	FPS Analysis	Reference: 12.30.07.80 Effective Date: 03.05.2024/02 Type of Document: Formulaire Page: 1 / 1	
I. DESCRIPTION			
Object:			
Ce formulaire est un modèle utilisé pour traiter les incidents internes et externes Il décrit la méthode utilisée pour éliminer les causes profondes de la non-conformité; il comprend les étapes suivantes :			
1) Constitution de l'équipe de résolution du problème. 2) Description du défaut 3) Implantation des actions immédiates 4) Identification des causes racines du problème 5) Identification des actions correctives permanentes 6) Implantation des actions correctives 7) Identification des actions préventives 8) Jugement et observation relative au rapport 8D.			
DOMAINE D'APPLICATION :			
Problèmes qualité			
UTILISÉ PAR :			
Equipe qualité			
DÉFINITION DES ANNOTATIONS :			
RAS			
II. HISTORIQUE DU CHANGEMENT			
DATE DE REVISION	VERSION	MODIFICATION	MODIFIÉ PAR
06.02.2024	01	1ère émission	Helmi Chebbi
03.05.2024	02	Ajout de la classification des incidents selon leurs criticités	Hazem Bououni
III. MATRICE D'APPROBATION			
Nom	Département	Fonction	
Hazem Bououni	Qualité	Resp.Qualité Client	
Helmi Chebbi	Qualité	Chef Dépt. Qualité	
Mhamed Drira	Direction usine	Directeur d'usine	
DDO: 12-6620			
IV. CLASSIFICATION DE CONFIDENTIALITÉ			
Extrêmement confidentiel	Confidentiel	Propriété/restreinte x Usage publique	
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Instructions de Travail pour le Traitement des Incidents Clients

1. Réception de l'Incident Client :

L'Ingénieur Qualité Client, l'IQC doit veiller à ce que toutes les informations pertinentes sur l'incident soient correctement documentées dans la base de suivi des incidents. Cela comprend :

- La date et l'heure de réception de l'incident.
- Les coordonnées du client (nom, entreprise, contact).
- Une description détaillée de l'incident, y compris les symptômes, les impacts et toute autre information pertinente.

2. Traitement de l'Incident :

L'IQC doit s'assurer que le fichier de suivi des étapes du 8D est correctement renseigné dès le début du processus.

L'envoi d'un e-mail aux parties concernées doit contenir des informations claires sur l'incident et ses implications. Les pièces jointes, telles que l'onglet "D1-D2 / D3", doivent être clairement identifiées et accessibles.

3. Création du Dossier de Travail sur OneDrive :

L'IQC doit organiser le dossier OneDrive de manière logique et structurée, en créant des sous-dossiers pour chaque phase du traitement de l'incident.

Il est important de limiter l'accès au dossier OneDrive uniquement aux membres autorisés de l'équipe pour garantir la confidentialité et la sécurité des informations.

4. Sécurisation de l'Incident (Containment) :

L'IQC doit collaborer étroitement avec le responsable qualité de la zone et son équipe pour élaborer des actions de containment efficaces qui visent à stabiliser la situation et à prévenir tout impact supplémentaire sur le client ou les processus internes.

L'alerte qualité envoyée doit fournir des instructions claires sur les mesures de containment mises en place et les actions nécessaires à suivre.

5. Réunion de Traitement :

Après l'étape du containment, le responsable qualité de chaque zone doit :

- Participer activement au traitement de la non-conformité.
- Remplir les annexes D4-1, D4-2 et D4-3 pour obtenir toutes les informations relatives à la bobine réclamée, côté traçabilité et process.

La réunion de traitement doit être soigneusement préparée avec un ordre du jour détaillé, y compris la présentation des données sur l'incident et les résultats préliminaires de l'analyse.

L'IQC et le Responsable Qualité de zone doivent encourager la participation active de toutes les personnes concernées pour garantir une compréhension commune de l'incident et des mesures correctives à mettre en œuvre.

6. Mise à Jour et Suivi :

L'IQC doit documenter toutes les activités et les progrès réalisés dans le fichier 8D de manière claire et concise.

Les rappels aux personnes en retard dans l'exécution des actions doivent être effectués de manière proactive, en identifiant les obstacles et en fournissant un soutien supplémentaire si nécessaire.

7. Finalisation du Processus :

L'IQC doit s'assurer que toutes les actions préventives sont intégrées de manière appropriée dans les procédures et les processus existants.

La révision des documents qualité tels que les FMEA et les instructions de travail doit être menée avec rigueur pour garantir leur pertinence et leur efficacité.

8D Methodology Steps Follow-up		StepsTime
01	D1-D2	0,5
02	D3-Containment	0,5
03	D3-Alert&Awareness	0,5
04	D4-Investigation Sheet	1
05	D4-Roout Cause Analysis	1
06	D5-Corrective Actions	0,5
07	D6-Effectivness control	5
08	D7-Prevention	0,5
09	NC Spools Follow-up & NQ Cost	0,5
Global Progress		10

Planning	Closing Date	Follow-Up	Progress
09/02/2024	05/02/2024	-4,5	100%
10/02/2024	-	-	0%
10/02/2024	-	-	0%
11/02/2024	-	-	0%
12/02/2024	-	-	0%
13/02/2024	-	-	0%
18/02/2024	-	-	0%
18/02/2024	-	-	0%
19/02/2024	-	-	0%
Cumulation		-4,5	11%
Overage Delay		-4,5	



Incident Pilote :

Name :

Function:

Incident Details

Customer Incident Nbre:

Incident Type

Claim

Contact Customer Details

Customer

From

Function

Tel.

Fax

E-mail

Progress Rate

100%

Closing Date

05/02/2024

Phone :

Localisation:

Incident Date

09/02/2024

Customer

Information about the Incident

ID Number

Reference

Color

Rejected Quantity (m)

Received date/BL

Prod. Date

D1

Team Assembled

Department

Department

Department

Department

Department

Department

Department

Department

Department

Department

Name :

Name :

Name :

Name :

Name :

Name :

Name :

Name :

Name :

Name :

Function:

Function:

Function:

Function:

Function:

Function:

Function:

Function:

Function:

Function:

D2

Problem Description

Customer Description

Defect Samples :

Did we recieve a sample from Customer ?

Yes

☐

No

☐

When

Defect Confirmation :

Did we confirm the defect ?

Yes

☐

No

☐

Not Yet

☐

COFICAB Description

Internal Claim Ref.

Defect Name

Defect Family

Photo of the Problem

What happened?

Why is it a problem?

When detected

Who detected?

Where detected?

How detected?

How many bad parts?

Production Process ?

In which Plant?

Last Similar Problem ?		
Incident criticality	Is the incident considered critical ? Classification :	<div><div>H</div><input type="checkbox"/></div> <div><div>M</div><input type="checkbox"/></div> <div><div>L</div><input type="checkbox"/></div>
Quality Manager Validation		<div><div>Yes</div><input checked="" type="checkbox"/></div> <div><div>No</div><input type="checkbox"/></div> <div><div>When</div><div>21-sept.-23</div></div>

D2 Calculate the criticality of the incident

Evaluation

Incident type	Customer impact	Special characteristic	Number of impacted customers by the incident	Potential escalation
Claim	Direct customer process	1	1	Non
3	2	4	1	1

Matrix:

Special characteristic	Number of impacted customers by the incident	Customer impact	Result	Criticality classification
1			H	
	More than 2		H	
		Risk of Call recall	H	
Different from 1	1-2	Different from "Risk of Call recall"	Total calculated points ≥ 20 H	
Different from 1	1-2	Different from "Risk of Call recall"	Total calculated points $10 < C < 20$ M	
Different from 1	1-2	Different from "Risk of Call recall"	Total calculated points ≤ 10 L	

Result:

Total calculated points "C"	Criticality classification
14	H

Issue Date:	
26-sept	

Number of suspected spools	Financial impact	Recurrence of the incident in the same year
1-2	Less than 10000€	Non
1	1	1

D2

Criticality matrix of incident classification

Classification criteria

Incident type	Customer impact	Special characteristic	Number of impacted customers by the incident	Potential escalation
Notification	Incoming inspection of the direct customer	4	1	Non
Alert	Direct customer process	3	2	Oui
Claim	Final customer	2	More than 2	
	Risk of Call recall	1		

Issue Date:	
26-sept	

Number of suspected spools	Financial impact	Recurrence of the incident in the same year
1-2	Less than 10000€	Non
3-5	10000€-20000€	Oui
5-10	More than 20000€	
More than 10		


Incident Pilote :
Progress Rate
0%
Closing Date

Name :

0

Phone :

0

Function:

0

Localisation:

0

D1
Containment Actions
E1

Suspect Spools tracability, Claimed by the Customer :

Spool N°1

Twisting

Taiping/Braiding

Extrusion

Irradiation

Expedition

Date: 13-sept.-23

PROCESS 1

Réf Bobine

Date:

PROCESS 2

Réf Bobine

Date:

PROCESS 3

Réf Bobine

Date:

Réf Bobine

Date:

Réf Bobine

Date:

Réf Bobine

Date:

Réf Bobine

Date:

Réf Bobine

Date:

Réf Bobine

Date:

Réf Bobine

E1-1

Suspect Spools tracability, Claimed by the Customer :

Spool N°2
E1-2

Suspect Spools tracability, Claimed by the Customer :

Spool N°3
E2

SORTING activity to protect customer

Localization

Action taken

Responsible

Date

Status

Comments

 In COFICAB
Stock

Results

ID Number

Reference

Lenght (m)

Production Date

EMP

Responsible

Date

OK/NOK Part

Localization

Action taken

Responsible

Date

Status

Comments

In production

Results

ID Number

Reference

Lenght (Km)

Production Date

EMP

Responsible

Date

OK/NOK Part

Localization

Action taken

Responsible

Date

Status

Comments

In Transit											
Results	ID Number	Reference	Lenght (Km)	Production Date	Color	Responsible	Date	OK/NOK Part			
	0										
	0										
Localization		Action taken			Responsible	Date	Status	Comments			
In Customer Stock											
Results	ID Number	Reference	Lenght (Km)	Production Date	EMP	Responsible	Date	OK/NOK Part			
Sorting Result		Nbr Of OK spools		Nbr of NOK spools		Result was Communicated to the Customer?					
						Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	When	
Customer Care Supervisor Validation					Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	When	septembre-23	

E2-2	Sorting Activity Result To Protect Customer
-------------	--

Data_Spools					
ID Line	Serial Number	Item	Description	Quantity	Date

E3	Urgent Replacement for the Customer
-----------	--

Spools_Data					
ID Line	Serial Number	Item	Description	Quantity	Date

Containment Actions

--

				Liste des Contrôle à effectuer			
Final Status	Type	N° Longuer	Location	Adherance	Bull d'aire	Facteur A	

--

			Liste des Contrôle à effectuer				
Final Status	Type	N° Longuer	Adherance	Bull d'aire			

	Issue Date:

--

er	

--

Expedition_Data	
Delivery Date	Customer Feedback



Progress Rate

0%

Closing Date

0

E3

Quality Alert

Concerned Zone:

Incident Details

Customer Incident Nbre:

0

Incident Date

09/02/2024

Incident Type

Customer

0

Problem Description

Customer Description

0

What happened?

0 janvier 1900

Why is it a problem?

0

When detected?

0

Who detected?

0

Where detected?

0

How detected?

0

How many bad parts?

0

Production Process ?

0

In which Plant?

0

Last Similar Problem ?

0

Photo of the Problem

E4

Awareness Session

Ensured By :

Helmi CHEBBI

Date :

sept.-20

Message To Be Transmitted

N°	Name	Function	Shift	Date	Signature
01					
02					
03					
04					
05					
06					
07					
08					
09					
10					
11					
12					
13					
14					
15					

In 24 Hours

Awareness Responsible

Dept Supervisor

Cust. Care Supervisor

Plant Quality Manag





3



jer



 4D		Diagnose Root Cause		Issue Date:			
D4 Diagnose Root Cause		Progress Rate		0%		Closing Date	
E1 Investigation Sheet		Concerned Zone Supervisor		Date			
What happen ?What is the difference between good and bad parts? <i>The defect must be described as the deviation between a good and a bad part.</i>		Bad Part		Good Part			
Was part produced in the standard process? <i>Any product or process deviation or rework or operation done by non qualified person must be taken in consideration</i>							
Who manufactured ? <i>These information are related to the person working at the station responsible for the defect and the person in charge of the detection of the defect.</i> <i>- Name of the person and/or his registered number</i> <i>- Function of the person. qualification. status</i>		Occurrence		Detection			
Where the defect is produced and in In which other application or processes product is used ?							
How can we detected the defetct? are we capturing the defect when reinjecting product in normal process ? <i>refrer to the contrôle plan & (PAC/PEV) identify the contrôle method of this defect , reproduce the defect and reinject it without warning the operator and see if we capturing the defect in the normal process</i>							
How many NOK Spool or meterage ? Did a similar problem happen previously at customer or internally ?							
MACHINE SETTINGS&Tooling <i>- is there any maintenance intervention recorded in the machine .</i> <i>-is the Poke Yoke Systeme or device implement and work properly ?</i> <i>- Is the machines parameter (pressure , force,temperature, speed,...) is secured and complient regarding the defined machine settings (Recette)?</i> <i>(Check the current machine settings and compare it regarding the claimed spool report and the standard)</i> <i>-Compliance of the Tool?</i>							
Man <i>-Is the person responsible for the defect or the detection of the defect are trained to apply the involved instruction or standard?</i> <i>-Are the users able to explain the standard ?</i> <i>-Are the users respecting the standard ?</i>							

METHOD & OPERATIONS

Is the Work Instructions describing how :
- to operate the workstation safely
- to produce a part
- to maintain the equipment (1 st maintenance level)

QUALITY CONTROLS

Is the defect existe in the contrôle activity (Pac , Pev,...)?
Is the control ensured by the operator or the quality agent ?
What is the result of control if the tracebeality Data availbale?

RAW Material

Raw material lots and supplier complience ?

PROJECT ACTIVITY

Check Design Validation, Process Validation,
Check the initial Prototypes and if design rules have been respected

Customer Care Supervisor Validation

Yes ☒ No ☐

When



P1

Process Parameters

Add the needed process parameters



E2-5 Raw Materials Investigation

Item :

Inner Core Spools Nbre	RAW Material	Temperature Class	Batch Nbre	Color	Color Batcs	Date	Comments

Lot Traceability

Lot	Fournisseur	Code Article	Date Production	Date_Reception	Qte	Num Sac	Comments



D4

Diagnose Root Cause

Progress Rate

0%

Closing Date

E2

Root Cause Analysis

Concerned Zone Supervisor

H. CHEBBI

Date

18/09/2023

Step1

List of all causes (Tools: Brain storming + Ishikawa)

Machines/Equipement

Methods/Process

Manpower /People

Ishikawa
Diagram

0

Materials

Environment

Measurements

5M

Process/Machine

Parameters

Potential causes / Factors

Selection

Argument / Validation (Mandatory if cause not retained)

Action / Argument

Pilote

Deadline

Result

Occurrence

Method - Process

Method - Process

Not Selected

Selected

Not Selected

Not Selected

Not Selected

Not Selected

Not Selected

Not Selected

Not Selected

Not Selected

Not Selected

Not Selected

Not Selected

Not Selected

Not Selected

Not Selected

OK

OK

OK

OK

OK

OK

OK

OK

OK

OK

OK

OK

OK

OK

OK

OK

Non Detection

Systemic

Step 3		Potential Causes Validation & Defect Reproduction					
Trial N°	Causes	Trial Description	Waiting Result	Parameters	Tools	Pilote & Date	Result/Conclusion
1							
2							
3							
4							
5							
6							
7							
8							

Step 2		Finding Root Causes (Tools: 5 Whys)				
Occurrence	Potential causes	Why1	Why2	Why3	Why4	Why5
Non Detection						
Systemic						

Step 4		Selected Root Causes			
ROOT CAUSES OF OCCURRENCE	OC1		OC2		
	OC3		OC4		
ROOT CAUSES OF NON-DETECTION	ND1		ND2		
	ND3		ND4		
SYSTEMIC ROOT CAUSES	SC1		SC2		
	SC3		CS4		



D5

Identify Solutions, Corrective Actions

Actions Plan Global Progress

#DIV/0!

Progress Rate

0%

Closing Date

Root Cause	Actions		Pilote	Deadline		Follow-up		
	N°	Intitulé		Date	Week	Progress	Postpone	Comments & Progress
OC					0			
SC					0			
					0			
					0			
					0			
					0			
					0			
					0			
					0			
					0			
					0			
					0			
					0			

Conclusion/Comments

Customer Care Supervisor Validation

Yes ☒

No ☐

When



D6

Validation of Effectiveness

Progress Rate

0%

Closing Date

E1

Validation of effectiveness method

E2

Actions Implimentation & Effectiveness Follow-up

Actions Count :

0

Week

1

2

3

4

5

6

7

8

Planed Actions

0

0

0

0

0

0

0

0

Actions Done

0

0

0

0

0

0

0

0

Report Blocage for progress :

Planed Actions Actions Done

1

0

1

2

3

4

5

6

7

8

N°

Actions Checked

Time Period Tracked

Result and Comments

1

From To

2

From To

3

From To

4

From To

5

From To

6

From To

E3

Process / Performance Evolution

Evaluation Period

From:

Wxx-2023

To:

Wxx-2023

1

Performance / KPI

Before

After

Comments

From:

To:

2

Follow Summary

Week

Result

Target

Arguments/Comments

Photo

Evolution-Chart

1

2

3

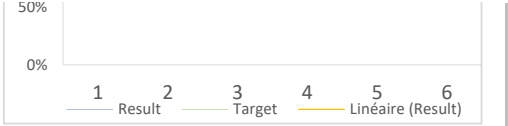
4

150%

100%



EVOLUTION AFTER
IMPROVEMENT

5			
6			
Average			



E4		Process Capability Analysis												
Evaluation Period						Carateristic		Before	After	Comments				
From:	Wxx-2023		To:	Wxx-2023		1	CP							
From:	Wxx-2023		To:	Wxx-2023		2	CPK							
Run chart										Comments				

E5		Conclusion									
----	--	------------	--	--	--	--	--	--	--	--	--

		7D	Prevention					Issue Date:		
D7		Prevention					Progress Rate		0%	Closing Date
E1		Preventive Actions								
Actions				Responsible		Date		Status		
E2		Review the following documents / systems								
Document		Modif.			Responsible	Date				
		Y	N	N/A		Planned	Status			
Management System Manual										
Process and inspection work Instructions										
Flow Charts										
Control Plans (PEV or PAC)										
Design/ Process FMEA										
Risk Analysis Table and lesson learned										
Forms										
E3		Lessons Learned & Next Steps								
1										
2										
3										
4										
D8		8D Closure								
Closed by:										
Closure Date:										



D8+1

8D Acceptance

Progress Rate

0%

Closing Date

Have the 8D been accepted by the Customer?

Yes



No



When

If Not, Why

Incident Details

Customer Incident Nbre: 0

Incident Date 45331

Incident Type Claim

Customer 0

Information about the Incident

0

ID Number 0

Rejected Quantity (m) 0

Reference 0

Received date/BL 00/01/1900

Color 0

Prod. Date 00/01/1900

NC Spools Decision

Accepted



Name :

Acceptance Date

Rewinded



Name :

Decision Date

New ID

Recovered Qte

120

Scrap

-120

Total Scrap



Name :

Decision Date

New ID

Scrap Date

Non Quality Cost

Replacement Cost 0,00 €

Cost of Sorting 0,00 €

Cost of Rework 0,00 €

Production Line Stopped 0,00 €

Scraped Finished Goods 0,00 €

Scraped Purchased Parts 0,00 €

Test Costs 0,00 €

Overtime Labor 0,00 €

Special freights 0,00 €

Other Costs 1 000,00 €

Total Non Quality Cost

1 000,00 €

Have the Costs of Non-Quality been accepted by COFICAB TN?

Yes



No



When

If Not, Why

New Non Quality Cost

1 000,00 €

Have the Credit Not been Signed by COFICAB TN?

Yes



No



When

If Not, Why

CNQ Closure

Cust. Care Supervisor

Dept Qlty Supervisor

Plant Quality Manager