Agenda

• Overview
  ▪ Concept
  ▪ Guidance
  ▪ Required Skills
  ▪ Level of Effort
  ▪ RCA Process
  ▪ Benefits
  ▪ Considerations

• Planning
  ▪ Information Gathering

• Fieldwork
  ▪ RCA Tools and Techniques

• Reporting
  ▪ 5 C’s
Root Cause Analysis (RCA)

A **root cause** is the most reasonably identified basic causal factor or factors, which, when corrected or removed, will prevent (or significantly reduce) the recurrence of a situation, such as an error in performing a procedure. **It is also the earliest point where you can take action that will reduce the chance of the incident happening.**

RCA is an objective, structured approach employed to identify the most likely underlying causes of a problem or undesired events within an organization.
IIA guidance includes:

- Standard 2320 – Analysis and Evaluation

Additional guidance includes:

- PCAOB Initiatives to Improve Audit Quality – Root Cause Analysis, Audit Quality Indicators, and Quality Control Standards
Required Auditor Skills for RCA

- Collaboration
- Critical Thinking
- Communication
- Business Acumen
- Creative Problem Solving
The resources spent on RCA should be commensurate with the impact of the issue or potential future issues and risks.
Steps for Performing RCA

01 Define the problem.

02 Identify the contributing factors.

03 Identify the root cause(s).

04 Formulate and implement corrective actions to eliminate the root cause(s).
Steps for Performing RCA

<table>
<thead>
<tr>
<th>Risk Assessment</th>
<th>Root Cause Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Objective</td>
<td>1. Problem</td>
</tr>
<tr>
<td>2. Risk(s)</td>
<td>2. Root Cause(s)</td>
</tr>
<tr>
<td>a) Identification</td>
<td>a) Identification</td>
</tr>
<tr>
<td>b) Measurement</td>
<td>b) Measurement</td>
</tr>
<tr>
<td>c) Prioritization</td>
<td>c) Prioritization</td>
</tr>
</tbody>
</table>


Benefits of RCA

RCA benefits the organization by identifying the underlying cause(s) of an issue. This approach provides a long-term perspective for the improvement of business/control processes. Without the performance of an effective RCA and the appropriate remediation activities, an issue may have a higher probability to reoccur.
RCA Considerations

Prior to performing RCA, internal auditors should anticipate potential barriers that could impede the effort and proactively develop an approach for handling those circumstances.

- Skill Sets
- Resistance From Management
- Time Commitment
- Independence
- Subjectivity
PLANNING
What Is a Process?

A process is generally defined as a series of steps or actions performed to achieve a specific purpose. The components of a process, including a control process are:

- Input
- Transformation
- Output
A SIPOC diagram is a high-level process map that provides a systematic way to analyze and describe the input and output relationships of process steps. It provides a graphical representation of the interrelationships of activities of the suppliers and customers and focuses on the interrelationship between those activities.
**Tool: SIPOC Diagram**

### SIPOC ＜Insert Process Title Here＞

<table>
<thead>
<tr>
<th>Suppliers</th>
<th>Inputs</th>
<th>Process</th>
<th>Outputs</th>
<th>Customers</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**Suppliers**
- List all the suppliers of the identified inputs.
  - Examples: Upstream Process, Vendors, Internal/External

**Inputs**
- List all the inputs of the process being evaluated.
  - Examples: Raw Data, Raw Materials, Requirements, Changes

**Process**
- Start here with a high-level process map.

**Outputs**
- List all the outputs of the agreed upon process being evaluated.
  - Examples: Reports, Products, Service, Raw Data

**Customers**
- List the customers who receive the outputs of the process. If the customer is a downstream process, make sure the outputs of this process match the inputs of the downstream process.
  - Examples: Downstream Process, Vendors, End User, internal/external
Steps for Creating a SIPOC Diagram

1. Clarify the start and stop of the process.
2. In the process column, map the 5 to 7 major process steps in sequence.
3. Brainstorm the key outputs and customers for each major process step.
4. List the key outputs of each step of the process in the corresponding row/column.
5. Identify the customers that will receive the outputs and list in the corresponding row/column.
6. Brainstorm the key inputs and suppliers for each key output identified.
7. List the key inputs for each key output in the corresponding row/column.
8. Identify the suppliers that provide the inputs and list in the corresponding row/column.
9. Review the completed SIPOC to verify all key components are completed/addressed.
10. Determine the areas of focus.
Tool: FMEA

Failure modes and effects analysis (FMEA) is a systematic tool used to evaluate a process and identify where or how it might fail, and to assess the relative impact of the failure.

• Similar to a risk and control matrix in internal auditing.

• Failure modes are any errors or defects in a process design, especially those that affect the intended function of the process, and can be potential or actual.

• Effects analysis refers to studying the consequences of those failures.
Failures are prioritized according to:
- How serious their consequences are
- How frequently they occur
- How easily they can be detected
# Example – FMEA Worksheet

<table>
<thead>
<tr>
<th>Key Process Step</th>
<th>Potential Failure Mode (How can the step go wrong?)</th>
<th>Potential Failure Effect</th>
<th>Severity Rating $(S_i)$</th>
<th>Potential Cause of Failure</th>
<th>Occurrence Rating $(O_i)$</th>
<th>Controls</th>
<th>Detection Rating $(D_j)$</th>
<th>Risk Priority Number $(RPN)$</th>
<th>Recommended Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customer Places Order</td>
<td>Customer address is wrong</td>
<td>Package shipped to wrong location</td>
<td>6</td>
<td>Customer information is captured incorrectly</td>
<td>5</td>
<td>Customers are required to verify address</td>
<td>2</td>
<td>60</td>
<td>System check of valid postal address</td>
</tr>
<tr>
<td>Customer Order is Picked</td>
<td>Wrong item is picked</td>
<td>Customer receives wrong item</td>
<td>8</td>
<td>Human error</td>
<td>3</td>
<td>Customer order compared to order fulfillment sheet</td>
<td>3</td>
<td>72</td>
<td>Require verification order is correct before shipping</td>
</tr>
<tr>
<td>Customer Order is Shipped</td>
<td>Customer does not receive order</td>
<td>Loss of future sales</td>
<td>10</td>
<td>Failure on part of package delivery service</td>
<td>2</td>
<td>Use reputable package delivery service</td>
<td>4</td>
<td>80</td>
<td>Research package delivery success rate before selecting delivery service</td>
</tr>
</tbody>
</table>

1. Identify failure modes and their effects
2. Identify causes of the failure modes and controls
3. Rate ability to detect
4. Calculate RPN and prioritize
5. Determine and assess actions
Steps for Performing an FMEA

1. List the key process step.
2. Identify what could go wrong in that step (potential failure mode).
3. Identify the possible consequence(s) (potential failure effect).
4. Assign a severity rating.
5. Identify the potential cause of a failure mode.
6. Assign an occurrence rating.
7. Document the present controls in place that prevent failure modes from occurring or detect the failure before it reaches the customer of the process.
8. Assign a detection rating.
9. Calculate the risk priority number (RPN).
10. Recommended actions are planned to lower high-RPN (high risk) process steps.
<table>
<thead>
<tr>
<th>Score</th>
<th>Severity Rating</th>
<th>EBIT</th>
<th>Duration</th>
<th>Description of Severity</th>
<th>Reputational Impact on Stakeholders (i.e., customers, shareholders, employees)</th>
<th>Impact on Value</th>
<th>Recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/10</td>
<td>Catastrophic</td>
<td>&gt; $200M</td>
<td>Irrecoverable</td>
<td>Enterprise-wide: Complete inability to business operations enterprise.</td>
<td>Complete loss of confidence in all 3 groups.</td>
<td>Collapse of market</td>
<td>Acquisition or restructuring, changes to strategic operating plans and execution.</td>
</tr>
<tr>
<td>7/8</td>
<td>Critical</td>
<td>&lt;</td>
<td>Recoverable Long Term 24-36</td>
<td>2 or more divisions: Significant, ongoing interruptions to operations within 2 or divisions</td>
<td>Sustained losses in 2 or stakeholder groups.</td>
<td>&gt; 50% reduction in capitalization, accessing $2 billion liquidity reserve.</td>
<td>2 or more changes senior leadership, restructuring, changes to strategic operating plans and execution.</td>
</tr>
<tr>
<td>4/5/6</td>
<td>High</td>
<td>&lt;</td>
<td>Recoverable Short Term 12-24</td>
<td>1 or more division(s): Moderate impact within more division(s).</td>
<td>Moderate loss in 1 or more stakeholder groups.</td>
<td>&gt;25% reduction in market capitalization, minimal operating cash maintenance of $2 billion reserve.</td>
<td>1 or more changes senior leadership, significant changes operating plans and execution.</td>
</tr>
<tr>
<td>2/3</td>
<td>Moderate</td>
<td>&lt; $50M</td>
<td>Temporary less than 12 months)</td>
<td>1 division; Limited impact within 1</td>
<td>Limited to minor/short-1 stakeholder group.</td>
<td>Miss forecast(s) and/or refinements or adjustments to plans and operating.</td>
<td>Refinements or adjustments to plans and operating.</td>
</tr>
<tr>
<td>1</td>
<td>Minimal</td>
<td>&lt; $20M</td>
<td></td>
<td></td>
<td>Minimal Impact</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Occurrence Rating

<table>
<thead>
<tr>
<th>Score</th>
<th>Occurrence Rating</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/10</td>
<td>Very high (failure is almost inevitable)</td>
<td>&gt; 90%</td>
</tr>
<tr>
<td>7/8</td>
<td>High (repeated failures)</td>
<td>≤ 90%</td>
</tr>
<tr>
<td>4/5/6</td>
<td>Moderate (occasional failures)</td>
<td>≤ 60%</td>
</tr>
<tr>
<td>2/3</td>
<td>Low (relatively few failures)</td>
<td>≤ 30%</td>
</tr>
<tr>
<td>1</td>
<td>No known occurrences on similar processes</td>
<td>&lt; 10%</td>
</tr>
<tr>
<td>Score</td>
<td>Detection Rating</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>9/10</td>
<td>Failure will be passed onto customer</td>
<td>Controls are non-existent or have major deficiencies and intended</td>
</tr>
<tr>
<td>7/8</td>
<td>Low</td>
<td>Limited controls in place, high level of risk remains</td>
</tr>
<tr>
<td>4/5/6</td>
<td>Moderate</td>
<td>Key controls in place, with significant opportunities for</td>
</tr>
<tr>
<td>2/3</td>
<td>High</td>
<td>Controls properly designed and operating, with opportunities identified</td>
</tr>
<tr>
<td>1</td>
<td>Certain – Failure will be caught by control</td>
<td>Controls properly designed and operating as intended</td>
</tr>
</tbody>
</table>
RCA Fieldwork Tools and Techniques

Simple techniques such as inquiry and observation are useful for determining the root cause in many of the issues to be analyzed.

More elaborate RCA tools and techniques should be reserved for situations where the benefit outweighs the cost.

Examples of these types of tools and techniques include:

- The 5 Whys
- Fishbone diagram
- Fault tree analysis
- Pareto chart
- Scatter diagram
- Cause and Effect Matrix
- Business Process RCA
The 5 Whys is a questions-asking technique used to explore the cause/effect relationships underlying a particular problem, with the goal of determining a root cause of a defect or problem. By repeating why five times, the nature of the problem as well as its solution usually becomes clear. Ask "why" and identify the causes associated with each sequential step towards the defined problem or event. "Why" is taken to mean "What were the factors that directly resulted in the effect?"
The following examples demonstrates the basic process of the 5 Whys:

- The vehicle will not start. (the problem)
  - The battery is dead. (first why)
  - The alternator is not functioning. (second why)
  - The alternator belt has broken. (third why)
  - The alternator belt was well beyond its useful service life and not replaced. (fourth why)
  - The vehicle was not maintained according to the recommended service schedule. (a root cause)

- The worker fell. (the problem)
  - There was oil on the floor. (first why)
  - A broken part. (second why)
  - The part keeps failing. (third why)
  - Changes in procurement practices. (fourth why)
  - By the fifth “why,” the internal auditor should have identified or be close to identifying the root cause.
**Problem:** The stones of the Jefferson Memorial are eroding!

- Why are they eroding?
  - The frequent washing of the stone.
- Why are the stones washed so often?
  - There are so many bird droppings on the stones.
- Why are there so many bird droppings?
  - A large number of birds come around to eat the abundant food supply of little black spiders.
- Why are there so many little black spiders?
  - To eat the millions of little midges around the memorial.
- Why are there so many midges?
  - At dusk they turn on the lights at the memorial. Midges are attracted to the light and dusk is their optimum time to mate.

**Solution:** Turned on the lights one hour later and the midges disappeared.
The 5 Whys – Techniques

There are two primary techniques used to perform the 5 Whys analysis:

- The 5 Whys can be used effectively in conjunction with the fishbone diagram and fault tree analysis tools
- A hierarchical table format – Comprised of creating a table in either a Word document or an Excel spreadsheet

<table>
<thead>
<tr>
<th>Proximate Cause</th>
<th>Intermediate Causes</th>
<th>Root Cause</th>
<th>Proposed Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why are they eroding?</td>
<td>Why are the stones washed so often?</td>
<td>Why are there so many bird droppings?</td>
<td>Why are there so many little black spiders?</td>
</tr>
<tr>
<td>The frequent washing of the stone.</td>
<td>There are so many bird droppings on the stones.</td>
<td>A large number of birds come around to eat the abundant food supply of little black spiders.</td>
<td>To eat the millions of little midges around the memorial.</td>
</tr>
</tbody>
</table>
Challenges with The 5 Whys Technique

• Solely using the 5 Whys approach can lead to a very linear thought process, where the auditor mistakenly assumes there is only one true root cause to an issue, and that if successful in finding that root cause, the problem will be permanently solved
  ○ Multiple Root Causes
  ○ Solving the Problem Completely
Tool: Fishbone Diagram

- Fishbone diagrams are causal diagrams that help you visually display the many potential causes for a problem or an effect.
- When utilizing a team approach to problem solving, there are often many opinions as to the problem’s root causes. The fishbone diagram facilitates capturing these different ideas and stimulating the team’s brainstorming on root causes.
Steps for Creating a Fishbone Diagram

1. Start with stating the problem.
2. Brainstorm the major categories of causes of the problem.
3. Write the categories of causes as branches from the main arrow.
4. Once you have the branches labeled, begin brainstorming possible causes and attach them to the appropriate branches.
5. Write sub-causes branching off the causes.
6. When the group runs out of ideas, focus attention to places on the chart where ideas are few.
7. Finalize the fishbone diagram by reviewing and getting consensus on the true root cause(s) of the problem.
Fishbone Diagram – Usage Tips

Tips for using fishbone diagrams include:

• State causes, not solutions
• Show relationship between causes
• Test the causal relationships by starting from the smallest bone and connecting each potential cause with the words “might cause”
• Take note of causes that appear repeatedly
• Review each major cause category
• Circle the most likely causes on the diagram.
The results of the fishbone diagram exercise can be summarized in a root cause summary table capturing each root cause noted by category and inserting the corresponding management action plan alongside.

<table>
<thead>
<tr>
<th>Issue: XXX</th>
<th>Date: XXX</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Causal factor # 1</strong></td>
<td><strong>Category</strong></td>
</tr>
</tbody>
</table>
| Description: XXXX | Man | • XXX  
| | | • XXX  
| | | • XXX  
| **Causal factor # 2** | **Category** | **Management Action Plan** |
| Description: XXXX | Machines | • XXX  
| | | • XXX  
| | | • XXX  
| **Causal factor # 3** | **Category** | **Management Action Plan** |
| Description: XXXX | Methods | • XXX  
| | | • XXX  
| | | • XXX  
| **Causal factor # 4** | **Category** | **Management Action Plan** |
| Description: XXXX | Measurement | • XXX  
| | | • XXX  
| | | • XXX  

Fishbone Diagram – Root Cause Summary Table
Cash account doesn’t reconcile

- Shortage in cash account
  - OR
  - Bank error
  - Accounting error
  - Fraud
    - OR
    - Skimming
    - Embezzlement
      - AND
      - Opportunity
      - Rationalization
      - Pressure
        - Cash accountant not required to take vacation
        - Cash accountant passed over for promotion
        - Cash accountant purchased expensive car in anticipation of promotion
Steps for Performing a Fault Tree Analysis

1. Begin constructing the Fault Tree by stating the problem/issue/undesired event, placing it in the first box, and labeling it the Failure Event.

2. The audit team brainstorms the immediate causes of the problem/issue/undesired event and determines whether an OR gate or AND gate should be applied.

3. Evidence is gathered by the audit team to confirm the paths to follow for OR gates and continue to build out the tree, along with AND gate paths as well.

4. The above process continues down through each level until all relevant causes are identified the root cause(s) are reached.

5. The audit team evaluates the Fault Tree and develops action plans corresponding to the root cause(s) determined.
While traditional internal audit methodologies have served the profession well for decades, those methodologies are now being updated and refined to incorporate data analytics in order to successfully leverage its potential.

Data analytics are being embedded into every single stage of the audit lifecycle, i.e., risk assessment, planning, fieldwork, and reporting. Additionally, the use of data analytics techniques are being considered core to many Internal Audit departments’ strategy and vision.
The Pareto Chart illustrates the Pareto principle, frequently referred to as “The 80/20 Rule,” which holds that 20 percent of the population accounts for 80 percent of the situation. The purpose of the Pareto chart is to highlight the most important set of factors or activities that most contribute to a problem or opportunity.
Pareto Chart

A Pareto Chart can be a useful measurement tool for the audit team in an RCA effort. It can focus their attention in the direction of the most important cause or causes to resolve in order to reduce or eliminate the problem. This is particularly helpful when the team is:

- Analyzing data about potential root causes or the frequency of problems.
- Dealing with many different problems and causes but wants to focus on the most significant ones.
- Analyzing wide-reaching causes by zeroing in on their individual components.
Steps for Creating a Pareto Chart

1. Choose the problem and causes that will be compared/rank-ordered by brainstorming, using a fishbone diagram.
2. Choose the time period for the analysis.
3. Collect the data.
4. Decide on appropriate measurement for your data, e.g., frequency, quantity, cost, time, etc.
5. Devise an appropriate scale for your measurements.
6. Decide on the categories that will be used to group your data items.
7. Create a bar for each category and add appropriate labels for each, placing the tallest on the far left, descending to the smallest on the far right.
8. Calculate the subtotal of each category’s measurements.
9. Beginning at the top of the first category bar, draw a line showing the cumulative percentage total reached with the addition of each cause category.
10. Draw a line at 80% on the y-axis running parallel to the x-axis. Then drop the line at the point of intersection with the curve on the x-axis. This point on the x-axis separates the important causes on the left from the less important causes on the right.
Tool: Scatter Diagram

A scatter diagram is a type of diagram that displays pairs of data, with one variable on each axis, to look for a relationship between them.
### Tool: Scatter Diagram

A scatter diagram is a type of chart that displays values for two variables for a set of data. Each point on the chart represents an observation, with the horizontal axis (x-axis) representing one variable and the vertical axis (y-axis) representing another. The points are plotted on a Cartesian plane, and the pattern of points can suggest a relationship or correlation between the variables.

The scatter diagram in the image shows the relationship between temperature and sales of jackets. The data is as follows:

<table>
<thead>
<tr>
<th>Temperature</th>
<th>Sales of Jackets</th>
</tr>
</thead>
<tbody>
<tr>
<td>110</td>
<td>0</td>
</tr>
<tr>
<td>100</td>
<td>1</td>
</tr>
<tr>
<td>90</td>
<td>3</td>
</tr>
<tr>
<td>80</td>
<td>5</td>
</tr>
<tr>
<td>70</td>
<td>25</td>
</tr>
<tr>
<td>60</td>
<td>49</td>
</tr>
<tr>
<td>50</td>
<td>87</td>
</tr>
<tr>
<td>40</td>
<td>104</td>
</tr>
<tr>
<td>30</td>
<td>276</td>
</tr>
</tbody>
</table>

The scatter diagram indicates a negative correlation between temperature and sales of jackets, as the sales increase with decreasing temperature.
Tool: Scatter Diagram

Degrees of correlation:
- None
- Low
- High
- Perfect

Types of correlation:
- Positive
- Negative
- Curved
- Partial
Steps for Creating a Scatter Diagram

1. Brainstorm potential causes and effects for the problem using a fishbone diagram.
2. Identify all potential pairs of cause and effect variables associated with the problem.
3. Use existing data or collect new data regarding to what extent causes contribute to the problem.
4. Select the most likely pairs of cause and effect variables to verify.
5. Draw a graph with the independent variable on the horizontal axis and the dependent variable on the vertical axis.
6. Select the scales for the x and y axes.
7. Plot the data by putting a dot for each pair of data where the x-axis value intersects the y-axis value.
8. Determine if there is a relationship between the cause and effect, noting whether the points clearly form a line or a curve.
### Cause and Effect Matrix

<table>
<thead>
<tr>
<th>Importance of Each Y to the Customer</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1 = not important; 10 = very important)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Output Variables (Ys)</th>
<th>Speed of Service</th>
<th>Taste</th>
<th>Peaceful Ambience</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>X ID</td>
<td>Input Variables (Xs)</td>
<td>Correlation with Ys (0 = none; 1 = weak; 3 = moderate; 9 = strong)</td>
<td>Total (Priority)</td>
<td></td>
</tr>
<tr>
<td>X1</td>
<td>Bean Type</td>
<td>0</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>X2</td>
<td>Brew Type</td>
<td>9</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>X3</td>
<td>Amount of Grounds</td>
<td>0</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>X4</td>
<td>Cleanliness of Shop</td>
<td>1</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>X5</td>
<td>Water Temperature</td>
<td>0</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>X6</td>
<td>Styrofoam vs Paper Designer Cups</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>
Steps for Creating a Cause and Effect Matrix

1. List the outputs along the top section of the matrix.

2. Rank each output numerically using an arbitrary scale.

3. Identify all potential inputs or causes that can impact the various outputs and list these along the left hand side of the matrix.

4. Numerically rate the effect of each input on each output within the body of the matrix.

5. Use the totals column to analyze and prioritize where to focus your efforts.
Key to business process RCA is to identify the following:

- Cost and time drivers
  - Reduce frequency of occurrences
  - Reduce cost and time of each occurrence.
- Bottlenecks and resolve
The 5 Cs

Here’s a mnemonic device for remembering the components of audit observations:

- **Condition** *(what is)*
- **Criteria** *(what should be)*
- **Cause** *(why)*
- **Consequence [Effect]** *(so what)*
- **Corrective action plans and recommendations** *(what is to be done)*
A Medical Analogy

The five components of audit observations are analogous to the components that medical doctors use.

<table>
<thead>
<tr>
<th>Medical Term</th>
<th>Example</th>
<th>Analogous Internal Audit Term</th>
</tr>
</thead>
</table>
| Healthy State    | • Absence of a cough  
                   • Temperature of 98.6° F  
                   • Clear lung sounds       | Criteria                          |
| Symptom          | • Cough  
                   • Fever  
                   • Rattling in the lungs    | Condition                         |
| Diagnosis        | • Common cold  
                   • Pneumonia                  | Cause                             |
| Prognosis        | • Feel sick for a week  
                   • Be seriously ill for several weeks with possible long-term consequences | Effect                            |
| Treatment        | • Drink fluids and rest  
                   • Receive antibiotics       | Recommendations and Action Plans  |
Condition

Condition is the factual evidence that the internal auditor found in the course of the examination (the current state). The condition answers the question: “What is?”

When documenting the condition, ensure the following is included:

- When (i.e., how often)
- Who
- What
- Why
Criteria

The standards, measures, or expectations used in making an evaluation and/or verification (the correct state). The criteria answers the question: “What should be?”
Types of Criteria

- Policies and procedures
- Industry standards
- Regulations and laws
- Others
  - Comparable operations
  - KPIs
  - Best or leading practices
  - Mission, vision, and strategy
  - Business plan
  - Goals or targets
  - Customer surveys
  - Competition
  - Benchmarking studies
Cause

Cause is the reason for the difference between the expected and actual conditions. The cause answers the question: “Why?”
Identify Causes

- Ask “Why do the conditions exist?”
- Identify proximate, intermediate, and root levels of cause.
- Identify which level of cause is actionable.
Levels of Cause

• Proximate cause(s) – The action(s) or lack of action(s) that led directly to the condition
• Intermediate cause(s) – The cause(s) (linear or branched) that led to the proximate cause(s); may be the actionable cause(s)
• Root cause – The underlying cause and may be the actionable cause.
When you repeatedly ask “so what,” you move through a series of effects:

- Direct, one-time effect on the process
- Cumulative effect on the process
- Cumulative effect on the organization
- High-level, systemic effect
Corrective Action Plans and Recommendations

**Guidance**

Communications must include the engagement’s objectives and scope as well as applicable conclusions, recommendations, and action plans. “What is to be done?”

**Matching and Linking Root Causes**

- Recommendation must address underlying root cause(s) and resolve both the Condition and the Cause
- Goal is preventing problem recurrence

**Multiple Root Causes**

- There may be more than one root cause for an event or a problem
- Focusing on a single cause can limit the solutions set
Types of Corrective Action Plans and Recommendations

- Condition-based
- Cause-based
- Recovery-focused
### Tying RCA Audit Findings to Planning Documentation

<table>
<thead>
<tr>
<th>Key Process Step</th>
<th>Potential Failure Mode (How can the step go wrong?)</th>
<th>Potential Failure Effect</th>
<th>Severity Rating (1-10)</th>
<th>Potential Cause of Failure</th>
<th>Occurrence Rating (1-10)</th>
<th>Present Controls</th>
<th>Detecting Rating (1-10)</th>
<th>Risk Priority Number</th>
<th>Recommended Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customer Places Order</td>
<td>Customer address is wrong</td>
<td>Package shipped to wrong location</td>
<td>6</td>
<td>Customer information is captured incorrectly</td>
<td>5</td>
<td>Customers are required to verify address</td>
<td>2</td>
<td>60</td>
<td>System check of valid postal address</td>
</tr>
<tr>
<td>Customer Order is Picked</td>
<td>Wrong item is picked</td>
<td>Customer receives wrong item</td>
<td>8</td>
<td>Human error</td>
<td>3</td>
<td>Customer order compared to order fulfillment sheet</td>
<td>3</td>
<td>40</td>
<td>Require verification order is correct before shipping</td>
</tr>
<tr>
<td>Customer Order is Shipped</td>
<td>Customer does not receive order</td>
<td>Loss of future sales</td>
<td>10</td>
<td>Failure on part of package delivery service</td>
<td>2</td>
<td>Use reputable package delivery service</td>
<td>4</td>
<td>80</td>
<td>Research package delivery success rate before selecting delivery service</td>
</tr>
</tbody>
</table>

1. Severity of failure impact (1 = lowest severity; 10 = highest severity)
2. Frequency of occurrence (1 = lowest frequency; 10 = highest frequency)
3. Ease of failure detection by control (1 = easiest to detect; 10 = most difficult to detect)
4. Risk priority based on $S 	imes O 	imes D$ (higher number requires more immediate attention; lower number is less risk)

---

**Condition:** Customer does not receive order

**Criteria:**

**Cause:** Failure on part of package delivery service

**Effect:** Loss of future sales

**Recommendation:** Research package delivery success rate before selecting delivery service
Summary

- Condition
- Criteria
- Cause
- Effect
- Recommendations/Management Action Plans
Recap

• Overview

• Planning
  - Information Gathering

• Fieldwork
  - RCA Tools and Techniques

• Reporting
  - 5 C’s
Action Plan
Questions and Answers
Thank You!