Q & A with Robert J. Latino, Reliability Center, Inc.

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Robert J. Latino is CEO of Reliability Center, Inc. (RCI). RCI is a Reliability Consulting firm specializing in improving equipment, process and human reliability. Mr. Latino received his Bachelor's degree in Business Administration and Management from Virginia Commonwealth University.

Mr. Latino has been facilitating RCA & FMEA analyses with his clientele around the world for over 20 years and has taught over 10,000 students in the PROACT® Methodology. Mr. Latino is co-author of numerous seminars and workshops on FMEA, Opportunity Analysis and RCA, as well as co-designer of the national award winning PROACT Suite Software Package.

Mr. Latino is an author of Root Cause Analysis: Improving Performance for Bottom Line Results (3rd Ed., 2006, c. 284 pp., ISBN: 0-8493-5340-8, Taylor & Francis) and Patient Safety: The PROACT Root Cause Analysis Approach (2008, c. 272 pp., ISBN 9781420087277, Taylor and Francis), contributing author of Error Reduction in Healthcare: A Systems Approach to Improving Patient Safety (1999, c. 284, ISBN: 1-55648-271-X, AHA Press) and The Handbook of Patient Safety Compliance: A Practical Guide for Health Care Organizations, (2005, c. 350 pp. ISBN 0-7879-6510-3, Jossey-Bass) .

Mr. Latino has been published in numerous trade magazines on the topic of Reliability, FMEA, Opportunity Analysis and RCA as well as a frequent speaker on the topic at domestic and international trade conferences.

Q: What types of typical hurdles do you often encounter when encouraging potential clients to adopt root cause analysis?

A: The most common objection I hear about with regards to implementing an effective Root Cause Analysis (RCA) process is that "We don't have time to do RCA!" Think about that statement for a minute. It is an oxymoron that the majority faces.

The reason that people do not have time to perform RCA is that they are too busy reacting to the needs of the field, or "fire fighting".

This stance says that we do not have time to analyze why failure occurs and prevent its recurrence, but we do have the time and resources to fix it again. RCA of chronic failures is a proactive activity; it is geared towards eliminating the need to do maintenance work. The concept is easy to understand, but extremely difficult to implement.

Q: How can root cause analysis supplement an existing maintenance program for the better?

A: With the current incentive systems rewarding reaction, this promotes the need to address failures consistently. In many cases a good backlog of maintenance work is a sense of job security to maintenance personnel. After all, what would happen to me if there were no failures and therefore nothing to fix? Will I lose my job? This is a valid fear by maintenance personnel in an era of "reengineering." What most people fail to realize is that the reason that proactive activities are not being done is that we lack the resources to do them.

The field of Reliability Engineering has a lot of jobs available; it is just that we do not have the resources to fill them. For instance, couldn't we use more vibration analysts, infrared thermographers, ultrasonic thickness testing inspectors, parts inspection personnel, failure analysts, boiler inspectors, etc. These are all proactive activities that currently are understaffed because the reactive work takes all the staffing.

Proaction using RCA can also provide employment security based on growth as a facility demonstrates to the corporation that they are a low cost producer. Typically, the capital money will go to such "stars." The capital money generally is involved with growth and adding personnel.

Q: When should a facility consider approaching a problem through root cause analysis?

A: Most people who tout RCA programs only use them when a "major incident" occurs. Usually an "incident" is defined by OSHA, ISO, EPA or some other regulatory

agency. This means that you will only analyze failures that the government requires you to look at. These failures usually involve excessive equipment damage, injuries/fatalities, toxic releases or near misses. Whether we like it or not, “incidents” of this nature WILL be analyzed by someone because of the potential safety issues and legal implications.

What about all those failures that do not hurt people or cause tremendous damage. We refer to these as the “chronic” failures because they are so repetitive that they are not considered a failure any more, they are part of the job.

They are seen as a nuisance. They are so repetitive that we account for them in the budget. Imagine that, we do not try to analyze them because they are perceived as insignificant, yet we will accept them as routine and set aside money to fix them when they occur.

Some of these type failures happen every shift. They are so small and occur so frequently that it becomes a hassle to put them in the Computerized Maintenance Management System (CMMS), so we do not. Now they are not even recorded. They are hidden gold for a true failure analyst.

Chronic failures typically far outweigh the cost of any sporadic failures that anyone may experience. Now think if we added up the cost of our accepted chronic failures on an annualized basis. Examples of chronic failures we tend to accept are bearing failures, seal failures, steam leaks, defective parts, and rate restrictions. These are of the mechanical nature. Think about the administrative delays that cost us money.

Events such as excessive time to get safety permits, excessive time to obtain a Management of Change (MOC) approval, excessive time to execute planned outages, and excessive time to procure a crane. They also cost you money because a lost hour is extremely expensive when you consider manpower costs, material costs and lost profit opportunities for the lost production hour. If there are any skeptics out there regarding this paradigm, please consider how large a maintenance budget is and what it is used for.

Q: What types of errors do you often see amongst users, after undergoing an RCA training process?

A: A common misperception about RCA training is that since you were trained, you are now the expert. You are also believed to be able to solve any failure in eight hours or less. You do not become an expert in RCA by sitting in a classroom for a week. Like anything else that you become proficient at, it involves practice, lots of it. If you only perform RCA on “incidents” as described earlier, you are not getting much practice (unless your facility has many incidents!).

It is also a common belief among managements that have not been educated in the RCA techniques, which their people are learning RCA and it is not their job and management is out of the picture. This is farthest from the truth. Lack of managerial support for RCA efforts is the most common reason of why legitimate

efforts fail. You can have the best analysts in the world, but if the environment they work in does not support their activities, the effort will fail. For example, management must provide access to the technical resources (metallurgical lab, chemical lab, etc.) to the analysts to verify hypotheses.

Management must make a change in the work order system to insure that the proactive recommendations from RCA are planned and scheduled in the reactive job pool of the CMMS system. Management must expect and provide the analysts the time and resources to form teams and meet periodically.

Management must gain cooperation from other departments if their expertise is necessary on a team. These types of activities typically cannot be executed by the analyst because he or she may not have the clout to make these things happen. RCA is a team effort between the people who must do the work and the management who must support the activities.

Q: What are the biggest misconceptions people often have about RCA?

A: That it costs a lot of money. If RCA is costing you too much money, then you are doing it wrong. This is a common paradigm that must be overcome. Many believe that implementing the recommendations from RCA will be an expensive venture. I am not saying that this is never the case, but I am saying that in my experience it is rare. It is rare because the majority of causes of these chronic failures are deficient organizational systems.

Organizational systems are the “rules” that govern how a facility operates. For example, organizational systems include maintenance procedures, operating procedures, policies, guidelines, training systems, purchasing systems, etc. People make decisions based on these systems. If these systems are flawed, then poor decisions are going to be made resulting in operational failures.

Correcting deficient systems is not expensive but it does take courage. Providing training or correcting procedures is not capital money but it does involve the “soft” issue of dealing with the human behaviors and attitudes. Sometimes we tend to think we can throw money at any problem and it will go away.

Sometimes it might! In my experience, most of the time we end up wasting money because we tend to spend the money on new equipment and do not invest it in our people. Money spent on helping our people to make better decisions in the field is money that will provide far greater returns than many equipment investments. The problem today is that there is no where on our Balance Sheet that accommodates an entry for intellectual capital, so it is trivialized.

As you can see, there are many obstacles in the way of doing RCA but most of them are mental paradigms that do not represent reality. If such paradigms exist in our work environments then we need to dispel them by creating an education and awareness around the facts instead of the perceptions. Remember, you cannot do what you cannot imagine!

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