Approval and Authorization

Completion of the following signature blocks signifies the review and approval of this Document.

Name	Job Title / Role	Signature	Date
Authored by	Assistant Director Inspection and Verification	Approved	10/02/2017
Checked by	Assistant Director Certification	Approved	10/02/2017
Approved by	Deputy Director Technical Services	Approved	10/02/2017

Periodic Review Approval and Authorization

Completion of the following signature blocks signifies the review and approval of this Document.

Required by: *(02/2020)*

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1.0 OVERVIEW CONTENT

1.1 Process Overview

This procedure entails the process of reviewing assessment reports by the scheme, and other internal reviews mechanisms prior to progression to the accreditation committee for decision making.

1.2 Purpose

This procedure defines the process of review to decision making on granting of accreditation to conformity assessment bodies after assessment is conducted.

1.3 Scope

This procedure applies to granting of accreditation to all Conformity Assessment Bodies (CAB) that have been assessed by KENAS or any subcontracted party that has performed assessments on behalf of KENAS.

1.4 Role(s) and Responsibility

Role	Responsibility
CEO / DDTS	The principal responsibility of administering this procedure and presentation of the case files for decision making by the accreditation committee
M.R	Ensures that this procedure remains adequate for its intended use.
Scheme Owners	Review of scheme files prior to presentation for peer reviews
Technical Services Team	Undertake peer reviews of case files and provide recommendations where applicable prior to progression to the accreditation committee
Accreditation Committee	Make decisions on the case files presented

2.0 DEFINITIONS ANDABBREVIATIONS

The table below defines new or changed terms that are included in or associated with this process.

Term	Definition
Accreditation Committee	A committee appointed by referred to in Legal Notice No. 55 of 2009
Accreditation body logo	Logo used by an accreditation body to identify itself
Accreditation certificate	Formal document or a set of documents, stating that accreditation has been granted for the defined scope
Accreditation symbol	Symbol issued by an accreditation body to be used by accredited CABs to indicate their accredited status
Appeal	Request by a CAB for reconsideration of any adverse decision made by the accreditation body related to its desired accreditation status.
Assessment	The process undertaken by an accreditation body to determine the competence of a CAB, based on particular standard(s) and/or other normative documents and for a defined scope of accreditation.
Assessor	Person assigned by an accreditation body to perform, alone or as part of an assessment team, an assessment of a CAB

3.0 PROCESS INSTRUCTIONS

3.1 The calendar of the accreditation committee shall be drawn annually for quarterly meetings and confirmations done at least a week before the meeting. Where adhoc meetings are required away from the normal meetings, the notice of two weeks shall be given to the accreditation committee members.

3.2 Once an assessment is completed and the assessment cycle closed through provision of a closure report or assessment cycle time lapse, The Scheme owner shall review the set of assessment requirements for completeness before progressing the same for further internal reviews.

3.3 The Scheme review shall ensure completeness of information from application to closure for all new applications and from effectiveness of previous actions taken by the CAB to closure of the assessment for surveillance, re-accreditation assessments and

re-assessments. This is done in line with checklists developed in Q-pulse or KENAS-TS-F-001. In case further clarifications are needed prior to progression of the case file, the scheme can do so, so long as this does not impact the assessment to accreditation decision making cycle.

3.4 Where the assessment cycle has lapsed and the CAB has not taken the desired action, the case file shall still be reviewed for progression to decision making noting the outstanding actions.

3.5 The outcome of the scheme review and all the associated documents are then presented for peer review, a team constituting of not less than four persons from Technical Services Department well versed with assessment requirements input for decision making shall review the case file, and provide recommendations to be progressed to the accreditation committee

3.6 Once reviewed, if no further information is required, the team shall progress the case file with a recommendation where feasible. The review outcome shall be populated in Q-pulse or in KENAS-TS-F-001 and progressed to the accreditation committee.

3.7 In case the team is not able to come up with a recommendation and further clarification/ information is required, this can be obtained through the scheme from the client so long as this does not impact the accreditation assessment to decision making cycle.

3.8 Once the accreditation committee meeting is confirmed, the assessment information shall be submitted bearing information on:

- Unique identification of the CAB;
- Date of the on-site assessment;
- Name of the assessor(s) and/or experts involved in the assessment;
- Unique identification of all premises assessed;
- Proposed scope of accreditation that was assessed and the recommended scope of accreditation;
- A statement on the adequacy of the internal organization and procedures adopted by the CAB to give confidence in its competence, as determined through its fulfilment of the requirements for accreditation;
- Information on the resolution of nonconformities;
- Any further information that may assist in determining fulfilment of requirements and the competence of the CAB;
- Where applicable, the adequacy of proficiency testing or other comparisons participated in by the CAB and any actions taken as a consequence of the

results;

- Where appropriate, a recommendation as to granting, reducing, extending or withdrawal of accreditation.

3.9 The information submitted shall be deliberated on by the Accreditation Committee and records of decisions made provided in minutes and populated as decisions into Q-pulse. These decisions shall facilitate preparation of certificates and / or associated schedules if accreditation is granted or continued accreditation upheld or the decisions if otherwise shall facilitate further communication to the clients.

3.10 The Accreditation Certificate and the associated schedule issued shall contain:

- The identity and logo of KENAS;
- The unique identity of the accredited CAB;
- All premises from which one or more key activities are performed and which are covered by the Accreditation.
- The unique accreditation number of the accredited CAB;
- The effective date of granting of accreditation, reaccreditation and the expiry date;
- The normative standard under which accreditation is granted;
- The scope of accreditation as indicated in the schedule including type, standards, other normative documents or regulatory requirements that the CAB uses to fulfil its scope and any other requirements as stated in KENAS-TS-OP-016.

3.11 For surveillance assessments, clause 3.9 shall be followed by a letter issued to the client for continued accreditation or suspension, withdrawal in case of non-fulfilment of the requirements.

3.12 In case of extension or reduction of scope, a letter informing the client of the accreditation for the extended scope or reduced scope and a revised schedule provided.

3.13 Accreditation shall be granted for a period of three years with a surveillance period of 6 months for all initial accreditations and thereafter if the surveillance is satisfactory, the period for surveillance will be increased and maintained at one year. However if the system is erratic/unstable as may be determined by the accreditation committee then the surveillance will be retained at 6 months until the system stabilizes. If the

surveillance was at one year surveillance already and instability sets in then an increased frequency of surveillance will be considered reverting back the period to 6 months until the system stabilizes.

3.14 Ordinarily, surveillance I – shall be run at 6 months from the date of initial accreditation and thereafter 12 months (if there are no issues as stated in 3.13). This means that Surveillance II will be planned at 18 months from initial decision and Surveillance III which should be done at the 30th month from Initial can be considered as a re-accreditation assessment in order to manage assessment time and decision for reaccreditation before expiry of the accreditation cycle of 36 months. For the circumstances where the surveillance is enhanced due to instability of the system, surveillance periods shall be based on the maintenance decision.

3.15 For other reaccreditation assessments for the cases not captured in detail under 3.14, the reaccreditation assessment should commence at least three months prior to expiry of the certificate, it is desired that the decision for reaccreditation is arrived at prior to the expiry of the certificate.

3.16 Where reaccreditation decisions are arrived at before the expiry of the certificate the expiry period of the new certificate shall be from the date of expiry of the old one. Where re-accreditation assessments commence before expiry of the accreditation certificate and the re-accreditation decision is made post the expiry date but within 6 months of expiry, the new certificate shall be issued on or after the date of the accreditation decision but the expiry date of the new certificate shall still hold for three years from the date of expiry of the old certificate. If the reaccreditation decision is arrived at greater than six months post expiry, the accreditation shall be treated as an initial thereby breaking the accreditation cycle.

3.17 Any reaccreditation assessments that commence post expiry shall be treated as initial accreditation, requiring fresh application for accreditation and hence initial accreditation decision.

3.18 Records of all accreditation processes including decision taken are confidential and shall be maintained within Q-pulse which requires password access while paper equivalents if any shall be maintained in the clients files and the accreditation committee minutes.

4 PROCEDURE TRAINING

All the staff involved in assessments, review and the accreditation committee will be required to be familiar with this procedure. A period of one month from issuance to effective date has been provided to enable reading, understanding and training if required.

5 REFERENCE AND RELATED DOCUMENTS

No.	Document Identifier	Document Title
1.	KENAS Legal Notice No. 55/2009	KENAS Legal Notice
2.	KENAS-QM-MAN-001	KENAS Quality Manual.
3.	ISO/IEC 17011	Conformity assessment — General requirements for accreditation bodies accrediting conformity assessment bodies
4.	KENAS-GUD-001	Accreditation Committee Team Charter
5.	KENAS-TS-OP-010	Management of assessments, surveillance, reassessment and reporting.
6.	KENAS-TS-OP-011	Procedure for suspension, withdrawal, reduction and extension of scope of accreditation
7.	KENAS-TS-OP-013	Procedure for management of confidentiality, impartiality and objectivity.
8.	KENAS-TS-OP-016	Formulation of Accreditation Scope

6 REVISION HISTORY

Date	Ver	Revised By	Reason For Revision
02-02-20-13	01	ADIV	Change of format from KENAS-OP-19
26-11-20-15	02	ADIV	Include; • Subcontracting in the scope • Recommended scope of accreditation as part of the information to be provided to the Accreditation Committee, • Decision making and cycles on reaccreditation • Additional references KENAS-TS-OP-010, KENAS-TS-OP-011, KENAS-TS-OP-013 and removal of normative standard references.

10/02/2017	03	ADIV	• Amended to clearly specify the surveillance and reaccreditation cycle in 3.14 and 3.15 as well as clearly specify the treatment of certificates for reaccreditation assessments carried out pre and post expiry of accreditation certificates in 3.17