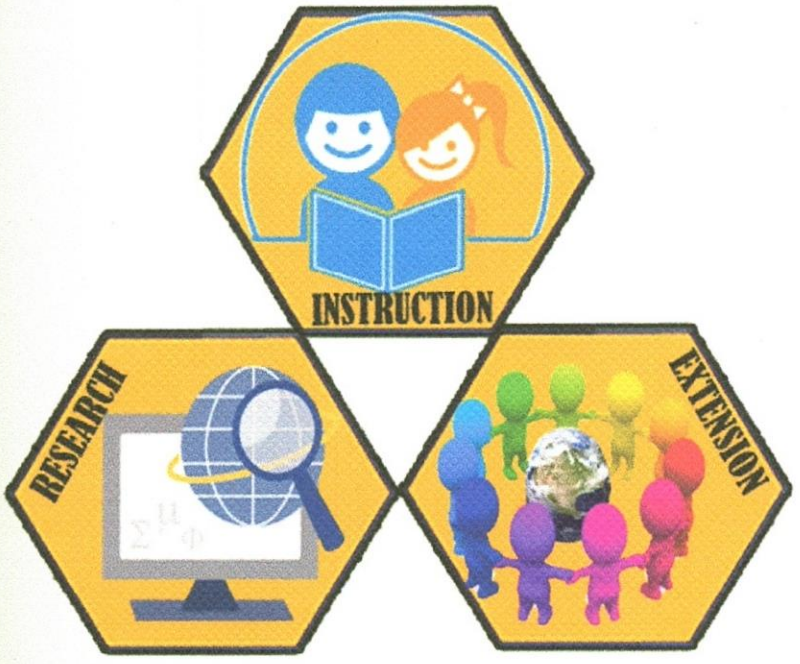
KALINGA STATE UNIVERSITY

Bulanao, Tabuk City, Kalinga



PROCEDURES AND WORK INSTRUCTIONS MANUAL

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DOCUMENT CONTROL PROCEDURE

1.0 Purpose:

To enforce a consistent method to maintain, evaluate and update the KSU QMS documentation and make sure that changes to this documentation are performed in a controlled and systematic manner.

2.0 Scope:

This procedure applies to all documents generated in the implementation of the KSU QMS. KSU personnel are responsible in adhering to this procedure to assure that controlled documents are appropriately used, updated and distributed in accordance to this procedure.

3.0 References:

National Archive of the Philippines
Administrative Manual (BOR Res. No. 670 s. 2018)
ISO 9001:2015
EO No. 2 FOI
Data Privacy Act

4.0 Definition of terms:

a. ***Internal Documents.*** These are documents generated within the confines of KSU which are identified to meet ISO 9001:2015 Quality Management System's standards such as policies, manuals, work instructions or forms. Documents may be in paper, electronic or compact discs, photograph or combination thereof.
b. ***External Documents*** .These are important information or advisories that emanate from outside and for KSU use.
c. ***Originator.*** This refers to a person or delivering unit who initiated the creation or revision of an internal document.
d. ***Copy Holders.*** This refers to a person/s or delivering unit who will effectively implement the document.
e. ***Document Creation and Amendment Form (DCAF)*** .This refers to the form used to request for creation and/or amendment of an internal document.
f. ***Reproduction Request Form.*** This refers to the form used when an internal document needs to be reproduced.
g. ***Recommending and Approving Authority.*** This refers to a person authorized to approve or reject the creation or modification and distribution of an internal document.
h. ***Board of Regents (BOR).*** This refers to the governing and policy-making body of Kalinga State University.

i. ***Records Officer.*** This refers to the person responsible in the records management of the university.
j. ***Delivering Units***. These refer to all administrative offices and academic units of the university.

5.0 Procedure of Details

1.1 Creation and Revision of Document

5.1.1 The originator accomplishes the *Document Creation and Amendment Form (DCAF)* with the approval of the concerned Unit Head.

5.1.2 The following guidelines are observed in the creation of documents:

5.1.2.1The standard contents of Quality Manual are the following

- Cover Page
- Approval Page
- Foreword
- Table of Contents
- Manual Details
- Annexes

5.1.2.2 The standard contents of a Quality Procedure are the following:

- Purpose
- Scope
- Reference
- Definition of Terms
- Details of Procedure
- Forms Used
- Standard Format Details

5.1.2.2 Control/standard content of other manuals (i.e. Central Lab Manual, Admin Manual, Faculty Manual, Library Manual, Instructional Materials Manual and among others)

- Cover Page
- Title page
- Table of content
- KSU VMGO & CORE VALUES

- OFFICE/COLLEGE GOALS AND OBJECTIVES
- Quality Policy
- Introduction
- Definition of Terms and Acronyms
- Office structure and function
- Legal basis and references
- Procedure/policies and guidelines/ flowchart
- Form
- Quality Control Plan
- KSU Hymn (Back Cover)
- Annexes (Planning tools- RIP, SWOT, RORA, Quality Objectives)

5.1.2.3 The standard contents of a form are the following:

- Title
- Form Code
- Latest Revision Date
- Control Number, if necessary
- Contents
- Prepared by, if applicable
- Approved by, if applicable

5.1.3 Documents are coded as follows:

5.1.3.1	***QUALITY MANUAL***	***KSU-QM-1***
5.1.3.2	***QUALITY PROCEDURE***	***KSU QP-1***
5.1.3.3	***QUALITY FORM***	***KSU QF-XXX-003***

Wherever necessary, the following Codes per Office shall be used;

OFFICE NAME	OFFICE CODE
Office of the University President	PRES
Office of the Board Secretary	OBS
Board of Regents	BOR
Office of the Vice President for Academics and Student Development	VPASD
Office of the Vice President for Administration and Finance	VPAF
Office of the Vice President for Research and Development, Extension and Training	VPRDET

OFFICE NAME	OFFICE CODE
Office of the Campus Administrator	OCA
Office of the Director for Student Development Services and Placement Services	DSDS-PS
Office of the University Registrar	UR
Office of the Director for Income Generating Unit	IGA
Office of the Director for Sports and Socio-Cultural Affairs	DSSCA
Office of the Director for Quality Assurance	QA
Office of the Director for Administration Services	AS
Office of the Director for Extension and Gender Development Focal Person	EGDFP
Office of the Director for Open Distance Education , Transnational Education and International Linkages	ODTEIL
Office of the Director for Professional Training and Development	PTD
Office of the Director for Library Services	DLS
Office of the Director for Central Laboratory	DCL
Office of the Director for Planning and Infrastructure	PI
Office of the Sentro ng Wika at Kultura	SWK
College of Law	LAW
College of Engineering, and Information Technology	CEIT
College of Agriculture	COA
College of Forestry	COF
College of Education	COED
College of Criminal al Justice Education	CCJE
College of Public Administration and Indigenous Governance	CPAIG
College of Health and Natural Sciences	CHNS
College of Liberal Arts	CLA
College of Business Administration, Entrepreneurial, and Accountancy	CBAEA
College of Agro-Forestry and Environmental Sciences	CAFES
Laboratory High School	LHS
Records and Archives Section	RAS
Office of the Director for Administrative Services	ODAS
General Services Office	GSO
Financial Management Office	FMO
Supply Office	SO
Procurement Management Office	PMO

OFFICE NAME	OFFICE CODE
Bids and Awards Committee Office	BAC
Record and Archives Section	RAS
Medical and Dental Office	MDO
Counseling, Placement and Testing Office	CPTO
Scholarship Office	SO
Administration Publication	AP
NSTP and ROTC Office	NSTP/ROTC

5.1.4 Standard Format Details

5.1.4.1 Official paper size: 21 cm X 29.7 cm (A4)

5.1.4.2 Margin: 1.5" left, 1 "other sides

5.1.4.3 Font: Arial, font size is 11

5.1.4.4 Alignment and spacing: Justified, 1.15 line spacing

5.1.4.5 Document header will appear on the first page of the form for official Communication

1.4.5 Forms Used

	Kalinga State University Quality Management System Control of Records	Doc. Ref No.:	
		Effectively Date:	
		Revision No.:	
		Page No.:	

5.2 Review and Approval

5.2.1 The concerned process owner submits the draft document or proposed document for deletion to the recommending and approving authority

Recommendation and approval of all documents are as follows:

DOCUMENT TYPE	REVIEW AND ENDORSEMENT	APPROVAL/DISAPPROVAL
Quality Manual	Academic and Administrative Council	Board of Regents
Policies, Procedures, and Guidelines	Academic and Administrative Council	Board of Regents
Forms • University wide • College/Campus wide • Unit/section wide	College Council College Council Unit/Section Committee	Board of Regents

5.2.2 Approved documents are forwarded to the Records and Archives Section. Disapproved documents are returned to the **originator**.

6.1 Registration of Documents

6.1.1 All approved new/revised documents will be forwarded to the Records and Archives Section.

6.1.2 The Records Officer will remove the superseded documents in case of revisions and old documents will be archived.

6.2 Controlling Documents of External Origin

The following are identifies as Documents of External Origin:

- *CHED Memorandum Order*
- *CSC Memorandum*
- *DBM Circulars*
- *Invitations/Communications e.i Trainings/Seminars, Scholarship grants, LGU activities, Research presentation*
- *Administrative orders from National and Local Government*

6.2.1 External documents are registered in a logbook at the Record Section for coding purposes and acknowledgement receipt will be issued.

6.2.2 External documents received electronically (e.g. via e-mail) is printed to facilitate registration (and subsequent review and distribution).

6.2.3 The Records Office shall ensure that ~~all~~ documents of external origin received by the University shall be included in the document Master for external documents.

6.2.4 In case a specific unit receives external documents, he/she surrenders the original copy to the Records and Archives Section for control and proper action or distribution if necessary.

6.2.5 The Records Officer will acknowledge the externally sourced documents through email if received electronically and manually if received by hard copy with corresponding control number.

6.2.6 The e-copy of the approved document should be submitted to the Records and Archives Section.

6.3 Distribution of Documents

6.3.1 A master copy of each internal document is retained by the Records Officer until revised.

6.3.2 Controlled copies of documents are photocopied from master copies, authenticated and stamped prior to distribution to copyholders within five (5) days upon receipt of the documents. The Record Officer shall ensure that all copyholders indicated in the distribution list in the procedure are provided with controlled copies.

6.3.3 All authorized copyholders are responsible in ensuring that the latest approved documents is used and filed properly. Copyholders sign on the LOGBOOK upon receiving their respective copies.

6.3.4 The superseded copies be returned to the Records Officer.

6.3.5. In case of requests for copies of documents, the requesting unit/individual accomplishes the Reproduction Request form with the approval of the unit head.

6.3.6 For confidential documents, only the concerned individual or the head of the Institution or representative of the concerned employee with Special Power of Attorney is allowed to request for a copy to ensure the secrecy of the documents.

6.4 Filing and Storage of documents

6.4.6 Each unit is responsible in filing and properly storing their documents.

6.4.7 The Records Office will ensure the availability of the documents anytime needed and shall be filed accordingly with proper labeling of all documents for easy retrieval and to prevent damage and loss.

6.5 Archiving of Obsolete Master Copy

6.5.6 Obsolete master copy is stamped "Obsolete Copy" in red ink to prevent unintended use. Obsolete master copies of documents are retained/disposed based on the provisions of the NAP.

6.5.7 Records Office ensures that superseded or obsolete documents are identified to prevent improper use.

6.5.8 Other obsolete controlled copies of documents are collected / disposed by the Records Office.

1.0 Purpose

This procedure defines the control needed to ensure that records are easily and readily identifiable, retrievable, and accessible when needed; and provide adequate security and suitable storage, to protect from physical deterioration or damage, loss, confidentiality and integrity

2.0 Scope

This procedure applies to records required by ISO 9001-2015 as well as records identified by Kalinga State University as required for the effective management and control of records.

3.0 References

Control of Documents
National Archives of the Philippines (NAP) Guidelines
Administrative Manual
ISO:9001.2015

4.0 Definition of Terms

Record	A document stating results or providing evidence of activities performed. Records can be used to document traceability and to provide evidence of verification, preventive action, and corrective action. Generally records need not be under revision control (Control of Documents Procedure). Records may use different media, including paper, electronic, photograph or a combination thereof.
Active Records	Records that are currently being maintained, used and controlled. These records are normally kept in desk/ workstation drawers or nearby filing cabinets, shelves or racks for easy access and retrieval.
Inactive Records	Records that are very rarely or no longer referred to, and which must be transferred to another place (e.g. the Office Records Center). These records have already served their purpose but must be kept just the same for legal requirements or some compelling reasons. They are only destroyed the moment their retention periods have expired.

Records Disposition Schedule	A listing of records series by organization showing, for each record series, the period of time it should remain in the office area, in the storage (inactive) area, and its preservation or destruction
Retention Period	Refers to the specific period of time established and approved by the National Archives of the Philippines as the life span of records, after which they are deemed ready for permanent storage or destruction.
Confidential Record	Records that can be released only to identified/ authorized persons

5.0 Procedure Details

Ref. No.	Key Activities		Responsible	Reference Document/ Record
5.1	Collect and identify records	• Collect records • Ensure identification of records • Establish a filing system (See Section 5.1.1-4,)	Records Officer Process Owner	
5.2	Store and protect records	• Store properly • Protect records appropriately (See Section 5.2.1)	Records Officer Process Owner	
5.3	Retrieve and maintain active records	• Update NRI • Maintain properly the active records (See Section 5.3.1-3)	Records Officer Process Owner	• National Records Inventory (NRI) • Logbooks
5.4	Maintenance and disposal	• Update NRI • Turnover inactive records • Convert to e-files	Records Officer	• NRI

5.1 Collection and Identification

5.1.1 Records are identifiable through the following information, as appropriate:

a. File Name
b. Date(s)
c. Document Tracking Number
d. Name of signatory/ies

5.1.2 Records are collected upon availability from their source, for appropriate filing by the Records Officer or concerned office.

5.1.3 In case of erasure or correction, the corrected data are countersigned by the employee who corrected it or any authorized personnel at the records office.

5.1.4 All records are signed by authorized personnel. The reviewer ensures that said records are legible and contain sufficient information as basis for its endorsement or approval. Hence, records without the signature of approving authorities except e-copies are considered "unofficial".

5.2 Storage and Protection

5.2.1 Records are safely kept in appropriate locations to minimize physical deterioration, damage and/or loss. For protection purposes, the following practices are observed:

a. Use of expanded folders/envelopes and/or ring binders;
b. Placed in a labeled magazine files and stored in shelves or steel cabinets to prevent wear and tear;
c. Electronic copies of records are saved in a computer, equipped with password at the records office.

5.3 Retrieval and Retention

5.3.1 For easy retrieval, filing cabinets, shelves, boxes, magazine files, folders, and envelopes are labeled. Likewise, the National Records Inventory is maintained indicating information, such as: Records series title and description, period covered/Inclusive date, Volume, Records Medium, Restrictions, Location of Records, Time Value, Retention Period and Name of signatory/ies

5.3.2 Photocopy of the records requested by other offices or personnel are traced using logbooks indicating the complete name, name of record borrowed, control number, date released and signature.

5.4 Maintenance and Disposal

5.4.1 Maintenance and disposal of records are done in accordance with the Records Retention and Disposition Schedule.

5.4.2 Records such as request form and request slip after it has served its purposed will be disposed

5.4.3 For easier safekeeping, permanent records may be converted to e-files, except for records that require original copy bearing authentic signatures.

6.0 Attachment

6.1 KSU Records Retention and Disposition Schedule. *(Annex A)*

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University President

1.0 Purpose

This document describes the procedure and resource requirements for the objective evaluation of the effectiveness of the established quality management system of Kalinga State University. It defines the system for the planning, preparation, execution, follow-up, and reporting of IQA activities in determining if the Quality Management System (QMS) conforms to the planned arrangements, to the requirements of ISO 9001, and to the established QMS; and if the QMS is effectively implemented and maintained.

2.0 Scope

The procedure applies to KSU main campus processes that include Admission, Registration, Instruction and Conferment of degrees.

3.0 References

Corrective Action Procedure
PNS ISO 9001:2015
KSU Faculty Manual

4.0 Definition of Terms

Auditee	The Office or person being audited
Auditor	The person with demonstrated personal attributes and competence, assigned or appointed to conduct an internal quality audit
Audit Team	Composed of more than one auditor who are assigned to conduct an audit in a particular office and prepare necessary report of findings; Led by an Audit Team Leader
Audit Plan	A documented yearly plan of audit activity of the agency.
Audit Itinerary	A documented plan prepared prior to the conduct of audit which details activities such as where to go, what to do, when to do, and whom to see A detailed implementation of the content of the audit plan in a particular office
Audit Checklist	A set of items/questions which serves as a guide to an auditor
Audit Criteria	Set of policies, procedures, or requirements which are used as reference against which audit evidence is compared
Audit Evidence	Record, statement of facts or other information, which is verifiable and relevant to the audit criteria

Audit Finding	Result of the evaluation of the collected audit evidence against audit criteria
Conformity	Fulfillment of a requirement
Nonconformity (NC)	A non-fulfillment of a requirement
Opportunity for Improvement (OFI)	A situation or process that may lead to potential nonconformity
Corrective Action (CA)	Action taken to eliminate the cause of a detected nonconformity or other undesirable situation to prevent its recurrence or occurrence elsewhere.
Request for Action (RFA)	A tool/form used to record the audit findings and the corresponding root cause analysis and appropriate actions taken to address it
IQA Committee	List of Internal Quality Auditors of Kalinga state University The IQA Committee is formed to oversee the IQA implementation The IQA committee is under the office of QA.
Faculty Training and Development Committee (FTDC)/Personnel Training and Development Committee (PTDC)	A committee that assesses and evaluates the trainings and seminars of the teaching and non-teaching staff; and the study leave of faculty members aligned to their fields of specializations.

5.0 Procedure

Ref. No.	Key Activities		Responsible	Reference Document/ Record
5.1	Select and manage audit team	▪ Refer to the required skills and knowledge ▪ Enhance the Auditors' competence	QA Director	▪ Auditor Training Certificates ▪ Pool of Auditors
5.2	Plan for the IQA	▪ Prepare the Audit Plan ▪ Initiate the conduct of the unplanned audit ▪ Disseminate the Audit Plan ▪ Communicate the Audit Itinerary	▪ QA Director ▪ IQA Committee Chairman	▪ Audit Plan ▪ Audit itinerary ▪ List of Internal Quality Auditors
5.3	Prepare for the IQA	▪ Review the applicable documents ▪ Develop Audit Checklist	▪ Audit Team Leader and Auditors	Audit Checklist
5.4	Conduct the IQA	▪ Conduct opening meeting ▪ Interview the auditees ▪ Review documents and records ▪ Record facts and evidence ▪ Inform the auditee regarding the audit findings and its classification ▪ Raise to the QA director or the IQA team leader the unresolved issues ▪ Conduct closing meeting	▪ Audit Team Leader and Auditors	▪ Audit Checklist
5.5	Reporting the IQA	▪ Document the findings ▪ Assign control numbers and recording in RFA Registry ▪ Issue the RFA ▪ Conduct root-cause analysis	▪ QA director ▪ IQA Committee Chairman ▪ Audit	▪ Audit Summary Report ▪ Control of Nonconforming Outputs

Ref. No.	Key Activities		Responsible	Reference Document/ Record
		▪ Determine and implement Corrective Action Procedure ▪ Submit accomplished RFA	Team Leader	▪ Corrective Action Procedure ▪ RFA ▪ RFA Logbook
5.6	Verifying Actions Taken	▪ Verify actions taken ▪ Monitor the verification	▪ Concerned Office, ▪ IQA Team Leader and Auditors	▪ Corrective Action ▪ RFA ▪ RFA Logbook

5.1 Selection and Management of Audit Team

5.1.1 Selection of audit team to conduct audit for a particular office will be done by the office of the Quality Assurance (QA) to be endorsed to the office of the president for approval and designation.

5.1.2 Selection of auditors for specific assignments, consider the following :

a. The personal attributes of the auditor include at minimum ethical, open-minded, diplomatic, observant, perceptive, versatile, tenacious, decisive, self-reliant, objective and impartial
b. Knowledge on auditing concepts and methodologies
c. Auditing skills
d. Knowledge on ISO 9001-2015 requirements and the QMS of the organization vis-à-vis audit requirements of the auditee
e. Attended training on auditing QMS

5.1.3 Auditor performance is reviewed considering the following:

a. Feedback from the IQA team leader, other auditors and the auditee
b. The quality of audit checklists and audit reports

5.1.4 The competencies and performance of auditors are periodically evaluated to identify training and development needs. The Director for Quality Assurance coordinates with the PTDC/FTDC to plan and implement training and development program for auditors.

5.1.5 The pool of auditors is maintained by the office of Quality Assurance.

5.1.6 To ensure impartiality, auditor must not audit their own respective department/unit

5.2 Planning for the IQA

5.2.1 The Audit Plan for the 12-month period is prepared by the QA director and approved by the University President before the start of a calendar year. Each QMS process is audited at least once in a year. Whenever necessary, unplanned IQA may be initiated by the QA Director based on, but not limited to the following:

a. unusual increase of quality-related problems
b. introduction of new services
c. major changes in QMS, personnel, and processes
d. as per client's complaint

5.2.2 Copies of the Audit Plan are disseminated to all concerned unit through a memorandum from the QA Director.

5.2.3 The IQA Committee shall meet a month before the conduct of IQA to prepare the audit itinerary. The Audit Itinerary is communicated through a memorandum from the QA Director to all concerned offices at least a month prior to the activity. The communication includes the following:

a. purpose
b. IQA scope
c. offices to be audited and auditee
d. assigned Audit Team
e. date and time of the IQA

5.3 Preparing for the IQA

5.3.1 The Audit Team reviews applicable documents such as the QMS Manual, Procedures, Guidelines, Office Orders, Memorandum Orders, Special Orders and applicable statutory and regulatory laws.

5.3.2 Audit Checklists are developed based on the audit scope, objectives, and document review.

5.4 Conducting the IQA

5.4.1 The Team Leader starts with an opening meeting to reconfirm audit schedule, audit objective, and audit participants.

5.4.2 The Audit Team gathers data by interviewing personnel, reviewing documents, observing processes, and verifying records.

5.4.3 The Audit Team records facts as evidence of the audit and evaluates the same to determine the objective evidence of the audit findings.

5.4.4 The audit findings are classified as Conformity, NC or OFI. Commendations and strengths of the system are also noted.

5.4.5 If and when the auditee has unresolved issues with an audit finding, he/she may contest such before or during the closing meeting.

5.4.6 If not resolved at this level, the issue may be raised to the QA Director. If further not resolved, then escalate it to the office head.

5.4.7 A closing meeting is conducted wherein audit findings are presented to the audited office.

5.5 Reporting the IQA

5.5.1 Audit findings are documented on the Request for Action (RFA) form and Audit Summary Report.

5.5.2 Control Numbers are assigned to the RFA for monitoring purposes. These are recorded in the RFA logbook maintained by the Office of QA.

5.5.3 The RFA with the Audit Summary Report are issued to the auditee within ten (10) working days after the closing meeting. The auditee acknowledges and signs the RFA.

5.5.4 The auditee with the unit head determines and implements appropriate correction and corrective action in accordance to Corrective Action procedure. The auditee returns the accomplished RFA to the IQA Committee within 10 working days.

5.5.5 The concerned unit head ensures implementation of actions taken.

5.5.6 The summary of the audit findings and actions taken shall be reported to the management during the management review.

5.6 Verifying Actions Taken

5.6.1 The auditors verify the implementation of the actions taken specified in the accomplished RFA. The results of such verification are monitored as per Corrective Action procedure.

6.0 Attachments

6.1 Audit Plan *(Annex B)*
6.2 Audit Itinerary *(Annex C)*
6.3 Audit Checklist *(Annex D)*
6.4 Audit Summary Report *(Annex E)*

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1.0 Purpose

The purpose of this procedure is to ensure that products and services that do not conform to the requirements are controlled to prevent their unintended use or delivery, or if delivered, to ensure that appropriate remedies are effectively taken.

2.0 Scope

This procedure applies to the outputs of Kalinga State University.

3.0 References

Corrective Action Procedure
Guidelines for Monitoring and Measuring Client Satisfaction

4.0 Definition of Terms

Nonconforming outputs	Outputs that do not fulfill requirements. Outputs may mean products or services. Products refer to physical items, such as reports and other documents prepared and released in conjunction with service delivery. Examples of physical products are documents like certificates issued, reports, etc. While coordination and advocacy activities are examples of services provided by Kalinga State University. Examples of nonconforming products are error on student's transcript of records, incorrect student's information, missing documents, etc. Delayed release of student's transcript of records, late submission of student's grades by faculty member and the like are nonconforming services.
Initial Disposition	Action taken to correct and contain the nonconforming product/service and minimize its immediate effect. This may include putting the nonconforming product on hold and setting it aside, or temporarily discontinuing service delivery.
Correction	Action taken to correct the nonconforming product/service, to make it conform to requirements or otherwise prevent its unintended use or delivery. This may include reworking, regarding or scrapping of nonconforming products, or redoing the service.

Concession	Permission to use or release a product or deliver a service that does not conform to specified requirements. A concession is generally limited to the delivery of a product that has nonconforming characteristics within the specified limits for an agreed time or quantity of that product.
Corrective Action	Action to eliminate the cause of a detected nonconformity (nonconforming product/service) or other undesirable situation, and prevent recurrence.
Process Owner	Individual/office whom/where the process being performed is where the NC is detected Employee/ office responsible for the performance of a process and ensuring that objectives are realized, and that appropriate actions are carefully reviewed and approved and are taken without undue delay to eliminate nonconformities and their causes.

5.0 Procedure Details

Ref. No.	Key Activities		Responsible	Reference Document/ Record
5.1	Identify nonconforming product/service	▪ Detect nonconforming product/service ▪ Receive citizen feedback on NC product/service	Process Owner	Applicable Issuance or Procedure
5.2	Determine and apply initial disposition	▪ Isolate NC product, and/or temporarily stop process/service delivery, following the control of NC matrix ▪ Provide initial response to client feedback, as needed	Process Owner	Control of Nonconformity Matrix, Applicable Issuance or Procedure

Ref. No.	Key Activities		Responsible	Reference Document/ Record
5.3	Determine and apply final disposition	▪ Review the nonconforming product/service situation and approve final disposition ▪ Obtain product concession, correct NC product, scrap product, or restart service delivery following the control of NC matrix ▪ Provide final response to client feedback, as needed	Service/ Office Head	Applicable Issuance or Procedure, Control of Nonconformity Matrix
5.4	Apply corrective action	▪ Prepare a Request for Action (RFA)	Process Owner	Request for Action (RFA), Corrective Action Procedure

5.1 Identifying Nonconforming Product/Service

5.1.1 Nonconforming products/services may be detected internally by concern university employee as they perform their functions, through observation, monitoring, inspection, verification and review.

5.1.2 The possible nonconformities may occur in the following areas, but not limited to:

a. Management Process (absence of communication protocol, lack or delayed provision of needed resources).

b. Core Processes

- Core Operations (eg: research, extension and instruction)

c. Support Processes (Absence of preventive maintenance schedule, delivery of products/ materials which are noncompliant to purchase request specifications)

5.1.3 Nonconforming products/services may also be detected externally by the client through feedback or complaints as detailed in the Guidelines for Monitoring and Measuring Client Satisfaction.

5.1.4 When nonconforming products/services are detected, they shall be evaluated against requirements defined in applicable operating procedures, process guidelines, product/service guidelines, or quality plans.

5.2 Determining and Applying Initial Disposition

5.2.1 Initial disposition is meant to contain the problem so that no additional nonconforming products/services are produced or delivered, and/or prevent already nonconforming product/service from worsening.

5.2.2 The Control of Nonconformity Matrix outlines the initial specific actions which need to be taken and by who. Actions may include the following:

a. Tagging or marking the documents or records to identify it as nonconforming (e.g. clear marking of ERROR)

b. Segregating the documents/records and storing it in a location designated for nonconforming products to prevent it from being mixed with conforming product (e.g. obsolete documents are archived in a separate cabinet)

c. Retrieving or withdrawing the nonconforming product from the client (e.g: error in the transcript of records, diploma)

i. When the nonconforming product/service is detected just prior to the client or at any time thereafter, the client shall be informed of the nonconforming product/service

5.3 Determining and Applying Correction

5.3.1 Final disposition is meant to correct the problem so that the product/service is made to conform to requirements, or if it cannot be made to conform, is prevented from unintended use or delivery.

5.3.2 The Control of Nonconformity Matrix outlines the initial specific actions which need to be taken and by whom. Actions may include the following:

a. Review- action on a product to make it conform to requirements.
b. Repair - action on a nonconforming product to make it acceptable for the intended use.
c. Scrap - action on a nonconforming product to preclude its originally intended use. This may include recycling or destruction.
d. Concession - obtaining permission (from the Unit, Department Head and/or the client) to use or release a product that does not conform to specified requirements.
e. Re-evaluations/re-testing to demonstrate conformity to specifications.
f. Adjusting an ongoing service.
g. Restarting a service that has been temporarily discontinued.
h. Redirecting to other services or service providers.

5.3.3 Final disposition may require the approval of the concerned unit and/or Department Head, depending on the gravity of the situation and its cost implications.

5.3.4 Final disposition is recorded through the Incident Report to provide traceability and evidence of actions taken and data may be used for analysis and continual improvement of the process.

5.4 Applying Corrective Action

5.4.1 Further action shall be undertaken to prevent recurrence of the problem, when:

a. the nonconforming product/service is identified via a client complaint
b. monitoring shows that nonconforming product/service are recurring
c. the frequency and extent of nonconforming product/service are increasing
d. correction requires that the nonconforming product be reworked or replaced, or for the service to be restarted or

redirected, incurring significant cost in time and resources

e. the nonconforming product/service represents legal implications to the organization, the client, or both

5.4.2 Further action shall be subject to the Corrective Action procedure.

5.5 Provisions for detecting and correcting nonconforming product/service shall be planned and outlined in the Control of Nonconformity Matrix. The plan links with controls built into the operating processes, as documented in the operating procedures, process guidelines, and product/service guidelines. The nature of nonconforming products/services and subsequent actions taken shall be captured in process and monitoring records. The plan shall be periodically reviewed for adequacy and effectiveness.

6.0 Attachment

6.1 Control of Nonconformity Matrix *(Annex F)*

Prepared by:

BERNADETTE C. AGGABAO, PhD
Audit Team Leader

Reviewed by:

SHEILA MAY CAROL A. BUSLIG,PhD
Director, Quality Assurance

Approved by:

EDUARDO T. BAGTANG,CPA,DBM
University President

1.0 Purpose

The purpose of this procedure is to ensure that causes of detected nonconformities are eliminated in order to prevent recurrence.

2.0 Scope

This procedure applies to nonconformities found in the implementation of the quality management system.

3.0 References

Internal Quality Audit
Control of Nonconforming Outputs

4.0 Definition of Terms

Nonconformity	Non-fulfillment of a requirement
Corrective Action	Action to eliminate the cause of a detected nonconformity or other undesirable situation, and prevent recurrence

5.0 Procedure Details

Ref. No.	Key Activities		Responsible	Reference Document/ Record
5.1	Review detected and potential nonconformity	▪ Receive and review the Request for Action ▪ Identify concerned staff who will be involved in corrective action	Process Owner	Request for Action (RFA)
5.3	Determine the cause of nonconformity	▪ Conduct root cause analysis	Process Owner	RFA
5.4	Determine and implement the action needed	▪ Develop, plan and recommend corrective actions ▪ Approve	Process Owner	RFA

Ref. No.	Key Activities		Responsible	Reference Document/ Record
		corrective actions ▪ Implement corrective actions		
5.5	Review corrective action taken	▪ Review the implementation status and evaluate the effectiveness of corrective actions	Management QMR	RFA, Corrective Action Status Report

5.1 Reviewing Nonconformity

5.1.1 The corrective action procedure is triggered by Request for Action from other processes/procedures in response to identified nonconformities from:

a. internal quality audits
b. client's complaints (from the Monitoring and Measurement of Client Satisfaction)
c. qualified nonconforming outputs (from Control of Nonconforming Outputs)
d. poor process performance results and unacceptable deviations from the organization's programs and plans (from management reviews)

5.1.2 The initial review of the Request for Action considers:

a. The extent and impact of the reported nonconformity.
b. The processes contributing to and affected by the reported nonconformity.

5.1.3 The Unit identifies concerned personnel who need to be involved in corrective action. This may extend to personnel outside his/her own department/college; coordination with the other concerned departments/college should be established.

5.2 Determining the Cause of Nonconformity

5.2.1 All occurring nonconformities are subjected to root cause analysis to be able to come up with corrective action plans.

5.2.2 Root cause analysis considers the different factors contributing to the nonconformity, including:

a. Manpower - personnel competencies and their ability to consistently perform their functions as required.
b. Machine - the availability of appropriate tools, equipment and facilities to enable effective operations
c. Methods - the availability and consistent application of appropriate procedures, guidelines and standards
d. Materials - the availability of the needed materials and supplies to enable effective operations.
e. Environment – the condition of the surroundings, facilities, and work environment

5.2.3 Where several root causes are identified, they are prioritized relative to their contribution to the nonconformity

5.3 Determining and Implementing Corrective Actions

5.3.1 Based on the root causes identified, corresponding corrective action plan is developed and approved by the Division Chief.

5.3.2 Planning of corrective actions (solutions) involves the following:
a. generation of alternative solutions
b. the selection of the best solution (from the alternatives)
c. the identification of activities, resources, responsibilities and timeliness needed to implement the selected solution.

5.4 Reviewing the Status of Corrective Actions

5.4.1 The IQA Committee reviews the root causes and corrective action plans documented in the RFA. The Committee also monitors the implementation of the action plans.

5.4.2 The implementation status and effectiveness of corrective actions is also periodically reviewed and evaluated by the concerned unit head; any related issues are primarily addressed.

5.4.3 Corrective actions are collectively reviewed by the Management Committee (under management review). Depending on the nature of the solution and the associated nonconformity, monitoring and review continues for at least 6 months after implementation, after which the corrective action is deemed completed.

6.0 Attachment

6.1 Request for Action *(Annex G)*

Prepared by:

BERNADETTE C. AGGABAO, PhD
Audit Team Leader

Reviewed by:

SHEILA MAE CAROL A. BUSLIG,PhD
Director, Quality Assurance

Approved by:

EDUARDO T. BAGTANG,CPA,DBM
University President

A. Definition of Terms

Issues	Internal and external issues, as well as issues of interested parties; should be stated with adjective
Risk	Effect of uncertainty
Opportunity	Can lead to the adoption of new practices, launching new products, opening new markets, addressing new clients, building partnerships, using new technology and other desirable and viable possibilities to address the organization's or its customers' needs
Consequence to Outputs	Possible impact to the quality of outputs
Consequence Rating	Measures of impact of the consequence; Refer to criteria for consequence
Likelihood Rating	Measures the probability of occurrence of the consequence
Risk/Opportunity Rating	Measures the need for action using the criteria for action matrix
Action Priority	Measures whether the risk should be treated or not; whether opportunity should be pursued or not
Action Plan	Plan of activities that will prevent the occurrence of the risk or that will maximize the benefits of the opportunity
Timelines	Period covered that the action plan shall be implemented

B. Criteria for Consequence

	Rate	Risk (Negative consequence)	Opportunity
Insignificant	1	Minimal (no customer complaint) or no impact	No perceived value for improvement and sustainability
Minor	2	Minor impact (noticeable effect, minor customer complaint)	Pursuing the opportunity will slightly improve QMS and sustainability
Significant	3	Moderate impact (customer complaints resulting in claim)	Pursuing the opportunity will considerably improve QMS and sustainability
Major	4	Major impact (catastrophic, recall, fatality, costly compensation, legal action) alternatives available	Pursuing the opportunity will highly improve QMS and sustainability
Catastrophic	5	Major impact (catastrophic, recall, fatality, costly compensation, legal action) no alternatives available	Pursuing the opportunity will greatly improve QMS and sustainability

C. Criteria for Likelihood

	Rate	Likelihood – Risk	Likelihood - Opportunity
Rare	1	Not known to happen	No chance of success within the next 12 months
Low	2	Low occurrence of 1 x a year	1-25% chance of success within the next 12 months
Medium	3	Known to happen, occurrence of 1 per quarter	26-50% of success within the next 12 months
High	4	Very likely to happen, occurrence of more than 1 time per quarter	51-75% of success within the next 12 months
Very High	5	Highly likely to happen, occurrence of 1 time per month.	>75% success within the next 12 months

D. Risk Rating Matrix

LIKELIHOOD						
	Rare	**1**	**2**	**3**	**4**	**5**
	Unlikely	**2**	**4**	**6**	**8**	**10**
	Possible	**3**	**6**	**9**	**12**	**15**
	Likely	**4**	**8**	**12**	**16**	**20**
	Certain	**5**	**10**	**15**	**20**	**25**
		Insignificant	**Minor**	**Significant**	**Major**	**Catastrophic**
	IMPACT					

E. Criteria for Action

Risk/Opportunity Rating	PRIORITY	MANAGEMENT'S DECISION	
		RISK	OPPORTUNITY
10-25	HIGH	Take immediate appropriate action to eliminate the risk	Pursue the opportunity
5-9	MEDIUM	More frequent monitoring of performance/complaints	May consider pursuing the opportunity
1-4	LOW	No action required	No action required

Knowledge management is the process of organizing and managing knowledge and information in the organization with the end view of sustained s systematic storage, refinement of knowledge systems and the creation of new knowledge.

Below is an example of the a knowledge matrix of the organization.

Process	Knowledge Required	Method of Acquisition	Method of Transfer	Documented Information
Ex. Strategic Planning	Knowledge in conducted SWOT and PESTLE analysis	Exposure to strategic planning workshops/training	Conduct workshop/training on strategic planning among unit heads	KSU Strategic Plan 2018-2022

Prepared by:

BERNADETTE C. AGGABAO, PhD

Audit Team Leader

Reviewed by:

SHEILA MAY CAROLA A. BUSLIG,PhD

Director, Quality Assurance

Approved by:

EDUARDO T. BAGTANG,CPA,DBM

University President

Prepared by:

BERNADETTE C. AGGABAO, PhD
Audit Team Leader

Reviewed by:

SHEILA MAE CAROL A. BUSLIG,PhD
Director, Quality Assurance

Approved by:

EDUARDO T. BAGTANG,CPA,DBM
University President

1.0 Purpose

Kalinga State University determine the internal and external communications relevant to the quality management system, including:

a) What to communicate;
b) When to communicate;
c) With whom to communicate;
d) How to communicate;
e) Who communicates

2.0 Scope

The procedure applies to KSU main campus processes that include Admission, Registration, Instruction and Conferment of degrees. All units/offices are responsible in adhering to this procedure to assure that internal and external communication are properly communicated to concern people or office.

3.0 References

PNS ISO 9001:2015 Clause 7.4

4.0 Definition of Terms

Internal Communications	Are communications that are applicable only between and among offices in the university
External Communications	Are communications that involve outside agencies either emanating from the college to outside agencies or vice versa

5.0 Procedure

See attach BOT approved internal communication flow (Chapter XIX Article 1 of the University Code)

6.0 Attachments

6.1 Communication Form (Annex H)
6.2 Chapter XIX Article 1 of the University Code (Annex I)

1.0 Purpose:

To enforce a monitoring and evaluation system in order to control all externally provided products and services.

2.0 Scope

Kalinga State University ensure that externally provided processes, products and services conform to requirements. The University determined the controls to be applied to externally provided processes, products and services such as infrastructure projects, goods and services.

A. Infrastructure Projects

Evaluation on the performance of contractors of KSU building projects shall be evaluated just after the completion of the project and again upon issuance of the Certificate of Final Acceptance which is one (1) year after the completion.

Two (2) categories of infrastructure projects will be subject for evaluation, one (1) for those that were awarded under small value (having an ABC of less than one (1) million pesos) and another for those that were awarded through competitive bidding projects having more than one million of ABC.

The evaluation will use the Evaluation Form attached. In addition to the provisions of RA 9184 the result of the evaluation will be used as one of the basis of the BAC action in recommending to the HOPE, through resolution, for his (HOPE) reference in his final decision.

Contractors rated as below satisfactory for two (2) previous projects in the university will not be considered in future projects.

B. Goods

Evaluation of external providers/suppliers of goods to the University will be evaluated semi-annually, except the DBM Procurement Service (DBM-PS). Suppliers/providers of goods for evaluation will be clustered in to the following categories: (a) the amount is greater than 3,000 pesos but less than 100, 000 pesos, (b) the amount is greater than 100,000 but less than 500, 000 pesos, (c) the amount is greater than 500,000 pesos but less than 1 million pesos, and (d) the amount is greater than 1 million pesos (awarded through competitive bidding).

The evaluation will use the Evaluation Form attached. The results of evaluation will be used as one of the basis of the BAC action is recommending to the HOPE, through resolution, for the HOPE's final decision.

External providers rated as below satisfactory for two (2) previous transactions in the University will not be considered in future projects.

C. Services

External providers of services shall be evaluated regardless of the ABC involved and shall be evaluated after the completion of the contract for short term contracts, and annually for Multi-year obligation contracts. The results of the evaluation shall be the basis of decision for future action of the university. Contractor's or External providers rated below satisfactory in one previous contract with the University shall not be considered in future projects of the University. Classified under services are the outsourced security and janitorial services, hire of sound system, transplanting of rice, land preparation, and other similar services.

The evaluation of services shall use the Performance Evaluation Form attached.
Description of Performance Level Rating Scale

1. Poor - The external provider/supplier has not met many of the provisions of the contract.
2. Needs Improvement - The external providers/suppliers has met 50% of the provisions of the contract.
3. Satisfactory - The external provider/supplier has met 100% of the provisions of the contract.
4. Very Satisfactory - The external provider/supplier has exceeded the provisions of the contract by ten (10%) percent.
5. Excellent - The external provider/supplier has exceeded the provision of the contract by more than ten percent (10 %.)

3.0 References:

RA 9184 rev. 2016
ISO 9001:2015 Clause 8.4

4.0 Attachments

Monitoring and Evaluation Form (Annex J)

Prepared by:

AMADO P. IMPER, PhD
VP for Admin & Finance

Reviewed by:

SHEILA MAE CAROL A. BUSLIG,PhD
Director, Quality Assurance

Approved by:

EDUARDO T. BAGTANG,CPA,DBM
University President

Annex A

KALINGA STATE UNIVERSITY
Tabuk City, Kalinga

RECORDS AND ARCHIVE SECTION
OUTGOING MAIL

Tracer Number	Date/Time Released	Source Name & Address	Subject Matter	Initial of Releasing personnel	Mode of Dispatch	Remarks

Annex A

KALINGA STATE UNIVERSITY
Tabuk City, Kalinga

RECORDS AND ARCHIVE SECTION
INCOMING CORRESPONDENCE

Control Number	Date Received	Source/Address	Subject Matter	Action Unit	Action Taken	Date Released	Remarks

KALINGA STATE UNIVERSITY
Tabuk City, Kalinga

RECORDS AND ARCHIVE SECTION
OUTGOING CORRESPONDENCE

Control Number	Date Received	Source/Address	Subject Matter	Action Unit	Action Taken	Date Released	Remarks

Annex A

NATIONAL ARCHIVES OF THE PHILIPPINES Pambansang Sinupan ng Pilipinas REQUEST FOR AUTHORITY TO DISPOSE OF RECORDS	AGENCY NAME: KALINGA STATE UNIVERSITY ADDRESS: Bulanao, Tabuk City, Kalinga	
DATE:		EMAIL ADDRESS:

GRDS/ RDS ITEM NO.	RECORDS SERIES TITLE AND DESCRIPTION	PERIOD COVERED	RETENTION PERIOD AND PROVISIONS COMPLIED

LOCATION OF RECORDS	VOLUME IN CUBIC METER:
PREPARED BY: JAY C. LAPUZ	POSITION: Administrative Officer V/ Head, Records and Archive Section

CERTIFIED AND APPROVED BY:

This is to certify that the above mentioned records are no longer needed and not invoved nor connected in any administrative or judicial cases.

EDUARDO T. BAGTANG, CPA,DBM
SUC President III

KALINGA STATE UNIVERSITY

RECORDS DISPOSITION SCHEDULE

1. AGENCY NAME: KALINGA STATE UNIVERSITY

2. ADDRESS: Bulanao, Tabuk City, Kalinga

3. SCHEDULE NO.

4. DATE PREPARED September 11, 2018

5. ITEM NO.	6. RECORD SERIES TITLE AND DESCRIPTION	7. RETENTION PERIOD			8. REMARKS
		Active	Storage	Total	
1	ACKNOWLEDGMENT RECEIPTS				To be filed with appropriate records series
2	BROCHURES/ LEAFLETS/PAMPHLETS (About or by the agency)	1		1	1 year provided 1 copy is retained reference
3	CALENDARS/SCHEDULES OF ACTIVITIES OF EVENTS	1		1	1 year
4	CERTIFICATES OF APPEARANCE/ CLEARANCES	1		1	1 year
5	CERTIFICATIONS	1		1	1 year
6	CHARTS Functional Organizational				PERMANENT
7	CORRESPONDENCES Non-routine Routine	2		2	To be filed with appropriate records series 2 years acted upon
8	DELIVERY RECEIPTS	2		2	2 years
9	DIRECTORIES OF EMPLOYEES/OFFICIALS	2		2	2 years after superseded
10	FEASIBILITY STUDIES				PERMANENT if implemented, otherwise dispose after 5 years fron date of record
11	GATE PASSES				6 months
12	INQUIRIES	2		2	2 years acted upon
13	ISSUANCES Issued by or for the head of agency documenting policies/functions/programs of the agency				PERMANENT
	Issued by or for the head of agency reflecting routinary information or instruction	2		2	2 years after superseded
14	LISTS Associations Committees Cooperatives Donors Mailing Transmittal Others	1		1	1 year after updated

IMPORTANT: Pursuant to Section 18, Article III, RA 9470 s. 2007, "No government department, bureau, agency and instrumentality shall dispose of, destroy or authorize the disposal or destruction of any public records, which are in the custody or under its control except with the prior written authority of the executive director."

Annex A

5. ITEM NO.	6. RECORD SERIES TITLE AND DESCRIPTION	7. RETENTION PERIOD			8. REMARKS
		Active	Storage	Total	
5. ITEM NO.	6. RECORD SERIES TITLE AND DESCRIPTION	7. RETENTION PERIOD			8. REMARKS
		Active	Storage	Total	
	PROCUREMENT AND SUPPLY RECORDS				
136	ACKNOWLDGMENT RECEIPTS FOR EQUIPMENT (ARE)/MEMORANDUM RECEIPTS OF EQUIPMENT (MRE), SEMI-EXPENDABLE AND NON-EXPENDABLE PROPERTIES	1		1	1 year after equipment had been returned
137	ANNUAL PROCUREMENTS Plans Programs	3		3	3 years
138	BIDS AND AWARDS COMMITTEE FILES Abstracts Invitations Minutes Pre/Post-Qualifications Publications Resolutions	5		5	5 years after contract of winner had been terminated/ settled, others dispose after 1 year
139	BILLS OF LADING	2		2	2 years after Delivery had been disposed
140	BIN CARDS/STOCK CARDS	3		3	3 years after date of last entry
141	CANVASS OF PRICES	10		10	10 years if attached to vouchers, otherwise,dispose after 2 years
142	EQUIPMENT LEDGER CARDS	2		2	2 years after equipment had been disposed
143	INVENTORY AND INSPECTION OF UNSERVICEABLE PROPERTIES	1		1	1 year after property had been disposed
144	INVENTORIES OF EQUIPMENT/SUPPLIES	1		1	1 year after updated
145	INVENTORY TAG CARDS	1		1	1 year after updated
146	INVOICES/RECEIPTS Accountable Forms Properties/Transfer of Properties	3		3	3 years after issuance of clearance had been terminated/ after property had been returned
147	INVOICES OF DELIVERY ON SUPPLY OPEN-END ORDER CONTRACTS	5		5	5 years
148	JOB ORDERS	1		1	1 year
149	LIST OF SUPPLIES UNDER SUPPLY OPEN-END	5		5	5 years
150	MONTHLY REPORTS OF SUPPLIES AND MATERIALS ISSUED	1		1	1 year
151	PROPERTY CARDS				PERMANENT
152	PURCHASE ORDERS	4		4	4 years
153	PURCHASE REQUESTS	1		1	1 year
154	QUERIES ON PRICES OF ARTICLES, ADDITIONAL FUNDS TO MEET QUOTATION	1		1	1 year
155	REPORTS OF WASTE MATERIALS	2		2	2 years

Annex A

5. ITEM NO.	6. RECORD SERIES TITLE AND DESCRIPTION	7. RETENTION PERIOD			8. REMARKS
		Active	Storage	Total	
5. ITEM NO.	6. RECORD SERIES TITLE AND DESCRIPTION	7. RETENTION PERIOD			8. REMARKS
		Active	Storage	Total	
	PROCUREMENT AND SUPPLY RECORDS				
136	ACKNOWLDGMENT RECEIPTS FOR EQUIPMENT (ARE)/MEMORANDUM RECEIPTS OF EQUIPMENT (MRE), SEMI-EXPENDABLE AND NON-EXPENDABLE PROPERTIES	1		1	1 year after equipment had been returned
137	ANNUAL PROCUREMENTS Plans Programs	3		3	3 years
138	BIDS AND AWARDS COMMITTEE FILES Abstracts Invitations Minutes Pre/Post-Qualifications Publications Resolutions	5		5	5 years after contract of winner had been terminated/ settled, others dispose after 1 year
139	BILLS OF LADING	2		2	2 years after Delivery had been disposed
140	BIN CARDS/STOCK CARDS	3		3	3 years after date of last entry
141	CANVASS OF PRICES	10		10	10 years if attached to vouchers, otherwise,dispose after 2 years
142	EQUIPMENT LEDGER CARDS	2		2	2 years after equipment had been disposed
143	INVENTORY AND INSPECTION OF UNSERVICEABLE PROPERTIES	1		1	1 year after property had been disposed
144	INVENTORIES OF EQUIPMENT/SUPPLIES	1		1	1 year after updated
145	INVENTORY TAG CARDS	1		1	1 year after updated
146	INVOICES/RECEIPTS Accountable Forms Properties/Transfer of Properties	3		3	3 years after issuance of clearance had been terminated/ after property had been returned
147	INVOICES OF DELIVERY ON SUPPLY OPEN-END ORDER CONTRACTS	5		5	5 years
148	JOB ORDERS	1		1	1 year
149	LIST OF SUPPLIES UNDER SUPPLY OPEN-END	5		5	5 years
150	MONTHLY REPORTS OF SUPPLIES AND MATERIALS ISSUED	1		1	1 year
151	PROPERTY CARDS				PERMANENT
152	PURCHASE ORDERS	4		4	4 years
153	PURCHASE REQUESTS	1		1	1 year
154	QUERIES ON PRICES OF ARTICLES, ADDITIONAL FUNDS TO MEET QUOTATION	1		1	1 year
155	REPORTS OF WASTE MATERIALS	2		2	2 years

AUDIT PLAN

(Year _____)

Objective	
Scope	

AUDIT SCHEDULE

Office	Process	Audit Team	Audit Month											
			Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec

	AUDIT PLAN **(Year _____)**

Prepared by: _____ Director for Quality Assurance					Approved by: _____ University President									

Annex C

	AUDIT ITINERARY (Year _____)

Criteria		
Scope		
Objectives		
Audit Team	**Team Leader**	
	Members	
Office:		

Audit Activities

Date	Time	Process/Activity	Auditee	Auditors

Prepared by: _____ Audit Team Leader	Approved by: _____ Director for Quality Assurance

Annex D

	AUDIT CHECKLIST

Source Document(s): ISO 9001:2015 Standard,	
Process:	**Office/s:**

Clause / Para. No.	Items/ Questions	C/NC/OFI	Findings / Remarks

Annex E

AUDIT SUMMARY REPORT

Office:	Audit Scope:
Date:	
Purpose:	

No.	Criteria (what should be happening) Define the requirements that must be satisfied. (i.e. client, regulatory, process, ISO 9001 requirements)	Evidence (what is actually happening) Describe your observations on the extent of conformance with the specified requirements.	Class C or NC
	Process: Enrolment/ Registration		NC

Commendable Findings (Note down exemplary practices, activities, methodologies, etc. which demonstrate significant innovations that go beyond the requirements/expectations.)

Opportunities For Improvement (Note down observed situations where the results achieved are perhaps not optimal, less than well-organized or over complicated that, based on the auditor's judgment and experience, necessitate improvement.)

Prepared by:	Acknowledged by:
Audit Team Leader	Auditee

Annex F

Process: _____

(One matrix for each process in operations, support and management)

Nonconforming Product/Service	Initial Disposition		Correction			Reference
	Action	Responsibility	Action	Responsibility	Authority	

Annex G

CORRECTIVE ACTION STATUS REPORT

(Year_____)

RFA No.	NC Description	Details (as a result of)	Initiator	Recipient	Date Issued	Target Date of Implementation	Verification Date/ Status	
							First	Second

REQUEST FOR ACTION (RFA)

Section 1 – Details of Nonconformity (To be accomplished by the Auditor/ Initiator)

Date:	References: *(manuals, procedures, policies, ISO clauses, etc.)*	RFA Number:	
Auditor/ Initiator: _____ Signature over Printed Name		☐	**Nonconformity** (Non-fulfillment of requirement)
		☐	**Observation** (Does not signify failure in the system but maybe enhanced)

Details: (As a result of)

☐ **Internal Quality Audit** ☐ **Customer Feedback** ☐ **Other** (Pls. specify) _____

Office:

Issued by: _____ Signature over Printed Name

Issued to: (Office Head) _____ Signature over Printed Name

Description of the Nonconformity/Observation: *(Include evidence)*

Acknowledged by: _____

Section 2 – Necessary Action(s) (To be accomplished by the Auditee/ Process Owner)

Correction: Target Completion Date: _____

Root Cause Analysis: Analyzed By: _____

Describe the necessary Corrective Action(s):

Approved By: _____ Target Completion Date: _____

Section 3 – Verification of Implementation and Effectiveness (To be accomplished by the Initiator)

Results of Action(s) Taken	Remarks

Verified By: _____ Verification Date: _____

Acknowledged By: _____ Next Verification Date: _____

Results of Action(s) Taken	Remarks

Verified By: _____ Verification Date: _____

Acknowledged By: _____ Next Verification Date: _____

INTERNAL AND EXTERNAL COMMUNICATION FORM

What to communicate	When to communicate	Whom to communicate	How to communicate	Who communicate
Audit program	2nd week of January	All Divisions	Office Orders	Lead Auditor/QMR President
Audit Plan	One month before the audit schedule	Auditee	Office Orders	QMR/Lead Auditor president
Internal audit results	3 days after the conduct of internal audit	All auditees management Quality Management Representative	Submission of audit summary reports, audit findings, and RFA	Audit Team Leader
	During the management review proceedings	Top Management Management Committee	Summary Report in PPT presentation	Lead Auditor
Effectiveness of Corrective Actions	3 days after verification audit	Auditee Management and QMR	Summary Report	Lead Auditor
	During the Management Review Proceedings	Top Management Management Committee	Summary Report in PPT	Lead Auditor

CHAPTER XIX

MISCELLANEOUS INTERNAL AFFAIRS

Article I. Communication Flow

The University hereby establishes a policy on the flow of communication between and among the offices, recognizing protocols and duly-accepted channels, to promote harmonious relationships among offices, campuses, and units thereby leading to efficient and effective management system thereby producing higher organizational outputs.

Section 1. *Bottom-to-Top Management Communication Flow*

Communications emanating from the bottom structure such as from the faculty, staff or students directed to higher offices should pass through channels to avoid by-passing. This is to give knowledge and information to the officials along the channels on the subject matter/object or substance of the said communication thus enabling said next higher office to make solutions on his level on the content of the communication especially if it is a problem. This is also to enable the officials along the channel to make an account of the content of the communication for monitoring purposes.

Section 2. *Top-to-Bottom Communication Flow*

Communications emanating from a higher office addressed to a lower office in the structure has to consider the line function in the organizational structure. Similarly, downward communications shall also pass through channels along the said line function.

Section 3. *Horizontal Communication Flow*

Horizontal communication flow shall consider the line of authority in the organizational Structure of the University. A middle level office in one function cannot channel its communication directly to an equal office in the other function without properly passing it through the Offices connected with line function.

Article II. Signatory to Official Documents

The university has in place policies based on existing laws, authorizing accountable officials to sign official documents such as but not limited to diplomas, certificates, reports for submission to higher offices, financial forms, Certification, clearances for students and employees, official Transcript of Records, Vouchers, Trip tickets, Travel Orders, etc.

Decentralization of signatories of documents is practiced by the University for efficiency purposes.

Annex J

PERFORMANCE EVALUATION FORM FOR EXTERNAL PROVIDERS

II. GOODS AND SERVICES

A. Suppliers Information

Name of Project: _____

End-user Unit: _____

Approved Budget: _____

Name of Supplier: _____

Business Address of Suppliers: _____

Delivery Schedule/Duration: _____

B. Performance Evaluation

PERFORMANCE LEVEL					
	P	NI	S	VS	E
1. Delivery of goods/services according to overall quality which include conformity with specifications.					
2. Delivery performance of goods/services according to timeliness and efficiency.					
3. Performance satisfaction as to installation of goods.					
4. Provision of warranty and/or repair experience					
5. The delivered goods conformed with the Green Procurement Programs pursuant to E.O. No. 301					
OVERALL RATING					

Performance Limits:

1.00 - 1.80 – Poor (P)
1.81 – 2.60 - Needs Improvement (NI)
2.61 – 3.40 – Satisfactory (S)
3.41 – 4.20 – Very Satisfactory (VS)
4.21 – 5.00 – Excellent (E)

C. Remarks:

_____
_____
_____
_____

Evaluators:

End user:_____ Procurement Officer: _____

Inspectorate (Goods & Services): _____

Noted by:

EDUARDO T. BAGTANG, CPA, DBM
SUC President III

Annex J

PERFORMANCE EVALUATION FORM FOR EXTERNAL PROVIDERS

I. FOR INFRASTRUCTURE PROJECTS

A. Project Information

Name of Project: _____
Location of Project: _____
Name of Contractor: _____
Project Engineer: _____
Business Address of Contractor: _____
Date of Issuance of NTP: _____
Duration of Contract:_____ calendar days
Expected Date of Completion:_____
Contract Amount:_____
Source of Fund:_____

B. Performance Evaluation

PERFORMANCE LEVEL					
	P	NI	S	VS	E
1. Completion of project is within the timeframe					
2. Project completed complies with the Plan					
3. Workmanship is acceptable					
4. Contractor follows rules and regulation/contract					
5. During the contract implementation, the contractor adhered with the Green Procurement Programs Pursuant to E.O. No. 301 issued in 2004.					
OVERALL RATING					

Performance Limits:

1.00 - 1.80 – Poor (P)
1.81 – 2.60 - Needs Improvement (NI)
2.61 – 3.40 – Satisfactory (S)
3.41 – 4.20 – Very Satisfactory (VS)
4.21 – 5.00 – Excellent (E)

C. Remarks:

_____
_____
_____
_____

Evaluators:

End user:_____ Procurement Officer: _____

Inspectorate: _____

Noted by:

EDUARDO T. BAGTANG, CPA, DBM
SUC President III