



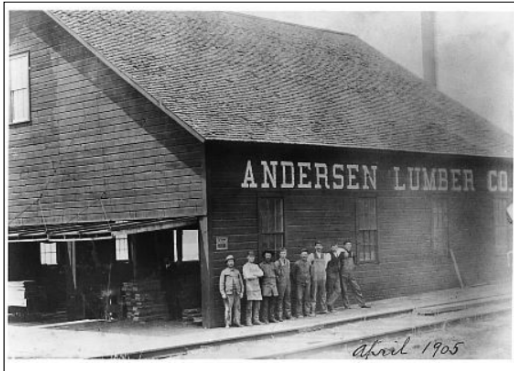
**Manufacturers Alliance Seminar**  
**Continuous Improvement**  
**Idea Systems**

Practical experiences from peers on engaging every individual in making improvements

**Continuous Improvement Idea Systems**

Lessons Learned

## Andersen: From Lumber Yard to Corporation



1903 – 2018

## First Attempts



### The Start:

- Improved Engagement\*
- Generated lots of ideas
- Helped us to "Learn to See"

### Later on:

- More work than Support could handle
- "Quantity" vs "Quality"

### Finally:

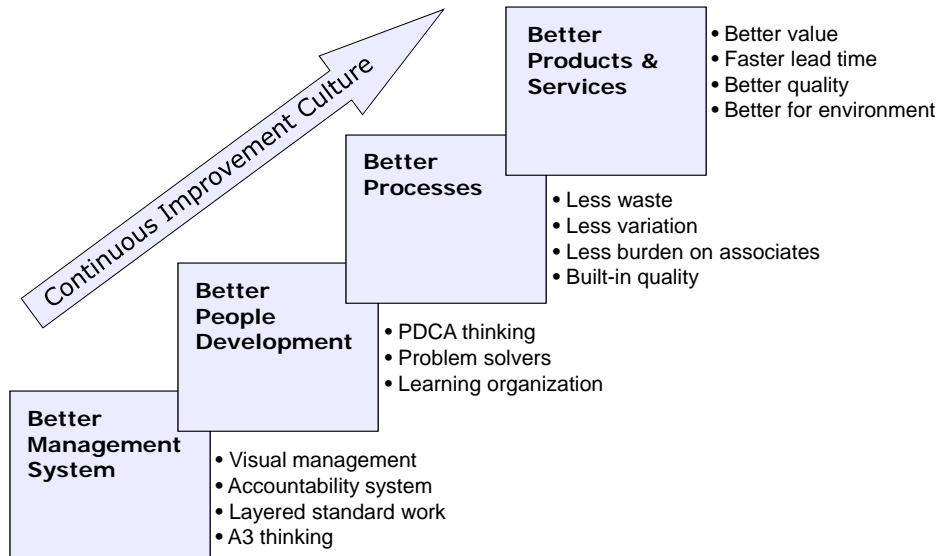
- Decreased moral
- Low return on investment
- Did not create **Process Improvers**

*We asked ourselves, Why?*



1. Ideas were not focused
2. Ideas were not prioritized
3. Ideas were a “baton passed”

*OUR SYSTEM FOSTERED THE ABOVE*



*Rethink Purpose: Engagement = Develop Process Improvers*



- Weiland acquired in 2013
- Focus on AMS began in 2016
- No pre-existing CI Card System
- Right Spirit, no path to practice

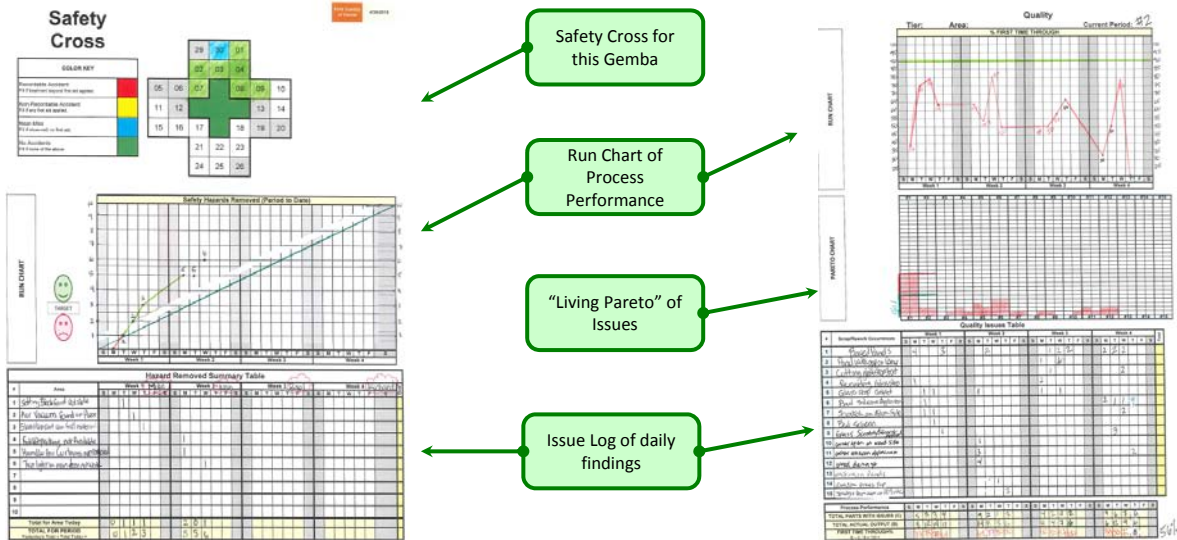
*First Step: Systematically Focus on Process*



<b>First Time Fail: 1 tick = 1 Unit</b>	0	5	10	15	20	25	30	35
<i>Example issue (13 units)</i>	+++	+++						
Equipment Error								
Test Fail	+++	+++	+++	+++	+++			
Label Error								
Defect Part	+++	+++						
Set-up	+++							
Damaged Tooling	+++	+++						
Glass Break	+++	+++	+++					
Network Outage								

*Team decided: Safety Hazards, Wrong-First Time & Lost Time*

## Second Step: Visualize & Prioritize Issues



Safety Cross for this Gemba

Run Chart of Process Performance

"Living Pareto" of Issues

Issue Log of daily findings

*Team decided on S-Q-C charts; 1 set for each process*

## Third Step: Make decisions & Set Actions



### Purpose of Managing Daily Improvement Walk:

- Can we all see if we had a good or bad day?
- Can we all see what our expectation is?
- Can we all see where/what the biggest opportunity is?
- Can we all see what we are doing about it?
- Can we all see if our work is making a difference?

*Team Leads decided daily "MDI" walks to the Gemba*

### Third Step: Make decisions & Set Actions

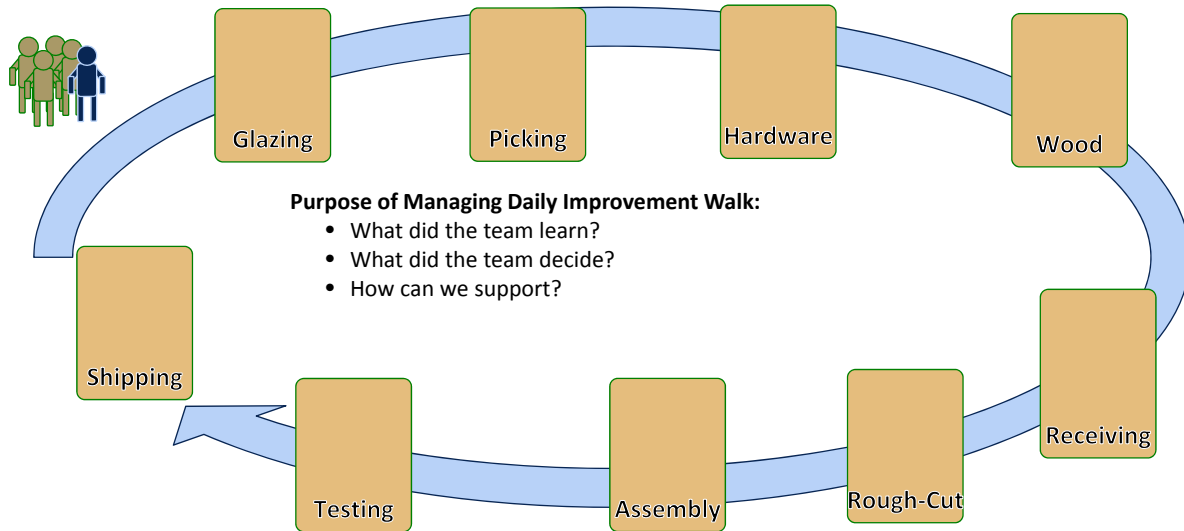


Glazing Period #5

GRASP THE SITUATION				PLAN		DO		CHECK		ACT	
Metric / MDC	Period / Date	Problem	Root Cause	Key Action	Expected Results	Who	By When / % Done	Actual Result	Verified by	Done	Notes
Q	4/10/12	Excessives	Operator	Operator	Operator	Operator	Operator	Operator	Operator	Operator	Operator
Q	4/10/12	Excessives	Operator	Operator	Operator	Operator	Operator	Operator	Operator	Operator	Operator
S	4/10/12	Excessives	Operator	Operator	Operator	Operator	Operator	Operator	Operator	Operator	Operator
S	4/10/12	Excessives	Operator	Operator	Operator	Operator	Operator	Operator	Operator	Operator	Operator
C	4/10/12	Excessives	Operator	Operator	Operator	Operator	Operator	Operator	Operator	Operator	Operator
S	4/10/12	Excessives	Operator	Operator	Operator	Operator	Operator	Operator	Operator	Operator	Operator
S	4/10/12	Excessives	Operator	Operator	Operator	Operator	Operator	Operator	Operator	Operator	Operator
Q	4/10/12	Excessives	Operator	Operator	Operator	Operator	Operator	Operator	Operator	Operator	Operator
S	4/10/12	Excessives	Operator	Operator	Operator	Operator	Operator	Operator	Operator	Operator	Operator
S	4/10/12	Excessives	Operator	Operator	Operator	Operator	Operator	Operator	Operator	Operator	Operator

Team Lead reviewing Kaizen (PDCA) Tracker with Team

### Fourth Step: Coach & Support



Leads and Managers decided daily "MDI" walks to the gemba



## Fourth Step: Coach & Support

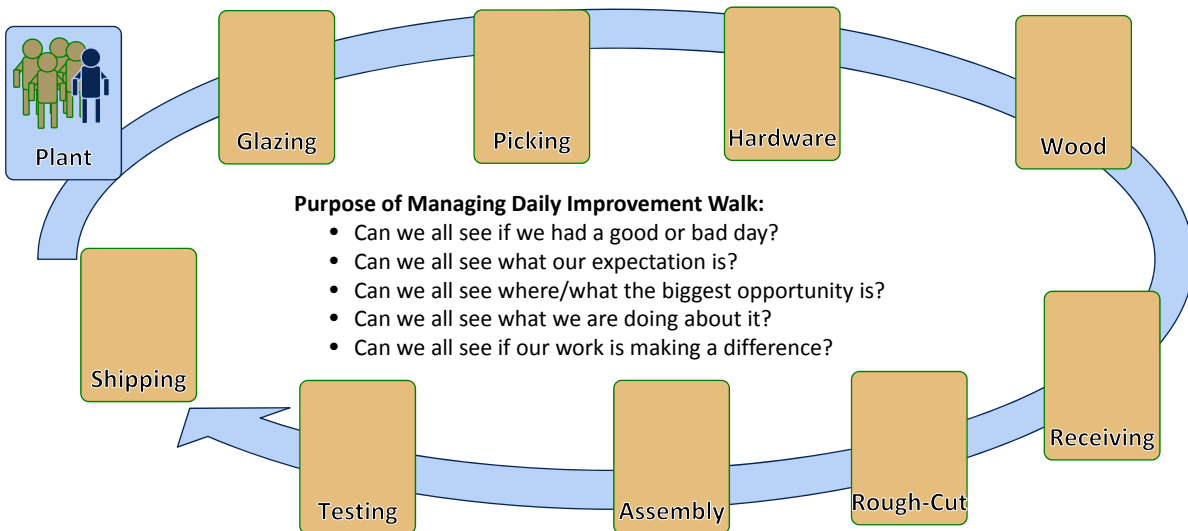


*Team Lead presents to Peers*



*Manager learns, then coaches*

## Fifth Step: Prioritize Support



*Managers decided daily "MDI" walks to make Plant Decision*

## Fifth Step: Prioritize Support



## Success revealed a “Big Rock”



### Safety Cross

* COLOR KEY	
Recordable Accident (MCA Required) PI if treatment beyond first aid applied	Red
Near-Miss (MCA Required) PI if any that aid applied	Yellow
Near-Miss PI if close-call; no first aid	Blue
No Accidents PI if none of the above	Green



*Team were fixing issues, but not improving Processes*



# Major Iteration: Require 5-Why for Safety

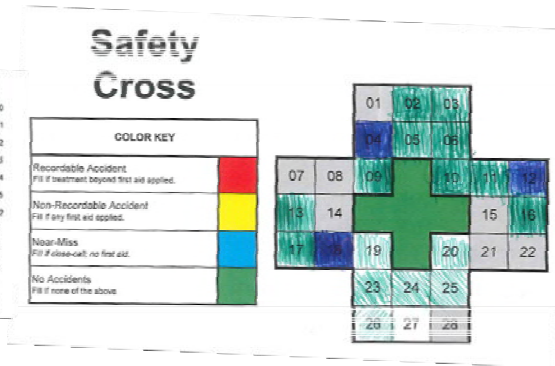
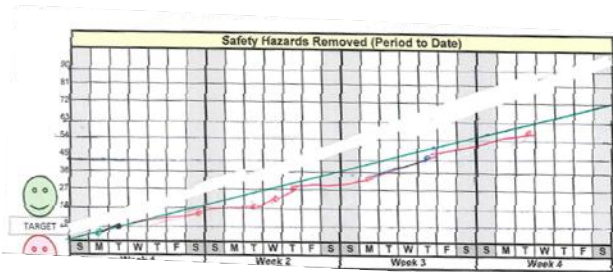
Safety *ISSUE Date: 04/23* *Period #4*

Problem	Because	Because	Because	Because	Because
Sand belt machine left on	I forget turn off	With all the noise I forget turn off			
Why?	Why?	Why?	Why?	Why?	Why?
Why they left on the machine	Why you forget				
Root Cause	The machine don't have any indicator that is on				
Adaptive Action	Talk on tier 1 with all the associates about this hazard				
Preventative Action	Put a visual to remain turn off the equipment (Light so we can see when we turn on)				

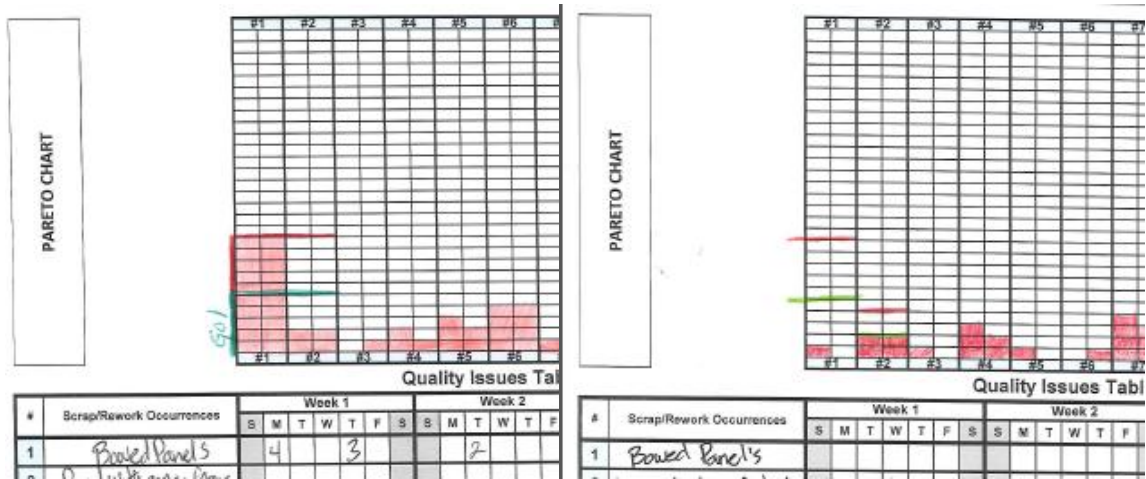
GRASP THE SITUATION				PLAN		DO		CHECK			
W	Metric #	Found Date	Problem	Root Cause	Plan	Who	By When	% Done	Actual Result	Verified By	DATE
1	S	04/23	Sand belt machine left on	With all the noise I forget turn off	Put a visual to remain turn off the equipment	EA	05/01	100%	Visual installed and working	EA	05/01
2	S	05/01	Sand belt machine left on	With all the noise I forget turn off	Put a visual to remain turn off the equipment	EA	05/01	100%	Visual installed and working	EA	05/01
3	C	05/01	Sand belt machine left on	With all the noise I forget turn off	Put a visual to remain turn off the equipment	EA	05/01	100%	Visual installed and working	EA	05/01
4	S	05/01	Sand belt machine left on	With all the noise I forget turn off	Put a visual to remain turn off the equipment	EA	05/01	100%	Visual installed and working	EA	05/01
5	S	05/01	Sand belt machine left on	With all the noise I forget turn off	Put a visual to remain turn off the equipment	EA	05/01	100%	Visual installed and working	EA	05/01

Team set clearer path: "Focusing on the Process to eliminate issues"

# Iterated Behavior is now Systematic



Team are improving Processes, which sustains their performance



*Practice of Kaizen with 5-Why & PDCA moving into Quality*

## Summary & What's Next

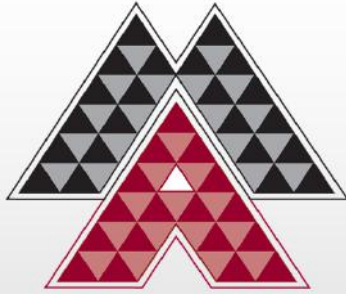
### What we did:

- ✓ Made a system of daily practice
- ✓ Focused on Proactive Safety
- ✓ Started the Journey

### Growing the Bright-Spots

- Teams applying skills on Quality
- Safety Advocate team has changed
- Teams practice 5S as counter-measures
- Team learning to use metrics in Kaizen

*Better Team, Better Process, Better Business*



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