=qy_mIEnnlF4&t=51s> | 1. 4:53
2. 2:05
3. 2:45
 | BAD example of positive reinforcementUsing Big Bang theory clips for a class presentation purpose. Presentation on Thorndike's Law of effect. | * Principle #4 - DOE Vol 1 Pg. 1-19
 |
| FedEx Disappear from Boss commercial<https://www.youtube.com/watch?v=0dewwjENhFg>fedex scary boss.mov<https://www.youtube.com/watch?v=lQmbc1_UyAw> | 0:32 | FedEx Disappear from Boss commercialBoss inquires “who shipped packages.” Others hide, Lewis is congratulated. | * Principle #4
* Feedback, encouragement
 |
| Kid gives motivational speech VERY FUNNY- inspirational (Original Video)<https://www.youtube.com/watch?v=BdCHgzU9beA> | 0:58 | Inspirational video from a kid learning to ride his bike | * Principle #4
* Motivational
 |
| 02 | How We Can Learn From Incidents<https://www.youtube.com/watch?v=NaXE5pbLI0E> | 3:46 | Swiss Air Force Investigations: why it made sense to that person, applying lessons learned, improving margin of safety | * Principle #5 - DOE Vol 1 Pg. 1-20
* Event Investigations
 |
| Mistakes to Avoid as a Beginner Photographer<https://www.youtube.com/watch?v=G60VlLsmCUs> | 3:52 | In this video I talk about the common mistakes I made as a beginner in my photography career, and how you can avoid them. By following these key steps, you'll be able to drastically improve your photos before you ever bring them in to photoshop. And getting better images means happier photography clients! | * Principle #5 - DOE Vol 1 Pg. 1-20
 |
| Tools in October<https://www.youtube.com/watch?v=HOkU3fP1xPs> | 0:30 | Video shows the consequences of assembling nail gun while being distracted by watching the World Series. | * Limited attention resources - DOE Vol 1 Pg. 2-2
 |
| Workplace Accidents<https://www.youtube.com/watch?v=MwCyVku1HvI> | 3:06 | Video #1 – The Restaurant accident: Chef slips on greaseVideo #2 – The Construction accident: Busted harness, explosive gas tank explosionVideo #3 – The Factory Accident: Forklift accident code deviationsVideo #4 – The Retail Store accident: Employee falls from defective ladder when trying to reach bannerVideo #5 – The Electricity accident: lack of training, hurrying | * Unsafe Attitudes - At-Risk Behaviors - DOE Vol 1 Pgs. 2-5 thru 2-7
* Drift and Accumulation
 |
| The Monkeys and the Bananas Story<https://www.youtube.com/watch?v=BdsVdFnUfCU&t=3s> | 3:53 | The Monkeys and the Bananas Story is a Metaphor of how activities and process happen in an organization. Such organizations still follow certain procedures and systems which may be obsolete in today's time. Many a times we are not ready to adapt to change. It appears funny, but this is how limiting beliefs are formed in life..! Its a classical example of how belief systems are formed. This simple video demonstrates through a simple experiment with monkeys, how people tend to resist change, even when it is for the best. | * Behavior modification
* Drift
 |
| Fast Brain / Slow Brain thinking<https://www.youtube.com/watch?v=JiTz2i4VHFw> | 4:40 | Ever wonder how your brain processes information? These brain tricks and illusions help to demonstrate the two main systems of Fast and Slow Thinking in your brain. Written and created by Mitchell Moffit (twitter @mitchellmoffit) and Gregory Brown (twitter @whalewatchmeplz). | * Human information processing - DOE Vol 1 Pg. 2-16, 2-18
 |
| Will This Trick Your Ears? (Audio Illusions)<https://www.youtube.com/watch?v=w40XcUP5KrI>  | 3:49 | AsapScienceHearing is about perception - | * Human information processing - DOE Vol 1 Pg. 2-16, 2-18
 |
| Lightbulb Moment | Gary Klein | TEDxDayton <https://www.youtube.com/watch?v=n5OO9L67jL4> | 17:09 | Insights are unexpected shifts in the way we understand how something works, and how to make it work better. Gary’s talk examines two mysteries. First, where do insights come from? This talk presents a new account of the nature of insights. Second, how can we trigger more insights? Gary describes a strategy for adopting an insight mindset. Gary Klein, Ph.D., is known for the cognitive models, such as the Recognition- Primed Decision (RPD) model, the Data/Frame model of sensemaking, the Management By Discovery model of planning in complex settings, and the Triple Path model of insight, the methods he developed, including techniques for Cognitive Task Analysis, the PreMortem method of risk assessment, and the ShadowBox training approach, and the movement he helped to found in 1989 — Naturalistic Decision Making. The company he started in 1978, Klein Associates, grew to 37 employees by the time he sold it in 2005. He formed his new company, ShadowBox LLC, in 2014 and is the author of five books. This talk was given at a TEDx event using the TED conference format but independently organized by a local community. Learn more at [http://ted.com/tedx](https://www.youtube.com/redirect?v=n5OO9L67jL4&redir_token=kOll2JJPdazF0H0FpeXGPe22NJ18MTU4MDI1MjM3N0AxNTgwMTY1OTc3&event=video_description&q=http%3A%2F%2Fted.com%2Ftedx) | * Human information processing - DOE Vol 1 Pg. 2-16, 2-18
 |
| Fast Brain / Slow Brain thinkingIdea Lab<https://www.youtube.com/watch?v=PirFrDVRBo4> | 6:35 | Daniel Kahneman: Thinking Fast vs. Thinking Slow | Inc. MagazineYou can avoid decision-making mistakes by understanding the differences between these two systems of thought. | * Human information processing - DOE Vol 1 Pg. 2-16, 2-18
 |
| 12 Cognitive Biases Explained - How to Think Better and More Logically Removing Bias<https://www.youtube.com/watch?v=wEwGBIr_RIw&t=146s> |  | We are going to be explaining 12 cognitive biases in this video and presenting them in a format that you can easily understand to help you make better decision in your life. Cognitive biases are flaws in logical thinking that clear the path to bad decisions, so learning about these ideas can reduce errors in your thought process, leading to a more successful life. These biases are very closely related to logical fallacies, which may help you win an argument or present information better. | * 1)Anchoring Bias
* 2)Availability Heuristic bias
* 3)Bandwagon Bias
* 4)Choice Supportive Bias
* 5)Confirmation Bias
* 6)Ostrich Bias
* 7)Outcome Bias
* 8)Overconfidence
* 9)Placebo bias
* 10)Survivorship Bias
* 11)Selective Perception Bias
* 12)Blind Spot Bias
 |
| Anti boredom campaign initiated by Antena<https://www.youtube.com/watch?v=uBr8XcZO9jE><https://www.youtube.com/watch?v=X-Igd-85PDg> | 0.39 | Just for a laugh, this is an anti-boredom campaign done by Antena. | * Incorrect Mental model
 |
| Ma & Pa Kettle Math<https://www.youtube.com/watch?v=Bfq5kju627c&t=73s> | 2:14 | Film clip of old Ma & Pa Kettle bit (Marjorie Main and Percy Kilbride). | * Humor
* Incorrect mental model
 |
| Asch Conformity Experiment<https://www.youtube.com/watch?v=TYIh4MkcfJA><https://www.youtube.com/watch?v=NyDDyT1lDhA> | 4:10 | I am forced to put something here! It won't let me upload if I don't. So that is another way of getting conformity, through force!Classic footage from the Asch conformity study. This version includes definitions of normative and informational conformity and the powerful effect of having an ally. | * Group-think
 |
| Engineering Psychology: Types of human error<https://www.youtube.com/watch?v=oCrf7n2lQtY> | 2:42 | Created as part of the course “Engineering Psychology“ By students of the master degree programme “Media Informatics“ at the University of Lübeck.https://www.uni-luebeck.de/index.php?...Engineering Psychology and Cognitive Ergonomics, Institute for Multimedia and Interactive Systems | * Performance Modes
 |
| Dymo Commercial - Teeth anyone<https://www.youtube.com/watch?v=rg4GiKXkSys> | 0:30 | Dymo CommercialThis video demonstrates skill based error when husband and wife get wear each other’s dentures | * Skill-Based Performance - DOE Vol 1 Pg. 2-21
 |
| Bill Dance - <https://www.youtube.com/user/billdancefishing><https://www.youtube.com/user/billdancefishing/search?query=bloopers>Volume 1: <https://www.youtube.com/watch?v=iK_h-2kot6s&t=24s>Volume 2: <https://www.youtube.com/watch?v=hoQIljOKwpo>Volume 3: <https://www.youtube.com/watch?v=InpVTPK6o9Q&t=30s>Volume 4: <https://www.youtube.com/watch?v=VSazi4GwRqI>Volume 5: <https://www.youtube.com/watch?v=zQSDI-GlPBc> | 1. 4:22
2. 4:59
3. 5:23
4. 5:36
5. 5:07
 | This video demonstrates Multiple Skill based errors by fishing show host Bill Dance | * Humor
* Skill-Based Performance - DOE Vol 1 Pg. 2-21
 |
| Accident Caught on Tape<https://www.youtube.com/watch?v=1Muy0_ftZNc> | 0:39 | This video records a “Crash at intersection caught on camera” where one of the drivers does not follow the rule (yield the right of way) prior to entering the intersection. Distractions and truck blocking view contribute to the event | * Rule-Based Performance - DOE Vol 1 Pg. 2-23
 |
| Pole Climbing FAIL<https://www.youtube.com/watch?v=JrDdx0eXJRU> | 0:19 | This video demonstrates the consequences of a rule based error when the lineman deviates from the rule and “cuts” the rope. | * Rule-Based Performance - DOE Vol 1 Pg. 2-23
 |
| Funniest double speak ever<https://www.youtube.com/watch?v=QaxqUDd4fiw> | 0:34 | This video demonstrates the various levels of things you know used to make decisions. | * Humor
* Knowledge Based Performance - DOE Vol 1 Pg. 2-25
 |
| Know your limitations navy captain<https://www.youtube.com/watch?v=ajq8eag4Mvc> | 0:54 | This video demonstrated knowledge based error when a navy crew sees an object on the radar that it thinks is another ship…but turns out to be a lighthouse. | * Knowledge Based Performance - DOE Vol 1 Pg. 2-25
 |
| The Exploding Whale (<http://theexplodingwhale.com/>)<https://www.youtube.com/watch?v=1_t44siFyb4> | 2:35 | This video demonstrates an explosives expert applying his trade to a dead whale on the beach.([www.theexplodingwhale.com](file:///%5C%5Cdcstorage.lanl.gov%5Cdcstorage_eshq_adeshq%24%5Cto%20OSH.HPI%5CHPI%20Practitioners%5CCommunity%20of%20Practice%20Workshop%5C2019-10-22%5Cwww.theexplodingwhale.com)) | * Knowledge Based Performance - DOE Vol 1 Pg. 2-25
 |
| FROM THE ARCHIVES: The exploding whale of Florence, Oregon<https://www.youtube.com/watch?v=ax7kENH-A7s>  | 6:37 | Post Mortem:You may have heard about the exploding dead whale of Florence, Oregon. You might even have seen some pictures, but not these.In 1970, a dead sperm whale was blown up by the Oregon Highway Division in Florence in an attempt to dispose of its rotting carcass. The resulting explosion was caught on film by KATU-TV photographer Doug Brazil and reporter Paul Linneman for a story reported by news.<https://abc7ne.ws/2Iu97Z2> | * Knowledge Based Performance - DOE Vol 1 Pg. 2-25
 |
| Citicorp Center | NYC skyscraper saved by a student’s question<https://www.youtube.com/watch?v=Bv2YQnT6pSo&t=21s> | 8:23 | The Citicorp Center repair is a classic engineering case study of how mistakes must be avoided in engineering and construction of public works. A skyscraper in New York City needed a unique structural system. While reviewing the design a student asked a question that made the engineer realize that a mistake had been made. There is a daring race to make the repairs for the building collapses. The video gives the details and then discusses how the engineer handled the situation. | * Knowledge Based Error - DOE Vol 1 Pg. 2-25
* Engineering HPI
 |
| The Best Method for Reducing Workplace Errors<https://www.youtube.com/watch?v=sHf46BLYl58>  | 2:45 | StreamlinedBusiness[http://www.comprose.com](https://www.youtube.com/redirect?redir_token=_vhTwyG08fjKdrZE0yo8xCFO0S98MTU4MDI1MTk5NUAxNTgwMTY1NTk1&q=http%3A%2F%2Fwww.comprose.com&v=sHf46BLYl58&event=video_description) This video shares scientific research about the most important factor in preventing routine task errors and the impact of clear, standard operating procedures (SOPs) can have on employee performance. It cites a research study published in "Human Factors" that compared re-training, SOPs, and other methods for preventing workplace errors. The results surprised even the researchers! Important take-home lesson for any manager needing to streamline employee performance, prevent errors, and improve quality. www.comprose.com | * Procedure use and adherence - DOE Vol 2 Pg. 20
* Human Factoring procedures
* Value of implementing HPI
 |
| Procedure Solutions Management LLC (Steve McCord)Identifying Human Error Likely Situations – What Does “Good” Look Like?Part 1: <https://youtu.be/x0MiJC9AXbY>Part 2: <https://youtu.be/ewHlYDZizXU>Part 3: <https://youtu.be/CVN8SimgOOA>Part 4: <https://youtu.be/lYNCJBoxM34><https://proceduresolutionsmgmt.com/> | 1. 8:21
2. 8:18
3. 6:41
4. 6:49
 | Since 2008, Procedure Solutions Management, LLC, has taught over (correction over 10,000) students on a variety of procedure-related topics. When we teach our classes there are 5 main principles that we want to convey:1. Level of Detail – What to do, OR how to do it.
2. Identify Common Error Likely Situations – What does “Good” look like?
3. General Technical Writing Guidelines – Writing Fundamentals
4. Organizing and Sequencing of Steps
5. Utilizing Templates or Human-Factored Writing Tools
 | * Procedure use and adherence - DOE Vol 2 Pg. 20
* Human Factoring procedures
 |
| Officer Asks Lady To Step To Roadside Seconds Before Crash<https://www.youtube.com/watch?v=BBdb9WG5DjQ> | 0:29 | \*\* (Disclaimer: This video content is intended for educational and informational purposes only) \*\*A police dash cam on May 05, 2000 in Seguin, Texas, captures a police officer telling a woman to move away from her vehicle because she could be hit while they talk! A large van smashes into the woman’s car causing the van to nearly overturn and the woman’s car to go flying off the road. | * Procedure use and adherence - DOE Vol 2 Pg. 20
 |
| THIS "EXACT INSTRUCTIONS CHALLENGE" IS SO HILARIOUS<https://www.youtube.com/watch?v=Ct-lOOUqmyY&t=15s>  | 5:28 | Check out the "exact instructions challenge" that will definitely make you laugh!This hilarious video has emerged of two kids trying to write exact instructions for their dad to make a peanut butter and jelly sandwich, with little success. This challenge was shot by Josh Darnit, who got the idea from a friend whose science teacher had done a similar experiment back in high school. It shows Johnna and Evan, his kids, taking turns trying to help their father create a peanut butter and jelly sandwich. However, Josh follows the instructions to the letter, leading to funny fails.Via: [https://www.newsflare.com](https://www.youtube.com/redirect?event=video_description&redir_token=QUFFLUhqblBFTktKWERueG9KTUlTblI3ZkpYOGU4NXY4QXxBQ3Jtc0trc2pXdnJXZE9JRHMzSGo1MmRENUplXy1WLVRJUk9weVNOZ1RFdVBKRU1qMGFEbUlWR1FXR3BUY0oxR2Q0VmZuU0pBV0MxSm1Ba2N6akxEU2tfSnY2RVlXTjZiWkFONFNrU2VzcEZfbGk1MkFRT05DZw&q=https%3A%2F%2Fwww.newsflare.com) | * Procedure use and adherence - DOE Vol 2 Pg. 20
 |
| How to outsmart robbers<https://www.youtube.com/watch?v=oxXX3lt7JDM> | 0:58 | This video demonstrates a person robbing a liquor store. The attendant is thoughtful enough to ask for ID…per the sign (e.g., following the procedure). | * Procedure use and adherence - DOE Vol 2 Pg. 20
 |
| StreamlinedBusiness: The Best Method for Reducing Workplace Errors<https://www.youtube.com/watch?v=sHf46BLYl58> | 2:46 | http://www.comprose.com This video shares scientific research about the most important factor in preventing routine task errors and the impact of clear, standard operating procedures (SOPs) can have on employee performance. It cites a research study published in "Human Factors" that compared re-training, SOPs, and other methods for preventing workplace errors. The results surprised even the researchers! Important take-home lesson for any manager needing to streamline employee performance, prevent errors, and improve quality. www.comprose.com | * Procedures
* Anecdotal evidence for SOP’s
 |
| The Best Method for Reducing Workplace Errors<https://www.youtube.com/watch?v=sHf46BLYl58> | 2:45 | http://www.comprose.com This video shares scientific research about the most important factor in preventing routine task errors and the impact of clear, standard operating procedures (SOPs) can have on employee performance. It cites a research study published in "Human Factors" that compared re-training, SOPs, and other methods for preventing workplace errors. The results surprised even the researchers! Important take-home lesson for any manager needing to streamline employee performance, prevent errors, and improve quality. www.comprose.com | * Reference
* Procedure Use and Adherence
 |
| No time to think[https://www.youtube.com/watch?v=k8QCTk7B0tE](https://www.youtube.com/watch?v=k8QCTk7B0tE%09)  | 0:48 | This video pauses a scenario where a motorcycle drive has made a decision (critical step) to pass a truck, for which that action becomes irreversible and consequential. | * Critical Steps (Definitions: Volume 2 Page 128)
 |
| Do you know who I am (teacher VS student)<https://www.youtube.com/watch?v=jAZpQhykOUk> | 1:01 | No Commercial Gain Is Being Made From This Video, it's only for fun and besides this is my first video any way have fun and enjoy the vid ;) | * Humor
* Situational Awareness
 |
| Changing tyres can be dangerous! Funny!<https://www.youtube.com/watch?v=fipo8Go09pY> | 2:13 | Funny Tire Commercial. bad way to change your tyre (3 videos) | * Humor
* Situational Awareness
 |
| Great Hospital<https://www.youtube.com/watch?v=yHRuAViivbw> | 0:40 | europeiske reiseforsikring – hooverThere are some hospitals you should stay clear of | * Situational Awareness
* Questioning attitude
* Humor
 |
| The Monkey Business Illusion - Daniel Simons<https://www.youtube.com/watch?v=IGQmdoK_ZfY&t=7s> | 1:42 | The Monkey Business Illusion by Daniel Simons. Check out our new book, THE INVISIBLE GORILLA for more information. Research based on this video was published in July 12 in the open-access journal i-Perception. Learn more at www.theinvisiblegorilla.com. | * Situational Awareness
 |
| Test Your Awareness: Whodunnit?<https://www.youtube.com/watch?v=ubNF9QNEQLA> | 1:54 | Test your Awareness with Do The Test's Whodunnit. Who Killed Lord Smithe? TFL cycling safety advert! How observant are you? How did you do? | * Situational Awareness
 |
| Situational Awareness and Tunnel Vision<https://www.youtube.com/watch?v=EG6NyCDN-Ts> | 2:05 | SAMattersTVThis short video, shot at Mount Rainier National Park, addressing the situational awareness barrier - tunnel vision | * Situational Awareness
* Tunnel Vision
 |
| Situational Awareness message on Complacency<https://www.youtube.com/watch?v=3X4lPx1Jd6k> | 1:14 | SAMattersTVThis short video was shot during a hike in Mount Rainier National Park. | * Situational Awareness
* Complacency
 |
| Will You Pass The Attention Test?<https://www.youtube.com/watch?v=U1saQoMRD8A> | 1:24 | The entire street changes before your eyes | * Situational Awareness
* Noticing changes
 |
| Pedestrian Safety Around Forklifts<https://www.worksafebc.com/en/resources/health-safety/videos/fields-of-vision/pedestrian-safety-around-forklifts?lang=en&origin=s&returnurl=https%3A%2F%2Fwww.worksafebc.com%2Fen%2Fsearch%23q%3Dforklift%2520safety%2520video%26sort%3Drelevancy%26f%3Alanguage-facet%3D%5BEnglish%5D> | 12:20 | WorkSafeBCThis video puts you into the driver's seat and shows you how difficult it is for the lift truck operators to see pedestrians. The video then outlines simple ways pedestrians can help lift truck drivers see them - and avoid a serious or fatal accident. | * Situational Awareness
 |
| Reporter Gets Hit by Snow Plow<https://www.youtube.com/watch?v=cc2Mf7dw5FY> | 0:15 | Reporter Gets Hit by Snow Plow | * Humor
* Risk Perception
* Situational Awareness
 |
| Banned Commercials - Karate Bloopers Marijuana<https://www.youtube.com/watch?v=NCgR_-qC-Ss> | 0:32 | Don’t do drugs kids... not the funniest video ever but yeah. | * Humor
* Risk Perception
 |
| Prison Break - New Guy in prison life insurance commercial<https://www.youtube.com/watch?v=DKBdiVs6fjY> | 0:47 | This video demonstrates an new inmate having a questioning attitude about a draft in his cell block | * Questioning Attitude - DOE Vol 2 Pg. 10, 13
 |
| Epic Fridge Fail<https://www.youtube.com/watch?v=3ruDGVa9Sms> | 0:46 | You really have to wonder what some people are thinking after watching this epic fridge fail | * Inadequate planning
* Questioning Attitude
* Humor
 |
| Copper Clappers<https://www.youtube.com/watch?v=sKGtb1t9iVw> | 2:49 | A Johnny Carson skit that demonstrates three-way communication technique. | * Three-part communication practices - DOE Vol 2 Pg. 26
 |
| Leg surgery<https://www.youtube.com/watch?v=fePMthG38FY> | 0:41 | Doctors ask patient “which leg”  | * Imprecise communications
 |
| Misunderstandings can be funny<https://www.youtube.com/watch?v=0QuVzUnquv0> | 0:39 | The funny flow of a message misunderstood.  | * Imprecise communication
 |
| The funniest misunderstanding scene that you will ever watch<https://www.youtube.com/watch?v=t3L5P-6OsxA> | 1:23 | Clip from “Rush Hour” | * Imprecise communication
 |
| Mayday, We're sinking! German Coast Guard!<https://www.youtube.com/watch?v=aOd1jIDCeN8> | 0:40 | This is a very funny ad for Berlitz language courses! | * Imprecise Communications
 |
| Ameriquest Advert - You're Getting Robbed<https://www.youtube.com/watch?v=YEJ6HBHjt1g> | 0:30 | One of the series of 'Don't Judge Too Quickly' ads from Ameriquest Mortgage. This one features a guy 'holding up' a convenience store | * Imprecise Communications
 |
| It's Not About The Nail<https://www.youtube.com/watch?v=-4EDhdAHrOg> | 1:41 | "Don't try to fix it. I just need you to listen." Every man has heard these words. And they are the law of the land. No matter what. | * Communication skills – Listening
 |
| It's Not About The Hammer<https://www.youtube.com/watch?v=Vov0F_valrY> | 1:41 | Calvary Miami Couples' Retreat Skit - Part 1 of 3 | * Communication Skills
* Mindset
 |
| Nursing Pharmacology - Safe Medication Administration and Error Reduction<https://www.youtube.com/watch?v=3sLXdSRzE_Q> | 10:54 | Cathy Parkes RN, covers Nursing Pharmacology - Safe Medication Administration and Error Reduction. The Nursing Pharmacology video tutorial series is intended to help RN and PN nursing students study for nursing school exams, including the ATI, HESI and NCLEX.  | * Patient Identifiers
* Unclear Communications
* Vague guidance
 |
| Pharmaguideline: Top 6 Ways to Reduce Human Errors<https://www.youtube.com/watch?v=4pEqr0-rZj0> | 3:22 | Human errors are common in pharmaceutical manufacturing. These errors cause the deviations and #incidence in manufacturing. Here are some useful tricks to reduce these human errors.Details: https://www.pharmaguideline.com/2016/... | * Error Reduction Techniques
 |
| Statoil Commercial - Car Ice Scraping Gone Wrong.<https://www.youtube.com/watch?v=WDoEO6kSVEk>Winter and fun times! Wrong car in Snow<https://www.youtube.com/watch?v=np9t413kNF8> | 0:40 | Guy ice scraping the wrong car in winter | * Humor
* Verification practices
 |
| Safety cord falls off harness as man hops on high bridge in SW China<https://www.youtube.com/watch?v=9Hi8ZseNdU8\><https://www.youtube.com/watch?v=dbvpVf-T0io> | 1. 0:38
2. 1:31
 | * A theme park with a bridge hanging some 300 meters above the ground in southwest China's Chongqing has long been popular with daredevils. However, a video uploaded online on Tuesday shows the safety cord of a man falling off the harness just as the adventurer reached the platform. The clip has been viewed more than 10 million times on Chinese social platform Weibo.
* A Chinese tourist’s safety harness came undone while he was leaping across a high-altitude gap bridge at the Wansheng Ordovician Theme Park in southwestern China’s Chongqing city. It was later confirmed as a safety harness malfunction.
 | * Verification Techniques
* Unexpected Equipment Failure
 |
| Pointing and Calling Japanese Safety Standard at Railway Companies & Toyota (HD)<https://youtu.be/9LmdUz3rOQU> | 3:55 | Pointing-And-Calling standard is a safety standard used in Japan by railway companies and industry as for example Toyota. For more details visit [http://wwwlallaboutlean.com/pointing](https://www.youtube.com/redirect?redir_token=PrAvb2SKziIVs7QTqrI45vJh2Dp8MTU2ODEzMjk1OUAxNTY4MDQ2NTU5&event=video_description&v=9LmdUz3rOQU&q=http%3A%2F%2Fwww.allaboutlean.com%2Fpointing-and-calling%2F) The video includes numerous examples of different railway companies, and at Toyota headquarter. All operators observed have been asked for permission before filming. An updated version with less delays due to slides is available here <https://www.youtube.com/9W6tHOmWyLQ> | * Verification Techniques
* Self-checking
 |
| Funniest Flight Attendant Ever<https://www.youtube.com/watch?v=1AE_hjOLDtU> | 5:03 | I was coming back home on a Southwest flight when I discovered I had one of the funniest flight attendants on board with me. It was one of the best flights I have ever been on!This probably isn't a video that you'd expect from my channel, but I'm sure that you guys will enjoy it anyways! Let me know how it looks in 4k ;). | * Pre-Job Briefing
* Humor
 |
| Hilarious Southwest Airline Safety Presentation (Open Captions)<https://www.youtube.com/watch?v=TxNrizGdhtY> | 3:05 | His is the full text version of this very funny but whip-speedy monologue of the Southwest flight attendant who got on the Ellen Show in April of 2014. I do this version for my deaf friends because the automatic closed captioning on the other videos is no good.Update: Yes, I know there are two kinds of peals/peels. I tried very hard to use correct spelling and grammar and punctuation but even with the aid of the computer's spell & grammar checkers, I missed that one. Once a youtube video has been uploaded, it cannot be edited or replaced. It can only be deleted. Is it worth losing this link and all the stats & comments just for an "e"? I don't think so. And who knows? At 30,000 feet - maybe bananas make sounds ...the deaf will never know! | * Pre-Job Briefing
* Humor
 |
| Trilliumhealthcenter: Part 1-Patient Safety 101<https://www.youtube.com/watch?v=Grox0sOfDKg> | 4:52 | Quality and Patient Safety are key imperatives at Trillium Health Centre. Within Trilliums current Strategic Plan, Quality by Design is the strategic theme that will drive the organization to deliver the highest standard of quality and safety to all patients. | * Anecdotal evidence – Consequences of human error
 |
| Trilliumhealthcenter: Part 2- Read-backs for Verbal and Telephone Orders<https://www.youtube.com/watch?v=G-sqOvf2mwM> | 4:02 | Quality and Patient Safety are key imperatives at Trillium Health Centre. Within Trilliums current Strategic Plan, Quality by Design is the strategic theme that will drive the organization to deliver the highest standard of quality and safety to all patients. | * 3-way communications
* Causes of events
 |
| Trilliumhealthcenter: Part 3-Transfer of Accountability and Surgical Safety Checklist<https://www.youtube.com/watch?v=NdxwRJ2EwmY> | 4:46 | Quality and Patient Safety are key imperatives at Trillium Health Centre. Within Trilliums current Strategic Plan, Quality by Design is the strategic theme that will drive the organization to deliver the highest standard of quality and safety to all patients. | * Bedside Turnovers
* Surgical Safety Checklists
* Communication
 |
| Trilliumhealthcenter: Part 4 - Safe Medication Practices<https://www.youtube.com/watch?v=gDQrbbLIoN8&t=137s> | 4:43 | Quality and Patient Safety are key imperatives at Trillium Health Centre. Within Trilliums current Strategic Plan, Quality by Design is the strategic theme that will drive the organization to deliver the highest standard of quality and safety to all patients. | * Adverse medication events
* Medication Reconciliation
 |
| Shadowguy1: Human Error<https://www.youtube.com/watch?v=PWQr_p0L41I> | 3:05 | My first short film for my Directing 1 class. I had a fun time making it. Hope you enjoy.A bumbling undergraduate student with a prior "incident" in the lab is able to redeem himself while his mentor leaves for a meeting.Alone in the lab with a stack of plates....a wire loop....a torch...and a rubber chicken. What could possibly go wrong? | * What’s the worst that could happen
* Lab HPI
 |
| Tom Hanks Oscar Worthy Acting in Sully (2016) - 'Human Factor' Scene 1080p<https://www.youtube.com/watch?v=tsOWjB2X5K8> | 2:53 | Here is the best scene from Sully starring Tom Hanks - where Sully asks to take human factor into consideration while simulating the plane landing.Movie : Sully (2016)Directed by : Clint EastwoodStarring : Tom Hanks , Aaron Eckhart and Laura Linney | * First time evolutions
* Problem solving
* Beyond design basis accidents
 |
| What Happens When the Boss Calls in Sick.wmv<https://www.youtube.com/watch?v=BWM9aoMYenA> | 0:52 | 1. Employee behavior when the boss call in sick
2. Employees – boss conference call from the golf course that goes badly
 | * Leadership
 |
| Old FedEx ads that are still hilarious<https://www.youtube.com/watch?v=wgypWuFqauk> | 1:59 | FedEx have made some great commercials over the years, but these commercials are still very funny.1. Employee recommends using FedEx to same 10%, Boss repeats it and it’s a great idea
2. Employee behavior when the boss call in sick
3. Employees – boss conference call from the golf course that goes badly
4. Tom needs to ship everything today (Even an MBA can do it)
 | * Leadership
 |
| FedEx Commercial - The boss is on the line<https://www.youtube.com/watch?v=s2Iu5Ppw3L0>EDEX commercial-How to avoid boss<https://www.youtube.com/watch?v=WxrXb_P5GZ0> | 1. 0:30
2. 0:31
 | A short commercial from FedEx...the boss is on the line...Employees – boss conference call from the golf course that goes badly | * Leadership
 |
| Hilarious Fedex Cup Ad - [www.cracker.co.za](http://www.cracker.co.za)<https://www.youtube.com/watch?v=MGpwbKpjdtI> | 0:3 | Employee behavior when the boss call in sickHilarious FedEx Cup commercial. Typical day at the office wishing that the boss wouldn't come in so that you can go off and play a round of golf instead of sitting at your desk all day. | * Leadership
 |
| Funniest Leadership Speech ever!<https://www.youtube.com/watch?v=SA7bKo4HRTg&t=56s> | 5:08 | LEADERSHIP VA class of 2008 soapboxHEY EVERYONE!!! I have published my first book A Gone Pecan. A funny murder mystery set in the deep south. Please support this starving artist (i've lost over 200 Ibs since this video, so leave the fat jokes to yourself LOL) and click on http://www.authorhouse.com/BookStore/...and buy my book!!!! I swear it'll make you snort your sweet tea. Thanks! | * Humor
* Leadership
 |
| Lund University – Human Factors and System Safety: Three analytical traps in accident investigation<https://www.youtube.com/watch?v=TqaFT-0cY7U> | 7:36 | In this video Dr. Johan Bergström introduces how the US NTSB investigation into the accident of Asiana 214 falls into the following three analytical traps:1: Counterfactual reasoning2: Normative language3: Mechanistic reasoningFor those who stand to watch the entire video, there will be a bonus trap at the end of the video :)[www.humanfactors.lth.se](file:///%5C%5Cdcstorage.lanl.gov%5Cdcstorage_eshq_adeshq%24%5Cto%20OSH.HPI%5CDOE%5CEFCOG%5Cwww.humanfactors.lth.se) | * Event Investigations
 |
| Blame poor conditions, not human error, for workplace accidents: Todd Conklin<https://www.youtube.com/watch?v=ZvpGPvM5wLc&t=49s> | 3:15 | When an accident occurs in the workplace, employers often search for the violation the worker committed that led to the incident, according to Todd Conklin, a senior advisor at the U.S. Los Alamos National Laboratory in New Mexico. Conklin spoke to Canadian HR Reporter TV about his view that human error may actually be system-induced. | * Reference
* Event investigations
 |
| 2018 USW HSE Conference: The New View of Safety with Todd Conklin<https://www.youtube.com/watch?v=IoYUQlWiRgc> | 1:15:55 | Todd ConklinThe New View of safety provides a fresh look at unsafe workplace conditions and resulting injuries to workers. Todd Conklin, speaking at the 2018 USW Health, Safety and Environment Conference on March 29, 2018 in Pittsburgh, PA, provides an overview of the New View of safety to the 1600 conference participants. The presentation is informative and entertaining to help workers and employers provide better health and safety management at their workplace. | * Reference
* Presentation
 |
| TFZ Safety Conference 2016 - Todd Conklin<https://www.youtube.com/watch?v=f8YHKxIGK8k> | 41:48 | Olie Gas DanmarkPublished on Apr 21, 2016Similar presentation to 2018 USW HSE Conference: The New View of Safety with Todd Conklin | * Reference
* Presentation
 |
| Why leaders need to build businesses that 'fail safely' by Dr Todd Conklin - chapter 1<https://www.youtube.com/watch?v=L2Dp5HIk2Ss> | 5:31 | Todd Conklin presentation at Business Leaders’ Health & Safety ForumOrganisational psychologist and H&S expert Dr Todd Conklin talks to Forum leaders at the Business Leaders’ Health & Safety Forum. | * Reference
* Presentation
 |
| Why leaders need to build businesses that 'fail safely' by Dr Todd Conklin - chapter 2<https://www.youtube.com/watch?v=lWPJzGtmiOQ> | 4:23 | Todd Conklin presentation at Business Leaders’ Health & Safety ForumOrganisational psychologist and H&S expert Dr Todd Conklin talks to Forum leaders at the Business Leaders’ Health & Safety Forum. | * Reference
* Presentation
 |
| Why leaders need to build businesses that 'fail safely' by Dr Todd Conklin - chapter 3<https://www.youtube.com/watch?v=qFDLmZXBaMs> | 6:33 | Todd Conklin presentation at Business Leaders’ Health & Safety ForumOrganisational psychologist and H&S expert Dr Todd Conklin talks to Forum leaders at the Business Leaders’ Health & Safety Forum. | * Reference
* Presentation
 |
| Dr. Todd Conklin speech "Risk Analysis is Fixed in Time - But Hazards Ebb and Flow<https://www.youtube.com/watch?v=X211fU39808&t=254s> | 6:25 | Dr. Todd Conklin speech "Risk Analysis is Fixed in Time - But Hazards Ebb and Flow" at the HPRCT Conference in Monterey CA June 23, 2014.To watch full presentation as well as other professional presentations and interviews please join the Human Performance Associaition at http://hpaweb.org/home/membership/ | * Reference
* Presentation
 |
| Organizational safety and pre-accident investigations: an introduction, keynote by Dr. Todd Conklin<https://www.youtube.com/watch?v=3xKR2_FB6Vk> | 2:47 | Short clip of a keynote recorded at the Second International CIP Conference in Amsterdam (July 2015). Full keynote recordings available for members.Join us: http://cipinstitute.org/event2015/bec...Subscribe for news: http://subscribe.cipinstitute.org/Read about this keynote: https://cipinstitute.wordpress.com/20... | * Reference
* Presentation
 |
| Tim Autrey interviews Dr. Todd Conklin Ph.D<https://www.youtube.com/watch?v=BdAHr5yAQeU> | 8:32 | In this eight minute long preview Tim Autrey, Executive Director of the Human Performance Association interviews Dr. Todd Conklin Ph.D author of Pre-Accident Investigation. To watch full interview and more professional presentations join the HPA at: <http://hpaweb.org/home/membership/> | * Reference
* Interview
 |
| TFZ Safety Conference 2016 - Todd Conklin<https://www.youtube.com/watch?v=f8YHKxIGK8k> | 41:48 | Olie Gas DanmarkPublished on Apr 21, 2016 | * Presentation
 |
| John Nance on Tenerife<https://www.youtube.com/watch?v=5qDaIK9-HH8> | 10:36 | John Nance talks about Tenerife accident | * Case Study (Aviation story)
 |
| John J Nance Near-Miss Story<https://www.youtube.com/watch?v=hW7LGxCLauo> | 6:18 | A galvanizing and oft-requested story from John J Nance's presentations to healthcare and industry regarding the inestimable value of getting people to speak up without fear in critical moments. | * Case Study (Aviation story)
* Value of HPI concepts
 |
| John Nance on the 3 Ways We Fail<https://www.youtube.com/watch?v=9MdB67Z4Dag> | 5:10 | John Nance speaks about the three ways we fail in healthcare at Leapfrog's Annual Meeting on December 6th, 2011 | * Case Study
 |
| Why Humans Can’t Be Perfect | John Nance | TEDxSanJuanIsland<https://www.youtube.com/watch?v=_qm2IVdnJfw> | 18:16 | John J. Nance exposes a dirty little (universal) secret: As humans, we expect ourselves to perform perfectly 100% of the time in our personal and in our professional lives, but in fact, we can never guarantee individual perfection. The key to perfect performance and zero disasters lies in continuously expecting mistakes, using teamwork, and a host of well-proven strategies. John Nance is an internationally recognized air safety advocate, and is best known to North American TV audiences as the longtime Aviation Analyst for ABC World News and Good Morning America. A pioneering advocate of Crew Resource Management, John wrote the landmark work Blind Trust, which is widely credited with helping spark a total revolution in aviation safety. John is a New York Times Bestselling author of 21 major best selling fiction and non-fiction works. He holds BA and JD (Juris Doctor) degrees from Southern Methodist University in Dallas, Texas, and an honorary PsD degree from the University of North Texas Health Science Center. A decorated Air Force pilot veteran of Vietnam and Operation Desert Storm, John is a Lt. Colonel in the USAF Reserve, and has piloted a wide variety of aircraft logging over 16,000 hours in a flight career spanning 50 years. This talk was given at a TEDx event using the TED conference format but independently organized by a local community. Learn more at https://www.ted.com/tedx | * Case Study (Aviation story)
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| Tenerife <https://www.youtube.com/watch?v=4MferspAuv4><https://www.youtube.com/watch?v=O7z69ikk4Lg&t=299s> (19 minutes – good detail)<https://www.youtube.com/watch?v=kjLrZ2SDDaU> (5 minutes – highlights major points) | 1. 45:13
2. 18:19
3. 5:51
 | <https://en.wikipedia.org/wiki/Tenerife_airport_disaster> | * Case Study -
* Identifying “Error Precursors”
 |
| This 1977 Plane Crash Occurred Right on the Runway<https://www.youtube.com/watch?v=36XzwJqo_tg> | 3:14 | On March 27, 1977, at Los Rodeos airport in Tenerife, Pan Am Flight 1736 was sitting on the taxiway waiting to take off. A thick fog obscured the approach of KLM 4805, as it bore directly towards them.Watch the Full Episode with your FREE trial for Smithsonian Channel Plus by signing up today at https://watch.smithsonianchannel.com/ | * Case Study -
* Identifying “Error Precursors”
 |
| Dryden AccidentPart 1: <https://www.youtube.com/watch?v=2R8YKpLVlsw>Part 2: <https://www.youtube.com/watch?v=Vw2KfXuDw_U> | 1. 9:52
2. 8:17
 | First accident investigation including human factors | * Case Study
 |
| Mixed Connection, Toxic Result<https://youtu.be/Tflm9mttAAI> | 11:00 | CSB safety video: detailing key lessons from investigation into 2016 chemical release at MGPI processing facility in Atchison, Kansas. | * Case Study
 |
| Piper Alpha<https://www.youtube.com/watch?v=tPA_6oEgc1s><https://www.youtube.com/watch?v=VXZRx7sE1qc> | 1. 15:06
2. 3:47
 | 2016 HD Piper Alpha was a North Sea oil production platform operated by Occidental Petroleum (Caledonia) Ltd. The platform began production in 1976, first as an oil | * Case Study
 |
| Lake Peigneur Drilling Accident<https://www.youtube.com/watch?v=p_iZr2-Coqc> | 8:23 | Oil driller breaches salt mine under a Louisiana lake. | * Case Study
* Engineering disaster
 |
| M+ I Ships collision in Gibraltar: Human Error-Case Study on true incident<https://www.youtube.com/watch?v=24P-ZRejD7U> | 9:38 | Maritime Training Videos series.Contact us for production of Maritime training & safety videos, Training Shoots & Films, Incident Analysis, Case Study VideosCorporate & Ad Films, Intro-Seminar-Conference Shoots, Documentary & Short films, Music Videoswww.banjaracinema.comE-mail: contact@banjaracinema.comdhhunkiproductions@gmail.com | * Case Study
 |
| 50 years after disaster: Honoring Apollo 1<https://www.youtube.com/watch?v=61SYZ1_sN5c> | 2:02 | CNN's Jake Tapper remembers the Apollo 1 crew 50 years since the fatal fire. | * Lessons Learned
 |
| The Apollo 1 Fire<https://www.youtube.com/watch?v=u7nPG45VCUg> | 2:13 | On January 27th 1967, the crew of Apollo 1 lost their lives in a tragic accident. A spark caused by faulty wiring ignited the pure oxygen atmosphere inside the Apollo 1 capsule and all three men were unable to escape. | * Case Study
 |
| Case Study No.1: 'Crossed Wires'<https://www.youtube.com/watch?v=566P25kin2g> | 8:22 | 'Crossed Wires' portrays a fictitious organisation, Perfect Twins Maintenance, which could be anywhere in Australia, and whose maintenance performance is far from perfect. It is designed to promote discussion about the key human factors issues outlined in the 'Safety Behaviours: Human Factors for Engineers' resource kit. | * Case Study
 |
| Annie's Story: How A System's Approach Can Change Safety Culture<https://www.youtube.com/watch?v=zeldVu-3DpM> | 5:34 | Annie's story is an example of how healthcare organizations seeking high reliability embrace a just culture in all they do. This includes a system's approach to analyzing near misses and harm events—looking to analyze events without the knee-jerk blame and shame approach of old. Learn more about Quality and Patient Safety (http://ow.ly/M1aZk) and Human Factors Engineering in Healthcare (http://MedicalHumanFactors.net).In the short five minutes we had to tell Annie's story, we chose to focus on the main theme—the human cost to our healthcare workforce when we fail to cultivate a just culture and systems approach overall, but especially when managing unfortunate harm events. As we had hoped, this story has inspired conversation, and we are grateful for that conversation. When patient harm occurs, caregivers involved are devastated along with the patient and family, yet for far too long many have had to navigate this storm alone. It is up to us as healthcare providers to demand that a systems approach be a given in our healthcare workplace, along with the just culture that cultivates the sharing of knowledge and helps prevent patient harm from occurring altogether.Please keep in mind this could have happened to any nurse or healthcare provider in any hospital using any equipment, process or tool. If we fail to analyze the entire system before placing blame on any one individual when things don't go as planned, we will unfortunately continue to harm patients and care providers at the same untenable rate as we have since called to light in 1999. This event provided an opportunity to improve a process across ten hospitals because of the willingness of healthcare providers involved to ask for help analyzing a threat to the system, and because leadership followed their instincts—that good healthcare providers should not be punished for system failures. Thanks for watching—please share and continue the conversation. | * Case Study
* Event
* Equipment message error
* Human Factors
* Design issues
 |
| Explosion at Formosa Plastics (Illinois)<https://youtu.be/IRbC4kowrrY> | 10:42 | CSB Safety Video: A preventable human error leads to a vinyl chloride explosion, killing five. Investigations: Formosa Plastics Vinyl Chloride Explosion. | * Case Study
 |
| Rye House Incident 2009<https://www.youtube.com/watch?v=VfFLPdOwtfs> | 11:15 | An explanation of an incident that took place at Rye House Power Station in 2009. Prepared to help prevent injury to others. | * Case Study
 |
| What Lies Beneath: Planning. Part 1<https://www.youtube.com/watch?v=udzCw2UpJ9g> What Lies Beneath: Planning. Part 2.<https://www.youtube.com/watch?v=BCV5Bhmcqxg>  | Part 1: 5:24Part 2: 10:07 | Baker HughesThis video is part of a facilitated learning session that helps the audience to take a different approach to preventing HSE incidents. The videos (part 1 and 2) demonstrate that focusing on organizational and human factors is a valuable approach for proactively evaluating operational workflow and conducting deeper incident investigations. HOW TO USE THE VIDEO:Play to the part 1 of the video without explaining the story. Do not mention that there is part 2. After watching the part 1, ask the participants “Why did it happen?”. Typically, participants will focus on the team. After the discussion, play part 2 (LINK), and ask “did you see anything influencing the actions and decisions of the employees?” and discuss. Is there any difference between the discussions after part 1 and part 2? Typically, participants having seen the contribution of organisational factors change their understanding of accident causation. | * Case Study
 |
| James Cordon – Celebrity Noses: Human Error<https://www.youtube.com/watch?v=8LWZQTm6_jQ&t=42s> | 4:35 | James ones again tries to pull off his Celebrity Noses bit, but audio and power issues complicate matters. | * Human Error
* Humor
 |
| Terry Tate - Office Linebacker <https://www.youtube.com/watch?v=x5dJb2YG7vU> | 4:35 | The best compilation of the world's greatest office linebacker. | * Humor
 |
| Funny golf tip from J.C. Anderson<https://www.youtube.com/watch?v=qQVFhqAKcMg> | 1:13 | PGA TOUR player J.C. Anderson's classic satirical instructional on what to think about when swinging the golf club. | * Humor
 |
| Superbowl 2019 (53) Commercials: Liberty Mutual Accidents<https://www.youtube.com/watch?v=ZUuLCSshnZg> | 0:57 | Superbowl 2019 (53) Commercials: Liberty Mutual Accidents | * Human Error
* Humor
 |
| Liberty Mutual Insurance "Humans" Commercial (London Olympics 2012 Ad)<https://www.youtube.com/watch?v=zfyWct2FJBU> | 1:05 | One of the funnier commercials to air during the American coverage of the London 2012 Olympics. Narrated by actor Paul Giamatti. The song is "Human" by The Human League — available at http://www.amazon.com/dp/B000TEAFA2 | * Human Error
* Humor
 |
| Liberty Mutual - Amateur Athletes <https://www.youtube.com/watch?v=2uLnioudDqs> | 0:31 | A funny TV commercial showing how wannabe athletes can get themselves into trouble. Alas, "we're only human." | * Human Error
* Humor
 |
| Warwick Agency in the Greater Danbury CT Area - Humans and Other Humans<https://www.youtube.com/watch?v=i4b3f0jivIA> | 0:40 | Funny Commercial Liberty Mutual insurance xD | * Human Error
* Humor
 |
| Liberty Mutual Commercial<https://www.youtube.com/watch?v=3H44EfHLgz0> | 0:31 | Liberty Mutual Commercial - Humans Better Car Replacement | * Human Error
* Humor
 |
| If You Are Going to Be Dumb You Gotta Be Tough<https://www.youtube.com/watch?v=VBlqedB6TEs><https://www.youtube.com/watch?v=1xZQehPNz4c><https://www.youtube.com/watch?v=GZQobHsXShY><https://www.youtube.com/watch?v=owqKlABQTuQ><https://www.youtube.com/watch?v=b_SqU8mbE2Q><https://www.youtube.com/watch?v=wsF5s8uijZw><https://www.youtube.com/watch?v=IDPO0qrqV7c> | 2:230:293:133:043:152:583:05 | Collection of humorous videos with music (If You're Gonna Be Dumb/Wait A Minute, I Know What My Future Is/Party Boy Theme, by Roger Alan Wade, Dave Roen) | * Human Error
* Humor
 |
| Funny “Japp” comercials<https://www.youtube.com/watch?v=z4qO-KRWgg8><https://www.youtube.com/watch?v=slB_LAzV87Q><https://www.youtube.com/watch?v=Z8OMGlDAYd8&list=PL0BEBA8E0CA574C46><https://www.youtube.com/watch?v=oUMo1il7me4&list=PL0BEBA8E0CA574C46&index=2> | 3:420.420:430:39 | Banned Commercials - Japp - Chocolate | * Human Error
* Humor
 |
| My last day at home depot<https://www.youtube.com/watch?v=olGSvLSwkG0><https://www.youtube.com/watch?v=g8fSS-V9C3o><https://www.youtube.com/watch?v=1r7k35NotXI> | 0:350:420:35 | An employee at Home Depot makes a horrible mistake on a forklift. A bad stacking job dominoes. | * Inaccurate Risk Perception
* Overconfidence
 |
| The Stroop Effect Explained <https://www.youtube.com/watch?v=EGpzftQf8oI> | 2:30 | The Stroop effect is a lapse in cognition caused by conflicting information in the Stroop test. During the Stroop test, participants are asked to name the color of a word, which is difficult to do since the word itself reads another color. | * Selective Attention
* Task switching
* Speed of cognition
 |
| How Fast Is Your Brain? The Stroop Test<https://www.youtube.com/watch?v=gjesfzWozo4> | 3:02 | The Stroop test is a task where you have to name the color of the words that are presented to you. It is very hard as your brain wants to read the word itself instead of stating the color. Can you do it? | * Selective Attention
* Task switching
* Speed of cognition
 |
| Take the Stroop Test | MythBusters<https://www.youtube.com/watch?v=xrowWGi20bM> | 1:22 | Play along with Adam as he participates in a brain game that tests cognitive speed and ability. | For more MythBusters, visit http://dsc.discovery.com/tv-shows/myt... | * Selective Attention
* Task switching
* Speed of cognition
 |
| Cat Herding<https://www.youtube.com/watch?v=m_MaJDK3VNE><https://www.youtube.com/watch?v=Pk7yqlTMvp8> | 1:001:08 | EDS, an HP Company 'Cat Herders' | * Humor
 |
| Improving your EnglishVery Funny! German coastguard viral video commercial<https://www.youtube.com/watch?v=yR0lWICH3rY> | 0:52 | German Coast guard trainee (Berlitz) | * Humor
 |
| Arkansas State Trooper Locks Keys In Patrol Car (08/23/91)<https://www.youtube.com/watch?v=iAy4aKlEop8> | 2:06 | Talk about a rookie mistake!State Trooper Jackie Clark pulls over a motorist for speeding. As the officer is heading back to his patrol car to run the driver's license, to his embarrassment, he discovers that he has locked his keys inside his patrol car. With no other options, he walks back to the motorist and cuts him a deal. The trooper agrees to let the driver off with a warning if he gives him a ride to the State Police headquarters, which the motorist kindly does. | * Humor
* Self-Checking
 |
| Yellow Pages Shark Tank Crack TV Commercial HD<https://www.youtube.com/watch?v=DxG11XnllVk> | 0:52 | Funny video from Very Funny Ads Collection 2009 - More video at rugra.com | * Humor
* Situational awareness
 |
| Tom Rush - Remember Song<https://www.youtube.com/watch?v=9yN-6PbqAPM> | 3:13 | "The Remember Song" was written by Steven Walters and is used with permission; this clip was recorded at Humphreys By The Bay, San Diego, CA, as part of Judy Collins' "Wildflower Festival" on June 30, 2002. | * Short term memory
* Humor
 |
| Who Wants to Be a Millionaire? (USA) - Chase Sampson's Epic Failure<https://www.youtube.com/watch?v=SM86gVnobEY> | 1:26 | Check out the sound that plays when Chase Sampson gets his first question wrong on an episode of the American version of Who Wants to Be a Millionaire? in 2006. | * Humor
* Fatigue
* Lack of sleep
 |
| SNICKERS® Recovery Room<https://www.youtube.com/watch?v=2RQS-2iiBXE> | 0:30 | You’re careless when you’re hungry. #EatASNICKERS | * Humor
* Forgetfulness
 |