CIVIL AIR PATROL INSPECTOR GENERAL

IG AUDIENCE

Volume 5 Issue 2   **April 2014**

FORWARD THIS NEWSLETTER TO ALL UNITS IN YOUR WING!

A note from Col Ken Parris, CAP/IG: **Over the course of this year, the IG Audience will evolve from a newsletter to become the Education Journal for the IG Program. Each quarterly issue will introduce a quality tool (or two) that will be implemented into program operations. The use of these tools by Wing IGs (first) and then Wing/Unit Commanders (with mentorship and assistance from IG) will be a contributing element towards moving CAP in the direction of continuous improvement and the establishment of a quality culture.**

A few fundamental quality concepts and tools are now being recognized as "value-added" in the halls of CAP NHQ. They're not new to US industries or the USAF – they have understood their value for many decades - but they are new for formal implementation in CAP.

The fact that these concepts and tools have their origin in quality history has sometimes been – amazingly – a barrier to organizational progress and success due to the misunderstanding that they were only used by "those people in the quality department". This perception resulted in a lack of quality ownership by those in key positions within the organization – leaders and managers – and it almost cost many major US industries their stronghold on the world's marketplace in the past for their products and services.

The leaders and managers in the CAP organization have the titles of Commanders and Staff Officers. They too need to take quality ownership and embrace the change to a quality culture. They will need a lot of help from "those people in the quality department" – equivalently known in CAP as the Inspectors General.

IG Refresher Course by Lt Col Don Barbalace, CAP/IGTA

The IG program has changed rapidly over the last few years, making it hard for any of us to keep up with the latest methods, procedures, or requirements. Last year we tried offering a refresher course that had mixed success. Mostly, it tried to do too much and we found that a once-a-year course could not keep up with the changes during the year.

This year we are using quarterly updates, with the *IG Audience* newsletter as a means of presenting the very latest changes. The refresher course is based on the content of the *IG Audience*. The total refresher course consists of 4 parts, one for each issue of the *Audience* and a 5-question quiz to keep everyone honest.

For the first issue, I prepared a test bank of 15 questions that were then vetted by the staff of the CAP/IG. Going forward, I enlist various authors to suggest or write questions (multiple choice or true/false).

We use two approaches to forming the questions. Most address something new you need to know; others follow the model of other LMS courses making you search the "IG Audience" for the exact wording that will answer the question correctly.

The best and easiest way to study for the quiz is to read the *IG Audience*. Everything is there.

Take the refresher course and you won't lose ground. Teach the most current material! Get in on the ground floor of the most recent process changes. This will cement you in the IG community as the professional "Chief Compliance Officer" for the CAP. The "IG Audience" refresher courses are meant to keep you in the know - don't you want to be the best?

New NHQ/IGT Contributor – Maj Les Manser, AZWG/IG

In this edition, one basic quality tool – **Plan-Do-Check-Act** – will be introduced by Maj Les Manser, Arizona Wing IG. Les has been a Wing IG for 3 years but has 35 years of extensive quality systems experience in both military and civilian organizations. He has been an **American Society for Quality (ASQ) Certified Quality Auditor (CQA)** for 20 years and works for **Honeywell International as a Green Belt Certified Product Development Quality Engineer**.

Maj Manser has been in CAP for eight years. Prior to becoming AZWG/IG, he was the Commander of Arizona's largest squadron and is still very active as a Mission Pilot. He has a Master rating in the IG Specialty Track and was a Distinguished Graduate of the 2012 Inspector General College. He will be returning to the college in 2014 as a Team Training Director (TTD) understudy.

Clarify & Validate the Problem by Lt Col Craig Gallagher, CAWG/IG

"You got a problem? I'm from HQ and I can help!" The US Air Force has been using **AFSO21 (Air Force Smart Operations for the 21st Century)** for solving problems they encounter in their core missions. We recently had a **Rapid Improvement Event (RIE)** where we used the 8-Step problem solving tool called the **A-3** to tackle improving the Subordinate Unit Inspection (SUI) process. This follows the successful RIE done last August for the Compliance Inspection process.

The first step is to clearly define and validate the problem – you don't want to spend a lot of time and resources solving the <u>wrong</u> problem! This is harder than you might think. During our RIE conducted April 7-11, 2014, we tackled the SUI Program. At first the problems seemed easy and numerous: outdated SUI Guide, process took too long for the units getting inspected, took too long for the inspectors, the data from the SUI reports didn't lend themselves to extracting trend data on where CAP was having problems, most SUIs were not being done in time or at all, or went on for hours. We finally came up with a simple statement with a problem that seemed solvable:

"The National HQ, CAP-USAF, cannot determine if any given subordinate CAP unit is compliant with applicable inspection requirements over the past two years.

A Piece of the Puzzle by Col Steve Miller, CAP/IGI

My piece of the puzzle during the RIE involved the issue of consistent grading and time needed to do SUIs. Here are some pearls for the IG Audience:

In preparation for the event, a survey was sent to all IGs and Assistant IGs. The purpose of the survey was to get feedback from the field on the SUI process as well as other items the IGs wanted to share.

One of the survey items that received a negative answer was SUI Grading Criteria. **36%** of the responses commented on the SUI grading process not being clear and **27%** said the grading process was challenging. One of the countermeasures in response to this item is the new grading matrix tool. This tool takes much of the subjectivity out of the grading process, therefore using it will ensure grading is done consistently.

Another issue identified in the survey was the length of time required to do an SUI. The old SUI Guide will be replaced by an updated and shortened **SUI Checklist**. All members should be pleased with the SUI Checklist approach. Watch for it! It will be released and published on the IG web page soon.

Countermeasures to Problems instead of Solutions by Col Larry Stys, CAP/IGT

Recognizing a solution to a problem will not fix a problem. As a senior citizen, not just a Senior Member, I have spent my life solving problems only to have them return in a new iteration. If I went after a problem with a solution, I fixed it for that moment, and that situation. However, without understanding the cause of the problem, or prioritizing different practical or necessary ways to address a problem, it will return.

An Analogy: So the light over the sink went out in my kitchen; and I went to get a new bulb. Unscrewing the old bulb, I noticed moisture in the light socket. It's a kitchen! It was no big deal. I replaced the bulb, tried the switch, the light went on. Solution! Moments later that light went out. New bulb. Repeat. Same result. I can do this all night or until I run out of light bulbs. So it is time to do a little "root cause." (There are numerous root cause analyses to use, so let me just move the story along to a logical conclusion before you fall asleep with boredom.)

FIVE WHYS of Root Cause: The light went out because there was moisture in the light socket. The moisture came from a leak in the ceiling above. In the floor above was a bathroom sink. Below the sink was a drain trap. Whenever someone used the faucet in the bathroom, water dripped out of the drain trap, found an opening in the floor, which led to the light socket below just above the kitchen. The countermeasure was to fix the leak in the drain trap, thus allowing the moisture to evaporate from the light socket, allowing the light bulb to stay lit more than a few moments.

Was this a solution? No, it wasn't, it was a countermeasure. Why? We all know that light bulb will go out again, but the next time the cause may be completely different, even if nothing more than the bulb burned out!

So did a light go on over your head?

Plan-Do-Check-Act: The Never-ending Cycle of Continuous Improvement in Quality by Maj Les Manser, AZWG/IG

You use this cycle more times in everyday life than you might imagine – typically for the repetitive tasks that you perform - you just didn't realize that you were employing a process improvement tool! **PLAN-DO-CHECK-ACT (PDCA)** is the most basic starting point on the journey towards continuous process improvement in CAP – starting with the IG Program at <u>all</u> levels.
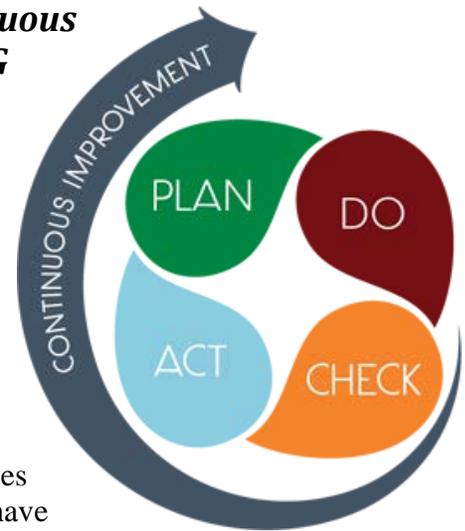
Everyday life – like CAP operations – is just a **series of processes**. A process is no more than a series of steps and decisions involved in the way work is accomplished. Everything we do in our lives involves processes - and lots of them. It could be that you may (or may not) have used a PLAN (process) along with the corresponding DO (process execution). It may have been that unless the DO resulted in something going wrong, you didn't even consider performing a CHECK on what happened – and without the CHECK – well, certainly there was no ACT performed to determine what needed to be done differently (either in PLAN and/or DO, as applicable) when the process was repeated.

To achieve process improvement, <u>all four</u> phases – PLAN+DO+CHECK+ACT – <u>must</u> be accomplished – and then accomplished again each time the process is adjusted and subsequently repeated. Without all four phases, the cycle is never completed, and continuous improvement does not occur.

In CAP, processes are formally defined in a regulation (the PLAN) which typically includes the major steps of the process. An extension of this PLAN could be applicable Supplements, Operating Instructions or Procedures supplying the details of the major steps. (Rule of Thumb: "Document to the detail necessary to ensure quality.")

The accomplishment of these process steps (the DO) should match the PLAN. When it doesn't (unless it's being done in a better way), variation, inefficiencies, process breakdowns and/or non-compliance are typically introduced. Determining <u>why</u> there was a difference between PLAN and DO and/or differences in process results (the CHECK) involves collecting all available facts/data supporting the executed process and the process outputs/results. Analysis and problem solving activities will identify the adjustments/changes/actions that are needed to be incorporated into the process (the ACT) for reducing & eliminating risk/waste and correct/prevent the undesirable process deviations/non-compliances from occurring the next time.

A common example for discussion: everyone wants to get somewhere on time (home-to-work, home-to-CAP Event) – so what does that involve?

    PLAN – Get all of the dependent processes done (waking, eating, showering, dressing, etc.) by a pre-determined time for departure; then accomplish all of the en route & arrival processes (vehicle operation, travel route, parking, walking, etc.) by the scheduled work/CAP event start time.

    DO – Accomplish all of the specific steps/activities as planned.

    CHECK – Did you get to work/CAP on time? If not, did you leave home on time? What caused you to be late departing and/or arriving? Was there variation in how you accomplished the processes? If YES, then WHY? Did any of the processes take longer than expected? What happened that was unplanned? What data was available for analyzing and trending the process results?

ACT – Incorporate the things that will minimize/eliminate the risk of being late again into the applicable process(es). For this example (to name a few): setting a battery alarm clock as a back-up (power went off overnight), refueling NLT ¼ Tank (had to stop to get gas on the way) and re-routing to avoid the intersection of Bang-up Road & Disaster Avenue (history of accidents – duh, the street names should have been a clue!).
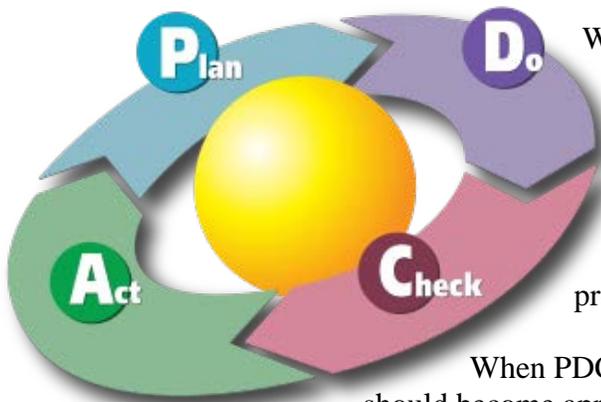
Whether the real problems (causes) were identified during CHECK and/or whether the implemented adjustments and corrective/preventive actions were effective during ACT won't be known until the process is accomplished again and the PDCA cycle is repeated. When the cycle is repeatedly accomplished, you should be able to observe/determine how a single process (or a sequence of processes) has/have improved over time.

When PDCA is applied to each of your IG Program activities, it should become apparent what process variation, deficiencies, breakdowns etc. may exist and what actions could be implemented to improve that particular process and get better results. Every step in a process can undergo PDCA.

To optimize the accomplishment of PDCA, other tools can supplement each phase activity. Standard tools for process mapping, data collection and problem solving will be introduced in subsequent articles.

Additionally, PDCA can be used within the problem solving activities of ACT. In this application, the four phases of the PDCA cycle involve:
- PLAN – Identifying and analyzing the problem.
- DO – Developing and testing a possible solution.
- CHECK – Measuring how effective the test solution was, and analyzing whether it could be improved in any way.
- ACT – Fully implementing the improved solution.

When we engage in true process improvement, we seek to learn what causes things to happen in a process and to use this knowledge to reduce variation, remove activities that contribute no value to the product/service produced and improve customer satisfaction.

The vast amount of process improvement activity accomplished by the Joint CAP-USAF IG Team during the past year – first with the Compliance Inspection (CI) process and currently with the SUI process – was accomplished using the tools that you will eventually learn to master. For now, warm up with PDCA.

Even after the initial process improvement actions are completely implemented for CI/SUI operations, the PDCA cycle does not stop – it continues – and it should never end.

No process is perfect – but there is always the potential to come
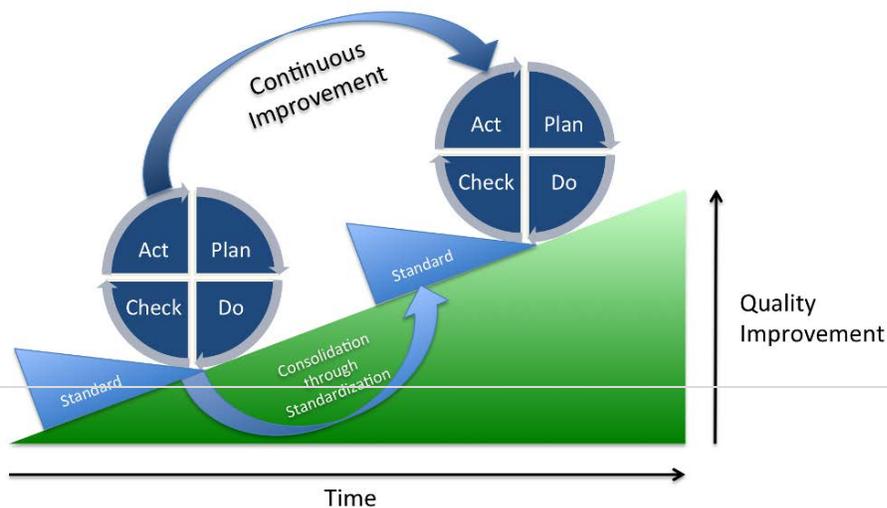
as close as possible with continuous improvement!

Upcoming IG Training

SER IG Senior Course in conjunction with the SER Conference, will be 15-16 May, in Peachtree City, GA (south west of Atlanta). Contact Lt Col Larry Julian, GAWG/IG at larry.julian@GAWG.CAP.GOV for information; and Missie, IG Support Coordinator at NHQ, mderocher-harris@capnhq.gov to enroll.

We have an IG Senior Course running the **two days prior** to the College (30-31 May) at Kirtland AFB. Billeting is on the base. Lt Col George Schank, SWR/IG, will be teaching the course. Enroll with Missie (see above).

The IG College is 1-6 June 2014 in scenic Albuquerque, NM. Enrollments have been capped! We can provide space for only 50 students both at the hotels we provide and at Air Force Inspection Agency HQ on Kirtland AFB. **IF** there is a cancellation you might be able to get in. If you are mandated by CAPR 123-1 as a recently appointed Wing or Region IG and have not been to the college, you may get first call on a cancellation (see above).

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Upcoming Compliance Inspections

WING	LAST CI DATE	LAST CI GRADE	NEXT CI DATE	MONTHS B'TWEEN CIs
WI	Apr-10	**HS**	3-5 May 14	49
MN	May-10	SUC	19-21 Jul 14	50
MA	May-10	SUC	2-4 Aug 14	51
UT	Jul-10	SUC	23-25 Aug 14	49

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