COMPLIANCE AUDIT PROGRAM FOR REGISTRANT FIRMS

HOW TO COMPLETE A CORRECTIVE ACTION PLAN

VERSION 1.0

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ENGINEERS &
GEOSCIENTISTS
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INTRODUCTION AND PURPOSE

This *How to Complete Your Corrective Action Plan* guide is designed to help registrant firms address and resolve any non-conformances identified during the mandatory compliance audit conducted by Engineers and Geoscientists BC. It provides a general framework for completing Corrective Action Plans (CAPs) and outlines possible steps that registrant firms can take to rectify non-conformances efficiently and effectively.

Registrant firms often face challenges with their CAP submissions by confusing "Correction" with "Corrective Action" and "Preventive Action" with "Corrective Action." Additionally, registrant firms may struggle with insufficient or unclear documentation, inadequate training on CAP processes, and ineffective root cause analysis. Inconsistent implementation across different departments and tight deadlines can further complicate the submission process. Addressing these issues can significantly improve the accuracy and effectiveness of CAP submissions.

While adherence to all the processes outlined in this guide is not commanded, we strongly encourage all registrant firms to fully utilize this guide and the concepts it contains. Doing so will enable registrant firms to maximize the benefits derived from implementing their CAPs. Additionally, although this guide primarily serves as a component of the Engineers and Geoscientists BC compliance audit process, registrant firms may also find it invaluable as a reference whenever they encounter non-conformances in their professional work.

This guide is not intended to replace any existing policies, procedures, or regulatory requirements specific to a registrant firm's professional work or industry standards. Instead, it serves as a supplement that aims to provide clear guidance on developing CAPs.

CORRECTIVE ACTION REQUESTS

WHAT IS A NON-CONFORMANCE?

During the compliance audit process, the auditor may encounter situations where the processes performed by a registrant firm do not comply with a specific regulatory requirement; these are called non-conformances. Non-conformances can arise from several factors, including evolving regulations, changes to industry standards, and/or unintentional oversight.

Non-conformances identified during a compliance audit are classified as either minor or major.

A **Minor Non-conformance** is a situation where, based on the collected objective evidence:

- there is a failure by the registrant firm undergoing a compliance audit to meet a specific regulatory requirement(s), the failure is not considered systemic but can be linked to a specific subsection of the Bylaws of Engineers and Geoscientists BC (the "Bylaws"); and
- there is no reasonable nor probable risk of injury to the environment or to the health and safety of the public or a group of people.

To align with international standards, here are key definitions from ISO 9000:2015 – Quality Management Systems – Fundamentals and Vocabulary:

- **Nonconformity (non-conformance)**: Non-fulfilment of a requirement.
- **Correction**: Action to eliminate a detected nonconformity.
- **Corrective Action**: Action to eliminate the cause of a nonconformity and prevent its recurrence.

A **Major Non-conformance** is a situation where, based on the collected objective evidence:

- there is a systemic failure by the registrant firm undergoing a compliance audit to meet a specific regulatory requirement(s); and
- there is reasonable and probable risk of injury or significant harm to the environment or to the health and safety of the public or a group of people.

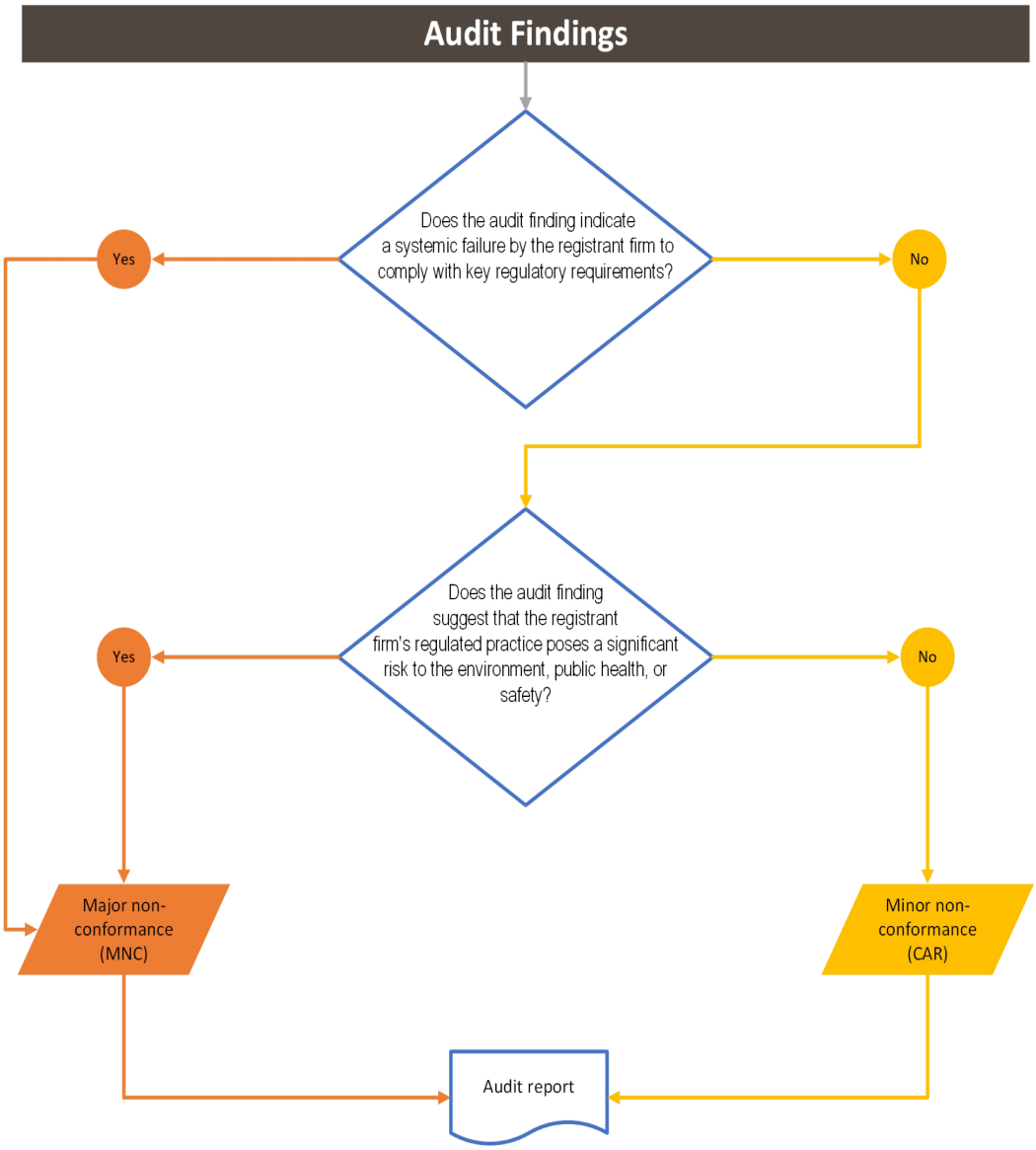

Figure 1: Process flow chart for both types of non-conformances

WHAT IS A CORRECTIVE ACTION REQUEST?

When an auditor identifies a non-conformance with regulatory requirements during the compliance audit, including those set forth by the *Professional Governance Act*, Regulations, the Bylaws, and Standards of Engineers and Geoscientists BC, the auditor gathers evidence to support this finding. The identified non-conformance and supporting evidence are then presented to the registrant firm through a Corrective Action Request (CAR) in the Compliance Audit Report (the "Report"). The CAR includes objective evidence obtained during the compliance audit and details the specific requirement that is not being met.

During the closing meeting, the registrant firm will be notified of any identified CARs and advised that a CAP is required for each CAR. After the compliance audit, the Primary Responsible Registrant will receive an email with a PDF copy of the Report and a link to the registrant firm's audit portal, prompting them to acknowledge the Report. Once the first email is acknowledged, a second email will be sent to the Primary Responsible Registrant, including a summary of the CARs and a link to access the CAP module for completion by the registrant firm. The registrant firm audit portal serves as the platform for the registrant firm to address each CAR and submit the CAPs. The registrant firm has 30 days from the delivery of the Report to complete the CAP in the registrant firm's audit portal.

Occasionally, the Audit and Practice Review Committee (APRC) may require the same process to be followed for a major non-conformance. If a registrant firm encounters a specific circumstance requiring that the CAP be completed within the registrant firm's audit portal due to a major non-conformance being identified, this guide may serve as a reference to complete the CAP.

COMPLETING A CORRECTIVE ACTION PLAN

When the Report identifies a CAR(s), the registrant firm must complete a CAP for each CAR. The purpose of a CAP is to provide guidance in addressing, rectifying, and preventing future deficiencies. This involves outlining specific steps the registrant firm intends to take to resolve each minor non-conformance (or major non-conformance if directed by the APRC). CAPs provide the registrant firm with an opportunity to determine how it can improve its practice and ensure the minor non-conformance(s) are not repeated.

The concept of corrective action planning extends beyond completing a CAP. It requires critical thinking on the part of the registrant firm. The steps for successful corrective action planning are outlined in Figure 2 and described in more detail below. While completing all these steps is not mandatory, it is highly recommended that registrant firms spend the necessary time to identify the root cause of each non-conformance and develop a comprehensive plan that works for their firm's size, structure, and industry(ies) of practice.

The Plan-Do-Check-Act (PDCA) cycle is a well-known iterative method used for continuous improvement and problem-solving in various industries. Both the PDCA cycle and the steps "Assess, Identify, Plan, Take Action, and Check" emphasize a systematic approach to problem-solving and continuous improvement. They start with assessing the current situation and identifying problems (Plan/Assess and Identify), followed by developing a detailed action plan (Plan). The next step involves implementing the plan (Do/Take Action), and then reviewing and analyzing the results (Check). Finally, based on the analysis, necessary adjustments are made to standardize successful changes or to start the cycle again if needed (Act). This structured methodology ensures that actions are planned, executed, evaluated, and refined based on feedback and results, promoting ongoing improvement.

Figure 2: Corrective Action Planning Steps

STEP 1: ASSESS

Once the receipt of the first email is acknowledged, a second email will be sent to the Primary Responsible Registrant, including a summary of the CAR(s) and a link to access the CAP module for completion by the registrant firm. The Primary Responsible Registrant should share the Report with other Responsible Registrants, the Responsible Officer, and key team members.

After all relevant parties have reviewed the Report, the registrant firm should begin collecting pertinent details, such as contributing factors and circumstances related to the minor non-conformance. It is advisable for the registrant firm to thoroughly review the information in each CAR and, if needed, seek clarification or additional guidance from the auditor.

Next, the registrant firm should assess each CAR to determine the root cause of the non-conformance. This involves analyzing the contributing factors and circumstances and identifying any systemic issues that may have led to the non-conformance. The assessment should be thorough and documented, ensuring that all relevant details are captured to facilitate effective corrective actions.

STEP 2: IDENTIFY

In this stage, the root cause(s) of each non-conformance must be identified. Without knowing the root cause of a problem, the registrant firm will not be able to effectively solve the problem and prevent it from occurring again. One of the most reliable approaches for identifying the root cause of a problem is known as the Root Cause Analysis (RCA) approach. RCA is a systematic process designed to identify and prevent the recurrence of problems or non-conformances. A registrant firm can use RCA to address any underlying inefficiencies and take the necessary steps to address them to prevent future recurrence.

RCA methods include the Failure Mode and Effects Analysis (FMEA), which identifies and prioritizes potential failures in complex processes, and the PROACT® RCA Method, which involves a detailed investigation for chronic issues. An Affinity Diagram organizes data into natural groups, while Fault Tree Analysis (FTA) maps out causal chains to identify root causes, especially in high-risk industries. Simplified methods such as the Ishikawa Fishbone Diagram categorize potential causes, while the Pareto Chart identifies and prioritizes significant factors, and the 5 Whys method uncovers root causes. Additional examples of the 5 Whys method can be found in Appendix I.

Regardless of the method chosen, the primary objective is to determine the root cause of the non-conformance identified by the auditor.

Once the registrant firm has identified the root cause, it must be entered into the 'Root Cause' box in the CAP window within the registrant firm's audit portal. For detailed instructions, please refer to the Audit Portal User Guide available in the registrant firm's audit portal.

STEP 3: PLAN

After determining and documenting the root cause(s) of a non-conformance, the registrant firm is ready to create an action plan to resolve the issue and prevent its recurrence. An effective action plan should include:

1. Details on the steps to be completed.
2. Any changes to documents, methods, specifications, processes, etc.
3. A list of responsible personnel.
4. Required training (if applicable).
5. A list of proposed evidence to validate the effectiveness of the action plan. This must include a proposed sampling plan to ensure audit integrity. For example, stating "We will submit a project list to Engineers and Geoscientists BC of our next 10 projects and will request Engineers and Geoscientists BC to randomly select 3 projects for which we will provide the following items of evidence" is acceptable, whereas self-selected examples of evidence are not.
6. A statement on whether the non-conformances noted during the compliance audit will be corrected (i.e., the deficiencies in the project files noted during the compliance audit, known as "Correction," as opposed to "Corrective Action"). If so, supporting evidence must be included as part of the evidence noted in item 5 above. If not, a documented risk assessment must be included to justify a "leave-as-is" (aka "concession") condition for the non-conformance.
7. Completion date or timeline. To create an effective action plan, ensure that the above items (1-6) are included. Enter the complete plan into the 'Action Plan' box within the CAP window. Additionally, specify the intended completion date for implementing the action in the "Targeted CAP Completion Date" box within the same CAP window.

   A registrant firm's CAP can encompass both short-term actions—such as updating policies, procedures, or templates—and long-term actions like additional training, changing work processes, or developing new systems. Therefore, when submitting the targeted completion date as part of the CAP, it's crucial to consider the relative difficulty and duration required to implement the CAP.

Once the root cause, action plan, and targeted completion date are prepared, the registrant firm must submit the CAP for review and approval by the auditor.

STEP 4: TAKE ACTION

After a CAP is submitted for review, the auditor will review the root cause, action plan, and targeted completion date to determine if the information provided in the CAP and the intent of the action plan correctly address the non-conformance. The registrant firm will be informed of the auditor's decision by email. The auditor's decision will be one of the following:

- Acknowledged: This status indicates the auditor received the CAP and will soon be reviewed.
- Rejected: This status indicates that one or more elements of the CAP were not completed correctly. The registrant firm must resubmit its CAP. It is advisable for the registrant firm to contact the auditor to discuss its approach for the next submission.
- Accepted—Follow-up Required: This status indicates the auditor approved the root cause, action plan, and completion date. The registrant firm can now begin implementing its plan. Most CAPs will need to include evidence demonstrating that the action plan has been implemented. If additional evidence is required to confirm the CAP's effectiveness by the implementation date provided by the registrant firm, the auditor will estimate when this will be needed in the registrant firm's audit portal. The nature and volume of evidence required by the auditor will depend on the non-conformance(s) and the registrant firm's areas of practice.
- Accepted—Closed: This status indicates the auditor approved the root cause, action plan, and completion date. The registrant firm can provide evidence concurrently with the CAP. If this evidence is deemed acceptable and sufficient to demonstrate that the non-conformance has been rectified and is unlikely to reoccur, no further actions are required from the registrant firm. A CAP must be closed for the compliance audit file to be closed.
- Referred to APRC: This status indicates that the CAR is awaiting the APRC motion.
- Closed by APRC: This status indicates that the CAR was closed according to the APRC motion.

STEP 5: CHECK

In some cases, it may be necessary for the registrant firm and the auditor to check the effectiveness of the action plan. The auditor will only close a CAP when they are satisfied that the registrant firm has successfully addressed the non-conformance and that systems are in place to prevent recurrence.

Effectiveness checks may take one of two forms:

- For a simple corrective action stemming from a minor non-conformance, the auditor will close the compliance audit file upon completion of STEP 4 above.
- For a complex corrective action stemming from a minor non-conformance, the auditor will leave the CAP open until the registrant firm has successfully demonstrated completion of the corrective action(s). If the routine compliance audit is scheduled within one year based on the risk assessed from the initial compliance audit, effectiveness will be checked during the routine compliance audit. Otherwise, demonstrating completed corrective action would include submitting revised documents, policies, or procedures, or proof of completion of additional training and other evidence as noted in items 5 and 6 of STEP 3 above.
- For a Major Non-Conformance corrective action, the APRC will determine the decision regarding the compliance audit file as follows:

    1. Prescribe corrective action that the registrant firm must complete within a specified period, with option of follow-up audit to check compliance;
    2. Authorize a practice review;
    3. Provide information about the compliance audit to the Investigation Committee; or

4. Close the compliance audit file.

For any non-conformance, and regardless of the type of compliance audit, it is recommended that the registrant firm revisits its CAP(s) approximately two to six months after the CAP(s) was closed to confirm that its action plan has been effective. For a simple corrective action, such as completing additional training, the check would confirm if relevant parties completed the training. For a more complex corrective action, such as redesigning a process, the effectiveness check could include a documentation review to ensure the referenced standard (e.g., the Guide to the Standard for the Authentication of Documents) is being met. By verifying the effectiveness of its corrective actions and action plan, a registrant firm will take full advantage of the CAP process and encourage continuous process improvement, and thus, its practice.

NAVIGATING THE FIRM AUDIT PORTAL

The four areas that must be completed for each CAP in the registrant firm's audit portal correspond to STEPS 2 through 4 above and are detailed below. An example of the CAP window is shown in Figure 3.

Root Cause

- List the root cause(s) for the non-conformance. (Note: Several root causes may be identified for the same non-conformance.)
    - Optional: Describe the RCA method used to determine the root cause(s) (or upload it as a supporting document).

Generally, root causes fall into one of the following major categories:

- Lack of resources;
- Lack of training; or
- Lack of monitoring (e.g., checks/ inspections/ audits).

Although this is not an exhaustive list, a root cause is reached when the registrant firm cannot identify any other cause, or the cause is outside the registrant firm's control. For the purposes of submitting a CAP, the registrant firm must identify a root cause that it has control over. If a registrant firm's root cause does not fall into one of these major categories, further analysis may be required.

One of the most common reasons CAPs receive a "Rejected" status is the submitted Root Cause re-states the non-conformance, rather than identifying the actual root cause (as illustrated by the typical examples provided above).

Action Plan

The Primary Responsible Registrant should list:

- All planned action items (immediate or scheduled).
- All interim control measures taken to mitigate the risks and prevent recurrence while the other action items are being implemented.
- The time frame required to implement these actions.
- All parties responsible for the implementation of the action items.
- All parties responsible for the verification of the effectiveness of the action items.

Implementation Date

The Primary Responsible Registrant should list the date of the action that will take the longest to implement by:

- Prioritizing all action items based on their risk level, focusing on critical tasks.
- Determining the scope of the change for each action item.
- Determining the resources required to implement each action item.
- Using professional judgment to set a deadline to complete each action item.

After setting the implementation date, the Primary Responsible Registrant should:

- Ensure all responsible parties are clear about the deadlines and the consequences of missing them.
- Ensure the rationale for the extension is documented if an extension is needed.

Supporting Documents

The Primary Responsible Registrant should upload any supporting documents that assist in justifying the registrant firm's root cause, action plan, or implementation date. Examples of supporting documents include:

- The action plan completed as per STEP 4 above;
- RCA method;
- Risk assessments;
- Documents that were revised to satisfy the action plan;
- Evidence of implementation completed as per STEP 3 (items 5 and 6); and
- Evidence of effectiveness (e.g., internal audits, internal metrics, outstanding long-term items).

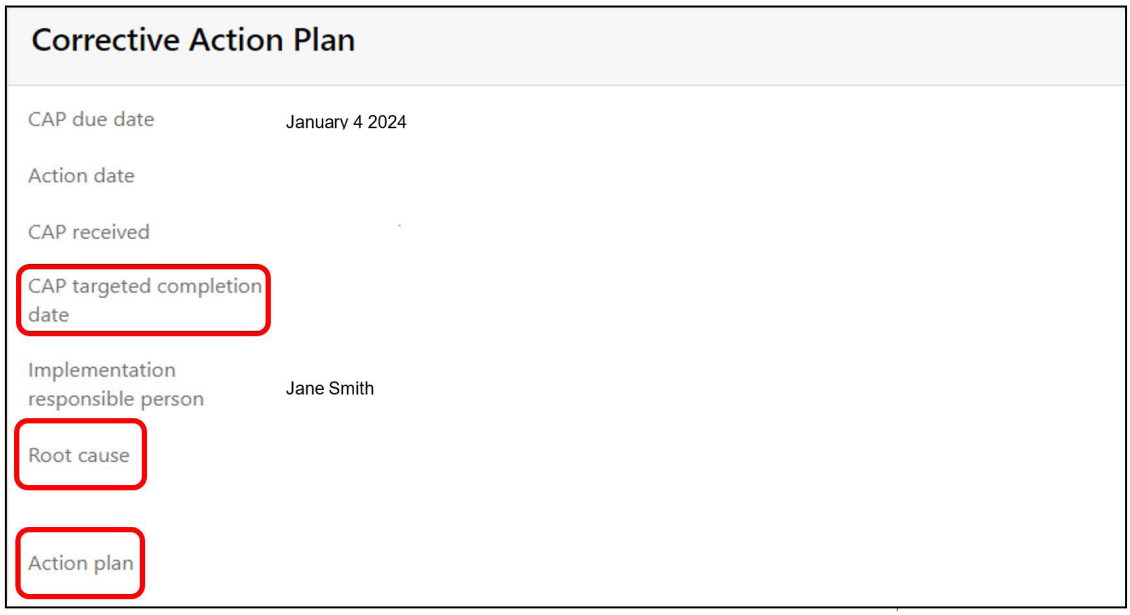

Figure 3: Sample CAP window displayed in the Firm's Audit Portal

APPENDIX I

ROOT CAUSE ANALYSIS (RCA)

When considering Root Cause Analysis (RCA), a registrant should thoroughly examine the issue and the evidence provided by the auditor, focusing on why the non-conformance occurred rather than on who was responsible. The emphasis should be on improving processes, not on individual oversights or failures.

A common tool for RCA is called the 5 Whys method. A registrant first defines the problem by describing the non-conformance, using the CAR provided by the auditor and questioning why that non-conformance occurred. Once the initial reasoning for the non-conformance is identified, a registrant should continue asking why, repeating the question until the root cause of the problem is identified. Although it may take more than five why questions to understand the root cause of the non-conformance, "five" it is typically the minimum number needed.

5 Whys method of RCA:

1. Define the problem: Clearly describe the non-conformance.
    - Example: "The product failed the quality test."
2. Ask the First Why: Why did the product fail the quality test?
    - Example: "Because the material used was substandard."
3. Ask the Second Why: Why was the material substandard?
    - Example: "Because the supplier provided a lower grade material."
4. Ask the Third Why: Why did the supplier provide a lower grade material?
    - Example: "Because the purchasing department ordered the wrong material."
5. Ask the Fourth Why: Why did the purchasing department order the wrong material?
    - Example: "Because the specifications were not clearly communicated."
6. Ask the Fifth Why: Why were the specifications not clearly communicated?
    - Example: "Because there was no standardized process for communicating specifications."

Figure 4 below illustrates a template for implementing the 5 Whys method in RCA.

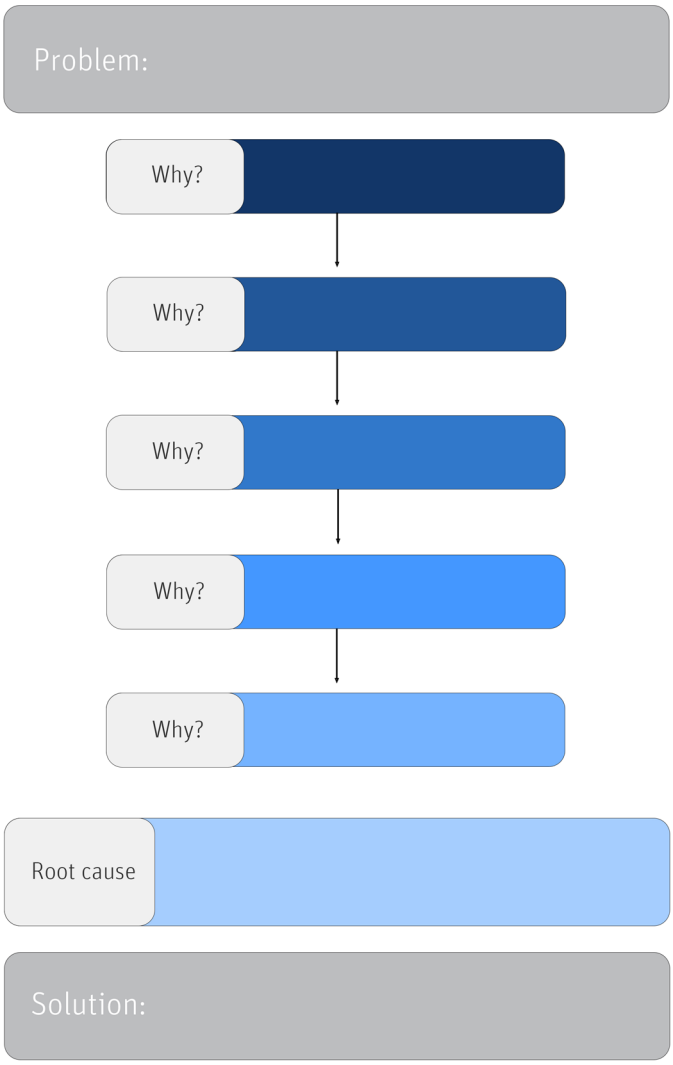

Figure 4: 5 Whys method template

Although employing the 5 Whys method is not mandatory for registrant firms, it has proven effective in identifying and eliminating errors before they escalate into major systemic issues.

EXAMPLES OF CORRECTIVE ACTION PLANS USING THE 5 WHYS METHOD

The following examples are provided for informational purposes only and should not be used as templates by registrant firms for their own Corrective Action Plans (CAPs). These examples address minor non-conformances.

EXAMPLE 1

Issue: A professional registrant deviated from the document retention policy stated in the registrant firm's Professional Practice Management Plan (PPMP) by retaining documents for only five years instead of the required 10 years as per Bylaw 7.3.2 Standard for Retention and Preservation of Complete Project Documentation.

RCA – 5 Whys method

1. Why were documents retained for only five years instead of 10 years?
    - Because the registrant was not aware of the 10-year retention requirement.
2. Why was the registrant not aware of the 10-year retention requirement?
    - Because the registrant firm did not provide adequate training on the document retention policy.
3. Why did the registrant firm not provide adequate training on the document retention policy?
    - Because there was no formal training program in place for the PPMP.
4. Why was there no formal training program in place for the PPMP?
    - Because the registrant firm did not prioritize the development of a comprehensive training program.
5. Why did the registrant firm not prioritize the development of a comprehensive training program?
    - Because there was a lack of dedicated resources for training and compliance.

Root Cause:

- The registrant firm did not prioritize the development of a comprehensive training program for the PPMP, leading to a lack of awareness about the document retention requirements.

Action Plan:

- Develop Training Program: Create a comprehensive training program for the PPMP, including the document retention policy.
- Conduct Training: Provide mandatory training sessions for all registrants on the document retention policy and Bylaw 7.3.2.
- Review and Update the PPMP: Review and update the PPMP to ensure it clearly outlines the document retention requirements.
- Implement Monitoring Process: Establish a monitoring process to ensure compliance with the document retention policy.
- Audit and Reporting: Conduct regular assessments or internal audits to verify adherence to the document retention policy and report any deviations.

Responsibilities – Timeline:

- Develop Training Program: Complete within 30 days.
- Conduct Training: Complete within 45 days.
- Review and Update the PPMP: Complete within 60 days.
- Implement Monitoring Process: Ongoing, with initial implementation within 75 days.
- Audit and Reporting: Conduct initial audit within 90 days and then on a regular basis.

CAP Target Completion Date:

- Enter the target date for the action item that will take the longest to implement. For example, if the CAP is approved on January 1, 2024, the target implementation date would be April 1, 2024.

Effectiveness Check:

- Conduct periodic assessments or internal audits on to verify the effectiveness of the implemented corrective actions, attaching appropriate supporting evidence to the assessment. Address any identified deviations promptly and take additional measures if required.

EXAMPLE 2

Issue: The registrant firm did not implement a Code of Conduct consistent with Engineers and Geoscientists BC's Code of Ethics, as per Bylaw 7.7.3 Professional Practice Management Plan.

RCA – 5 Whys method

1. Why was the Code of Conduct not completed?
    - Because the registrant firm did not prioritize the development of the Code of Conduct.
2. Why did the registrant firm not prioritize the development of the Code of Conduct?
    - Because there was a lack of awareness about the importance of aligning with Engineers and Geoscientists BC's Code of Ethics.
3. Why was there a lack of awareness about the importance of aligning with Engineers and Geoscientists BC's Code of Ethics?
    - Because the registrant firm's leadership did not receive adequate training on Engineers and Geoscientists BC's requirements.
4. Why did the registrant firm's leadership not receive adequate training on Engineers and Geoscientists BC's requirements?
    - Because there was no established process for ongoing professional development related to regulatory compliance.
5. Why was there no established process for ongoing professional development related to regulatory compliance?
    - Because the registrant firm did not have a dedicated compliance officer to oversee and implement such processes.

Root Cause:

- The registrant firm did not have a dedicated compliance officer to oversee and implement ongoing professional development related to regulatory compliance.

Action Plan:

- Appoint Compliance Officer: Designate a compliance officer responsible for overseeing regulatory compliance and professional development.
- Training: Provide training for leadership and relevant staff on Engineers and Geoscientists BC's Code of Ethics and the importance of compliance.
- Develop Code of Conduct: Create a Code of Conduct that aligns with Engineers and Geoscientists BC's Code of Ethics.
- Review and Update Policies: Regularly review and update the Code of Conduct and related policies to ensure ongoing compliance.
- Monitor and Reporting: Implement a monitoring process to ensure adherence to the Code of Conduct and effectiveness of the corrective actions.

Responsibilities—Timeline:

- Appoint Compliance Officer: Within 15 days.
- Training: Complete training within 30 days.
- Develop Code of Conduct: Complete within 45 days.
- Review and Update Policies: Ongoing, with initial review within 60 days.
- Monitoring Process: Implement ongoing monitoring and reporting.
- Audit and Reporting: Conduct initial internal audit within 90 days and then on a regular basis.

CAP Target Completion Date:

- Enter the target date for the action item that will take the longest to implement. For example, if the CAP is approved on January 1, 2024, the target implementation date would be March 1, 2024.

Effectiveness Check:

- Conduct periodic assessments or internal audits to verify the effectiveness of the implemented corrective actions, attaching appropriate supporting evidence to the assessment. Address any identified deviations promptly and take additional measures if required.

EXAMPLE 3

Issue: There is no policy for the use of Engineers and Geoscientists BC's professional practice guidelines. Additionally, there is no procedure that requires registrants to document the applicable professional practice guidelines and practice advisories before commencing work on a project, as per Bylaw 7.3.1 Standard for Use of Professional Practice Guidelines.

RCA – 5 Whys method

1. Why is there no policy for the use of Engineers and Geoscientists BC's professional practice guidelines?
    - Because the registrant firm did not recognize the necessity of formalizing the use of these guidelines.
2. Why did the registrant firm not recognize the necessity of formalizing the use of these guidelines?
    - Because there was a lack of awareness about the regulatory requirements and best practices.
3. Why was there a lack of awareness about the regulatory requirements and best practices?
    - Because the registrant firm did not have a dedicated compliance training program.
4. Why did the registrant firm not have a dedicated compliance training program?
    - Because there was no designated individual responsible for regulatory compliance.
5. Why was there no designated individual responsible for regulatory compliance?
    - Because the registrant firm did not prioritize the establishment of an internal compliance role.

Root Cause:

- The registrant firm did not prioritize the establishment of an internal compliance role to oversee regulatory requirements and best practices.

Action Plan:

- Appoint Compliance Officer: Designate an internal compliance officer responsible for overseeing regulatory compliance and the implementation of Engineers and Geoscientists BC's professional practice guidelines.
- Develop Policy: Create a policy for the use of Engineers and Geoscientists BC's professional practice guidelines.
- Establish Procedure: Develop a procedure that requires registrants to document the applicable Engineers and Geoscientists BC's professional practice guidelines and practice advisories before commencing work on a project.
- Training: Provide training for all staff on the new policy and procedure to ensure understanding and compliance.
- Monitor and Reporting: Implement a monitoring process to ensure adherence to the new policy and procedure and to verify the effectiveness of the corrective actions.

Responsibilities—Timeline:

- Appoint Compliance Officer: Within 15 days.
- Develop Policy: Complete within 30 days.
- Establish Procedure: Complete within 45 days.

- Training: Complete within 60 days.
- Monitoring Process: Implement ongoing monitoring and reporting.
- Audit and Reporting: Conduct initial internal audit within 90 days and then on a regular basis.

CAP Target Completion Date:

- Enter the target date for the action item that will take the longest to implement. For example, if the CAP is approved on January 1, 2024, the target implementation date would be March 1, 2024.

Effectiveness Check:

- Conduct periodic assessments or internal audits to verify the effectiveness of the implemented corrective actions, attaching appropriate supporting evidence to the assessment. Address any identified deviations promptly and take additional measures if required.