



How to Respond to Audit Findings

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CREATED	REVIEWED	APPROVED
01.09.2014	01.02.2025	15.04.2025
Head of Accreditation and Technical Department	Quality Manager Head of Accreditation and Technical Department	Secretary General

SCOPE

This document provides information on how to report on corrective actions established and implemented following an ISTA (re-)accreditation assessment.

RELATED DOCUMENTS

ISTA Rules

ISTA Accreditation Standard for Seed Testing and Seed Sampling

Acc-F-03A (Final) Audit Detail Report

Acc-F-03B (Re-)Audit Detail Report

RESPONSIBILITY

Audited member: for following the procedure

ISTA auditors: for verifying that the procedure is followed

Audit administrator: for supporting the process

Head of Accreditation and Technical Department (HoAT): for supervising the process

ISTA Secretary General (SG): for supporting the process

ECOM Accreditation Working Group (AWG): for supporting the HoAT and SG for any special decision related to the audit process

DEFINITIONS/ABBREVIATIONS

Audit/Assessment: systematic, independent, and documented process for obtaining records, statements of fact or other relevant information and assessing them to determine the extent to which specified requirements are fulfilled.

Audit finding: indicates the non-conformity with audit criteria or opportunity for improvement.

Corrective action: action to eliminate the root cause of an identified non-conformity.

Correction: action to eliminate an identified non-conformity.

Document: information and its supporting medium (e.g. documented procedures, forms, records, extracts from databases)

- **Substantial non-conformities (S):** are non-conformities that have a significant influence on the quality of the work or the data leaving the laboratory. This could be, e.g. a requirement given by the Accreditation Standard not implemented and described or described but not yet implemented. In either case, the ISTA Rules and/or the Accreditation Standard are not followed.
- **Non-substantial non-conformities (NS):** are non-conformities that are not expected to have a significant influence on the quality of the laboratory's work, e.g. accreditation requirements that are implemented but insufficiently described in the laboratory's documentation.
- **Recommendation (Rec):** a statement that does not affect the integrity of the laboratory's work but is providing valuable information.
- **For accreditation being granted all non-conformities must be addressed.**

PROCESS DESCRIPTION

CORRECTIVE ACTION PROCEDURE

Non-conformities must be addressed through a formal corrective action procedure following the audit (see section 10.6. in the ISTA Accreditation Standard for Seed Testing and Seed Sampling).

The laboratory must use its own procedure for each non-conformity given at the audit. The identified root cause and details on the corrective action investigation and evaluation of effectiveness shall be stated.

The laboratory must:

- where necessary apply corrections related to the non-conformity
- investigate the root cause for the identified non-conformity
- decide which action it will take to remove the root cause and to ensure that this non-conformity does not re-occur
- decide how to implement these corrective actions e.g. change of process steps, change of documents, is training needed, is additional calibration of equipment needed, is purchasing of new equipment needed
- implement the corrective action
- decide how to measure the effectiveness of corrective action taken
- measure the effectiveness and keep records
- define responsible and due date for the established steps

REPORTING TO THE ISTA ACCREDITATION AND TECHNICAL DEPARTMENT

When the corrective actions for the identified non-conformities have been implemented but not later than the agreed due date at the closing meeting of the ISTA audit, the laboratory must report to the ISTA Accreditation and Technical Department.

For reporting, the laboratory should:

- use the word-file of the audit detail reports ("Final audit detail report").
- in the appropriate place write its investigation for each non-conformity, (e.g. root cause), corrective action (e.g. changes of SOPs), and how and when the effectiveness of the corrective action is implemented and evaluated.
- in the appropriate column refer to which documents of the laboratory QMS the change belongs.
- in the appropriate column refer to the provided documents as a proof of implementation (e.g. photos, training records, revised paragraph of an SOP, new SOP, new form).

To facilitate the auditors' evaluation, it is necessary to use the audit detail number at the beginning of the file name of the documents. e.g. the laboratory addressed the non-conformity number 2.3 and has provided the auditors with four different documents; in this case the documents shall be named 2.3.1, 2.3.2, 2.3.3, 2.3.4. It will also facilitate the evaluation if the revised paragraph/information is highlighter (e.g. a different colour, a sign to mark the change/addition).

Documents should be submitted electronically.

TIMING

Corrective action measures pertaining to all identified non-conformities must be reported.

The submission must not be later than the date agreed at the closing meeting of the assessment day. Usually, the first corrective action (CA1) is submitted not later than three months after the audit date. If an extension of the due date is necessary due to justified reasons, the Accreditation and Technical Department/assigned System Auditor must be contacted.

The due date for submission of a corrective action can be prolonged by a maximum 14 calendar days from the date established at the audit day and stated on the Audit Report. The prolongation is approved by the HoAT. If the new due date is not respected by the laboratory this will lead to the issuance of a warning letter signed by the Head of Accreditation and Technical Department (HoAT). If, after another 14 calendar days after the issuance of this warning letter the corrective actions are not submitted, in consultation with the ECOM Accreditation Working Group (AWG), the accreditation may be suspended by a letter signed by ISTA Secretary General (SG).

Any exception to the above will be considered on a case-by-case base (e.g. justified reasons provided by the laboratory, force majeure) and will be discussed and approved or not by the ECOM-Accreditation Working Group.

OBJECTIVE EVIDENCE

The corrective action taken can be documented e.g. via a change in the Quality Manual, changes in SOPs, working instructions, forms, including the laboratory's completed corrective action form. Minutes from staff meetings, invoices (e.g. in case of purchase of new equipment), training records, other records (e.g. audit plan, audit reports), control charts, photographs (e.g. equipment), newly issued ISTA certificates might be suitable evidence for the auditors to see proper implementation.

Amended procedures in case of non-conformities related to the quality documentation and declarations of intent are in general not sufficient corrective measures, as they only show how the laboratory corrected the non-conformity and not the corrective action.

DOCUMENTS

Due to the nature of the follow-up of corrective action, the comprehensiveness of documents supplied by the auditee is crucial. However, a complete set of quality documents (Quality Manual, procedures, instructions, forms, and other relevant external documents) is not required.

If quality documents were amended as part of a corrective action, then only the revised section(s) should be made available, and the changes must be highlighted. The corrective actions are uploaded to the related Audit SharePoint. The access to the laboratory is granted by the Accreditation and Technical Department.

LANGUAGE

The reporting language for the covering letter and supporting documentation is English. This does not necessarily imply that all documents submitted as part of the corrective action report must be translated. The reporting laboratories are requested to adopt a common-sense approach. It is recommended to confer with the audit team when questions arise regarding the reporting process.

REPORTING

Laboratories receive a formal follow-up corrective action report including the auditors' comments with respect to the corrective actions reported. If necessary, the laboratory is requested to provide additional information. A new due date is fixed by the auditors.

APPROVAL OF CORRECTIVE ACTIONS

When the Accreditation and Technical Department has received the corrective actions, they will be evaluated with the assistance and input of both auditors and supported when needed by the HoAT. In the document "CA Final audit detail report" the auditors will state if the corrective actions taken are approved or not. The evaluation of any corrective action must be submitted back to the laboratory in maximum 10 working days after the corrective action receipt.

The substantial non-conformities(S) must be address not later than 6 months and the non-substantial non-conformities (NS) not later than 9 months after the audit date.

APPROVAL OF (RE-)ACCREDITATION

(Re-)Accreditation can only be granted after all non-conformities are properly address and approved.

ANNEX

Annex 1. Example of the Final Audit detail report

DISTRIBUTION LIST

ISTA website

Audited laboratory or sampling entity

REVISION HISTORY

Version #	Changes
2.6	Introducing responsibilities Introducing revision history Updating related documents Updating the name of the Accreditation Standard Elaborating the timing Updating the Annex 1
3.0	Layout change
4.0	Update to reflect the ISTA policy regarding the non-conformities identified during an ISTA audit
5.0	The change is due to the updated policy and also the format for reporting the non-conformities (Responsibilities amended, Chapter "Timing" amended, Annex 1 updated)

Annex 1. Example of the Final Audit detail report

Detail Report Number **2.3**

Division/department/activity assessed

Accompanying representative/s

Reporting assessor/s

S/NS/Rec	S: Substantial non-conformity; NS: Non-substantial non-conformity; Rec: Recommendation	
S	Submitted sample for Moisture testing	
<p><i>Description:</i></p> <p>The sampler did not take a minimum of three subsamples from different positions of the composite sample. Only one large scoop was taken.</p>		
Reference	ISTA Accreditation Standard	6.2.2, 7.2
	ISTA Rules	2.5.1.5

Follow-up Corrective Action

Description (The audited organisation is responsible for filling out)

Identified root cause:

- Sampling demonstration has been performed by a sampler in the authorisation process;
- Insufficient knowledge of the ISTA Rules;
- The SOP describing the sampling for moisture test was not detailed enough.

Corrective action:

The sampler was removed from the list of the authorised ISTA samplers as he was in the authorisation process; his training still in progress.

The related SOP has been revised and distributed to the staff involved in the sampling process (authorised and in the authorisation process)

A refreshing training for the ISTA Rules – Sampling aspects and the revised SOP was organized for all ISTA samplers (authorised and in the authorisation process)

Evaluation of effectiveness:

A questionnaire was completed by the trained staff. The answers they provided demonstrate that the training was effective.

The List of authorised samplers was verified and contains the authorised samplers only.

Reference to QMS	Standard operational procedures
Reference to annex attached	2.3.1 SOP-Sampling, revised, 2.3.2 Training records of staff, 2.3.3 Results obtained by the trainee 2.3.4 Communication with the next internal auditors, 2.3.5 List of approved ISTA samplers

Approval of Follow-up Corrective Action

Description of observed facts (To be filled in by the ISTA Auditors)	Approved	Not approved
The laboratory provided detailed evidence of corrective actions established and implemented: the related SOP is now revised; the list of ISTA samplers is update, and the ISTA samplers are trained and evaluated for the updated procedures. The non-conformity is appropriately addressed.	01.02.2025	