



Iowa Food Protection Task Force

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*Iowa Department of Inspections and
Appeals*

*4/10/19
10:30 AM*



Background

- Began 2001
- Predominantly funded by FDA grant
 - Except 2010
- 32 members
- Meets 3 to 4 times a year

Background

- Centrally located meeting Des Moines or Ames (200 miles)
- Focused “conferences” for retail, processors, and producers
 - Many in collaboration with the Heartland Partnership

Background

- Standards & Task Force
 - Task Force website and mobile application
 - Alert Application
 - Foodborne Illness Line
 - Root Cause Analysis

Projects

- Website & Mobile app. rollout 2015
 - <https://ia.foodprotectiontaskforce.com/>
 - lowafs – app store

Projects

Task Forces

Alerts

Home + Create Event Send Alerts Track Alerts

1 Choose Event 2 Upload Spreadsheet 3 Alert Message 4 Preview 5 Confirm

end Alerts: Choose Event

Upload Template

Choose Event: 07/20/18 Tornado July 19, 2018

Spreadsheet Template

Download Template

Next Step Cancel



Projects



HOME

MEETINGS

LIBRARY

VIDEOS

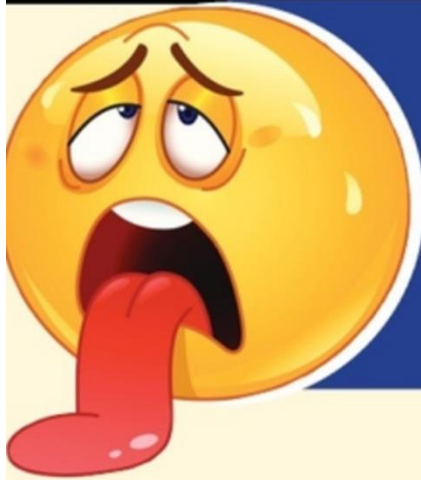
LINKS

RESOURCES

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Feeling Queasy?
Call, it's Easy!

844-IowaSic
(or your local health department)
to report **food poisoning**

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IA's Root Cause Analysis

- Recognizing the need to know why consumers are ill resulted in even more questions:
 - Lack of managerial control...but why?
 - Lack of resources...buy why?
 - Lack of training...but why?
 - Lack of sick leave...but why?
 - Lack of supplies...but why?

IA's Root Cause Analysis

- We are charged with ensuring compliance with state and federal regulations for facilities that provide food to the public
- We are conscientious public servants that are committed to protecting public health
- We are aware that other industries experience successes in root cause analysis and we want that too

IA's Root Cause Analysis

- Enrolled in the CDC's National Environmental Assessment Reporting System (NEARS)
- Face to Face training with NEARS Cadre
- Required inspectors to complete EATS 101
- Adapted the NEARS reporting instrument in our database
- Developed procedures for responding to FBI outbreaks
- Conducted investigations using the environmental assessment reporting instrument

IA's Root Cause Analysis

- Identified the need to develop a root cause analysis team:
 - Inspectors that have an innate curiosity
 - Inspectors that are looking for more
 - Inspectors that are not afraid to probe for answers
 - Inspectors that are willing to offer a hypothesis
- Train the RCA Team:
 - Attended Face to Face National NEARS meeting
 - Attended ASQ Root Cause Analysis
 - Required completion of CDC's EATS 101 and EATS102
 - Identified leadership role for environmental assessments

RCA/FPTF

- Sharing of research and practical application
 - PEW
 - Kwik Trip
 - Iowa Department of Inspections and Appeals

Guide for Conducting Food Safety Root Cause Analysis

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Corrective & Preventative Action SOP

DOCUMENT ID: SOP # IIA Corrective/Preventative Actions	PAGE	1 of 1
PLANT NAME: Kwik Trip, Inc. Production Operations	ISSUE DATE	3/3/18
ADDRESS: 1626 Oak Street, La Crosse, WI 54601	SUPERSEDES	41317

Co-workers, supervisors and management are responsible for completing corrective actions.

When issues occur with product, processes, or paperwork a corrective action is needed to document how the problem was fixed. Corrective and preventive actions must state how the deficiency was corrected, who is responsible and what will be done to prevent any future recurrence. Not all issues need a CAPA form filled out; a note in the CAPA/Comment box may be sufficient. For example, if a check on a production form was not done at the proper frequency or the information is illegible, a note explaining what happened in the CAPA box would be sufficient.

The CAPA process shall include investigation, action, review, and follow up to make sure the problem is corrected. Root cause analysis combined with corrective action helps to understand the cause of the deviation and prevent recurrence of a similar problem. Here are ways to approach a problem.

1. Define the problem

State the problem. Do not make assumptions or suggest ways to improve it.
Problem stated based on facts, not beliefs. Include what, when, where and impact of the problem.

2. Ask Why

Why #1 - Ask why did the problem occur? Why #2 - Why did the action in why #1 occur? Keep asking why until you can determine the root cause - which is what started the chain of events leading to the problem.

3. Root Cause/Corrective Action

Determine the Root Cause and how it can be prevented from happening again.
WHAT changes will be implemented? WHO is going to implement the change? WHEN will the changes be implemented?

4. Implement, Verify, Spread

Record what was changed, by whom and when the change was made
Verify that changes have eliminated the Root cause
Identify all areas where this solution could be reapplied to prevent similar incidents from occurring

All Regulatory and Third Party audit reports received by Kwik Trip, Inc. production facilities are to be forwarded to Production Quality Assurance. Production Quality Assurance will forward to the Director of Operations.

Quality Assurance will assist the appropriate production department personnel with the corrective action responses to the Regulatory or Third Party audit reports. The production departments should not respond directly to ensure a consistent response can be provided.

Records for Corrective Action

Each production facility is to maintain a file of all internal audits, third party audits, regulatory actions, visits, reports or other notifications received from any regulatory agency along with the corrective action. All information from the corrective action must be documented and kept on file via hard copy or stored electronically for a minimum of two years.

KWIK TRIP[™]

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