

Root Cause Analysis



Perry K. Parendo
651-230-3861
Perry@PerrysSolutions.com

Agenda

- Discuss RCA process
- Recognize need for another level for complex situations
- Understand alternative approaches

Lost experience – “what to do when stuck?”

Common Processes

- **PDCA (or PDSA)** Formal and informal situations
 - Plan, Do, Check (Study), Act
- **DMAIC**
 - Define, Measure, Analyze, Improve, Control, Sustain*
- **DMADV**
 - Define, Measure, Analyze, Develop, Verify
- **LAMDA**
 - Look, Ask, Model, Discuss, Act
- **8D**
 - Plan, Team, Define, Interim containment, Find root cause and escape point, Verify permanent solution, Implement, Preventive measures, Congratulate team

The RCA Process

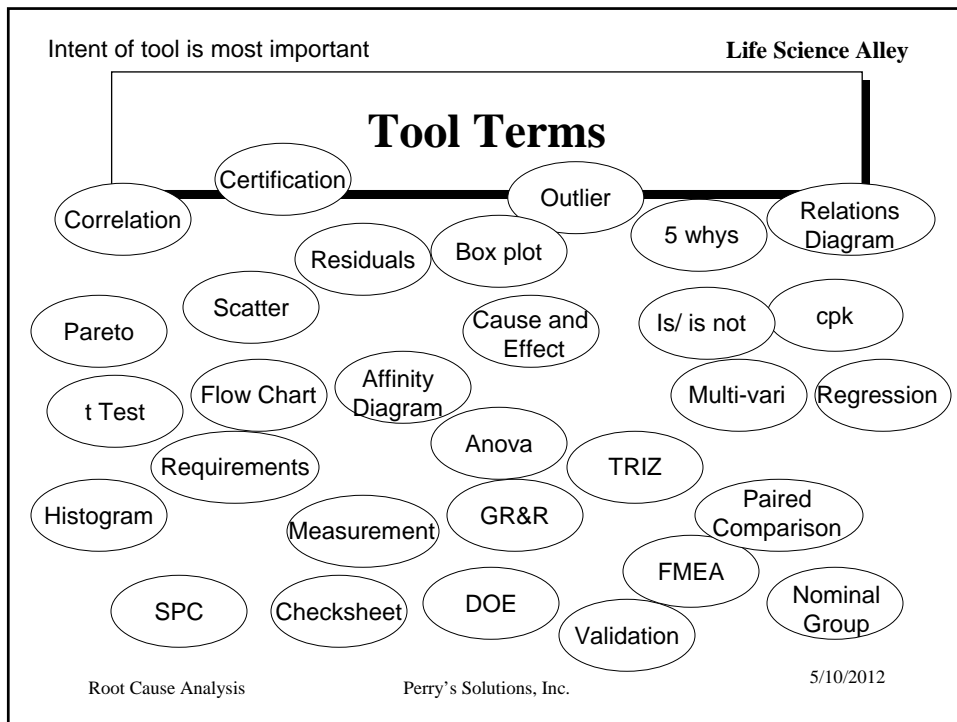
- There are many “systems” to solve a problem. What matters most is what you emphasize.
- Solving a problem in R&D, manufacturing or in the field – really ends up being about the same thing.

Differences

- **The big additional item for manufacturing or field issues is to contain the bad stuff!**
 - On order, in process, in storage, in field
 - Why is that seldom talked about? Seems critical to me.
- **Short term and long term solution**

7 Simple Tools

- **Flow Chart**
- **Cause and Effect**
- **Pareto chart**
- **Histogram**
- **Scatter Plot**
- **Check sheet (map)**
 - Data collection
- **SPC (Statistical Process Control)**



Life Science Alley

Root Cause Analysis Situation

- How is it different than problem solving?
- Customers and vendors involved
- Lots of money on the table
- Complex problem, where the quick and dirty solutions did not work yet
- Likely been an issue for months or years

Root Cause Analysis Perry's Solutions, Inc. 5/10/2012

Dealing with Root Cause

- If it is a suspect lot of material, then it should be dispositioned by the key stake holders
 - Do we use it until confirmed?
 - Do we pull it out of the process?
 - Do we return it to the supplier?
 - What if it passes the supplier spec, but does not perform for us?
 - Is our change something that could require customer approval?
 - Does our change even work?
 - Is there a way to rework the parts to pass?
- If it is known bad, then can we
 - Screen for it in the future
 - Change our design to be “robust” to it in the future
 - Change materials
 - Change our process

Weaknesses

- We've been there before, we should be able to get back there again
 - Have you?
- Egos and control
- Rewarded for closing out items in short amount of time, prohibits time required to find a root cause
- Ignore interactions
- Test a point versus testing an area

Situation Examples

- **Several black magic processes**
 - Address internal first
- **Several wide tolerances from vendors**
 - Need to be stable over that range
- **Development of complex, new technology**
 - Redesign and major process changes
- **Mold new part**
- **Not what it was, but still in their spec**

Common (bad) Approach As Executed

- **Brainstorm list of possible causes**
- **Cross things off the list when evidence is provided that it was not the cause**
 - Often an unsubstantiated claim/ opinion
- **There are 2 or 3 remaining items...**
- **Quick tests (OFAT)**
- **Make data fit a cause**
- **Sign off the correction**
- **Resume production, hoping it does not return again**

As Executed

- Find issue and resolve: quick and clean
- Stand off – memos “we didn’t change anything. It’s not our fault”
- Guess, guess, guess (informal, unstructured, but sounds like “scientific method”)
- Is/ Is not (formal)
- Analysis (do the theoretical homework)
- Empirical results (knowledge)
 - “Just make it go away” – speed and stability

Decision Making Process

- State problem (or opportunity)
- Identify alternatives
- Evaluate alternatives (funnel down number of choices)
 - Existing knowledge
 - Design and conduct experiments
- Make decision
- Implement
 - Does not need to be all or nothing, phased implementation is also an alternative (gathering more data)

Pareto, Minnesota Council for Quality, 2012

DOE Process

- Define goal / need
- Define response to measure progress to goal
- List all variables and down select to “key” variables using engineering judgment
- Select appropriate design matrix
- Select safe/consistent test levels for variables
- Address response priorities
- Perform test
- Analyze results
- Discuss next step

Parendo, MN ASQ Conference, 2001

The Homework that Needs Done

- The work that should be done up front includes:
 - Knowing the requirements and their basis
 - Knowing the measurement system is representative
 - Understanding specifications for incoming materials
 - Understanding other design inputs – design variables
 - Understanding process nominals and extremes

More on Homework

- What we need is:
- “Help setting OQ limits and making sure the process limits are tied to a real specification with statistical evidence ("proof") of validity.”

When Need Advanced

- Hit the wall
- It's been “this” solution before, why not now?
- What if/ What else testing
- How often? Probably not more than 20% of the time...
- Depends on maturity of project

Advanced Techniques

- Cause and effect with Is/ Is not chart
- Simulations/ Digital Manufacturing (white paper – coming soon on my website)
- DOE (Product and Process)
- SPC (incoming and in process)
- Risk management

Is/ Is Not Chart

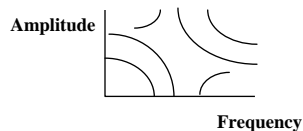
- This collects information about the situation
 - What the problem is and what it is not, and if those positions are based on fact or opinion
- The biggest danger is that it looks at things in a “One Factor at a Time” manner. We can show it is not a main effect – but if it was, we would have noticed much quicker
- Once crossed off the list, it then is not considered for interactions and DOE related work
 - Doing a DOE on the 2-3 remaining this is not going to work, as they are often less likely items if no previous information existed

What can make this effective

- **Simulations can enhance understanding**
- **Test strategies to confirm understanding**
 - Verification testing over a period of time/ lots to ensure stability
 - Basing this on weak assumptions is dangerous – a potential schedule savings if accurate. A frustrating, head scratching adventure if not.
 - Development tests that address the “what ifs” involved
 - Understanding the “design window”
 - Understand the margins and the nominal
 - I have not found a better approach to do this than Design of Experiments

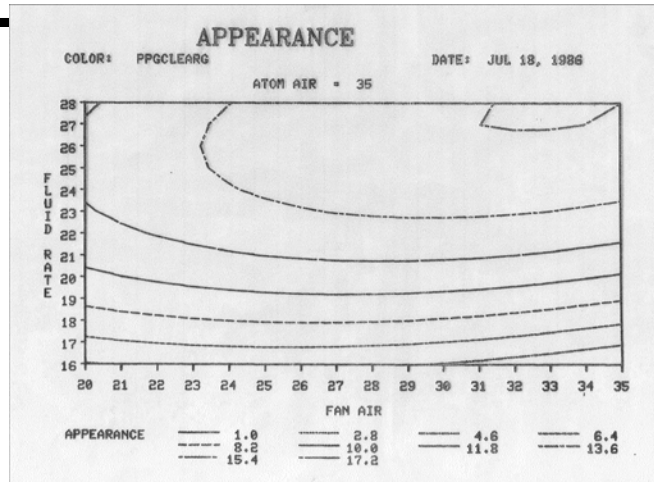
Injection Molding Example

- **Goal: Predicting where to operate would be great!**
Need to rebuild trust with customer.
- **Response: leakage and appearance**
- **Approach: Executed first DOE at vendor recommended ranges**
- **Result: Found “bad” and “ok” areas; could predict better area!**



* Predicted operation area

GM Chart



Root Cause Analysis

Perry's Solutions, Inc.

5/10/2012

Conclusion

- The process and tools are fairly simple and common. But the key questions are:
- Do we have the knowledge
- When do we admit/ recognize we do not have it?
- Can we avoid getting to this point of needing to do root cause analysis?
 - Do your homework – and manage risk
 - Or instead of risks, what about “things that could mess someone else up, but I should be ok with...”
- Once we find it, how do we make sure it does not happen again? SPC...

Root Cause Analysis

Perry's Solutions, Inc.

5/10/2012

Questions

- **If you have questions or thoughts, feel free to share them with us**
 - 651-230-3861
 - Perry@PerrysSolutions.com
- **If interested, email us to be on our quarterly newsletter where we share recent trends and learning.**
 - They are all archived on our publications page