

# COMPLIANCE AUDIT PROGRAM FOR INDIVIDUAL REGISTRANTS

## HOW TO COMPLETE YOUR CORRECTIVE ACTION PLAN

VERSION 1.0  
JULY 6, 2023



**ENGINEERS &  
GEOSCIENTISTS**  
BRITISH COLUMBIA

VERSION 1.0, JULY 6, 2023

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## INTRODUCTION AND PURPOSE

This *How to Complete Your Corrective Action Plan* resource can help you to address and resolve any non-conformances identified during the mandatory compliance audit conducted by Engineers and Geoscientists British Columbia (BC). This document is designed to offer a general framework for completing Corrective Action Plans (CAPs) and offer possible steps you can take to rectify any non-conformance identified during the mandatory compliance audit in an efficient and effective manner. This document includes a systematic approach to addressing non-compliances, and provides you with clear steps on rectifying any issues discovered during the compliance audit process.

This document includes instructions, best practices, examples, and recommendations to assist individual registrants through each phase of the corrective action process. Each section includes information and tools you can use to develop appropriate corrections.

Although this document is intended to be used as part of the Engineers and Geoscientists BC compliance audit process, registrants may also use this guide as a reference whenever a non-conformance is identified in your professional work.

This document is not intended to replace any existing policies, procedures, or regulatory requirements specific to your professional work or standards of practice specific to your industry of practice. It is designed to be a supplement that aims to provide individual registrants with clear guidance on corrective actions.

## CORRECTIVE ACTION REQUESTS

### WHAT IS A NON-CONFORMANCE?

During the compliance audit process, the assessor may encounter situations where the processes performed by individual registrants do not comply with a specific regulatory requirement; these are 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 individual registrant 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; and
- there are no reasonable nor probable risk of injury to the environment or to the health and safety of the public or a group of people.

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

- there is a systemic failure by the individual registrant undergoing a compliance audit to meet a specific regulatory requirement(s); and
- there are 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 shows a process flow chart for both types of Non-conformances.

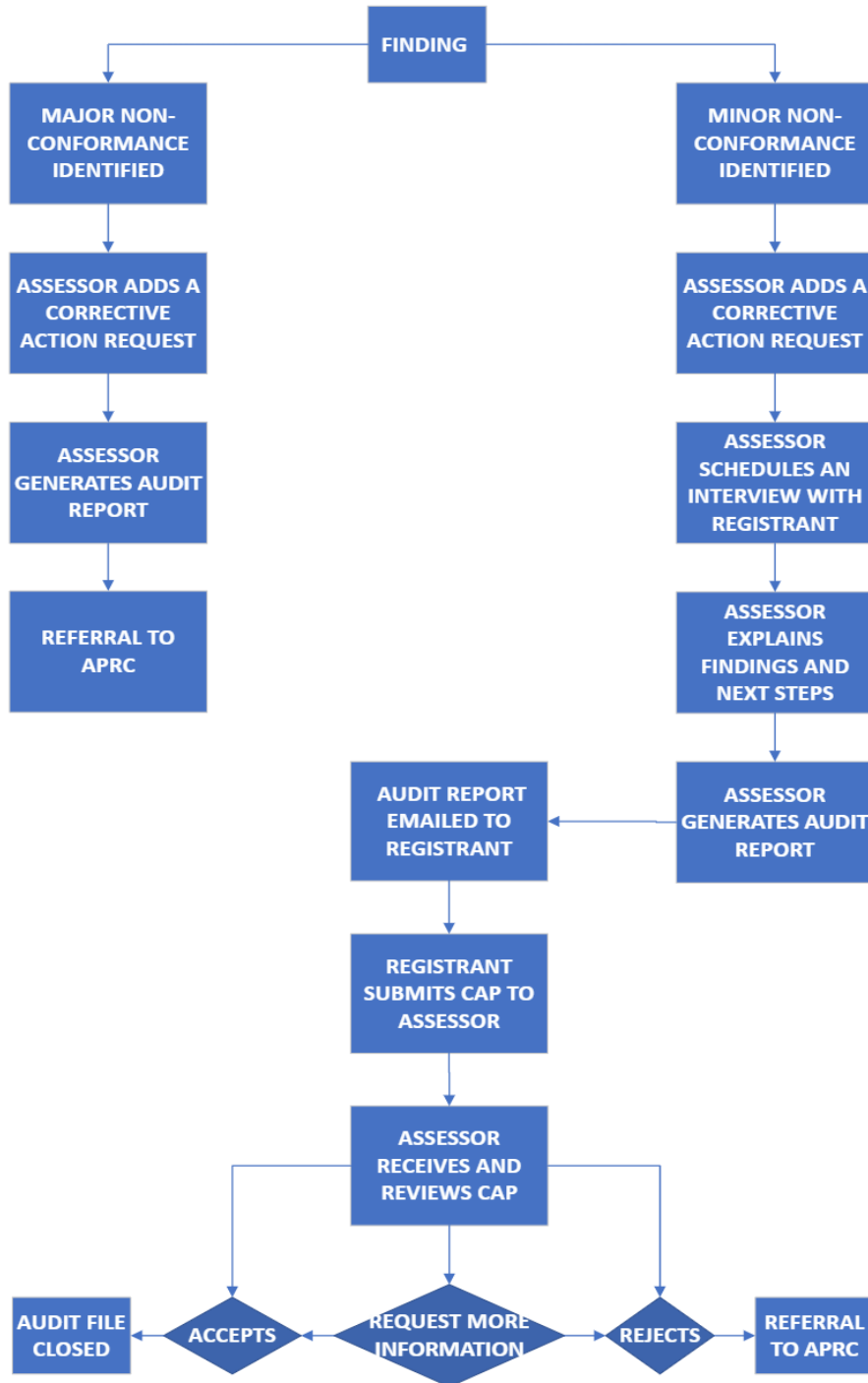


Figure 1: Process Flow Chart for Major and Minor Non-conformances

## WHAT IS A CORRECTIVE ACTION REQUEST?

When an assessor believes they have identified a Minor Non-conformance in the registrant's practice, the assessor will gather sufficient evidence to support their conclusion. The identified Minor Non-conformance and evidence will be presented to the registrant through a Corrective Action Request (CAR), which will include all the relevant information about the Minor Non-conformance, including findings, objective evidence, and the requirement.

Each CAR requires the Registrant to complete a Corrective Action Plan (CAP). If a CAR is prepared for your audit, you will be notified by email. The email will include a link to the audit portal, where you can review the CAR and complete the CAP.

## COMPLETING A CORRECTIVE ACTION PLAN

Once you receive one or more CARs from you Assessor, you will be required to complete a Corrective Action Plan (CAP) for each CAR. The purpose of a CAP is to help you address, correct, and prevent future deficiencies; you do this by describing all steps that you intend to take to address each Minor Non-conformance. CAPs help you determine how to improve your practice to ensure the Minor Non-conformance is adequately addressed.

The concept of corrective action planning is larger than just completing your CAP, however. The steps in successful corrective action planning are shown in Figure 2 and described in more detail below.

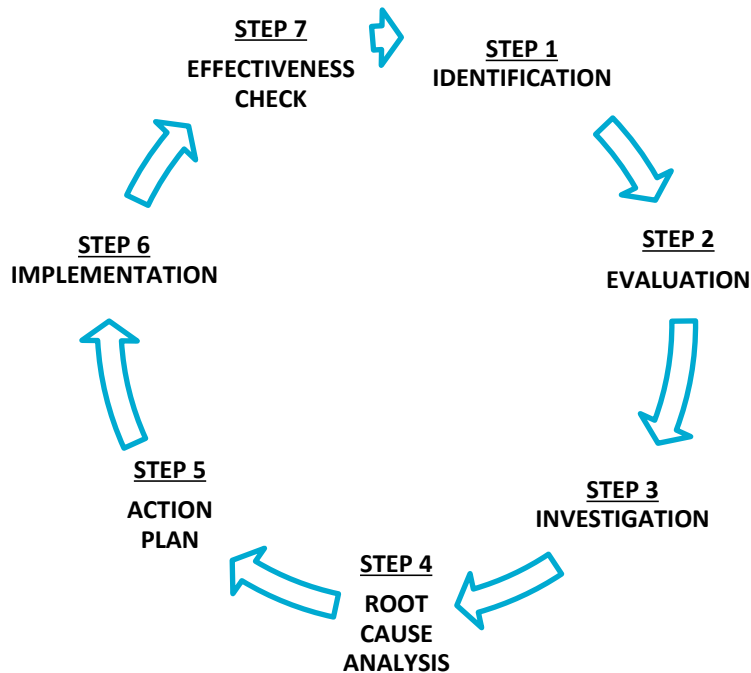


Figure 2: Corrective Action Planning Steps

## **STEP 1: IDENTIFICATION**

During the compliance audit, the Assessor may identify one or more Minor Non-conformances and communicate them to the registrant using the CAR. As outlined above, the CAR will include all the relevant information about the Minor Non-conformance, including findings, objective evidence, and the requirement.

## **STEP 2: EVALUATION**

Once the registrant receives the CAR, they must evaluate the documented issues to assess their appropriateness. This can be done by the registrant while reviewing the CAR sent to them. This is an important step to ensure that the information recorded by the assessor is accurate and that registrants are fully aware of the reasons the Minor Non-conformance is concerning and the possible impacts on the environment and health and safety of the public.

## **STEP 3: INVESTIGATION**

At this stage, registrants may choose to do more investigation to help ensure the information documented in the CAR is accurate and to determine all the contributing factors, circumstances, and responsible parties that led to the Minor Non-conformance.

## **STEP 4: ROOT CAUSE ANALYSIS**

When a Minor Non-conformance or other issue is identified, Root Cause Analysis (RCA) is a method that can be used to identify and address the Minor Non-conformance by determining what led to it. Registrants can use RCA to address any underlying inefficiencies and take the necessary steps to address them to prevent future recurrence. RCA is an effective tool that helps to zero in on minor errors that could be eliminated before they become major systemic concerns.

When thinking about RCA, registrants should take a thorough look at the issue and the evidence provided by the assessor and focus on “why” the non-conformance occurred, rather than “who” was responsible for it. The focus of this step should be on improving processes, not on the oversights or failures of individuals.

A common tool for RCA is called the “5 WHY” method. Registrants first define the problem by describing the non-conformance, either using the CAR provided by the assessor or by re-writing the non-conformance in their own wording. A registrant should then proceed to ask 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 5 “why’s” to understand the root cause of the non-conformance, 5 “why’s” is typically the minimum number needed.

Figure 3 below shows a graphical representation of the “5 Why” method of RCA.

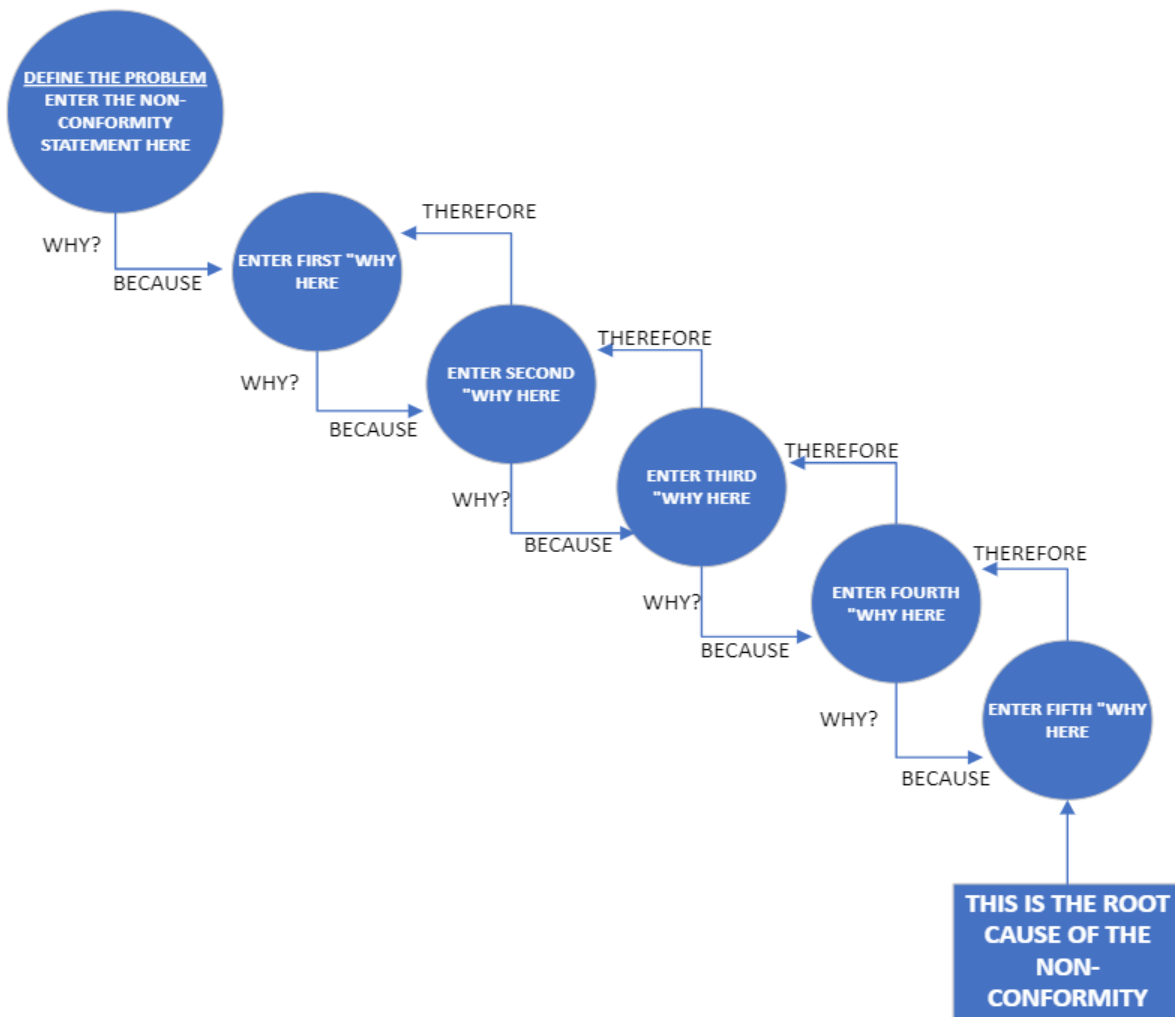


Figure 3: 5 Why Diagram

There are many other tools that can be used for RCA, including brainstorming and fishbone diagrams (also known as an Ishikawa diagram); whichever method you use, the goal is to determine the root cause of the non-conformance identified by the Assessor.

Once the registrant has identified the root cause, it must be filled into the Root Cause box in the Corrective Action Plan window, in the Audit Portal.

## STEP 5: ACTION PLAN

Once the root cause of the Minor Non-conformance has been determined and documented, the registrant must create an action plan to resolve the issue and prevent it from recurring. The 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 needed); and
5. completion date or timeline.

Items 1-4 should be filled into the Action Plan box in the Corrective Action Plan window, while the targeted completion date for implementing the action must be selected from the date selection menu below the Action Plan box.

## **STEP 6: IMPLEMENTATION**

Once an action plan is developed, the registrant can start working to put their corrective action(s) into practice. This may involve a short term action; such as updating policies, procedures, or templates, or a longer term action; such as taking additional training, changing work processes, or developing new systems. The targeted completion date submitted as part of the Corrective Action Plan should take into account the relative difficulty and duration required to implement the corrective action(s).

## **STEP 7: EFFECTIVENESS CHECK**

To complete the final step of the corrective action planning process, the registrant and the assessor must check in on the effectiveness of the corrective action proposed.

For the registrant, it is recommended to revisit the Corrective Action Plan approximately two months after the implementation of the corrective action to confirm that it was effective. For a simple corrective action, such as taking additional training, the check would be to confirm if the training was completed by the target implementation date. For a more complex corrective action, such as redesigning a process, the effectiveness check could include a review of documentation to ensure the reference standard (e.g., the Standard for Authentication) is being met.

For the assessor and Engineers and Geoscientists BC overall, effectiveness checks may take one of two forms.

- For a simple corrective action, the assessor will leave the compliance audit file open until the registrant has demonstrated completion of their required corrective action. Demonstration of completed corrective action could include submitting revised documents, policies, or procedures or proof of completion of additional training.
- For a complex corrective action (e.g., corrective action that would take multiple months or years to implement and demonstrate effectiveness on), the assessor will close the current compliance audit file and recommend that the registrant undergo a follow-up audit at a future date.

## COMPLETING YOUR CORRECTIVE ACTION PLAN IN THE AUDIT PORTAL

Once you have completed your personal corrective action plan, you must complete the Corrective Action Plan (CAP) in the Audit Portal. The four areas that you must complete for each CAP are listed below with more detail.

### **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 Root Cause Analysis method used to determine the root cause(s) (or upload as a supporting document).



## **ACTION PLAN**

Please 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 timeframe 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**

Please list the date of the implementation action that will take the longest to complete. You should:

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

After setting the implementation date, you should:

- Ensure all responsible parties are clear about the deadlines and the consequences of not completing the tasks on time.
- If an extension is needed, ensure the rationale for the extension is documented.

## **SUPPORTING DOCUMENTS**

You may upload any supporting documents that help justify your root cause, action plan, or implementation date. Documents might include:

- Root Cause Analysis method
- Risk Assessments
- Documents that were revised to satisfy the action plan
- Proofs of implementation (e.g., updated policies, procedures, or documents)
- Proofs of effectiveness (e.g., internal audits, internal metrics, outstanding long-term items)

## EXAMPLES OF CORRECTIVE ACTION PLANS

### **EXAMPLE 1**

*Note: This example is written for a registrant who works for a Firm registered under the Permit to Practice Program. In this example, the registrant is following their firms' policies and procedures for meeting the quality management requirements in the Bylaws.*

**Minor Non-Conformance identified:** Individual deviated from the document retention policy with an insufficient explanation.

### Root Cause Analysis – 5 WHYS:

1. Why was a deviation made from the documented policy?

Answer: Because the individual required additional storage space for the new documents

2. Why was additional storage space needed?

Answer: Because the existing document storage system was reaching its capacity limit, and no immediate expansion options were available.

3. Why were there no immediate expansion options?

Answer: Because the budget allocated for upgrades did not prioritize storage expansion.

4. Why was storage expansion not prioritized?

Answer: Because there was a lack of awareness about the growing need for document storage and the potential impact on regulatory compliance.

5. Why was there a lack of awareness?

Answer: Because the individual in charge of managing document storage had an inadequate understanding of the regulatory requirements for retaining project documents by registrants.

**Root cause:** Individual in charge of managing document storage had an inadequate understanding of the regulatory requirements for retaining project documents that registrants must follow.

### Action Plan:

- Review and update document retention policy: Since our document retention policy is listed in our firm's PPMP, I will provide recommendations to our Responsible Registrants to update our document retention policy to ensure it aligns with current and anticipated storage needs. After updating, the policy will clearly define acceptable deviations and the process for approvals.
- Increase document storage capacity: I will recommend our Responsible Registrants to explore cloud-based storage solutions and to include the budgeting team in the discussion to allocate resources.
- Enhance communication: I will recommend that our firm enhance communication and collaboration between the IT team and our professional registrants to ensure awareness of compliance risks are clearly identified.
- Training and awareness: I will recommend that training sessions be conducted regularly to educate individuals on the importance of their individual compliance to the standards and to the requirements set out in the Bylaws.
- Monitoring and reporting: I will recommend incorporating a monitoring process to track and trace deviations and effectiveness of the corrective actions.

Responsibilities – Timeline: to ensure effective implementation of the corrective actions.

- Compliance Team: Review and update document retention policy within 30 days.
- Individual: Develop a more robust training program within 45 days to ensure there is clear understanding of individual requirements.
- IT department: Implement a cloud-based storage solution to address document storage limitations within the next year.

**Implementation Date (to be entered in the Audit Portal):**

- Enter the target date for the action item that will take the longest to implement. In this example, the target date will be one year from the date the CAP is approved. For example, if the CAP is approved on July 1, 2023, the target implementation date would be July 1, 2024.

**Effectiveness check:**

- All responsible teams will carry out a periodic assessment to verify the effectiveness of the implemented corrections actions. Any identified deviations or issues will be addressed promptly, and if required, additional measures shall be taken.

**EXAMPLE 2**

*Note: This example is written for a registrant who does not work for a Firm registered under the Permit to Practice Program. In this example, the registrant has their own policies and procedures to address the quality management requirements in the Bylaws.*

**Minor Non-Conformance identified:** Individual failed to provide sufficient and accurate requirements when appointing a checker carrying out documented checks.

**Root Cause Analysis – 5 WHYS:**

1. Why did the individual fail to provide sufficient and accurate requirements when appointing a checker to carry out documented checks?  
Answer: Because the registrant’s policy regarding the appointment of checkers lacks clarity and specific guidelines.
2. Why did the policy lack clarity and specific guidelines?  
Answer: Because the policy was not adequately reviewed during the development phase.
3. Why was the policy not adequately reviewed during the development phase?  
Answer: Because there was insufficient understanding of the specific requirements by the registrant.
4. Why there was insufficient understanding of the specific guidelines by the registrant?  
Answer: Because the registrant was not aware of the importance of including these specific requirements as stated in the Bylaws.
5. Why was the registrant not aware of the importance of including these specific requirements as stated in the Bylaws?  
Answer: Because the registrant has not completed sufficient continuing education and training to understand the Standard for Documented Checks.

**Root Cause:** The registrant has not completed sufficient continuing education and training to understand the Standard for Documented Checks.

**Action Plan:**

- Training: Since I have not completed a specific training module on the Standard for Documented Checks, I will complete training to ensure I remain aware and compliant with this Standard.
- Review and update the policy: After completing the training module, I will review and update the policy to ensure it more accurately reflects the requirements stated in the Bylaws.

- Policy Revisions: I will ensure all revisions to the policy are documented, made easily available, and traceable.
- Monitor and reporting: I will incorporate a monitoring process to verify compliance and the effectiveness of the corrective actions.

Responsibilities – Timeline: to ensure effective implementation of the corrective actions.

- Individual: complete the training module within 15 days.
- Individual: review and update the policy within 30 days.
- Individual: develop a more robust training program that needs to be completed within 90 days.
- Individual: Establish a monitoring process to generate ongoing internal compliance reports (on an ongoing basis).

**Implementation Date (to be entered in the Audit Portal):**

- Enter the target date for the action item that will take the longest to implement. In this example, the target date will be 90 days from the date the CAP is approved. For example, if the CAP is approved on July 1, 2023, the target implementation date would be October 1, 2023.

**Effectiveness check:**

- All responsible teams will carry out a periodic assessment to verify the effectiveness of the implemented corrections actions. Any identified deviations or issues will be addressed promptly, and if required, additional measures shall be taken.