1.0 PURPOSE:

1.1 To establish, document, implement and maintain a procedure for the PSC's Internal Quality Audit (IQA) process.

1.2 To define the procedure for the, preparation, implementation, follow-up, and reporting of IQA activities in determining whether:

1.2.1 The PSC QMS conforms to applicable requirements/planned arrangements; and,

1.2.2 The QMS is effectively implemented, maintained and improved.

2.0 SCOPE:

2.1 This procedure applies to the PSC's quality management system whose processes directly affect the quality of products and services delivered to its clients/customers.

3.0 DEFINITION OF TERMS:

3.1 **Audit**- Systematic, independent, and documented process for obtaining evidence and evaluating it objectively, to determine the extent to which criteria are fulfilled.

3.2 **Audit Criteria-** Set of policies, procedures, or requirements, used as reference against which audit evidence is compared

3.3 **Audit Evidence**- Records, statements of facts or other information, which are verifiable and relevant to the audit criteria. It can be qualitative or quantitative

3.4 **Audit Findings**- Results of the evaluation of the collected audit evidence against audit criteria

3.5 **NC**- Nonconformity, Non-fulfillment of requirement

3.6 **Disposition**- Actions to be taken to address nonconformities

3.7 **Corrective Action** - Actions to be taken to prevent occurrence of an identified NC.

3.8 **RFA Form** - Request for Action form

3.9 **OFI**- Opportunity for Improvement; Statement of fact or condition that does not signify a failure in the system but may be enhanced

4.0 PROCEDURE DETAILS:

4.1 Responsibilities

4.1.1 The IQA Team Leader is responsible for ensuring that a complete audit on the quality management system takes place at least twice a year (i.e., all processes of the QMS must be audited at twice in a year).

4.1.2 The IQA Team Leader is responsible for ensuring the proper implementation of this procedure.

4.1.3 The Process Owners (i.e., Division Chiefs, Section/Office/Unit Heads) are responsible for ensuring that appropriate actions are taken without undue delay to eliminate the root causes on nonconformities that have been raised/identified.

4.1.4 Preferably, the auditor(s) who performed the audit, and raised the nonconformities, will be assigned to follow up and verify the completeness and the effectiveness of the corrective actions taken.

4.1.5 The Audit Team Leaders are responsible for preparing the **Audit Checklist** to be used during the Audit.

4.2 Planning the Audit

4.2.1 An **Audit Schedule** is prepared by the IQA Team Leader before the start of a calendar year.

4.2.2 The **Audit Schedule** contains the schedule for a period during which all processes of the quality management system will be audited.

4.2.3 In addition to the planned internal quality audits, unplanned internal quality audits may be decided on by the QMS Leaders, if deemed necessary. Decisions for conducting unplanned internal quality audits should be based on:

- unusual increase of quality related problems;
- introduction of new products and services;
- changes on the quality system, personnel and processes; and,
- customer's request.

4.2.4 The Audit Schedule is reviewed and approved by the QMS Leader prior to its implementation.

4.2.5 Copies of the approved Audit Schedule are disseminated to all process owners concerned through a memorandum prepared by the IQA Team Leader.

4.2.6 Prior to conducting an audit, both planned and unplanned audit require a notification, to be given to process owners concerned at least a week before the conduct of audit.
Notification of an audit shall be in the form of a **Memorandum** attached with the Audit Schedule to be prepared by the IQA Team Leader.

4.2.7 An Audit Schedule shall include the:

- Objective(s)/purpose(s) of the internal quality audit;
- Date and time of the audit.
- Departments/offices to be audited with their designated auditees and representatives;
- Audit scope (i.e., processed to be covered for each area (Department/Office) to be audited;
- Assigned auditors (leaders and members of each Audit Team); and,

4.2.8 Auditors, who are assigned to conduct the audit shall be selected from the pool of certified internal quality auditors listed on the Special Order duly signed by the Chairman. Certified auditors are trained and qualified in accordance with appropriate education, training, skill, and experience, as suggested in ISO 9001:2015.

4.3 Preparation for the Audit

4.3.1 Upon notifying the auditors and auditees through the Audit Schedule, relevant and necessary documents(e.g., Quality Manual, PAWIM, QMS and project management records) are obtained and reviewed by auditors.

4.3.2 Taking into account the audit scope, audit objectives, and the information gained from the review of various documents and records, **Audit Checklists** are prepared by the Audit Team Leaders.

4.3.3 The Audit Checklist is used flexibly. It is not used as a questionnaire which, when completed, signals the end of the interview. During the audit, the auditor may add to the checklist, depart from it, and return later, or may decide not to cover some items.

4.4 Conducting the Audit

4.4.1 An opening meeting is conducted prior to actual conduct of the audit to reconfirm/review the audit schedule, the reference documents used as basis for determining the audit criteria, and the audit participants (auditees). The meeting is usually an informal one with no record being kept except those necessary for the smooth conduct of the audit.

4.4.2 The following activities are performed during the Audit proper:

- Establish facts by interviewing personnel, reviewing documents, observing processes, and verifying records.
- Record facts as evidence of the audit.
- Evaluate facts to determine the objective evidence of a nonconformity.
- Classify audit findings as to NC or OFI.

- A Closing Meeting is conducted to present audit findings to the Process Owner (Department Heads of the audited area).

4.5 Reporting of Audit Findings

4.5.1 An **Audit Findings Report** is prepared by the Audit Team Leaders and submitted to the QMS Team Leaders for approval.

4.5.2 Nonconformities raised during the audit are documented using the **Request for Action (RFA)** form.

4.5.3 The approved Audit Findings Report together with the RFA's prepared are submitted to the Auditees (Process Owners concerned) for

immediate action. Copies of the Audit Findings Report are provided the Division Chief and/or the Bureau Chief, as appropriate.

4.5.4 Correction/s to be made on the identified NC's shall be noted by the Process Owner in the "Correction" portion of the RFA.

4.5.5 Using root-cause analysis, the Process Owner determines the root cause(s) of the NC, generates alternative solutions to eliminate these, selects the best solution(s), and prepares an action plan to implement the selected solution(s)

4.5.6 The action plan is submitted to the Process Owner's superior (or to a higher-up level authority) for proper approval. Upon approval, the Process Owner shall implement the action plan without undue delay.

4.5.7 Audit follow-up is conducted on or after the target implementation/completion date of the action plan, to verify whether the appropriate action is effectively implemented.

4.5.8 Details of the actions taken and the verification results are written on the follow-up portion of the RFA.

4.5.9 In case of a rescheduled follow-up, the auditor ensures that the new follow-up date is properly recorded in the RFA.

4.5.10 "Closed" RFAs are returned to the IQA Team Leader.

4.5.11 To provide evidence of a systematic audit and for useful references, the IQA Team Leader maintains all relevant records of concluded internal audits.

4.5.12 Results of internal audits are discussed and presented during management review meetings.

4.6 Verification of Actions Taken

4.6.1 RFAs are forwarded to the IQA Team Leader, who assigns control numbers for monitoring purposes.

4.6.2 The IQA Team Leader maintains a registry of all RFAs.
Corrective/preventive actions are implemented without undue delay. Guidelines are given on Corrective Action Procedure.

4.6.3 Actions to address OFIs are recommended but not required.

5.0 REFERENCES:

5.1 Corrective Action Procedure

5.2 Internal Quality Audit Schedule
5.3 Audit Checklist
5.4 Audit Findings Report
5.5 RFA Form

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