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Performing an effective root cause analysis: Strengthening audit quality

SMALLER FIRM SERIES

CPAB is committed to supporting smaller audit firms improve audit quality. The scenarios in this publication have been tailored towards smaller audit firms; however, they are applicable to all firms conducting root cause analysis.

Learning from the past is key to continuous improvement. A robust and timely root cause analysis plays a vital role in enhancing audit quality. The Canadian Public Accountability Board (CPAB) has observed that firms that invest the necessary resources in their root cause analysis process are better positioned to identify weaknesses in their system of quality management and develop targeted actions that contribute to improved audit quality.

The Canadian Standard on Quality Management (CSQM) 1 requires[1] firms to investigate the root cause(s) of identified deficiencies in order to evaluate their severity and pervasiveness so that remedial actions can be designed and implemented.[2] This publication is intended to provide insights into how firms can conduct effective root cause analyses. It highlights good practices observed and provides illustrative scenarios from our review of root cause analyses performed by firms.

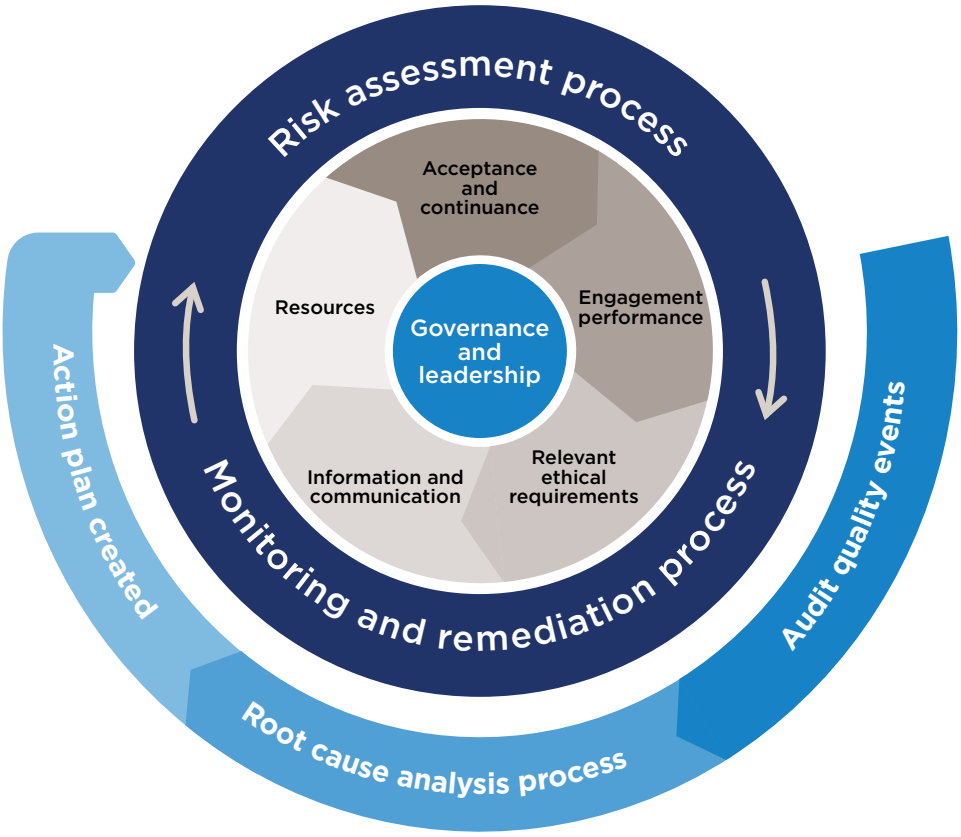
[1] Root cause analysis is required as part of the firms monitoring and remediation components in CSQM 1. CPAB's observations relating to a firm's implementation of CSQM 1 were outlined in our 2024 publication, Strengthening audit quality through systems of quality management.

[2] CSQM 1, paragraphs 41-42.

The role of root cause analysis

Root cause analysis enables a firm to make continuous and iterative improvements to the firm's system of quality management as it can help to identify weaknesses that exist in the firm's policies, procedures and controls. Root cause analysis can also help uncover audit quality risks not previously identified. Although not specifically required, it may also help to identify what is working well so that positive behaviours and actions can be reinforced. This could include examining key success factors in an engagement inspection without findings by examining what worked well in the firm's processes and controls.

CSQM 1 requires a firm to identify, understand, and evaluate the root cause(s) of deficiencies.[3] This includes external inspection findings, internal quality monitoring results, system of quality management deficiencies as well as restatements.[4] When multiple engagement level root cause analyses are reviewed collectively, leadership can use this to pinpoint systemic issues.



Examples of audit quality events:

- External inspection
- Internal quality monitoring
- System of quality management deficiency
- Restatements

[3] CSQM 1, paragraph 40 requires a firm to evaluate findings to determine whether deficiencies exist.
[4] CSQM 1 paragraphs A157-A158 clarifies that this includes accumulating findings from the performance of monitoring activities, external inspections and other relevant sources.

Performing an effective root cause analysis

An effective analysis requires engaging appropriate individuals with the necessary skills, training, experience, and understanding of how to conduct a thorough root cause analysis.[5] In some instances, CPAB has observed that a firm's root cause analysis only identifies a singular causal factor attributed to an audit quality event. For example, solely identifying factors such as insufficient partner capacity, incorrect use of a form or template by the engagement team, or a lack of technical expertise. While these areas represent contributing factors that need to be considered, they do not represent the underlying reason the quality event occurred, and more importantly, what could have prevented it. Further investigation is often necessary to uncover meaningful connections between broader causal factors that contributed to the audit quality event. The process may involve:

- Identifying an initial number of causal factors that led to the audit quality event.
- Obtaining an understanding of their impact.
- Performing a stand-back to consider if all factors were identified.
- Performing a final re-evaluation of all factors identified.

During the stand-back and re-evaluation, some of the initial causal factors should be reassessed, new factors may be identified, or the firm may decide to expand the initial scope of the root cause to other areas. This process will help the firm develop an action plan that addresses the underlying root cause(s).

Recurring and systematic themes

Recurring audit quality events are often indicative of underlying deficiencies in the firm's system of quality management.

It is important that firm leadership evaluate these thematically through an ongoing and iterative process. This can be done by gathering individual root cause analyses and compiling all causal factors such that firm leadership can perform a comprehensive review.

Effective root cause analyses drive changes that improve audit quality

The causal factors identified during a root cause analysis are used by firm leadership to develop an audit quality plan that is responsive to the causal factors. The firm should also establish appropriate monitoring metrics to evaluate the effectiveness of actions taken.

[5] There are various methods that a firm can use to perform a root cause analysis. The following articles provide additional resources on how to effectively complete a root cause analysis.

Good practices for performing an in-depth root cause analysis

Root cause analysis should involve a thorough examination of the audit quality event. It is important for the analysis to be conducted in a constructive way focused on identifying audit quality improvements.

Examples of good practices observed in firms' root cause analysis include:

Causal factors that led to the audit quality event

Using a qualified and independent interviewer

- Ensuring that the root cause analysis is performed by an independent and objective individual or group of people, who were not directly involved in the audit engagement or quality response where there was an audit quality event. For example, we have observed firms using an external service provider or a member of the firm's audit quality group.
- Providing relevant training on how to perform root cause analysis to the individual(s) conducting the root cause analysis.
- Performing interviews using tailored questions to uncover specific issues by asking the right questions.

Data collection sources and methods

- Completing the root cause analysis on a timely basis, ideally within 30-90 days of identification of the audit quality event. Prompt identification of issues can help prevent their reoccurrence.
- Collecting data using a variety of different methods. This might include conducting both individual in-person interviews as well as hosting group discussions. Other data collection methods could include the use of questionnaires or surveys.
- Conducting one-on-one interviews with key members of the engagement team. Ensure that all relevant members of the engagement team (i.e. staff/associates through to the partners, consultants, and Engagement Quality Reviewer) are given an opportunity to provide input.
- Interviewing members of the firm's quality monitoring team who were involved in the internal inspection of the impacted engagement file in the prior or current year to understand why the quality monitoring program did not identify the issue.
- Analyzing engagement and/or firm level data. For example, reviewing key resource hours on the engagement and all other chargeable and non-chargeable time incurred during the period to identify time constraints and/or conflicting demands on the engagement team.

Understanding the impact

Documentation of the analysis

- Utilizing a comprehensive template that incorporates internal and external resources on how to perform an effective analysis.
- Documenting the process performed, including all individuals that provided input and feedback.
- Documenting the tools and methods used to complete the analysis, including explaining what methods were used to gather information and how conclusions were reached.

Performing a stand-back to consider if all factors were identified

Perform the stand-back analysis

- Evaluating whether all causal factors were identified, or if there are areas where additional information may be needed. Firms may need to revisit the data collected or methods used to identify additional information.
- Investigating areas where there may be contradictory information. For example, if the engagement team noted they were working long hours, but the chargeable hours/workload analysis does not support this.

System of quality management considerations

- Examining the relationship between the audit quality event and the firms system of quality management to assess whether there is a gap in an existing quality risk or response.

Performing a final re-evaluation of all factors identified

Complete the analysis and prepare the firm's action plan

- Identifying new or modified quality risks in the firm's system of quality management.
- Developing action plans to address causal factors identified or additional quality responses for relevant quality risks identified.
- Ensuring that action plans are properly monitored and effectively completed.

Illustrative scenarios

These scenarios are based on observations from CPAB's review of firms' root cause analyses. Facts have been modified to safeguard the identities of the firms.

Scenario one: External inspection finding

A firm conducts a first-year audit for a reporting issuer in the technology industry. The reporting issuer has a high volume of low-value transactions that are processed by the company's IT platform. An external inspection found that the engagement team did not test the effectiveness of general information technology controls (GITCs) or evaluate whether substantive procedures alone provided sufficient and appropriate audit evidence. This resulted in multiple findings, including insufficient understanding of the entity, its environment and their system of internal control,[6] and insufficient audit procedures performed to test the occurrence, accuracy, and completeness of revenue.

The firm's most recent system of quality management self-evaluation did not identify any deficiencies. The following is an illustrative example of the firm's root cause analysis for the audit quality event:

Root cause analysis	Action plan
Causal factors identified: **Why**[7]: The reporting issuer was more complex than originally expected. **Why:** Technical expertise of the engagement team did not match the complexity needed for the audit engagement. **Why:** There was no process to consider matching resources based on skills and competencies. **Why:** The firm's acceptance procedures did not consider whether the engagement team had the necessary experience with the technology industry and its complex IT environment.	**Acceptance and continuance process:** The following acceptance and continuance procedures will be implemented before finalizing the acceptance and continuance decisions for any audit engagement: • Identify all necessary skills and competencies required to complete the engagement (i.e. type of entity, industries, required IT/technical expertise and any other relevant factors). • Identify and consider whether the firm has the required expertise or, if not, whether external experts are required. • Identify whether additional training is needed prior to accepting an engagement in an industry where the firm does not have experience.

[6] CPAB continues to identify significant findings around the application of Canadian Auditing Standard (CAS) 315. For more information on applying the requirements of the standard, review our publication on Identifying and assessing the risks of material misstatement.

[7] The analysis employs the Five Whys methodology, which was originally developed by Sakichi Toyoda and later detailed by Taiichi Ohno in the book *Toyota Production System: Beyond Large-Scale Production* (1988). Since its inception, this technique has been widely cited in problem-solving literature.

Root cause analysis	Action plan
Root cause identified: The firm's culture prioritizes profitability and revenue growth without considering if they have the necessary skills and resources.	• Proposed budgets for the audit engagement are prepared and reviewed to ensure an engagement team with the relevant skills and expertise is available for the audit. **Governance and leadership process:** The following key performance indicators (KPIs) for partners were implemented that focus on audit quality, including: • External inspection and internal quality monitoring results with no findings. • Compliance with the firm and professional requirements within a defined timeline. For other specific KPIs, refer to the CPAB publication, Strengthening audit quality through systems of quality management.
Causal factors identified: **Why:** The engagement team did not obtain a sufficient understanding of the business. **Why:** The budgeted hours did not include sufficient time to complete tasks because the complexity was underestimated. **Why**: All engagement activities, including engagement planning, were completed after year-end. **Why:** Partner conflicts resulted in lower supervision and review time. **Root cause identified:** The firm did not have a resourcing tool or process in place that would enable firm leadership to identify staffing concerns and whether any individuals were overextended.	**Resources process:** A new audit practice resourcing plan will work in conjunction with the acceptance and continuance procedures noted above. This plan requires that the internal or external resources be reviewed and appropriately matched for all of the firm's audit engagements. The resource plan incorporates planning time before year-end and expected filing dates, so that action can be taken early to manage competing priorities for engagement teams. The partners implemented regular meetings to review workload, monitor engagement activities, and changes to the resourcing plan, to identify issues or concerns as they arise.

Root cause analysis	Action plan
Causal factors identified: **Why:** The engagement team utilized the firm revenue template, but did not have a complete understanding of the revenue process or considerations of specific risks related to the reporting issuer. **Why:** There was a lack of professional skepticism and limited challenge of management's assumptions. **Why:** Limited supervision and review. **Why:** Lack of understanding and expertise of how to test GITC's. **Root causes identified:** • Staff and partners have insufficient training, guidance and support in the following areas: CAS 315, CAS 330, revenue and understanding, identifying and testing GITCs as well as internal controls. • Staff and partners do not have the time to prioritize learning.	**Engagement performance process:** Training and guidance materials will be obtained through external resources to cover the following topics: CAS 315, CAS 330, revenue and understanding, identifying and testing GITCs as well as internal controls. An external consultant will be engaged to provide training tailored to the issues identified in the inspection. All members of the firm are required to attend the training. Monthly lunch and learns were scheduled and are to be attended by all members of the firm. These sessions allowed continuous touchpoints for raising technical issues or concerns. Developed guidance on complex IT system and considerations of when to engage external experts.

Good practices observed during the firm's root cause analysis process:

The following good practices that contributed to the sufficiency and robustness of the analysis:

- Analysis was performed by the same external service provider that performs monitoring as part of the firms system of quality management. As this individual was independent and objective, they provided an unbiased assessment that allowed the firm to identify additional issues, nuances and subtleties that individuals more closely involved may have overlooked. The analysis performed included:
  - One-on-one interviews for all members of the engagement team with questions tailored to their role and involvement.
  - Review of the acceptance and continuance process.
  - Review of the budget to actual hours for each engagement team member for the audit engagement.
  - Review of all hours incurred by the engagement team during the audit fieldwork.

- The firm's root cause analysis template was developed by leveraging external resources. The template had links to additional training and firm guidance and external resources on how to perform an effective root cause analysis.
- The individual with operational responsibility for the firm's system of quality management reviewed the causal factors. As a result, they identified additional quality risks for the acceptance and continuance, engagement performance and resource components.
- The firm's system of quality management testing was expanded to ensure teams were using the implemented tools and templates as intended, and to gain visibility on the appropriateness of remediation activities. This increased monitoring allowed the firm to evaluate the effectiveness of the actions and provide more training and/or guidance on a timely basis.

Scenario two: Firm system of quality management deficiency

A firm identifies a deficiency in its acceptance and continuance component during its system of quality management testing to support its self-evaluation. Specifically, the firm approved the continuance of an existing audit engagement without appropriately identifying certain risk factors, which would have triggered a higher risk rating. The audit engagement was a start-up that had acquired another business during the year.

The audit firm has an audit quality group made up of two partners, one of whom has operational responsibility of monitoring and remediation.

The following is an illustrative example of the firm's root cause analysis for the audit quality event:

Root cause analysis	Action plan
Causal factors identified: **Why:** Incomplete documentation of engagement-specific risks during the engagement continuance. **Why:** Lack of firm policies or process on what is considered for acceptance and continuance decisions. **Why:** Inconsistent risk ratings for new and existing audit engagements. **Why:** No additional firm guidance on risk factors or how to evaluate risk factors were included in the form used for documenting acceptance and continuance decisions.	**Acceptance and continuance process:** The following acceptance and continuance procedures will be implemented: • Firm guidance was developed and provided to engagement teams for reference when performing acceptance and continuance procedures. This guidance provided examples and scenarios that will help engagement teams identify and evaluate risk factors. • A new formal acceptance and continuance committee made up of three of the firm's partners and a member of the audit quality group. Each member is assigned specific responsibilities to ensure all the firm's acceptance and continuance decisions are consistent and adequately reviewed.

Root cause analysis	Action plan
Why: An acceptance and continuance form is often completed by a member of the engagement team and reviewed by the engagement partner only. This process lacked a formalized review to challenge the engagement team's assessment and to ensure consistency of the acceptance and continuance decisions. **Root causes identified:** • Gaps in the design and effectiveness of responses related to the acceptance and continuance component. These gaps resulted in inconsistent risk ratings for new and existing audit engagements. • Lack of guidance and training for staff and partners to enable them to both identify the relevant engagement risk factors and how to evaluate these when determining the engagement risk rating. • There is a deficiency in the firm's monitoring and remediation process as the engagement risk rating is a data point used to select files for internal quality monitoring.	**Engagement performance process:** The following guidance and training will be implemented: • The firm's acceptance and continuance form will be enhanced to include additional questions that will help engagement teams evaluate the nature of circumstances of the audit engagement. • Specialized training will be developed and delivered to all partners and staff. This training will highlight the changes in the firm guidance and the reason for the incremental requirements in the revised templates. **Monitoring and remediation:** • A comprehensive review of the risk ratings was performed on all the firm's audit engagements. Risk ratings for new engagements will be reviewed as part of the acceptance and continuance committee review. • Semi-annual meetings were scheduled to review and assess changes to risk ratings for engagements based on media monitoring or information identified by engagement teams. • The firm's system of quality management testing is scheduled to be performed more frequently throughout the year to ensure teams were using the revised acceptance and continuance templates as intended, and to ensure the remediation activities addressed the relevant quality risks.

Good practices observed during the firm's root cause analysis process:

The following good practices contributed to the sufficiency and robustness of the analysis:

- Analysis was performed by the director of audit quality (a member of the firms audit quality group), who was independent of the audit engagements and was not involved in the design and implementation of the current processes. It was also reviewed by the partner with operational responsibility for monitoring and remediation. The analysis performed included:
  - Solicited feedback from all partners in the public company audit practice through group discussions. This included tailored questions relating to the specific engagement in question, as well as other engagements within the firm.
  - Utilized a firm survey to collect anonymous feedback from audit staff through partners about the acceptance and continuance process.
  - Reviewed the firm's audit engagement portfolio and the attributed risk rating to identify engagements with similar factors.
- The individual with operational responsibility for the firm's system of quality management reviewed the causal factors and as a result identified additional quality risks relating to the acceptance and continuance.

Key takeaways

Firms that invest in robust root cause analysis processes are better positioned to identify underlying issues, audit quality risks and to reinforce positive behaviours. As illustrated throughout this publication, an effective root cause analysis includes:

- Identifying all relevant causal factors.
- Analyzing the impact of each factor.
- Performing a stand-back analysis to ensure that all factors were identified.
- Re-evaluating all identified factors.

Firm leadership should use this information to develop targeted action plans that address underlying factors and establish monitoring metrics to evaluate the effectiveness of the actions taken.

Learn more

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