

**MSS SUCCESS SPACES**

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ROOT CAUSE ANALYSIS TRAINING IN THE PHILIPPINES

STOP FIXING SYMPTOMS. SOLVE THE REAL CAUSE.

Practical Root Cause Analysis for Problem Definition, Evidence Gathering, Cause Identification, Five Whys, Fishbone Analysis, Process Analysis, Cause Validation, Corrective Action, and Prevention of Problem Recurrence

This program is strategically developed for organizations searching for **Root Cause Analysis Training in the Philippines, Training on Root Cause Analysis in the Philippines, Analyzing the Root Cause Training in the Philippines, Training on Analyzing the Root Cause in the Philippines, Analyzing Root Causes Training in the Philippines, or Training on Analyzing Root Causes in the Philippines.**

Organizations repeatedly experience problems such as:

- Customer complaints;
- product defects;
- service failures;
- late deliveries;
- inventory discrepancies;
- equipment breakdowns;
- recurring errors;
- missed deadlines;
- system failures;
- supplier problems;
- workplace incidents;
- quality failures;
- billing errors;
- process delays;
- employee-performance issues;
- repeated rework.

Yet many of these problems return because organizations address:

What happened

without adequately determining:

Why it happened.

A customer complaint is resolved.

But the same complaint appears next week.

A defective product is replaced.

But another defect occurs.

An employee is reminded to be careful.

But the error happens again.

A delayed order is expedited.

But deliveries remain late.

The immediate problem may have been:

Corrected.

The underlying cause may never have been:

Removed.

That is the difference between:

FIXING THE INCIDENT

And

PREVENTING RECURRENCE.

Stop Fixing Symptoms. Solve the Real Cause.: **Root Cause Analysis Training in the Philippines** develops the practical capability employees, supervisors, specialists, engineers, Quality personnel, managers, and leaders need to investigate recurring workplace problems systematically, identify evidence-supported causes, develop appropriate corrective actions, and verify whether the problem has genuinely been prevented from recurring.

The program introduces the proprietary **MSS R.O.O.T.™ Root Cause Analysis Framework**:

- **R — Recognize and Clearly Define the Problem**
- **O — Observe the Process, Facts, Patterns, Changes, and Evidence**
- **O — Open Up, Organize, Analyze, and Validate Possible Causes**
- **T — Treat the Root Cause, Track Corrective Action, and Test Effectiveness**

The Root Cause Analysis flow becomes:

Problem → Evidence → Possible Causes → Analysis → Root Cause → Corrective Action → Implementation → Verification → Learning

The course combines practical Root Cause Analysis tools such as:

- Problem Statements;
- Is-Is Not Analysis;
- Process Mapping;
- Timeline Analysis;
- Change Analysis;
- Pareto Analysis;
- Five Whys;
- Fishbone or Cause-and-Effect Analysis;
- Cause-and-Effect Matrix;
- Data Stratification;
- Barrier Analysis;
- Cause Validation;

- Corrective Action Planning;
- Effectiveness Verification.

Following MSS Corporation's **EnterTRAINment** methodology, approximately **30% of the program consists of concise facilitator input, demonstrations, facilitated discussion, and synthesis**, while approximately 70% consists of **Root Cause Analysis cases, evidence examination, Five Whys exercises, Fishbone Analysis, process analysis, cause-validation challenges, corrective-action design, recurrence-prevention exercises, and workplace application.**

TRAINING OVERVIEW

A recurring organizational mistake is:

Solution before analysis.

Problem:

“The employee made an error.”

Immediate solution:

“Retrain the employee.”

But what if:

- The procedure was unclear?
- Two systems showed conflicting information?
- The form itself encouraged the error?
- A required approval step was bypassed?
- Workload exceeded realistic capacity?
- The employee never received the updated procedure?
- The system allowed an invalid entry?

Training the employee may not eliminate the true cause.

Another example:

Customer orders are repeatedly delivered late.

Someone concludes:

“The warehouse is slow.”

But investigation may reveal:

- Sales enters orders late;
- inventory records are inaccurate;
- products are unavailable;
- approval takes too long;
- pick lists are generated late;
- trucks arrive unpredictably;
- route planning is poor;
- supplier deliveries are delayed.

The visible failure happened in:

Delivery

but its root cause may exist much earlier in the process.

Root Cause Analysis therefore asks:

Where did the problem originate?

What evidence proves that?

What conditions allowed it to happen?

Why did existing controls fail to prevent it?

What must change so that recurrence becomes less likely?

WHAT IS ROOT CAUSE ANALYSIS?

Root Cause Analysis is a structured process used to investigate why an undesirable event, problem, failure, error, defect, or recurring issue occurred and identify the underlying causes that should be addressed to prevent or substantially reduce recurrence.

A true Root Cause Analysis should move beyond:

Who made the mistake?

toward:

What conditions, processes, decisions, controls, or system weaknesses allowed the problem to happen?

ROOT CAUSE VERSUS SYMPTOM

Symptom

The visible effect.

Example:

Customer complaints increased.

Root Cause

An underlying condition that materially contributed to the problem and whose effective removal or control should reduce the likelihood of recurrence.

Example:

Incorrect product instructions were automatically generated because an outdated template remained active in the system.

If the organization merely:

Apologizes to customers

the symptom has been addressed.

If it:

Corrects the template control process
the underlying cause begins to be addressed.

ROOT CAUSE VERSUS DIRECT CAUSE

Suppose an order was delivered late.

Direct Cause

The truck departed two hours late.

Ask:

Why?

Because loading was delayed.

Ask:

Why?

Because products were not staged.

Ask:

Why?

Because the pick list was released late.

The immediate cause may not be the deepest actionable cause.

ROOT CAUSE VERSUS CONTRIBUTING CAUSE

Many problems do not have only one cause.

A failure can result from several conditions operating together.

Possible contributing causes may involve:

- People;
- process;
- equipment;
- technology;
- materials;
- environment;
- policies;
- information;
- controls;
- management.

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The objective is not always to discover:

The One Magical Root Cause.

The objective is to identify:

The meaningful causal conditions supported by evidence.

ROOT CAUSE ANALYSIS VERSUS PROBLEM SOLVING

Root Cause Analysis

Focuses heavily on:

Why did this happen?

Problem Solving

Continues toward:

What should we do about it?

Root Cause Analysis is therefore a critical component of strong problem solving.

Organizations that want a more complete end-to-end problem solving methodology may complement this program with MSS Corporation's **Problem Solving and Decision-Making Training**.

ROOT CAUSE ANALYSIS VERSUS TROUBLESHOOTING

Troubleshooting often focuses on:

Restoring normal operation quickly.

Root Cause Analysis focuses on:

Understanding why the failure happened and reducing recurrence.

Example:

Machine stops.

Troubleshooting:

Restart machine.

Root Cause Analysis:

Why did it stop, and what must change so it does not keep stopping?

Both may be necessary.

CORRECTION VERSUS CORRECTIVE ACTION

This distinction is essential.

Correction

Addresses the immediate nonconformity or problem.

Example:

Replace the defective item.

Corrective Action

Addresses the cause of the problem to reduce recurrence.

Example:

Modify the production control process causing repeated defects.

A company can perform hundreds of:

Corrections

while never eliminating:

The causes generating them.

TRAINING GOAL

To equip participants with practical Root Cause Analysis knowledge, investigative discipline, analytical tools, evidence-based reasoning, cause-validation techniques, and corrective-action planning skills necessary to determine why recurring workplace problems occur and develop actions that address causes rather than merely symptoms.

TRAINING OBJECTIVES

By the end of the program, participants should be able to:

1. **Explain** Root Cause Analysis and its organizational importance;
2. **Differentiate** symptoms, problems, direct causes, contributing causes, and root causes;
3. **Differentiate** Root Cause Analysis from troubleshooting, correction, problem solving, and corrective action;
4. **Apply** the MSS R.O.O.T.™ Root Cause Analysis Framework;
5. **Recognize** situations that warrant formal Root Cause Analysis;
6. **Define** a problem clearly before investigating causes;
7. **Develop** an evidence-based Problem Statement;
8. **Avoid** embedding unverified causes inside Problem Statements;
9. **Specify** what happened;
10. **Identify** where the problem occurred;
11. **Identify** when and how frequently the problem occurred;
12. **Determine** the magnitude and business impact of the problem;
13. **Establish** what should have happened;

14. **Establish** what actually happened;
15. **Gather** relevant facts and evidence;
16. **Differentiate** evidence from assumptions and opinions;
17. **Use** Is-Is Not Analysis to define problem boundaries;
18. **Use** process mapping to identify where failures may originate;
19. **Analyze** timelines where sequence matters;
20. **Use** change analysis to investigate what changed before a problem emerged;
21. **Use** Pareto Analysis to prioritize recurring failure categories;
22. **Apply** the Five Whys appropriately;
23. **Avoid** forcing every Root Cause Analysis into exactly five questions;
24. **Develop** Fishbone or Cause-and-Effect Diagrams;
25. **Identify** possible causes across relevant categories;
26. **Use** brainstorming without confusing possibilities with proven causes;
27. **Organize** causal hypotheses logically;
28. **Differentiate** correlation from causation;
29. **Identify** missing evidence;
30. **Test** possible causes;
31. **Validate** causes using evidence;
32. **Reject** unsupported causal explanations;
33. **Recognize** when "human error" is an insufficient root-cause statement;
34. **Analyze** why existing controls failed;
35. **Identify** system and process weaknesses;
36. **Use** Barrier Analysis where appropriate;
37. **Prioritize** causes according to contribution and business impact;
38. **Develop** appropriate corrective actions;
39. **Differentiate** containment from corrective action;
40. **Align** corrective actions with validated causes;
41. **Avoid** defaulting automatically to retraining;
42. **Establish** action owners and deadlines;
43. **Determine** appropriate measures of successful implementation;
44. **Establish** effectiveness checks;
45. **Verify** whether recurrence was actually reduced;
46. **Recognize** unintended consequences of corrective actions;
47. **Document** Root Cause Analysis findings clearly;
48. **Communicate** findings without creating a blame culture;
49. **Capture** organizational learning from completed Root Cause Analyses; and
50. **Develop** a 30-, 60-, or 90-day Root Cause Analysis Improvement Plan.

LEARNING DOMAINS ADDRESSED

Cognitive Domain

Participants strengthen their understanding of:

- Problem definition;
- evidence;
- causation;
- symptoms;

- root causes;
- analytical tools;
- corrective action;
- effectiveness verification.

Affective Domain

Participants strengthen:

- Curiosity;
- objectivity;
- evidence orientation;
- willingness to challenge assumptions;
- openness to systemic causes;
- accountability;
- learning orientation;
- avoidance of blame.

Behavioral Domain

Participants practice:

- Problem definition;
- evidence gathering;
- questioning;
- process analysis;
- Five Whys;
- Fishbone Analysis;
- cause validation;
- corrective-action development;
- effectiveness planning.

FROM POINT A TO POINT B

Point A: Before the Training

Participants may:

- Jump immediately to solutions;
- confuse symptoms with causes;
- blame employees;
- write “human error” as the root cause;
- automatically recommend retraining;
- investigate based on assumptions;
- accept the first explanation;
- use Five Whys mechanically;
- create Fishbone Diagrams but never validate causes;
- brainstorm causes without gathering evidence;
- identify twenty possible causes but prioritize none;
- treat correlation as causation;
- ignore process factors;

- overlook system weaknesses;
- focus on the last person who touched the process;
- address isolated incidents but ignore patterns;
- repeatedly fix the same problem;
- close corrective actions because tasks were completed;
- fail to verify whether the problem actually stopped;
- or produce Root Cause Analysis reports that do not influence operations.

Point B: After the Training

Participants should be better able to:

- Define problems precisely;
- separate symptoms from causes;
- gather evidence systematically;
- map the process;
- identify patterns;
- investigate changes;
- use Five Whys appropriately;
- construct meaningful Fishbone Diagrams;
- develop multiple causal hypotheses;
- validate causes;
- identify control failures;
- distinguish correction from corrective action;
- design cause-linked corrective actions;
- assign ownership;
- establish effectiveness measures;
- verify recurrence;
- document findings;
- and turn Root Cause Analysis into organizational learning.

ORGANIZATIONAL CHALLENGES ADDRESSED

This **Training on Root Cause Analysis in the Philippines** may help organizations address:

- Recurring customer complaints;
- repeated production defects;
- repeated rework;
- quality nonconformities;
- supplier quality problems;
- inventory discrepancies;
- warehouse errors;
- late deliveries;
- process bottlenecks;
- equipment downtime;
- service failures;
- billing mistakes;

- payroll errors;
- data-entry errors;
- recurring employee mistakes;
- project delays;
- audit findings;
- safety incidents;
- process-control failures;
- repeated Information Technology incidents;
- unresolved customer issues;
- corrective actions that do not work;
- managers repeatedly blaming people;
- departments blaming one another;
- weak quality investigations;
- superficial incident reports;
- organizations implementing Quality Management or continuous-improvement systems;
- teams seeking stronger evidence-based problem analysis.

WHEN SHOULD ROOT CAUSE ANALYSIS BE USED?

Not every tiny workplace problem requires a full Root Cause Analysis.

It is particularly valuable when a problem is:

Recurring

It keeps coming back.

Significant

The business impact is meaningful.

High Risk

Safety, compliance, customers, reputation, operations, or finances may be affected.

Complex

Several possible causes exist.

Unexplained

The reason is not obvious.

Systemic

The issue may extend beyond one individual or incident.

Corrective Action Has Failed

Previous solutions did not prevent recurrence.

The effort spent investigating should generally reflect:

Impact + Frequency + Risk + Complexity

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THE MSS R.O.O.T.™ ROOT CAUSE ANALYSIS FRAMEWORK

R — RECOGNIZE AND CLEARLY DEFINE THE PROBLEM

Never begin Root Cause Analysis with:

“We already know what caused it.”

Begin with:

“What exactly happened?”

THE PROBLEM STATEMENT

A strong Problem Statement should describe:

What?

What happened?

Where?

Where was it observed?

When?

When did it occur?

How Much?

What was the magnitude?

Compared With What?

What requirement, standard, or expected condition was not met?

WEAK PROBLEM STATEMENT

“Warehouse staff are careless and causing inventory problems.”

This already assumes:

Cause = careless staff

without sufficient evidence.

STRONGER PROBLEM STATEMENT

“Physical count for Product A on August 25 showed 840 units while the inventory system showed 920 units, creating an 80-unit discrepancy.”

Now investigate:

Why?

DO NOT PUT THE CAUSE INTO THE PROBLEM

Weak:

“Delivery is late because drivers are inefficient.”

Better:

“Twenty-three percent of deliveries during August arrived after the confirmed customer delivery window.”

Now analyze.

ESTABLISH IMPACT

Determine possible effects on:

- Customers;
- quality;
- cost;
- productivity;
- safety;
- service;
- compliance;
- employee workload;
- revenue;
- reputation.

This helps determine how much investigative effort is justified.

CONTAIN BEFORE YOU ANALYZE WHERE NECESSARY

Some problems require immediate action before investigation finishes.

Example:

Defective product may be reaching customers.

Immediate containment may include:

- Stop shipment;

- isolate inventory;
- inform affected stakeholders;
- inspect available stock.

Containment protects the business.

It does not automatically eliminate the underlying cause.

IS-IS NOT ANALYSIS

A useful problem definition technique asks:

Dimension	IS	IS NOT
What?	Product A	Product B
Where?	Line 2	Line 1
When?	Night shift	Day shift
Extent?	Recent three batches	Earlier batches

This can reveal important boundaries.

Ask:

What is different between where the problem occurs and where it does not?

O — OBSERVE THE PROCESS, FACTS, PATTERNS, CHANGES, AND EVIDENCE

After defining the problem:

Go where the evidence leads.

FACT VERSUS ASSUMPTION

Fact

Machine stopped at 2:16 PM.

Assumption

Operator caused the shutdown.

Do not treat the second statement as fact until supported.

SOURCES OF ROOT CAUSE ANALYSIS EVIDENCE

Possible evidence includes:

- Records;
- system logs;
- transaction data;
- Quality reports;
- customer complaints;
- equipment readings;
- photographs;
- process observations;
- interviews;
- audit findings;
- timestamps;
- production data;
- supplier records;
- maintenance history.

GO TO THE PROCESS

Where practical, understand:

How work actually happens

not merely:

How the procedure says it should happen.

There may be a gap between:

Documented Process

And

Actual Process

That gap may itself be relevant.

PROCESS MAPPING

A process map can reveal:

- Handoffs;
- delays;
- rework;
- missing controls;

- duplicate steps;
- decision points;
- failure opportunities.

Ask:

At which step could the problem have been introduced?

TIMELINE ANALYSIS

Useful when sequence matters.

Example:

9:00 AM — Order received

→ **10:30 AM — Order encoded**

→ **1:45 PM — Credit approval**

→ **3:10 PM — Pick list generated**

→ **4:00 PM — Truck cutoff**

The problem may appear to be:

Late dispatch

but the timeline may show earlier delays.

CHANGE ANALYSIS

Many problems emerge after something changes.

Ask:

What changed before the problem began?

Possible changes include:

- Supplier;
- material;
- employee;
- schedule;
- software;
- policy;
- equipment;
- workload;
- product;
- procedure;
- customer mix.

A change is not automatically the cause.

But it can provide a valuable hypothesis.

PATTERN ANALYSIS

Ask:

- When does the problem happen?
- When does it not happen?
- Where?
- With which product?
- Which shift?
- Which customer?
- Which supplier?
- Which employee group?
- Which machine?
- Under what conditions?

Patterns help narrow investigation.

DATA STRATIFICATION

Instead of looking only at total defects:

Break them down by:

- Product;
- shift;
- supplier;
- machine;
- location;
- date;
- defect type.

An overall average may hide the actual concentration.

PARETO ANALYSIS

The Pareto principle can help prioritize where investigation should begin.

Example:

Complaint Category	Number
Late Delivery	45
Wrong Item	18
Damage	12
Billing Error	7
Other	6

Instead of investigating everything simultaneously:

Begin with the category creating the greatest meaningful impact.

Pareto Analysis identifies:

Where to focus

not automatically:

Why the problem exists.

O — OPEN UP, ORGANIZE, ANALYZE, AND VALIDATE POSSIBLE CAUSES

Now generate possible causes.

The key word is:

Possible.

A cause becomes credible only when supported.

FIVE WHYS

The Five Whys uses repeated questioning to move beyond immediate explanations.

Example:

Problem

Order delivered late.

Why?

Truck departed late.

Why?

Loading started late.

Why?

Picking was incomplete.

Why?

Pick list was released late.

Why?

Order approval was delayed.

Now the investigation may shift from:

Transportation

To

Order approval.

FIVE WHYS IS NOT LITERALLY ALWAYS FIVE

Sometimes:

Three Whys are enough.

Sometimes:

Seven are needed.

The objective is not to satisfy the number five.

The objective is to reach:

An evidence-supported actionable cause.

POOR FIVE WHYS

Problem:

Employee made an error.

Why?

Employee was careless.

Why?

Employee lacked focus.

Why?

Employee has poor attitude.

This becomes:

A blame ladder.

It does not investigate the work system.

STRONGER FIVE WHYS

Problem:

Incorrect price entered.

Why?

Employee selected outdated price.

Why?

Two price lists were available.

Why?

Old price list was not removed.

Why?

Document control responsibility was unclear.

Now corrective action can target:

Price document control

rather than merely:

“Tell employee to be careful.”

FISHBONE OR CAUSE-AND-EFFECT ANALYSIS

The Fishbone Diagram helps teams generate possible causes systematically.

Categories may include:

People

Knowledge, skills, workload, communication.

Process / Method

Procedures, sequence, approvals, controls.

Machines / Technology

Equipment, systems, tools, software.

Materials / Inputs

Quality, availability, specifications.

Measurement

Data, calibration, standards, indicators.

Environment

Physical conditions, workload conditions, external environment.

Categories should be adapted to the actual problem.

SERVICE ENVIRONMENT FISHBONE

Service organizations might use:

- People;
- Process;
- Technology;
- Policy;
- Information;
- Customer;
- Environment.

The tool should fit:

The problem

rather than forcing every issue into manufacturing terminology.

FISHBONE IS A HYPOTHESIS TOOL

A completed Fishbone Diagram does **not** prove the root cause.

It identifies:

What might explain the problem.

Each meaningful hypothesis should then be:

Tested against evidence.

CAUSE-AND-EFFECT MATRIX

When many possible causes exist, participants can prioritize them based on:

- Strength of relationship to the problem;
- available evidence;

- frequency;
- impact;
- controllability.

This helps avoid investigating everything equally.

HUMAN ERROR IS RARELY ENOUGH

Suppose an employee enters incorrect data.

Writing:

Root Cause: Human Error

adds little value.

Ask:

Why was the error possible?

Possible deeper issues:

- Poor interface;
- duplicate fields;
- unclear instructions;
- insufficient checking;
- conflicting sources;
- fatigue;
- excessive workload;
- no validation control.

People do make mistakes.

Strong systems should anticipate reasonable human error.

ASK WHY THE CONTROL FAILED

Important question:

Why didn't the existing control prevent or detect the problem?

Examples:

- Approval existed but was routinely bypassed.
- Checklist existed but was outdated.
- System validation existed but could be overridden.
- Inspection occurred too late.

Sometimes the control failure becomes as important as the initiating cause.

BARRIER ANALYSIS

Barrier Analysis asks:

What should have prevented the event?

Was the barrier present?

Was it adequate?

Did it fail?

Was it bypassed?

Was no barrier designed?

Possible barriers include:

- Procedures;
- approvals;
- system validation;
- alarms;
- inspections;
- segregation of duties;
- physical guards;
- training
- checklists.

CAUSE VALIDATION

Before declaring a root cause, ask:

What evidence connects this cause to the problem?

A possible cause may be:

Supported

Evidence strongly supports it.

Partially Supported

Some evidence exists, but additional investigation is needed.

Not Supported

Evidence contradicts it.

THE REMOVAL TEST

A useful conceptual question:

If we remove or control this cause, should the probability of the problem recurring materially decrease?

If:

No,

you may still be dealing with a symptom or weak contributing factor.

REPRODUCTION TEST

Where safe and practical:

Can the condition reproduce the failure?

This may be particularly useful in:

- Technical;
- manufacturing;
- Information Technology;
- engineering;
- process environments.

Safety and operational requirements always take priority.

CORRELATION IS NOT AUTOMATIC CAUSATION

Suppose errors increased after:

New employees joined.

That does not automatically mean:

New employees caused the problem.

Perhaps at the same time:

- Volume doubled;
- the system changed;
- supervision decreased.

Strong Root Cause Analysis examines competing explanations.

T — TREAT THE ROOT CAUSE, TRACK CORRECTIVE ACTION, AND TEST EFFECTIVENESS

The analysis is not complete when:

The cause is identified.

It is complete only when the organization determines:

What should be done about it

and later checks:

Did it work?

CORRECTIVE ACTION MUST MATCH THE CAUSE

Root cause:

Employees use conflicting price files.

Weak corrective action:

Remind everyone to double-check.

Stronger corrective action:

Establish one controlled price source and remove superseded files automatically.

CORRECTIVE ACTION HIERARCHY

Where appropriate, stronger actions often:

Eliminate the Cause

Remove the source.

Engineer the Process

Redesign the system.

Strengthen Controls

Prevent or detect failure.

Standardize

Clarify procedures.

Train

Develop capability when lack of knowledge or skill is genuinely causal.

Training should not be the automatic answer.

CONTAINMENT VERSUS CORRECTIVE ACTION

Containment

Protect now.

Corrective Action

Prevent recurrence.

Both may appear in the same Root Cause Analysis plan.

CORRECTIVE ACTION PLAN

A practical plan may contain:

Element	Question
Root Cause	What validated cause are we addressing?
Action	What will change?
Owner	Who is accountable?
Due Date	By when?
Resources	What is required?
Success Measure	How will we know implementation occurred?
Effectiveness Measure	How will we know recurrence was reduced?

ACTION COMPLETION IS NOT EFFECTIVENESS

Example:

Corrective action:

Conduct refresher training.

Training completed:

100%.

Does that mean the root cause is solved?

Not necessarily.

Ask:

Did the error rate decline?

Did recurrence stop?

Did the intended behavior change?

Activity completion proves:

The action occurred.

Effectiveness verification tests:

Whether it worked.

EFFECTIVENESS CHECK

Possible methods include:

- Follow-up audit;
- defect-rate monitoring;
- complaint trend;
- error recurrence;
- process observation;
- control-testing;
- performance-data review.

The verification period should reflect the nature and frequency of the problem.

AVOID CREATING A NEW PROBLEM

A corrective action may solve one issue but create another.

Example:

Add five approvals to prevent errors.

Result:

Errors decline.

But:

Cycle time triples.

Corrective actions should consider:

- Effectiveness;
- feasibility;
- cost;
- risk;
- customer impact;
- operational consequences.

STANDARDIZE THE IMPROVEMENT

When corrective action works, consider whether changes should be reflected in:

- Procedures;
- forms;
- system rules;
- Job Aids;
- training;
- work instructions;
- controls;
- Key Performance Indicators.

CAPTURE ORGANIZATIONAL LEARNING

Ask:

Could this same cause exist elsewhere?

Example:

Poor document control caused an error in Department A.

Could the same weakness affect:

- Department B?
- another product?
- another site?
-

Strong Root Cause Analysis can prevent:

The next incident

not merely explain:

The last one.

COMPLETE MSS R.O.O.T.™ ROOT CAUSE ANALYSIS FLOW

R — RECOGNIZE

What exactly happened, where, when, how often, and compared with what expectation?

↓

O — OBSERVE

What do the process, facts, records, patterns, changes, and evidence tell us?

↓

O — OPEN UP

What possible causes exist, which ones are supported, and what conditions allowed the failure?

↓

T — TREAT

What corrective action addresses the validated cause, and how will we verify effectiveness?

ROOT CAUSE ANALYSIS TOOL SELECTION GUIDE

Situation	Useful Tool
Problem is vaguely described	Problem Statement
Need to define boundaries	Is–Is Not Analysis
Need to understand workflow	Process Mapping
Sequence of events matters	Timeline Analysis
Problem began after a change	Change Analysis
Many categories of problems exist	Pareto Analysis
Need to drill deeper into causal chain	Five Whys
Many possible causes need to be generated	Fishbone Analysis
Too many hypotheses exist	Cause-and-Effect Matrix
Need to understand failed safeguards	Barrier Analysis
Root cause has been proposed	Cause Validation
Cause has been confirmed	Corrective Action Plan
Corrective action has been implemented	Effectiveness Verification

The training deliberately teaches participants:

Choose the tool according to the problem.

Not:

Use every tool because it appeared in the training.

ONE-DAY ROOT CAUSE ANALYSIS TRAINING OUTLINE

Time	Modules and Essential Topics	Major Activity and Participant Output
8:00 AM–10:00 AM	MODULE 1: DEFINE BEFORE YOU DIAGNOSE—ROOT CAUSE ANALYSIS FUNDAMENTALS, PROBLEM DEFINITION, AND EVIDENCE 1. Why Problems Recur • Symptoms versus causes • correction versus corrective action	Major Activity: The Problem Behind the Problem — Participants receive a workplace case initially written with assumptions and blame. They rewrite it into a measurable Problem Statement, determine what is known and unknown, perform an Is–Is Not Analysis, and identify the evidence required for investigation.

Time	Modules and Essential Topics	Major Activity and Participant Output
	2. Root Cause Analysis versus Troubleshooting and Problem Solving 3. Introducing the MSS R.O.O.T.™ Framework • Recognize • Observe • Open Up • Treat 4. R — Recognize and Define the Problem • What • where • when • extent • expected versus actual • business impact 5. Is-Is Not Analysis and Containment 6. O — Observe the Evidence • Facts versus assumptions • process observation • records • patterns	Major Output: Root Cause Analysis Problem Definition Sheet, Is-Is Not Matrix, and Evidence Collection Plan
10:00 AM–10:15 AM	MORNING BREAK	
10:15 AM–12:00 NN	MODULE 2: FOLLOW THE EVIDENCE—PROCESS, PATTERN, TIMELINE, CHANGE, AND DATA ANALYSIS 1. Understand Where the Problem Happens • Process Mapping • handoffs • controls • failure points 2. Timeline Analysis • sequence • event reconstruction 3. Change Analysis • What changed? • when? • what stayed the same? 4. Pattern and Data Stratification	Major Activity: Root Cause Investigation Room — Teams receive process records, timelines, transaction data, operational observations, and new evidence in stages. They map the process, identify patterns and changes, and determine where further investigation should focus. Major Output: Current-State Process Map, Problem Timeline, Change Analysis, and Root Cause Evidence Map



Time	Modules and Essential Topics	Major Activity and Participant Output
	• Product • shift • supplier • location • date 5. Pareto Analysis • Prioritizing meaningful failure categories 6. Building Evidence-Based Hypotheses	
12:00 NN–1:00 PM	LUNCH BREAK	
1:00 PM–3:00 PM	MODULE 3: DIG PAST THE SYMPTOM—FIVE WHYS, FISHBONE ANALYSIS, CAUSAL HYPOTHESES, AND ROOT CAUSE VALIDATION 1. O — Open Up Possible Causes • Multiple hypotheses • avoid premature conclusions 2. Five Whys • Causal chains • branching causes • avoiding blame ladders 3. Fishbone or Cause-and-Effect Analysis • People • process • technology • materials • measurement • environment or customized categories 4. Cause-and-Effect Prioritization 5. Human Error and System Factors 6. Barrier Analysis • Why did controls fail? 7. Validate Before You Declare • Evidence • competing explanations • removal test • unsupported causes	Major Activity: Find the ROOT Challenge — Teams analyze a recurring operational problem using Five Whys and Fishbone Analysis. They must distinguish possible causes from validated causes and defend their final Root Cause Analysis using available evidence while another team challenges their conclusions. Major Output: Five Whys Analysis, Fishbone Diagram, Cause Validation Matrix, and Evidence-Supported Root Cause Statement

Time	Modules and Essential Topics	Major Activity and Participant Output
3:00 PM–3:15 PM	AFTERNOON BREAK	
3:15 PM–5:00 PM	MODULE 4: MAKE THE PROBLEM STAY SOLVED—CORRECTIVE ACTION, EFFECTIVENESS VERIFICATION, STANDARDIZATION, AND PREVENTION 1. T — Treat the Root Cause • Containment versus correction versus corrective action 2. Corrective Action Design • Eliminate • redesign • control • standardize • develop capability 3. Action Planning • Root cause → action → owner → due date → measure 4. Verify Effectiveness • Completion versus effectiveness • recurrence measures • monitoring period 5. Prevent Unintended Consequences 6. Standardize and Share Learning 7. Root Cause Analysis Governance and 30/60/90-Day Application	Major Activity: R.O.O.T.™ Corrective Action Board — Participants receive validated causes and must design corrective actions, challenge weak “retrain and remind” solutions, establish effectiveness measures, anticipate unintended consequences, and determine how learning should be standardized. Major Output: Root Cause Corrective Action and Effectiveness Verification Plan plus 30-, 60-, or 90-Day R.O.O.T.™ Workplace Application Plan
5:00 PM	PROGRAM CLOSING	Learning synthesis, workplace commitments, evaluation, and recommended next steps

CORE PARTICIPANT OUTPUTS

Participants are expected to complete:

1. **Root Cause Analysis Problem Definition Sheet, Is–Is Not Matrix, and Evidence Collection Plan**
2. **Current-State Process Map, Problem Timeline, Change Analysis, and Root Cause Evidence Map**
3. **Five Whys Analysis, Fishbone Diagram, Cause Validation Matrix, and Evidence-Supported Root Cause Statement**
4. **Root Cause Corrective Action and Effectiveness Verification Plan plus 30-, 60-, or 90-Day R.O.O.T.™ Workplace Application Plan**

SAMPLE ROOT CAUSE ANALYSIS CASES

Training cases may be customized around:

- Recurring product defects;
- rising customer complaints;
- repeated billing errors;
- late customer deliveries;
- inaccurate inventory;
- missing warehouse stocks;
- high scrap;
- frequent machine downtime;
- supplier defects;
- repeated shipment shortages;
- poor On-Time In-Full performance;
- recurring employee errors;
- incorrect reports;
- project delays;
- production stoppages;
- Information Technology outages;
- system incidents;
- documentation errors;
- audit findings;
- safety incidents;
- high rework;
- processing backlogs;
- excessive approval delays;
- service-level failures;
- recurring payroll discrepancies;
- repeated customer escalations.

SAMPLE FIVE WHYS

Problem

Customer received the wrong item.

Why 1:

Why did the customer receive the wrong item?

Warehouse picked Product B instead of Product A.

Why 2:

Why was Product B picked?

Product locations were beside each other and packaging looked similar.

Why 3:

Why did the picker not detect the difference?

Pick list showed only product codes.

Why 4:

Why did the system not provide additional identification?

Picking template was never updated after similar product variants were introduced.

Why 5:

Why was the template not updated?

Product-launch process did not assign responsibility for updating warehouse picking controls.

Possible deeper cause:

Product launch governance does not require verification and updating of warehouse picking controls when similar product variants are introduced.

Corrective action should therefore go beyond:

“Remind picker to be careful.”

SAMPLE FISHBONE ANALYSIS

For a recurring **Late Delivery** problem:

People

- Insufficient manpower;
- unclear ownership;
- coordination gaps.

Process

- Late order approval;
- poor picking sequence;
- manual routing.

Technology

- System delays;
- inaccurate inventory;
- no route optimization.

Materials / Products

- Stock unavailable;
- packaging not ready.

Measurement

- Wrong delivery Key Performance Indicator;
- no cut-off monitoring.

Environment

- Traffic;
- weather;
- facility congestion.

The next question is:

Which of these possibilities are actually supported by evidence?

SAMPLE CAUSE VALIDATION MATRIX

Possible Cause	Supporting Evidence	Contradicting Evidence	Status
Employee lacked training	No documented training record	Employee correctly performed same task 40 times before	Needs further analysis
System allows invalid entry	Error recreated during test	None identified	Strongly supported
Workload too high	Error occurs mainly during peak volume	Same employees manage normal volume accurately	Supported contributing cause
Employee careless	Supervisor opinion only	No objective evidence	Not supported

SAMPLE CORRECTIVE ACTION QUALITY TEST

Before accepting an action, ask:

Cause Link

Does the action address the validated cause?

Effectiveness

Should it materially reduce recurrence?

Sustainability

Can it be maintained?

Feasibility

Can the organization implement it?

Risk

Could it create another problem?

Verification

Can effectiveness be measured?

TRAINING METHODS

This **Analyzing the Root Cause Training in the Philippines** and **Analyzing Root Causes Training in the Philippines** follows MSS Corporation's **EnterTRAINment** methodology:

- Approximately **30% concise facilitator input, demonstration, facilitated discussion, and synthesis**
- Approximately **70% investigation exercises, workplace cases, process analysis, Five Whys, Fishbone Analysis, cause validation, corrective-action design, effectiveness planning, and workplace application**

Methods may include:

- Root Cause Analysis pre-assessment;
- symptom-versus-cause challenge;
- Problem Statement rewrite;
- fact-versus-assumption exercise;
- Is-Is Not Analysis;
- process mapping;
- timeline reconstruction;
- Change Analysis;
- Pareto exercise;
- Five Whys challenge;
- Fishbone Analysis;
- cause-and-effect prioritization;
- Barrier Analysis;
- cause-validation challenge;
- corrective-action critique;
- effectiveness-verification exercise;
- Root Cause Analysis case competition;
- workplace application planning.

TARGET PARTICIPANTS

This **Root Cause Analysis Training in the Philippines** is recommended for:

- Rank-and-file employees involved in problem solving;
- Team Leaders;
- supervisors;
- managers;
- department heads;
- Operations personnel;
- Quality Assurance personnel;
- Quality Control personnel;
- engineers;
- technicians;
- Manufacturing personnel;

**MSS SUCCESS SPACES**

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- Production personnel;
- Maintenance personnel;
- Supply Chain professionals;
- Procurement personnel;
- Purchasing personnel;
- Supplier Quality personnel;
- Warehouse personnel;
- Logistics personnel;
- Inventory personnel;
- Customer Service professionals;
- Information Technology teams;
- Finance personnel;
- Human Resources professionals;
- Project Managers;
- Process Improvement personnel;
- Continuous Improvement teams;
- Internal Auditors;
- Quality Management System teams;
- Safety personnel;
- business owners;
- professionals responsible for recurring operational problems and corrective actions.

INDUSTRIES THAT MAY BENEFIT

The program may be customized for:

- Manufacturing;
- electronics;
- automotive;
- food and beverage;
- pharmaceuticals;
- healthcare;
- logistics;
- retail;
- distribution;
- banking;
- financial services;
- insurance;
- telecommunications;
- Information Technology;
- business process outsourcing;
- shared services;
- construction;
- engineering;
- utilities;
- hospitality;
- education;

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- government;
- professional services;
- other organizations experiencing recurring process, service, quality, or operational problems.

RECOMMENDED NUMBER OF PARTICIPANTS

Approximately **12 to 20 participants** is recommended for intensive Root Cause Analysis cases, tool application, facilitator coaching, and team presentations.

Groups of approximately 25 participants may be accommodated through:

- Root Cause Analysis teams;
- Quality circles;
- cross-functional investigation groups;
- breakout cases;
- competing hypothesis teams.

For customized programs, participants may bring appropriately anonymized:

- Corrective Action Reports;
- customer complaints;
- audit findings;
- defects;
- process failures;
- recurring workplace problems.

DELIVERY OPTIONS

The program may be delivered through:

- Face-to-face in-house training;
- live online instructor-led training;
- hybrid training;
- offsite corporate workshop;
- Quality Management training;
- Continuous Improvement program;
- Operational Excellence initiative;
- Supply Chain development;
- Customer Experience improvement;
- Process Improvement Academy;
- Management Development Program;
- customized training-and-consultancy engagement.

AVAILABLE PROGRAM FORMATS

Half-Day Root Cause Analysis Essentials

Exactly two modules:

Module 1 — Define and Analyze the Problem

Root Cause Analysis fundamentals, problem definition, evidence, Is-Is Not Analysis, process analysis, Five Whys, and Fishbone Analysis.

Module 2 — Validate and Eliminate the Cause

Cause validation, control failure, corrective action, effectiveness verification, standardization, and recurrence prevention.

One-Day Root Cause Analysis Training

Recommended for the complete:

MSS R.O.O.T.™ Root Cause Analysis Framework

Recognize → Observe → Open Up → Treat

Two-Day Intensive Root Cause Analysis Workshop

Recommended when organizations require deeper application involving:

- Actual workplace cases;
- detailed Process Mapping;
- Pareto Analysis;
- data stratification;
- timeline and Change Analysis;
- multiple Fishbone analyses;
- cause validation;
- corrective-action redesign;
- effectiveness measures;
- participant presentations.

ROOT CAUSE ANALYSIS DEVELOPMENT SERIES

The program may also be expanded into:

1. Root Cause Analysis Fundamentals
2. Problem Definition and Evidence Gathering
3. Five Whys Analysis
4. Fishbone and Cause-and-Effect Analysis
5. Pareto Analysis
6. Process Mapping for Problem Analysis
7. Cause Validation
8. Corrective and Preventive Action
9. Root Cause Analysis for Quality

10. Root Cause Analysis for Operations
11. Supplier Root Cause Analysis
12. Root Cause Analysis for Customer Complaints

CUSTOMIZATION OPTIONS

This **Training on Analyzing the Root Cause in the Philippines** may be customized using the client's:

- Actual recurring problems;
- process maps;
- customer complaints;
- quality records;
- supplier problems;
- Corrective Action Reports;
- audit findings;
- production defects;
- service failures;
- downtime records;
- inventory discrepancies;
- safety cases;
- incident records;
- performance data;
- existing Root Cause Analysis templates.

Sensitive information should be anonymized appropriately.

POSSIBLE POST-TRAINING PERFORMANCE MEASURES

Organizations may evaluate application through:

- Reduction in repeat problems;
- recurrence rate;
- Corrective Action effectiveness;
- number of reopened incidents;
- repeat customer complaint rate;
- defect recurrence;
- rework reduction;
- supplier corrective-action effectiveness;
- audit finding recurrence;
- time to determine validated root cause;
- percentage of Root Cause Analyses supported by evidence;
- percentage of corrective actions verified for effectiveness;
- reduction in “human error” as unsupported root-cause classification;
- percentage of corrective actions completed on schedule;
- problem-resolution cycle time.

The objective should not simply be:

“Did employees learn the Five Whys?”

A stronger question is:

“Are recurring problems actually recurring less often because employees are identifying and addressing the right causes?”

PROFESSIONAL AND METHODOLOGICAL BOUNDARIES

Root Cause Analysis should not become:

A sophisticated way to blame someone.

The investigation should focus on:

- Facts;
- process;
- systems;
- conditions;
- controls;
- evidence.

This does not remove individual accountability where misconduct, negligence, or failure to follow requirements is genuinely supported by evidence.

However:

“Employee error”

should not automatically stop the investigation.

Ask:

Why was the error possible?

What process conditions contributed?

What controls should have prevented or detected it?

Is the same error reasonably possible again?

Strong Root Cause Analysis balances:

Individual Accountability

With

Systemic Learning.

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FREQUENTLY ASKED QUESTIONS

What is Root Cause Analysis Training in the Philippines?

Root Cause Analysis Training in the Philippines develops practical skills for defining problems, examining evidence, identifying possible causes, using Root Cause Analysis tools, validating causes, developing corrective actions, and preventing problem recurrence.

What is Training on Root Cause Analysis in the Philippines?

Training on Root Cause Analysis in the Philippines teaches employees and managers how to investigate recurring workplace problems systematically and distinguish symptoms from evidence-supported root causes.

What is Analyzing the Root Cause Training in the Philippines?

Analyzing the Root Cause Training in the Philippines develops participants' ability to move beyond visible symptoms, investigate why failures occur, validate causes, and implement appropriate corrective actions.

What is Training on Analyzing the Root Cause in the Philippines?

Training on Analyzing the Root Cause in the Philippines provides practical tools for problem definition, evidence gathering, Five Whys, Fishbone Analysis, cause validation, corrective action, and effectiveness verification.

What is Analyzing Root Causes Training in the Philippines?

Analyzing Root Causes Training in the Philippines helps participants systematically examine multiple possible and contributing causes behind recurring operational, quality, customer, service, and process problems.

What is Training on Analyzing Root Causes in the Philippines?

Training on Analyzing Root Causes in the Philippines teaches a disciplined process for identifying evidence-supported causes instead of relying on assumptions, blame, or quick fixes.

Does this program teach the Five Whys?

Yes.

Participants learn how to use the Five Whys without treating the number five mechanically.

Does the training include Fishbone Analysis?

Yes.

Participants create and analyze Cause-and-Effect or Fishbone Diagrams.

Does it cover Pareto Analysis?

Yes.

Pareto Analysis is introduced as a prioritization tool where appropriate.

Does it teach Is-Is Not Analysis?

Yes.

It is used to define problem boundaries and identify meaningful differences.

Does it include Process Mapping?

Yes.

Participants learn how process mapping can reveal where problems originate.

Does it include Corrective Action?

Yes.

Corrective Action is essential to completing the MSS R.O.O.T.™ process.

Does it cover Corrective and Preventive Action?

The course strongly addresses corrective action and recurrence prevention. Organizations requiring a specialized Quality Management System-oriented Corrective and Preventive Action program may customize or expand the intervention accordingly.

Is Root Cause Analysis the same as Problem Solving?

No.

Root Cause Analysis focuses particularly on understanding why the problem occurred.

Problem solving is broader and includes solution generation, selection, implementation, and decision making.

Does it cover problem solving?

Yes, insofar as Root Cause Analysis supports problem resolution, but the course primarily focuses on causal investigation.

Does it teach participants how to identify one root cause?

The program teaches participants not to assume that every problem has only one cause.

Some problems involve:

- Multiple root causes;
- contributing causes;
- interacting conditions.

Does it discourage blaming employees?

It discourages unsupported blame.

If evidence genuinely shows an individual's action contributed to the problem, that evidence can be considered. However, participants are trained to continue asking why the system allowed the failure.

Does it cover human error?

Yes.

Participants examine why “human error” is often an incomplete Root Cause Analysis.

Can this be applied to customer complaints?

Yes.

Customer complaints are an excellent application area.

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Can this be applied to supplier problems?

Yes.

Supplier quality and delivery problems can be analyzed using the framework.

Can this be applied to Information Technology incidents?

Yes.

The methodology can be adapted to system incidents, although highly technical Information Technology environments may require additional specialist tools.

Is it useful for Human Resources?

Yes.

Human Resources can apply Root Cause Analysis to recurring:

- Turnover;
- absenteeism;
- recruitment problems;
- payroll errors;
- employee-service issues;
- process breakdowns.

Is it useful for service organizations?

Yes.

The program is not restricted to manufacturing.

Can actual company problems be used?

Yes.

This is highly recommended for customized in-house delivery, subject to appropriate confidentiality and anonymization.

Is the course suitable for managers?

Yes.

Managers need Root Cause Analysis capability because they make decisions about problems, corrective actions, resources, and accountability.

Can this be delivered virtually?

Yes.

Online delivery may use digital process maps, Fishbone Diagrams, Five Whys exercises, breakout-room investigations, and case-analysis presentations.

Is one day enough?

One day provides a strong practical foundation using the complete **MSS R.O.O.T.™ Root Cause Analysis Framework**.

Organizations seeking deeper mastery or analysis of actual complex problems may use a two-day workshop or a broader Root Cause Analysis consultancy.

RELATED MSS CORPORATION TRAINING PROGRAMS

Organizations considering this program may also explore:

- Problem Solving and Decision Making Training;
- Critical Thinking Training;
- Analytical Thinking Training;
- Business Process Improvement Training;
- Continuous Improvement Training;
- Lean Management Training;
- Lean Six Sigma Training;
- Quality Management Training;
- Corrective and Preventive Action Training;
- Supplier Management Training;
- Inventory Management and Control Training;
- Warehouse Management Training;
- Customer Service Training;
- Project Management Training;
- Key Performance Indicator Development Training;
- Process Mapping Training.

WHY CHOOSE MSS CORPORATION FOR ROOT CAUSE ANALYSIS TRAINING IN THE PHILIPPINES?

Root Cause Analysis Begins With Problem Definition

Participants do not immediately ask:

“Why?”

until they understand:

“What exactly happened?”

Proprietary MSS R.O.O.T.™ Framework

Participants receive a practical sequence:

Recognize → Observe → Open Up → Treat

Symptoms and Causes Are Deliberately Separated

Participants learn why:

Late delivery

is not automatically a root cause.

Evidence Comes Before Conclusion

The course teaches participants to distinguish:

- Facts;
- assumptions;
- possible causes;
- validated causes.

Multiple Tools Are Integrated

Participants apply:

- Is–Is Not Analysis;
- Process Mapping;
- Timeline Analysis;
- Change Analysis;
- Pareto Analysis;
- Five Whys;
- Fishbone Analysis;
- Barrier Analysis;
- Cause Validation.

Five Whys Is Used Properly

Participants learn:

Five is a guide—not a quota.

Fishbone Analysis Does Not End the Investigation

Possible causes are:

Generated

Then

Validated.

“Human Error” Is Challenged

Participants investigate:

Why was the human error possible?

Corrective Action Must Match the Cause

The course moves from:

Root Cause → Corrective Action

rather than:

Problem → Random Solution.

Effectiveness Is Verified

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Participants distinguish:

Action completed

From

Problem prevented from recurring.

EnterTRAINment Methodology

Participants:

Define → Observe → Map → Question → Analyze → Validate → Correct → Verify

rather than merely listening to Root Cause Analysis concepts.

CALL TO ACTION

Recurring Problems Are Expensive Evidence That the Real Cause Has Not Yet Been Removed.

Equip your employees, supervisors, managers, Quality teams, Operations personnel, engineers, Supply Chain professionals, Customer Service teams, Information Technology teams, and problem solvers to move beyond quick fixes, identify evidence-supported causes, design stronger corrective actions, and prevent the same problems from repeatedly consuming time, money, resources, and customer confidence.

Partner with MSS Corporation for a customized:

- **Root Cause Analysis Training in the Philippines**
- **Training on Root Cause Analysis in the Philippines**
- **Analyzing the Root Cause Training in the Philippines**
- **Training on Analyzing the Root Cause in the Philippines**
- **Analyzing Root Causes Training in the Philippines**
- **Training on Analyzing Root Causes in the Philippines**

designed around your organization's actual recurring problems, quality issues, customer complaints, process failures, operational errors, supplier concerns, audit findings, service breakdowns, and corrective-action requirements.

R.O.O.T.™ — DON'T JUST FIX WHAT HAPPENED. FIND OUT WHY IT HAPPENED.

Recognize the problem. Observe the evidence. Open up and validate the causes. Treat the root cause and verify effectiveness.

STOP FIXING SYMPTOMS. SOLVE THE REAL CAUSE.

With MSS, We Make Strong Success.