



## Supplier Request for Corrective Action (RFCA) Report

Problem Description:			
Product(s) / Part Number:		Issue Date:	Click or tap to enter a date.
RFCA #:		Issued By:	
Initial Response Due:	Click or tap to enter a date.	Initial Response Actual:	Click or tap to enter a date.
Corrective Action Due:	Click or tap to enter a date.	Corrective Action Close:	Click or tap to enter a date.
Supplier:		Supplier POC:	Click or tap to enter a date.
Follow Up Due Date:	Click or tap to enter a date.	CAR Closure Date:	Click or tap to enter a date.
Issue addressed?		CAR Closed By:	
RFCA Effectiveness Supplier Rating [self]		RFCA Effectiveness Rating [SDE / SQE]	

### Special Instructions, Comments & Other Information:

1. Complete all cells highlighted in Blue.
2. Use drop down menu to fill in due dates.
3. Promptly notify your Supplier Development Engineer prior to the expiration of action item. SDE will determine if an extension is warranted. Please have the extension in writing.
4. Un-extended Past due action items will count against Supplier Score Card Reports.
5. Refer to "Supplier RFCA Response Effective Scale". Engineering solutions [Scores > 3] mitigate opportunities for reoccurrence. Supplier will self-evaluate their response against provided scale. SDE / SQE will also rate suppliers' response against scale.



## Fishbone Diagram (also called Ishikawa diagram, and cause-and-effect diagram)

#	Step	Description	Result	Completion Date
1	Define Problem	Restate the issue as you see it, in your terms. Team needs to address the issue by what you call things, not what we call them.		Click or tap to enter a date.
2	List team members involved	List people and functions or titles.		Click or tap to enter a date.
3	Immediate Containment	What is done <b>today</b> to contain issue? Consider material in transit.		Click or tap to enter a date.
4	Certified Stock	What is done to assure certified stock exists? Certified shipments must be labeled per SQAM.		Click or tap to enter a date.
5	Ongoing Containment	What containment remains in place until issue resolved?		Click or tap to enter a date.
6	Root Cause (this issue, detection and systemic)	What is the actual root cause for the occurrence, failure to detect & business system issues? Use 5 Why and/or Fishbone at end of document.		Click or tap to enter a date.
7	Permanent corrective actions that eliminate root causes	What permanent actions are taken to eliminate those root causes defined above?		Click or tap to enter a date.
8	Verification of corrective action	Evidence that this is the root cause. Can you turn it on and off?		Click or tap to enter a date.
9	Prevention actions	What actions can be taken to prevent this type of issue in the future?		Click or tap to enter a date.
10	Systemic corrections	What changes are made to your system to prevent future issues?		Click or tap to enter a date.



1 Look  
1 across.  
Where  
else does  
this apply?

Where else can this  
corrective action be applied  
to improve? Consider  
different machines, lines,  
parts, plants, etc.

Click or tap  
to enter a  
date.

1 Congratula  
2 te the  
team

Let us know what you've  
done to tell your team  
they did a good job

Click or tap  
to enter a  
date.



## Fishbone diagram (also called Ishikawa diagram and cause-and-effect diagram)

3 legged 5 Whys is an iterative technique used to explore the cause-and-effect relationships underlying a particular problem. The primary goal is to determine root cause of a problem by repeating the question "Why?" Each answer forms the basis of the next question. The "5" in the name derives from an anecdotal observation on the number of iterations needed to resolve the problem. The number of whys may be more or less than five.

The 3 legs are: 1) Why the specific problem, 2) Why did it get to the customer, 3) Why the business system allowed the issue

Notes: 1. Attach documents as needed. 2. See example below.

	Issue	Why	Why	Why	Why	Why
What caused the specific problem?	Issue					
	Evidence→					
What allowed the problem to reach the customer?	Detection/ Control					
	Evidence→					
What in the business system allowed the issue to	System					
	Evidence→					

### Example: 3 Legged 5 Why

	Issue	Why	Why	Why	Why	Why
What caused the specific	Increase in warranty returns on a new line of toasters.	Toast is exposed to heat for too long in toaster	Toast does not eject	Toast ejection mechanism fails after repeated	Ejection spring does not compress and lift toast	Spring is not strong enough to lift toast after repeated

What problem?	Evidence→	Summary of customer return complaints	Performed tests on five returned units (report # xxxx –	Ran test with automatic cycling until failure (report vvvv	Examined failed units	Identified as root cause
What allowed the problem to reach the customer?	All toasters passed all outgoing test	Weak spring not detected by product development process	Spring failure did not occur during product testing	Ejection system durability test not completed	Durability testing is not required on these systems	
	Evidence→	Reviewed last 3 months of reject report from Final	Reviewed product testing reports	No durability test in file	Identified as root cause	
What in the business system allowed the issue to	Business System	Durability testing is not required on this systems	Only the first system released uses duty cycle to determine	Assumed duty cycles to be similar for all toaster lines	Company design guidelines directed assumption	
	Evidence→	Reviewed design guide	Examined design reports	Examined design reports	Identified as root cause	

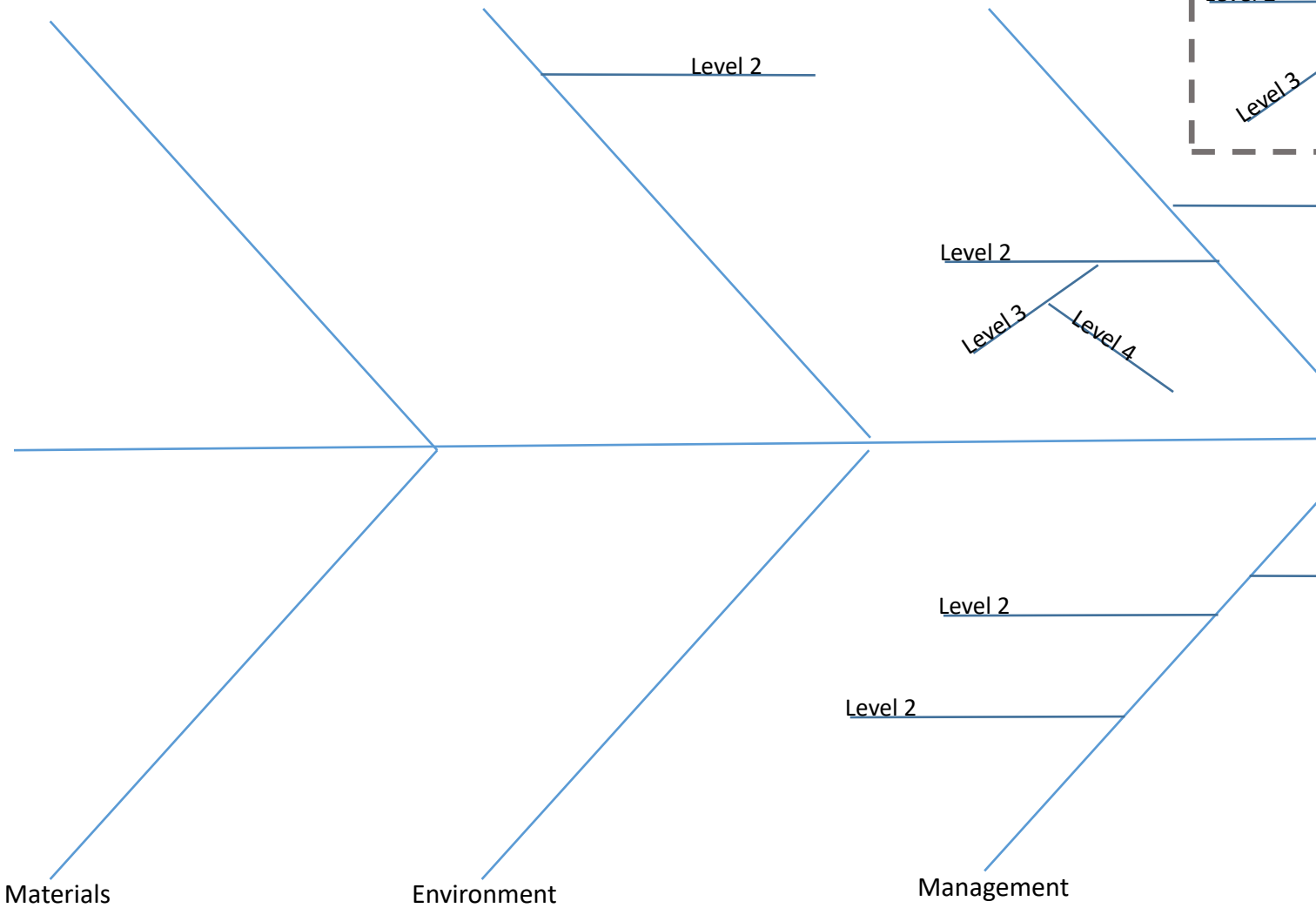


## Supplier RFCA Effectiveness Scale

Rating	Response Category to RFCA Request	Reoccurrence
0	<ul style="list-style-type: none"> <li>Tell someone to do something</li> <li>Retrain on an existing procedure</li> <li>No root cause discovered</li> </ul>	>75% probability it will happen again
<b>Operator Dependent Solution</b>		
1	<ul style="list-style-type: none"> <li>Rewrite a procedure</li> <li>Add a new process step</li> <li>Reword a process step</li> </ul>	>50% probability it will happen again
2	<ul style="list-style-type: none"> <li>Develop a new procedure</li> </ul>	
<b>Engineering Solution</b>		
3	<ul style="list-style-type: none"> <li>Add automatic alarm to the process</li> </ul>	<50% probability it will happen again
4	<ul style="list-style-type: none"> <li>Redesign product to remove failure point</li> <li>Redesign tooling to remove failure point</li> <li>Add automatic shutdown to prevent failure point</li> </ul>	
5	<ul style="list-style-type: none"> <li>Same solution as "4" plus one of the following               <ul style="list-style-type: none"> <li>Other process reviewed for same potential failure</li> <li>Applied solution to process other than where failure was originally discovered</li> </ul> </li> </ul>	

## Fishbone diagram (also called Ishikawa diagram and cause-and-effect diagram)

Fishbone diagrams are created to show the causes of a specific event. The defect is shown as the fish's head, facing to the right, with the causes extending to the left as fish bones; the ribs branch off the backbone for major causes, with sub-branches for root-causes, to as many levels as required.



Example: Fishbone diagram (also called Ishikawa diagram and cause-and-effect diagram)

