Accreditation Education Research & Scientific Service Center

Management System Manual

Reviewed by: CEO, AERSSC

Approved by: Conformity Assessment Accreditation Board of AERSSC

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Revision Records

S. No.	Page No.	Section No.	Issue no.	Issue Date	Revision Detail
1			02	13/03/2022	To cover new amendments in ILAC/APAC document.
2	19	3.7	03	13/04/2022	Addition of feedback and corrective action procedure
3	21	4.5.1.1	04	25/04/2022	Every two years replaced by at least once a year
4	19	3.7	05	05/05/2022	Revision of Procedure for taking corrective Action
5	24	4.8.6	06	05/16/2022	Revision of the procedure
6	17	3.4.4	07	01/06/2022	Inclusion of Form no. F 24 a
7	19	3.7	07	01/06/2022	Addition of other sources in the list

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1. Procedure Manual for Document Control

1.1. Purpose

This document outlines the procedure for the drafting, formatting, classification, approval, control, publication, review and maintenance of all AERSSC documents classified as Quality Manual, Procedures Manual, Forms, Guidance Documents and to ensure that all the documents are reviewed and approved by authorized personal prior to issue and pertinent issues are available at place of use.

1.2. Scope

The procedure is applicable to all documents related to quality system in the organization including quality manual, Plan, policies and programs; Procedures, Work instructions and Formats for records in accordance with clause no 9.3 of ISO/IEC 17011:2017.

1.3. Responsibility

1.3.1 The CEO is responsible for establishing and maintaining procedures to control all document.

1.3.2 The CEO is responsible for distribution of the controlled copy of documents to all users and maintains a master list thereof, to ensure distribution of currently revised documents. The respective record holder is also responsible for filing of documents.

1.3.3 The CEO is responsible for periodically review/revise of the documents as and when necessary.

1.4. Controlled Documents

1.4.1 All documents issued by AERSSC for internal or external use shall be maintained by the AERSSC Secretariat and shall be controlled. The controlled AERSSC documents are listed in the AERSSC Documents Master List (F XX), which is maintained by the AERSSC Secretariat.

1.4.2 All copies of obsolete or superseded versions of documents shall immediately be destroyed /deleted by the holder / user. It is the users' responsibility to ensure that only current published documents are in use.

1.4.3 All AERSSC documents and forms shall follow a standardized format to ensure that they are legible and identifiable.

1.5. Document formatting

1.5.1 AERSSC Logo and Document Cover Page

The following requirements apply to all AERSSC policies and procedures, excluding forms and workplans:

The cover page of the document shall contain the title of the document, the year of the publication and the publication reference, which is the unique document number and version.

1.5.2 Each page of the document (excluding the cover page) shall contain a:

- Header: Contains the AERSSC logo, unique identification number and version of the form, the issue date, the authority that approved the form, the application date. Copyright of this text is held by AERSSC.
- Footer: Contains the page number, e.g. Page 1 of 2

1.5.3 Unique Identification and Version

For control purposes, all AERSSC documents shall have a reference number as follows: AERSSC XX

- Header: Contains the AERSSC logo, unique identification number and version and the date (month and year) of approval; and

- Footer: Contains the page number, e.g. Page 1 of 2
  Issue Number:
  Prepared by:
  Approved by:
  Issue and application date:
  The 2nd page of the document shall contain the "*CONTENTS*" of the document.

1.5.4 The following requirements apply to all AERSSC forms:

- The 1st page shall specify the title of the form and Form no F XX

1.6. Document Preparation and Approval Process

1.6.1 All documents are prepared as per need identified and requirement of management system. The documents shall be prepared by CEO followed by comments/suggestions from the concerned technical experts/users of the laboratories/assessors/members of the Accreditation Committee. All documents shall require approval of the Board prior to release.

1.6.2 The Master copy is the originally signed copy of documents maintained by issuing authority. Master copy comprises of originally signed below listed documents:

- Quality Manual;
- Plan, Policies, Programs
- Procedures;
- Formats;
- Work Instructions

1.6.3 Controlled Copy is copy of master copy which shall be prepared in number as mentioned in distribution list of manual.

1.6.4 Distribution copy of documents is collection of respective procedures, formats and works instruction.

1.6.5 International Standard/National Regulation/Acts/Guideline/Policy maintained in original or duplicate within the organization are classified as External documents.

1.6.6 The obsolete documents that are used as reference are listed and issuance of such documents are recorded in list of Obsolete Documents.

1.6.7 In case of preparation of the new, draft document shall be sent to the Secretariat, who shall allocate a unique number and ensure that the document is correctly formatted.

1.6.8 The Secretariat shall then circulate the document to the appropriate audience (i.e. Members of the Accreditation Committee)

1.6.9 The Secretariat shall proof-read the final draft and ensure that it does not contradict any other AERSSC publication, and that it contains all the correct references to other AERSSC/ILAC/IAF publications.

1.6.10 Once approved, the Secretariat shall add the version number, issue (approval) and application dates on the document, convert it to PDF and publish it on the AERSSC website, as required.

1.6.11 The Secretariat shall notify all concerned Members that the document has been published.

1.7. Revision OF AERSSC Documents

1.7.1 Documents may be changed on account of changes in standard/feedbacks received from internal or external sources in response to nonconformities or comments raised during internal audits and APAC evaluation etc. All amended documents shall require the approval by the Board.

1.7.2 The master copy of approved amendment and amended sheet, reflecting the Amendment made is maintained as record.

1.7.3 The AERSSC Secretariat, as appropriate, shall carry out a review of the applicable documents at least every five (5) years, or sooner if required.

1.7.4 The same commenting and approval process as in section 6 above shall apply for revised document.

1.7.5 The Secretariat shall change the version of the revised document to the next sequential number.

1.8. Distribution of Documents

1.8.1 CEO will be responsible for issue and control of all documents which will bear the signatures of the CEO.

1.8.2 All documents issued by AERSSC for internal and external use are to be controlled. The hierarchy of AERSSC documents is as follows:

- Quality Manual (AERSSC 01)
- Accreditation Procedure (AERSSC 02)
- Procedural Documents (AERSSC XX)
- Board Policies and Procedures (AERSSC XX)
- AERSSC Forms (F XX)
- Technical Requirements Documents (TR)

1.8.3 The Secretariat shall publish all current versions of approved AERSSC documents, except those specifically for internal use by the Secretariat, on the AERSSC website in pdf format, subject to confidentiality requirements.

1.8.4 International Standard/National Regulations/Acts/Guideline/Policy maintained within the organization are classified as External Documents.

1.8.5 Any changes required in document shall be identified and will be approved after reviewing by the Board. After every change within an issue, the issue number of documents shall be changed with the effective date. The change shall be incremented by 01. When the number of amendment reach 10, the next edition of the document shall be released.

1.8.6 Whenever amendments or new documents are issued, they will be made available to assessors/experts, accredited and applicant conformity assessment bodies through AERSSC website depending on the type of the document.

1.8.7 The amended documents shall be distributed to the controlled copy holders and concern holder shall return the invalid page to AERSSC Secretariat. The Secretariat may distribute current versions of editable forms or documents to members and/or evaluators on request.

1.9. Distribution lists

The AERSSC Secretariat is responsible for maintaining an up-to-date list member's contact details, which shall include: The member's name, delegation, organisation, email address and phone number.

1.10. Filing and Archiving

1.10.1 The AERSSC Secretariat shall maintain an organised electronic folder containing editable versions of each document. All AERSSC documents shall be appropriately filed in the following folder categories:

- Quality Manual;
- Procedures;
- Forms
- Guidance Documents;
- MRA Publications.

1.10.2 The AERSSC Secretariat shall also keep a suitably marked electronically file of "Obsolete Documents" containing all previous obsolete versions of documents, or record purposes, and to which only the Secretariat has access.

1.11. Control of AERSSC Documents

1.11.1 The Master List (F XX) of AERSSC Documents shall be prepared, updated and controlled by the AERSSC Secretariat.

1.11.2 The Documents Master List shall identify the following information for each AERSSC document:

1.11.2.1 Document number;
1.11.2.2 Title;
1.11.2.3 Issue no.;
1.11.2.4 Preparation by;
1.11.2.5 Date of approval;
1.11.2.6 Approved by.

1.12. References

AERSSC 01 Quality Manual

AERSSC 02 Accreditation Procedure

IAF/ILAC-A1 Multi-Lateral Mutual Recognition Arrangements: Requirements and Procedures for the Evaluation of a Regional Group

2. Procedure for Record Control

2.1 Purpose

The purpose of this document is to define the controls needed for the identification, storage, protection, retrieval, retention and disposition of AERSSC's records to control records generated and received as an evidence for verifying compliance to specified

activities, conforming to the requirements with the Standard and effective operation of Quality System.

2.2 Scope

This procedure is applicable in identification, collection. Indexing, filing, access, storage, maintenance and disposition of records generated within AERSSC in accordance with clause no. 9.4 of ISO/IEC 17011:2017.

2.3 Responsibility

2.3.1 The CEO/Quality Manager is responsible for maintaining various records related to Management System.

2.3.2 The CEO/Quality Managers/Concerned Technical Officer are responsible for maintaining Technical records related to the accreditation of laboratories.

2.4 Definition of Records

2.4.1 Records are those documents that provide objective evidence of executed activities or achieved results.

2.4.2 Records may be in a predetermined format as described in the AERSSC Document Control Procedure or in a free format, for example: e-mails, letters, presentations etc.

2.5. Procedure

2.5.1 Record Management Planning shall be done considering the various types of records that have been generated within AERSSC. Planning shall include the function, responsible for the short term storage and maintenance of the record for long term, minimum retention period and the indexing method utilized.

2.5.2 Records shall be maintained in compliance with system/process requirements in order to provide objective evidence of compliance to the process requirements.

2.5.3 All the records are kept legible, readily identifiable, stored with adequate protection against deterioration, damage or loss, protected and easily retrievable. While creating a file, the information requires shall include:

- Title of file;
- File number;
- Date created;
- Previous/subsequent/related files, if any

2.5.4 Master list of stored records shall be prepared and it shall be updated with every change of record status.

2.6 Storage of AERSSC Records

2.6.1 The AERSSC Secretariat shall be responsible for the proper identification, maintenance, access and disposal of the records according to the minimum requirements of this Procedure.

2.6.2 All AERSSC records shall be stored electronically on the AERSSC Secretariat's computer(s) and clearly identified and organised as described to allow for easy access and retrieval.

2.7 Confidentiality of Records

2.7.1 All oral and written information received relating to evaluations, re-evaluations, appeals and complaints (except that information which is already publicly accessible) shall be treated confidentially by all parties and persons concerned. This includes information relating to applicants and/or signatories to the Arrangement.

2.7.2 F-06 "Declaration of Impartiality and Confidentiality" forms shall be signed by all persons before given access to confidential information, and these forms shall be filed by the AERSSC Secretariat in the appropriate folders, and includes declarations from:

- All members and observers of an AERSSC Pre-Peer or Peer Evaluation Team;

Task Force group members reviewing final evaluation reports;

- All members and any observers of the MRA Council, MRA Committee, Executive committee
- any person involved in the internal audit of AERSSC,
- any person involved in the investigation of a complaint or appeal
- all applicants and signatories of the Arrangement who request or are given access to any report on pre-evaluation, evaluation and re-evaluation of other applicants or members;
- any other person that has access to confidential AERSSC information.

2.7.3 Confidential information shall only be disclosed to those persons authorized by the relevant AERSSC Board Member or Committee Chair, who have signed concerned AERSSC Declaration of Impartiality and Confidentiality form F XX.

2.8 Protection of Records

2.8.1 The AERSSC Secretariat shall file in electronic format all records, files or documents related to the work of AERSSC, its Board or Committees, evaluation and decision-making processes to prevent unintended damage and loss of information:

2.8.2 Access to records is restricted to AERSSC Secretariat personnel. AERSSC Board Member / Committee members and evaluators / trainee evaluators shall only have access to those records which are necessary for them to perform their duties and obligations to AERSSC.

2.8.3 All Accreditation Body records and information related to an evaluation or decision-making process, which are submitted to evaluation team members, MRA Council or Committee are held secured to ensure confidentially.

2.9 Retention and disposal of Records

2.9.1 The AERSSC Secretariat shall retain all other AERSSC records relevant to the AERSSC management system and MRA process, for a minimum period of 7 years, unless otherwise determined by the Chairman of AERSSC Board.

2.9.2 After the respective retention period, the AERSSC Secretariat shall destroy the records. Any hard copies of records shall be destroyed by shredding, whereas electronic records can be deleted or archived.

2.9.3 The Chairman of AERSSC Board shall decide whether files relating to evaluated AB's should be destroyed after their minimum retention period or retained for a longer period should it be necessary.

2.10 Types of Records

2.10.1 The AERSSC Secretariat shall as a minimum, maintains records related to:

- AERSSC peer evaluations of AB's;
- The selection, training, qualification and monitoring of AERSSC peer evaluators, including their approved scopes;
- Peer evaluator training and/or workshops, including any changes made to the peer evaluation criteria and to the availability of peer evaluators;
- Peer evaluators' participation in evaluations at the global level.
- Signed declarations of impartiality and confidentiality;
- Complaints and appeals AERSSC internal audits;
- AERSSC management reviews;
- Correspondence between the AERSSC Secretariat and ILAC/APAC
- Suspension, reduction or withdrawal of signatory members. including the subsequent actions by AERSSC and the consequences of suspension.
- Technical support, harmonization and education activities within the region through activities such as workshops, conferences, task groups, etc.;
- The promotion of the Arrangement with major stakeholders, including promotional materials;
- Technical Cooperation projects and activities undertaken to support continuing demonstration of equivalence within AERSSC and between Regional Groups;
- AERSSC Recognition Arrangements with IAF and ILAC;
- Peer evaluations of AERSSC by APAC/ ILAC; and
- A listing of all AERSSC Documents, including the respective issue and/or amendment status;

2.10.2 The following AERSSC Records shall be Retained Permanently

- AERSSC Articles of Incorporation and Memorandum of Understanding;
- Minutes and resolutions of the AERSSC Board.
- Reports and relevant records of AERSSC MRA peer evaluations;
- ILAC Recognition Arrangements with AERSSC;

2.11 Records

Records Register

2.12 Reference Documents

Reference to the following documents may also be required in order to correctly apply this document:

AERSSC - 01	Quality Manual
AERSSC - 02	Accreditation Procedure;
AERSSC- 03	Document Control Procedure;
IAF/ILAC-A1	Multi-Lateral Mutual Recognition Arrangements: Requirements and Procedures for the Evaluation of a Regional Group

3. Procedure for Control of Nonconformities and Corrective Actions

3.1 Purpose and Scope

This document outlines the procedure of identifying and managing nonconformities in order to ensure that root causes of nonconformities are thoroughly investigated and effectively resolved to eliminate their recurrence.

This procedure covers all nonconformities which have a bearing on the quality Management system and is applicable to the Management System of AERSSC in accordance with clause no 9.5 of ISO/IEC 17011:2017.

3.2 Responsibility

All personnel involved in the accreditation activity of AERSSC are responsible for the identification of nonconformities and implementation of corrective actions within their scope of operation.

The CEO will be responsible for closing nonconformities. Nonconformities raised during internal audits will be closed by the auditor who performed the audit.

3.3 Definitions

3.3.1 Non Conformity is the non-fulfillment of a requirement of ISO/IEC 17011 and AERSSC quality management system.

3.3.2 Improvement are actions taken to improve the effectiveness of AERSSC quality management system

3.3.3 Continual Improvement is the use of repeated activities to increase the ability to meet requirements.

3.3.4 Preventive action an initiative to remove the reason for a potential nonconformity or potentially undesirable situation.

3.4. Activity Description

3.4.1 Sources of Non Conformities

The Non Conformities may be identified through any of the following sources:

- Internal Audits;
- customer feedback system;
- NC due to unsatisfactory performance during operation;
- NC due to inadequate resources;
- Complaints from laboratories, AERSSC staff/Assessors/Committee member, etc
- APAC-MRA Evaluation

3.4.2 These non-conformities may be related to:

- Established policies and procedures;
- Accreditation Activities
- ISO/IEC 19011 and ILAC documents

3.4.3 Identification and Management of Non-Conformities

All interested parties are encouraged to look for identification of nonconformities since it is considered as the first step towards improvement.

3.4.4 Registration of Nonconformities

3.4.4.1 All nonconformities identified shall be documented in AERSSC F 24 a. Nonconformity, and corrective Action shall be referred to the CEO/Quality Manager who shall assign responsibility for handling the nonconformity and corrective action.

3.4.5 Correction of Identified Non Conformities

3.4.5.1 CEO takes immediate action to correct detected nonconformities. The CEO uses cause analysis to identify potential causes and corrective actions. Potential corrective actions are evaluated and these most likely to eliminate the problem and prevent its recurrence are implemented which may include revision of document.

3.4.5.2 The proposed corrective action will be implemented within 4 months.

3.4.5.3 The CEO will maintain records of corrective actions taken.

3.4.6 Implementation of Corrective Actions

3.4.6.1 Upon assignment of the responsibility for handling the nonconformity identified from routine work, the responsible person shall:

- Investigate the cause of nonconformity
- Scan the entire system to ensure that no similar nonconformity could occur
- Analyze the impact that the nonconformity may have had before it was discovered
- Take corrective actions appropriate to the impact, and that eliminates the causes of the nonconformity in order to prevent recurrence
- Identify any further opportunities for improvement required; and
- Conduct a thorough follow up to ensure the corrective action is effective and recurrence has been prevented.

3.4.6.2 Upon assignment of the responsibility for handling nonconformity (ies), the person responsible shall propose corrective action and improvements in consultation with the Quality Manager. The proposed corrective action shall be implemented within 4 months for internal audit findings, and within 1 month for nonconformities identified from customer feedback or other sources. Once implemented, the responsible person shall advise the CEO/Quality Manager accordingly.

3.4.6.3 Records of all investigations and corrective action(s) taken shall be recorded by the CEO/ Quality Manager.

3.4.7 Verifying Implementation and Effectiveness of Corrective Action

3.4.7.1 Results will be monitored to ensure the effectiveness of such actions by CEO. If initiated corrective actions are found to be adequate to prevent occurrence or recurrence of non-conformance then such action shall be continued. Otherwise other corrective action shall be proposed and approached.

3.4.7.2 A follow up audit will be carried out by an auditor to verify the effectiveness of corrective actions implemented to address nonconformities raised during internal audits. Auditors close out nonconformities raised during internal audits once corrective action has been implemented.

3.4.7.3 The CEO/Quality manager will report on nonconformities, and status of corrective actions taken and its effectiveness shall be discussed at the management review meeting.

3.4.7.4 The CEO/ Quality Manager shall review all corrective actions implemented, for effectiveness, verify and close out the nonconformity raised during routine work.

3.5. Opportunity for improvement

AERSSC staff members hold regular meetings (management, technical and operational) which provide forum where possible areas in which nonconformities can occur are identified. When such areas are identified, measures are taken to prevent recurrence of the nonconformity. The system described in this procedure provides a platform for the implementation of corrective actions that prevent recurrence of nonconformities.

3.6. Continual improvement

Potential non-conformities, including identified from previous NCs and risk & opportunities shall be discussed and determined. If necessary, appropriate actions shall be implemented in order to prevent the occurrence of potential non-conformities. Continual improvement in AERSSC is achieved through internal audit, management reviews, customer feedback, and corrective action on nonconformities, training and monitoring of assessors.

3.7 Feedback & Corrective Action Procedure

As a part of quality improvement, AERSSC shall take necessary corrective action on feedback obtained from several sources on the effectiveness of the accreditation program or whenever any discrepancy is detected. The corrective action shall be taken on feedback from any of the sources as listed below:

- Accredited CABs
- Assessors
- Members of the Appeals Committee and Technical Committee
- Users of the accredited CABs
- Members of AERSSC Board
- Staff of AERSSC
- Internal Audit/Self - Assessment
- Reports of external assessment (e.g. APAC)
- Complaints and Appeals
- Other sources (F 43)

Procedure for taking Corrective Action

CA/PA will be taken in each case as per the requirements then and there itself e.g finding during external evaluation by APAC Team.

Similarly actions will be taken collectively for internal audits and other findings.

References

Quality Manual Clause no 9.5

Procedure for Internal Audit

Procedure for Management Review

3.8 Records

3.8.1 Record register

4. Procedure for the Internal Audit

4.1 Purpose

This procedure describes the AERSSC shall follow in executing internal audits of its Management System, which also includes the Mutual Recognition Arrangement (MRA) management process in order to verify that Management System of AERSSC has been effectively implemented and maintained as per relevant clauses of ISO/IEC 17011:2017, ILAC P8:03/2019, ILAC P9:06/2014, ILAC P10:07/2020 and ILAC G8:09/2019.

4.2 Scope

Applicable to the established quality system of AERSSC as per clause no. 9.7 of ISO/IEC 17011:2017 as follows:

4.2.1 The internal audit shall cover activities of the AERSSC Board, Committee and MRA Council, the APAC/ILAC Secretariat and the AERSSC Management System.

4.2.2 The scope will be determined by the CEO/Quality Manager in consultation with the Board.

4.3 Responsibility

The CEO/Quality Manager is responsible for the planning and execution of internal audits.

4.4. Internal Audit Teams

The Internal Audit shall be conducted by a team leader and if necessary, team members selected on the basis of competence, independence and objectivity taking into account the functions/areas to be audited.

4.4.1 Qualifications of Internal Audit Team Leaders and Members

4.4.1.1 - Knowledge of the requirements of ISO/IEC 17011;
- Knowledge of the requirements of the ILAC A series and mandatory documents; and
- Experience in accreditation.

4.4.1.2 An internal audit team leader or team member should preferably be a qualified peer evaluator that has participated in a peer evaluation of an accreditation body.

4.4.2 Selection of Internal Audit Teams

4.4.2.1 The team leader of each internal audit shall be selected by the CEO/Quality Manager in consultation with the Chairman of the Board.

4.4.2.2 One or more team members (if necessary) shall be selected by the CEO/Quality Manager in collaboration with the team leader.

4.4.2.3 The team leader and team member(s) shall not evaluate the activities for which he/she is responsible for implementing in AERSSC.

4.5 Implementation of the Internal Audit

4.5.1 Frequency of Internal Audits

4.5.1.1 The internal audit shall be conducted at appropriate intervals determined upon review of the latest audit results by the AERSSC Chair in consultation with the CEO. As a minimum, AERSSC shall conduct Internal Audit at least once a year.

4.5.2 Preparation of Internal Audits

4.5.2.1 The team leader shall determine the dates of the internal audit in consultation with the team member(s) where applicable, and with the agreement of those being audited.

4.5.2.2 The team leader shall ensure that copies of the current AERSSC documentation and other related documentation are available to the team member(s), if any, at least one month before the commencement of the audit.

4.5.2.3 The team leader shall prepare a detailed internal audit plan in consultation with the audit team members, if any.

4.5.2.4 The team leader shall send the audit plan to the AERSSC Secretariat at least two weeks before the internal audit.

4.5.2.5 The internal audit plan shall contain the following as minimum requirements:

4.5.2.5.1 The objective of the audit;

4.5.2.5.2 The scope of the audit;

4.5.2.5.3 The date(s) of the audit;

4.5.2.5.4 Whether the audit will be conducted at the AERSSC offices, or by electronic means;

4.5.2.5.5 The names of the team leader and team member(s) (where applicable);

4.5.2.5.6 The requirements and documents to be considered; and

4.5.2.5.7 Where applicable, identification of AERSSC personnel that will be required for particular audit activities.

4.6. Procedure

4.6.1 Internal Auditors shall be selected (based on past internal QMS audit experience or newly trained personnel who have successfully passed the Internal Audit training) by the Board.

4.6.2 The CEO holds the responsibility to notify auditor/s regarding details of the audit schedule one week prior to the date of the audit. Depending on the effectiveness of the management system and the status of noncompliance revealed in the audit, the CEO will plan for additional audit/s.

In addition, unscheduled audit may be initiated by CEO when serious problems occur in the operation of Management system.

4.6.3 The internal audit will be scheduled at a minimum of once per year for each area/activity, as defined in the quality system.

4.6.4 Findings of the audit will be classified as either:

- Non-conformity
- Concern
- Comment

4.6.5 The auditor appointed by the Board will normally be a trained and qualified of auditing techniques, accreditation activities and requirements of ISO/IEC 17011:2017.

4.6.6 While constituting the auditors for the conduct of audits, it will be ensured by the CEO that auditors are in no way involved in the activities being audited.

4.6.7 The CEO will establish an audit plan which includes the audit scope, the audit criteria, the audit schedule reference documents (such as quality manual and audit procedure) audit team members and dates of audit.

4.6.8 The audit plan may include both horizontal audits and vertical audits so that every aspect/clause of the quality system, including the work of concerned officer, is audited.

4.6.9 Each auditor may be assigned specific quality elements or activity. Such assignments are made by the CEO in consultations with the auditors concerned.

4.7 Audit Preparation

4.7.1 An audit time table is required to be developed by each auditor in conjunction with their audited to ensure the smooth and systematic progress of the audit.

4.7.2 Prior to the actual audit a review of documents, manuals, preparation of checklist is required to be made by the audit team member(s) to finalize an overall action plan for the conduct of the Audit.

4.8 Procedure for Conduct of Internal Audit

4.8.1 Internal audit will be conducted with an opening meeting to confirm the audit scope and procedure and to clarify any relevant details including the time, date and attendees for the closing meeting.

4.8.2 An internal audit includes investigation and analysis. The investigation process for gathering objective evidence, involves asking questions, observing activities and examining records for verifying the conformity of the activities with the quality system.

4.8.3 Auditor will record his/her findings in "Internal Audit Observation Sheet" (F 41) and nonconformity in "Nonconformity and Corrective Action Request Form" (F 42) where applicable.

4.8.4 After all activities audited, the audit team will carefully review and analyze all their findings as non-conformances or as comments or as recommendations for improvement.

4.8.5 Prior to preparing the audit report the closing meeting with those responsible for the sections audited will be organized by the audit team to discuss the findings and the period required for the implementation of any corrective actions.

4.8.6 The audit team will prepare a clear and concise report supported by objective evidence of non-conformances and request Accreditation Body to submit corrective actions for improvement within the allocated time period for their completion.

4.9. Execution of Internal Audits

4.9.1 The team leader shall verify effective implementation of AERSSC Policies and Procedures and related standards/requirements by auditing relevant records, reports, documentation, meeting resolutions, and/or minutes, and by interviewing the Secretariat and any other AERSSC personnel, as needed.

4.9.2 The audit shall be conducted during a meeting with the AERSSC Secretariat or by electronic means.

4.9.3 If an electronic audit is conducted, the team leader may consult by email or telephone, as appropriate.

4.9.4 AERSSC may reimburse the employer of the team leader and each team member (if any) for the travel and incidental expenses incurred in executing the internal audit, as agreed in advance.

4.10 Internal Audit Reports

4.10.1 The team leader shall prepare a written draft summary on the audit, findings and observations using AERSSC F 23.

4.10.2 Findings of the audit shall be classified as either a:

4.10.2.1 Non-conformity: Where AERSSC does not meet a requirement of an applicable standard(s), its own management system or an AERSSC or applicable ILAC/IAF requirement;

4.10.2.2 Comment: Where AERSSC documents or practices have a potential for improvement, but still fulfills the requirements.

4.10.2.3 Findings shall be clearly recorded on AERSSC F 23, making reference to the specific clause of the relevant document and/or standard.

4.10.2.4 A verbal report, where appropriate, and a copy of the draft audit report and findings shall be given to the AERSSC Secretariat at the closing meeting at the end of the internal audit.

4.10.2.5 The team leader shall give the AERSSC Secretariat an opportunity to comment on and discuss the findings and clear up any misunderstandings.

4.10.2.6 The draft audit report shall be signed by the team leader and team member(s) (if any) and the AERSSC Secretariat.

4.10.2.7 After the audit, the team leader shall complete the internal audit report and forward it to the AERSSC Secretariat within 30 days.

4.10.2.8 The AERSSC Secretariat in consultation with the Chair of other Committees (where appropriate) shall review the report and prepare a proposed corrective action plan and time-schedule for implementation for all non-conformances.

4.10.2.9 The AERSSC Secretariat shall provide a response to each finding identified as a comment.

4.10.2.10 The AERSSC Secretariat shall submit the report and the proposed corrective action plan to the Chair, Committee for their review, and to the internal audit team leader within 30 days.

4.10.2.11 The team leader, in consultation with the team member(s), if any, shall provide a response as to the acceptability of the proposed corrective action plan within 30 days.

4.10.2.12 The AERSSC Secretariat, in consultation with the other Committees (as appropriate), shall address each non-conformity by:

4.10.2.12.1 Investigating the root cause of the non-conformance; and

4.10.2.12.2 Take the corrective action(s) needed appropriate to the impact, and that eliminates the causes of the nonconformance in order to prevent recurrence.

4.10.2.12.3 The Secretariat shall provide the team leader with the corrective actions taken, and evidence of effective implementation within the timelines as agreed upon.

Where timelines cannot be met, the Secretariat shall provide the AERSSC Chair, with justification, and a revised time-schedule for implementation of any specific corrective action.

4.10.2.12.4 The audit team leader or team member, as appropriate, shall review the corrective action and evidence of implementation in order to verify whether the corrective action taken.

4.11 Follow up Actions

4.11.1 The CEO will take any necessary corrective action for the activity audited within a specified time frame.

4.11.2 The AERSSC Chair in consultation with the CEO/Quality Manager shall monitor the effective implementation of the corrective actions.

4.11.3 The Secretariat shall report on the status of the corrective actions to the AERSSC Chair s during their next scheduled meeting, and until such time that all non-conformances raised have been verified by the auditor(s) as appropriately addressed.

4.11.4 Any nonconformities shall be followed-up for verification of effective implementation of corrective actions, by the next appointed audit team at the next scheduled internal audit.

4.11.5 The CEO may arrange for additional internal quality audits to verify the implementation of corrective action at appropriate time.

4.11.6 The CEO will maintain complete record of the audit (even if no non-conformance exists) and corrective actions taken.

4.11.7 The audit report will be circulated to all to assess their impact on all related activities.

4.11.8 Results of an internal audit and status of NCs shall be discussed in management Review Meeting for continual improvement of the process and record of so with details of decisions and responsibilities shall be retained.

4.12. Related Documents and References

4.12.1 ISO/IEC 17011:2017

4.12.2 AERSSC documents (Quality Manual and other Procedure Manual)

4.12.3 Previous audit findings and actions taken effectively addressed the non-conformance.

4.13. Records

The CEO maintains following records:

- List of qualified auditors
- Original copy of Internal audit observation sheet and Nonconformity and corrective action Request Form
- Audit Summary Report.

4.14. References

4.14.1 The AERSSC Quality Manual, and any other associated MRA Policy and Procedures documents.

4.14.2 IAF/ILAC A1: IAF/ILAC Multilateral Mutual Recognition Arrangements: Requirements for Evaluation of a Regional Group.

4.14.3 IAF/ILAC A2: IAF/ILAC Multilateral Mutual Recognition Arrangements: Requirements for Evaluation of a Single Accreditation Body.

5. Procedure for Management Review

5.1. Purpose

This document describes the procedure to be followed by the AERSSC Secretariat for the review of the AERSSC management system to ensure its continuing adequacy and effectiveness in satisfying the relevant requirements, and the AERSSC policies and objective.

5.2. Scope

Applicable to the entire management system of AERSSC in accordance to clause no. 9.8 of ISO/IEC 17011:2017.

5.3. Management Review

5.3.1 The CEO/Quality Manager is responsible to carry out the Management Review (MR) on an annual basis.

5.3.2 The CEO/Quality Manager will review all matters (as in clause 2.5) since the previous Management Review

5.3.3 The MR meetings are for the:

5.3.3.1 Reporting and monitoring of Strategic issues affecting the performance of AERSSC;

5.3.3.2 Improvement of the management system processes through the review of the adequacy and effective implementation of AERSSC policies and procedures;

5.3.3.3 Improvement of AERSSC's service and peer evaluation processes; and

5.3.3.4 Identification of the need for resources.

5.3.4 The AERSSC Chair will receive input from all the Committee Chairs, the Treasurer and other AERSSC Members as required.

5.3.5 The MR Agenda shall include the following matters:

5.3.5.1 Review of progress on previous AERSSC Board decision;

5.3.5.2 Review of previous MR reports to determine if any corrective actions and improvement actions are being effectively implemented;

5.3.5.3 Reports from the Chairs of the AERSSC Board;

5.3.5.4 Appeals and complaints;

5.3.5.5 Internal audit results and associated corrective actions;

5.3.5.6 Outcome of ILAC/IAF evaluations of AERSSC, when applicable;

5.3.5.7 Additional AERSSC documents to be revised or issued as deemed necessary by the AERSSC Chair, and/or the Chairs of each Accreditation; and

5.3.5.8 Changes in ILAC/IAF documents, when applicable

5.3.6 The expected outputs of the MR will include the following:

5.3.6.1 Improvement of the management system and its processes;

5.3.6.2 Improvement of the MRA processes and extensions of the MRA scope (where applicable);

5.3.6.3 Need for resources (where applicable); and

5.3.6.4 Defining or re-defining of policies, goals and objectives.

5.4. Procedure

5.4.1 Management Review Meetings will be conducted at least once a year after the internal audits.

5.4.2 The agenda for management review meetings will include:

- Minutes of the previous management review;
- The suitability of policies and procedure;
- The results of audits;
- Results of peer evaluation;
- Safeguarding impartiality;
- Trends in non-conformities;
- Status of Corrective actions;
- Feedback from interested Parties;
- New areas of accreditation;
- The status of actions to address risk and opportunities;
- Follow up actions from earlier management reviews;
- Fulfillment of objectives;
- Changes that could affect management systems;
- Analysis of appeals;
- Analysis of complaints;

- Participation in International activities, where relevant;

5.4.3 The management review is chaired by the Chairman/CEO and attended by the Quality Officer, Technical Officer and any other invitees as described in ISO/IEC 17011:2017.

5.4.4 The CEO will be responsible for preparation of agenda. The CEO/Quality Manager is responsible for the reporting the findings of the Internal Audit as well as preparation of minutes of the management review.

5.4.5 Approved minutes mentioning the summary of the Quality system review covering the decisions taken, responsibility for actions and target dates of implementation will be circulated.

The CEO is responsible for monitoring actions on the decisions of management to ensure the effectiveness of the decision.

5.5. Management Review Outcome & Distribution

5.5.1 The AERSSC Secretariat in consultation with the AERSSC Chair shall complete a detailed draft MR Report to document the matters that were discussed during the meeting.

5.5.2 The AERSSC Secretariat shall distribute the draft report to all concerned prior to the next MR meeting.

5.5.3 The Members shall have the opportunity to submit comments on the draft MR Report which shall be discussed during the MR meeting, or via email.

5.6. Approval & Records

5.6.1 The MR Report shall be approved by the AERSSC Board.

5.6.2 After approval by the Board, the AERSSC Secretariat shall distribute the final MR Report to all concerned and file it accordingly.

5.6.3 The AERSSC Secretariat shall submit a copy of the MR Report to the next Board meeting for ratification of any action items contained in the report via email ballot.

5.6.4 If required, the Board may request the Advisory Committee to carry out additional actions resulting from the MR.

5.7. Responsibility

The Chairman/CEO, AERSSC is responsible for review of management system as described in ISO/IEC 17011:2017. CEO is responsible for organizing these review meetings and keeping the record.

5.8. References

Quality Manual clause no. 9.8

Quality Manual clause no. 9.2.3

Procedure for Internal Audit

Procedure for Control of Non-Conformities and Corrective Action

Procedure for Preventive Action

5.9. Records

5.9.1 Agenda and Minutes of Main Review Meetings and any other summary/analysis report for presentation at the Management Review Meetings.

5.9.2 Various Forms submitted by Auditor.

Forms

	Accreditation Education Research And Scientific Service Center	F 23
	INTERNAL AUDIT PLAN	

AUDIT

Standard(s)/Internal Document/Regulation(s):	**Kind of Audit / Assessment:**	
ISO 17011:2017 ILAC P9:06/2014 ILAC P8:03/2019 ILAC G8:09/2019 ILAC P10:07/2020		
Audit objective:	**Start:**	**End:**
Evaluation of compliance to ISO 17011:2017		

Time **From to**	**Standard Section**		**Topic for Auditor**	**Auditor**	**Auditte**
	ISO 17011:2017				
Date: ----------					

9 9.:00	9:30		Opening Meeting • Introduction of audit participants and their roles • Discussion of audit agenda		
9.30	10:00	4.4.3, 4.4.8, 4.4.12 5.6, 5.7, 9.1.3	Top Management: Impartiality requirements, Structural requirements Management system requirements		CEO, AERSSC
10:00	11:00	4.1, 4.2, 4.3, 4.4, 4.5, 4.6	General requirements: Accreditation agreement, Use of accreditation symbols and other claims of accreditation, Impartiality requirements, Financing and liability, Establishing accreditation schemes		CEO, AERSSC
1 11:00	1:00	5	Structural requirements		CEO, AERSSC
		6	Resource requirements: Competence of personnel, Personnel involved in the accreditation process, Personnel records, Outsourcing		CEO, AERSSC
1 1:00	2:00		LUNCH		
1 2:00	3:00	7.1 to 7.14	Process Requirement: Accreditation requirements, Application for accreditation, Resource review, Preparation for assessment, Review of documented information, Assessment, Accreditation decision-making, Accreditation information, Accreditation cycle, Extending accreditation, Suspending, withdrawing or reducing accreditation, Complaints, Appeals, Records on conformity assessment bodies		CEO, AERSSC
3:00	4:00	8.1, 8.2	Information requirements: Confidential information, Publicly available information,		CEO, AERSSC
		9.1 to 9.8	Management system requirements: General, Management system, Document control, Records control, Nonconformities and corrective actions, Improvement, Internal audits, Management reviews,		CEO, AERSSC
4:00	5:00		Closing Meeting		

Summary Report of 1st Internal Audit of AERSSC Management System

Dates of Audit	
Auditor & Affiliation	
Auditees	
Period of audit of Records	
Compliance to Documents	
Scope of Audit	
Summary of Audit findings	
Conclusion	
Audit Schedule	
Audit Findings	

Area of Improvements	
Supporting records	

Audit Findings

S. No.	ISO/IEC 17011:2017 Clause No.	Findings	Classification
1		.	
2			
3			
4			
5			

6			
7			

Area of Improvements

S. No.	ISO/IEC 17011:2017 Clause Ref.	Findings
1		
2		
3		.
4		
5		
6		
7		

8		

------- E N D -------

Nonconformities, concern & comments and corrective action record register form

Date of Evaluation:

S.N	NC raised by the Evaluation Team	Corrective Action	Type of evidence	Comments by the Evaluation Team	Remarks
1					
2					
3					
4					
5					
6					
7					
8					
9					

	AERSSC	F 41

Internal Audit Observation Sheet

Audit Area: Audit No: Audit Date:

Auditor: Auditee:

Audit Criteria:

Clause No	Audit Finding	Status	Remarks

Auditor: Auditte:

Notes:

C: Compliance M: Major Non Compliance m: Minor Non Compliance

AFI: Area for Improvement

AUDITOR'S SUMMARY ON NON-CONFORMITY

Nonconformity and Corrective Action Request form

Accreditation Education Research and Scientific Service Center	
Date:	Activity Assessed:
NC No:	Reference to Observation No. in Audit Observation Sheet:
NON-CONFORMITY RAISED:	
Ref to ISO/ IEC 17011:2017 Clause No.	Type of NC: **MAJOR / MINOR**
Signature & Name of AERSSC's Representative	Signature & Name of Auditor
Auditor's comments on corrective action proposed by AERSSC Signature of Auditor	

REMARKS BY TEAM LEADER, IF ANY:

Signature & Name of Team Leader

Form 43

ACCREDITATION EDUCATION RESEARCH AND SCIENTIFIC SERVICE CENTER
Corrective action request Form from other sources

1. Request for Amendment

Document number	
Proposed Amendment (Number of the current text)	
Reason for Amendment	

II. Others

Any proposals for preventive Action/Corrective action/Improvement

Name/Signature of Proposing Officer/Staff/CAB	Quality Officer