8D Problem Solving Process

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- The 8D problem solving (Eight Disciplines) is an approach used to identify, correct and eliminate the reoccurrence of quality problems.
- It is structured into eight disciplines, emphasising team synergy...The team as a whole is believed to be smarter than the sum of individuals.





- The U.S Government first used an 8D like process during the second world war referring to it as Military standard 1520 (Corrective action and disposition system for nonconforming material).
- Ford Motor Company first documented the 8D method in 1987 in a course manual entitled "Team Oriented problem solving".
- This course was written at the request of senior management of the power train organisation of the automaker, which was facing growing frustration at the same problems that were recurring year after year.





- Major non conformances
- Customer complaints (Inc. Warranty)
- Supplier complaints
- Reoccurring issues

8D Purpose



- Required by the Customer
- Forms part of the Continuous Improvement process
- ISO 9001:2015 requirement (Clause 8.3)
- Is a systematic method to problem solving and reporting

8D Purpose (cont'd)



- Provides an orderly team-oriented method for solving problems using facts rather than personal bias. Creative and permanent solutions usually require input from many activities.
- Applies to any problem or activity and assists in achieving effective communication between departments, which share a common objective.
- Requires documentation through the AIE Corrective Action Report (C.A.R).

8D steps



- D0 Prepare for the 8D Process
- D1 Establish Team
- D2 Describe the Problem
- D3 Develop Interim Containment Actions
- D4 Define and Verify Root Cause and Escape Point
- D5 Choose and Verify Permanent Corrective Actions for Root Cause

and Escape Point

- D6 Implement and Validate Permanent Corrective Actions
- D7 Prevent Recurrence
- D8 Recognise Team and Individual Contributions

D1 Establish the team



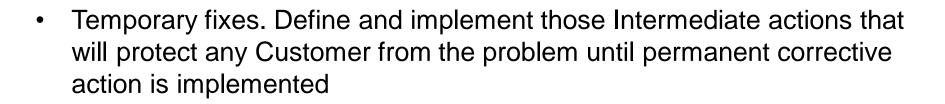
- Assemble a cross functional team (with an effective leader) that have the knowledge, time, authority and skills to solve the problem and implement corrective actions
- Set the structure goals, roles, procedures and relationships to establish an effective team

D2 Describe the problem



- A Problem Statement is a simple concise statement that identifies the object and the defect of a problem for which the cause is unknown
- Define the problem in measurable terms
- Specify the internal or external customer problem by describing it in specific quantifiable terms
- Who, What, When, Where, Why, How, How many (5W, 2H analysis)

D3 Implement and verify interim containment actions



Advanced

- Material / Product locations; Raw Material, Semi-finished Goods (WIP), Finished Goods, At Customer, At Supplier, In transit (from Supplier or to Customer), Shipping and/or Receiving Dock, Materials on order (future shipments from Supplier)
- Verify the effectiveness of the containment actions with data

D4 Identify and verify root causes



- Identify all potential causes that could explain why the problem occurred. Cause and Effect diagrams may be used.
- Note that two parallel types of root cause exist:
 - Root cause of event (the system that allowed for the event to occur)
 - Root cause of escape (the system that allowed for the event to escape without detection)

D4 What has Changed



- Problems appear because something has changed. The search for the root cause is a search for changes.
- Ask "What changes have occurred?"
 - What changes have occurred in the plant?
 - What new suppliers are being used?
 - Have any new operators been hired?
 - Has new material been used? A new batch?
 - Is the process capability the same as usual?
 - Was the weather unusual when the problem occurred?

D4 Select Root Cause



- Interpret data and develop potential hypothesis
 - Many different ideas may exist as to what the true cause of a problem is
- Compare all hypothesis to is/is not data (investigation facts)
 - The true cause will have all facts either supporting the explanation of being unrelated
 - Any fact refuting a hypothesis means that either the fact is incorrect (bad data) or the hypothesis needs revision
- Continue research as needed
 - Verify/validate facts in question
 - Revise hypothesis or identify cause interactions.

D4 Root Cause Verification



- Through experimentation (or simulation), verify that the real root cause has been found. It should be possible to create and eliminate the problem by installing and removing the cause
- The true root cause should be able to explain all of the data and fact collected up to this time

D5 Choose and verify corrective actions



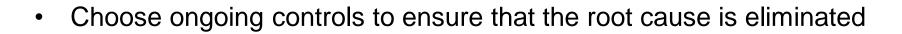
- Confirm that the selected corrective action will resolve the problem for the customer and will not cause undesirable effects
- Define contingency actions, as necessary based on the potential severity of the side effects

D5 Choose and verify corrective actions



- Corrective action decision criteria is established through the decision making process
- Objectively evaluate each possible action against a predetermined decision criteria
- Prove that the corrective action (or combination of
- actions) will eliminate the problem
 - Conduct verification tests
 - Remove containment temporarily (Only normal production influences should be present)
- Establish indicators to ensure the defect is eliminated with high confidence

D6 Implement and validate permanent actions



Advanced

• Once in production, monitor the long term effects and implement additional controls and contingency actions as necessary

D7 Prevent reoccurrence



- Identify and implement steps that need to be taken to prevent the same or a similar problem from occurring in the future
- Modify specifications, update training, review workflow, and improve management systems, operating systems, practices and procedures

D7 Prevent reoccurrence



- Sustain the gains for current improvements
 - Update procedures/documentation, training, fixtures,
 - error-proofing, etc.
- Similar problems within the same work area
 - Apply improvements to prevent similar problems from occurring
 - Use FMEA to help identify opportunities (e.g. multiple causes for a single failure mode/symptom)
- Same or Similar problem in another part of the organisation
 - Apply improvements to prevent future problems
 - Learn from prior mistakes/problems
 - Share the learning

D8 Congratulate the team



- Recognise the collective efforts of your team
- Publicise your achievements
- Share your knowledge and learning throughout the organisation

The Quality Tools



- The Quality Circle (Deming Cycle)
- Affinity Diagrams
- Cause and Effect
- Pareto Analysis
- Trend Charts
- Brainstorming
- Use Cross Functional Teams

Is / Is not Tool



- Establish:
 - what the problem is, and what it is not but could be
 - where the problem **is**, and where it **is not** but **could be**
 - when the problem occurs, and when it does not but could
 - how big the problem **is**, and how big it **is not** but **could be**

Cause and Effect (Fishbone Diagram)



- Developed to represent the relationship between all the possible causes for a specific effect
 - Manpower
 - Machines
 - Methods
 - Materials

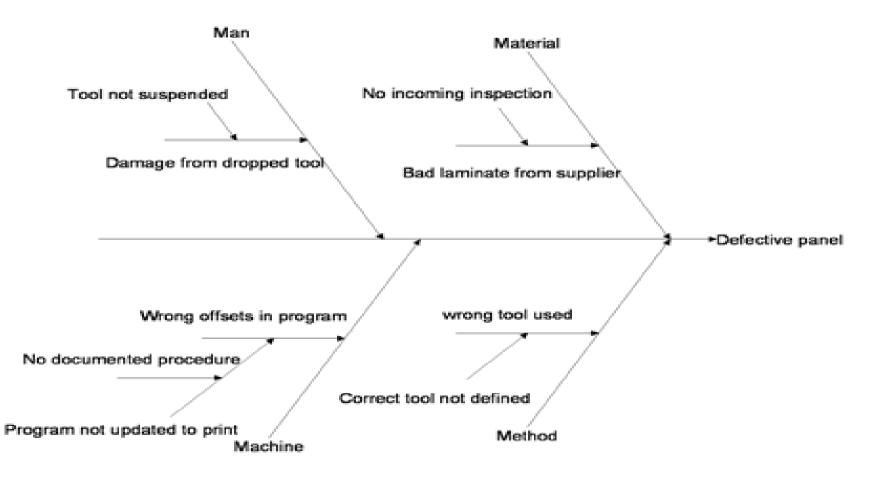
Cause and Effect (Fishbone Diagram)



- Push the causes back as much as is practically possible to ensure we reach the root cause. Ask as many "Why's" as possible
- When examining each root cause, look for things that have changed, deviated from normal or patterns in order to identify the most likely cause
- The solution will not be effective if the real root cause is not identified

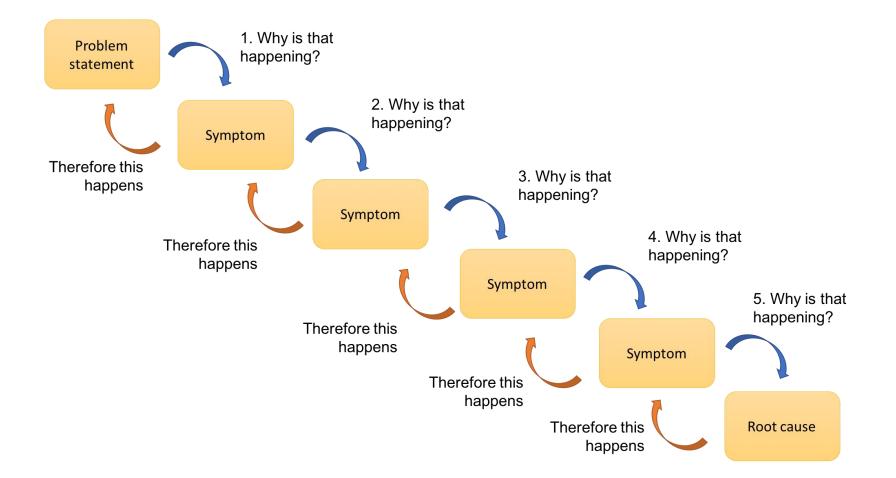


Cause and Effect (Fishbone Diagram)



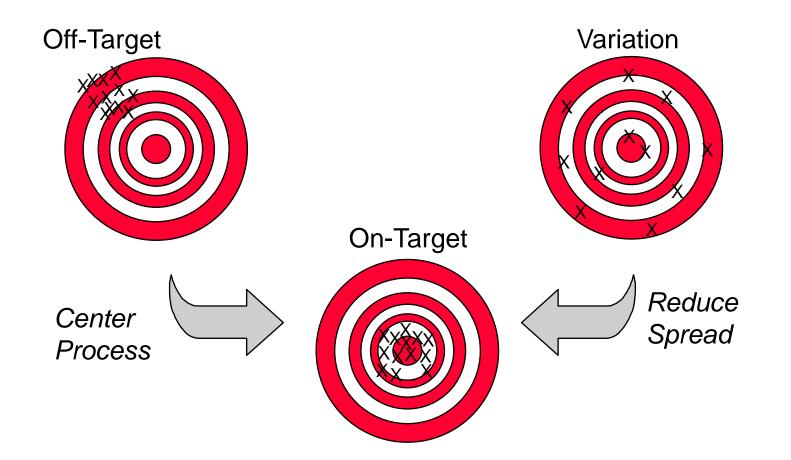
The 5 Why's





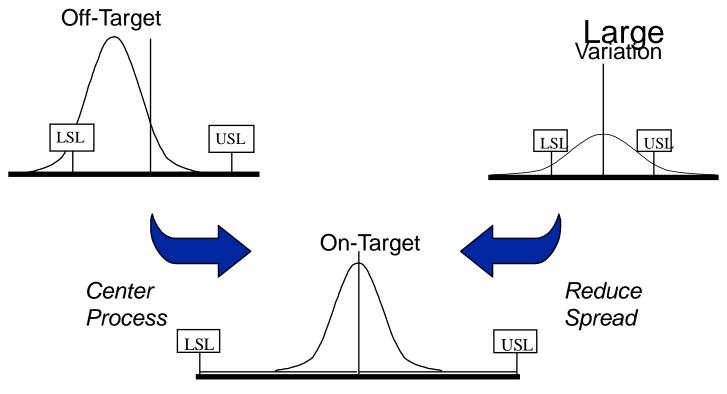
Understanding problems





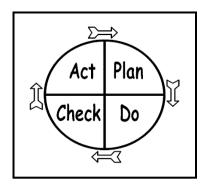
Understanding problems





LSL = Lower spec limit USL = Upper spec limit

The Quality Circle





- Plan: Define the system or process/ Access the current system or process/ Analyse the process, where has it gone wrong?
- Do: Try the improvements to see if they work. Test your theories / measure
- Check: Study the results, are they what you expected? If so make them permanent
- Act: Act to improve the process further, don't stop. Make the process better

The Quality Circle - Plan



- Develop plan for implementing specific actions
- What documentation needs to be updated?
 - Work instructions, Drawings, Control Plans, FMEAs, Computer programs, etc
- What people need to be retrained?
 - Operators, Inspectors, Engineers, other Support personnel
- What organisations need to be notified?
 - Internal departments, Suppliers, Customers
- What new problems are presented by changes and how will
- they be addressed?
 - FMEA, Risk Assessment, etc.
- Who owns each task and what is the targeted implementation
- date?
- How will progress be tracked?
- Develop contingency plans if problems are encountered
- When will containment actions be removed?

The Quality Circle - Do



- Execute the Plan
- Use existing control processes:
 - Document control
 - Engineering Change
 - Customer notification
 - Supply Chain processes
 - Training processes
- Identify the effective date of changes

The Quality Circle - Check



- Review process to ensure things are working according to Plan
 - Track progress and determine resources needed to meet commitment dates
 - Review performance results to ensure improvements are being realised
 - Review costs to ensure financial impacts are in line with expectations
 - Ensure that no unintended consequences are happening (quality, efficiency, safety, etc)

The Quality Circle - Act



- Make necessary adjustments as needed
- Reapply containment actions if problems still present and revise corrective actions (back to problem solving and "Plan" phase)
- Deploy resources in different way to get execution back on track
- Move on to next opportunity if everything is complete and achieving desired results