Corrective Action Register

Transition Audit for ISO 45001:2018 & ISO 14001:2015, Philippine Carabao Center, Date: March 23 – 24, 2021,
Auditor: **Lily Agnes Manuel-Picardo (LAMP-LA), Kristine Villaruel (KV)**

C.A.R Number	Date	Client Ref.	Client Details	Corrective Action Details	Closed By	Closed Date
1	23/24 March 2021	KV/LAMP OFI 1	<u>Documented Information</u> **Document Control Officer** 1) Presented Master List of Records has different document codes (PCC-MLIP-01) vs details encoded on the procedure (PCC-DCIF-06). 2) The newly appointed person as DC can handle and control documents related to standard therefore, the DC may attend training related to control of documented information process for competency enhancement. 3) Veterinary Procedure Manual was not listed as External documents in the Masterlist of documents.	1) Master list of Records has been reviewed and recoded as PCC-DCIF-06. Comprehensive review of all IMS registered documents will be implemented. 2) Upon evaluation awareness and internal audit training for the three standard is sufficient to enhance competency. DCO has already attended in-house training for QMS and OHSMS. Will look forward to attend on EMS awareness training. 3) Veterinary Diagnostic Procedure was already registered as External Reference Documents in Master list of Registered Documents. The section's Quality Control Plan will be revised to correct the document number.		

C.A.R Number	Date	Client Ref.	Client Details	Corrective Action Details	Closed By	Closed Date
			Human Resource 1) To properly identify all needed documents for enrolment especifically if those internal documents are being used under the established IMS. 2) There is one internal controlled procedure (Staff Developing Training, PCC-HRQP-01 Rev 04, 11.20.08) that still uses the old organization logo. The team may check for revision of documents that still uses the old logo. **Purchasing** 1) Improper correction of encoded data on the controlled document (ex. revision number for PCC-PRQP-01 Rev 3 01.08.18, encoded data under revision # is 2, correction made by using a slash but no undersigned). 7.2 / 7.3 / 7.5	**Human Resource** 1) Review existing documents that need to be registered and determine others that are relevant to the process. 2) Review all documents and revise all those that are outdated including those that use old logo. **Purchasing** 1) DCO will ensure that all documents are thoroughly reviewed for accuracy prior to reproduction and distribution to prevent handwritten corrections.		
2	23 March 2021	KV OFI 2	<u>Preventive Maintenance</u> 1) The main lobby has 9 emergency lights, upon checking one of the lights, it is not working properly.	1) Non-working bulbs will be replaced immediately.		

C.A.R Number	Date	Client Ref.	Client Details	Corrective Action Details	Closed By	Closed Date
			2) The monitoring checklist attached to the fire extinguisher in Madamba Hall acquired last December 2020 is not updated. The auditee verbalized that a monthly checking is conducted. 3) There are some outlets that are not being used without the cover. 6.1.2.1 / 8.1.1 / 8.1.2	2) Will remind the in-charge of fire extinguisher monitoring to update the checklist 3) The outlets are intact and have standard covers. Outlets referred to are used indoors.		
3	24 March 2021	KV OFI 3	<u>Operations: Research and Development Division</u> 1) The team may consider reviewing/updating their mitigation and control measures in compliance and as stipulated on the actual implementation to COVID-19 safety measures (possible exposure of personnel from offsite visit) 2) Proper installation of emergency light on areas where it is needed.	1) Since what was presented during the audit was the OCP of NDBH (formerly NIZ) section, the auditee will coordinate with them for the necessary updates to include mitigation and control measures pertaining to risk of possible exposure to COVID 19 of field personnel. 2) Thorough inspection and testing of emergency lights and replacement if needed.		

C.A.R Number	Date	Client Ref.	Client Details	Corrective Action Details	Closed By	Closed Date
			3) The team may consider facilitating enrolling of new OCP immediately as a proper and continuous implementation in the monitoring of identified risk both for OHS and EMS. 6.1.2.3	3. The Section is in the process of developing its OCP that is aligned to the HIRADC and aims to submit to MSAO for registration on or before April 6.		
4	24 March 2021	KV OFI 4	<u>Occupational and Safety Team</u> 1) The certificate for Red Cross – Certificate of Proficiency issued last 06 September 2018 is valid until September 5, 2020. No updated certificates at the time of audit. 2) There is no poster/placard indicating # of days without accident within the facility. This can also help the organization monitor, measure, and communicate to employees if the OHS objectives/procedures have been met and implemented properly. 3) There is no appointed safety officer only an officer-in-charge. The team may need to review and appoint an alternative person in case of the resignation of personnel.	1) New and valid certificates will be issued once the Staff concerned have participated in the BLS Training planned for July in the Annual Health Program. 2) A simple poster will be designed to demonstrate the performance of the agency in terms of preventing accidents. 3) The agency is in the process of hiring a Nurse who will be designated as Safety Officer. Another staff will be sent to BOSH so he/she can be designated as alternate SO.		

C.A.R Number	Date	Client Ref.	Client Details	Corrective Action Details	Closed By	Closed Date
			4) The unit may review/check the posting of signages on important locations/areas such as clinics' location/entrance signages, designated entrance and exit on each building/area, etc. This can help in giving information to other personnel for health and safety purposes. 5) The auditee verbalized that they do not conduct fire and earthquake drills as a response to the COVID-19 health protocol issued by the Department for Health. It is advisable to still conduct these activities in lieu of the stated mandatory requirements of the standard. 5.3 / 6.1.3 / 7.1 / 7.4.1	4) The General Services Section and EPRTeam will evaluate the necessity of placing signages for important locations 5) Conduct of fire drill will be coordinated with the Bureau of Fire Protection so that it can be conducted with less risks relative to the continuously increasing number of COVID cases		
5	23 March 2021	LAMP OFI 5	ENVIRONMENTAL PROTECTION AND POLLUTION Following are the lapses observed 1) Wastewater analysis should increase the frequency of testing for monitoring on Effluent standard thus eliminating non-compliance to regulatory requirements. To incorporate changes in the procedure	1) Conduct of quarterly effluent testing to strengthen monitoring of compliance to regulatory requirements will be included in the guideline (PCC-IMGL-01).		

C.A.R Number	Date	Client Ref.	Client Details	Corrective Action Details	Closed By	Closed Date
			2) As per PCC-IMGL-01, Item 10.3 (2) Orient all concerned (employees, housing occupants, GSU staff, garbage collectors) about the existing waste management scheme of the organization semi-annually. Keep records of orientation done. Orientation is being done however no objective evidence such as record was presented. A video at the lobby is being played regarding the waste management scheme of the organization,may consider editing the procedure. 3) MRF Hazardous container van, may consider putting up shelves to maximize storage placements, thus eliminating expired hazardous waste containment at laboratories. 6.1/6.2/7.5/8.1	2) Revision of the guideline (PCC-IMGL-01) to include alternative methods to be done (e.g. playing of video presentation) in case physical/ actual orientation cannot be conducted. 3) Installing of additional shelves in the MRF will be considered once hazardous wastes are hauled by the service provider.		
6	23 March 2021	LAMP OFI 6	Internal Audit 1) There are 43 Internal Auditors who attended the in-house training on the IMS awareness, however, no objective evidence/record was presented. Competency of Internal Auditors on IMS Awareness was not established. Competency is a mandatory record on ISO standards (ISO 14001).	1) Copy of training certificates as proof of competency of Internal Auditors will be secured in the future trainings to be attended.		

C.A.R Number	Date	Client Ref.	Client Details	Corrective Action Details	Closed By	Closed Date
			2) 2nd batch Internal Audit Result Summary Report dd October 16-20, 2020 have open findings. Update on remarks/status is essential and should be time-bounded for proper verification. 7.2/9.2	2) Ensure that all audit findings in the Internal Audit Summary Report have remarks regardless the status of the findings.		
7	23 March 2021	LAMP OFI 7	System Improvement Report SIR # 2020-02-RGB-02 was not properly filled up, standard stated is 9001 but it should be 14001/45001. No entry on nature on audit finding, internal or external Audit finding,clause #, ref document,date. May consider generating SIR procedure to prevent occurrence. 7.4/10.2	To conduct orientation/ refresher course on how to properly accomplish System Improvement Report.		

PLEASE COMPLETED THIS REPORT AND REPLY TO WQA OFFICE WITHIN ONE WEEK. Email: admin@wqaph.com and sales@wqaph.com
PLEASE SUBMIT ATTACHED RELEVANT EVIDENCE(S) FOR THE ABOVE FINDINGS AS A MANDATORY REQUIREMENT FOR CERTIFICATE EXTENSION.