I was speaking with a business owner the other day about a recent catastrophe that occurred within his company. He and another senior leader in the company spent a good day and a half cleaning up the issue and the aftermath, and he was quite exasperated.

I asked him, "What did the organization learn from this?"

We often move fast to f x a problem and get operations back on par — but we rarely take the time to analyze what caused the problem in the f rst place and determine what can be done in the future to prevent it from happening again.

In the military — and often in corporate America — this is known

taken, decisions made, and any key challenges or successes. Ensure that the group agrees on what factually happened.

» **Engage the group in a discussion to identify what could have been done differently at each stage of the event.** Add these alternatives in a different color to each flip chart page. Encourage open and honest feedback from all participants. The benefit of arranging the flipcharts (or whiteboard) sequentially is that you can see cause-and-effect or dependencies more clearly. For instance, in the case of the asbestos removal project, was the overage caused by a poor estimate to begin with? Should you have scheduled a bigger team? Was there an equipment failure? Each potential "fix" will have to be considered in relation to events before and after the event itself.

» **Finally, after you have identified what the failure point was in this event; stand back and look at the big picture.** Are there overarching lessons? These may include best practices, strategies, areas for improvement, and potential risks or challenges to be addressed in the future.

» **Capture these lessons and recommendations in a clear and actionable format** such as a checklist or if/then diagram that can be easily accessed in the future as a preparatory document.

Interestingly, the Blue Angels (the elite Naval flying team) conducts an AAR after every performance — even when it went perfectly! Before the pilots go out to meet attendees of an airshow, they sit around a table and one-by-one review their own performance, delineating what they did well, what they could have done better, and what they intend to do to improve both their own and the team's performance the next time.

When you make AARs "standard operating procedure" — like the Blue Angels - they become part of the learning and development culture of your organization and not an examination of events gone wrong. By following this process when all projects conclude, an After-Action Review can serve as a powerful tool building critical thinking and problem-solving skills of your future leaders. ✒