




# QUALITY PROCEDURES AND FORMS

2016

# PROCEDURES

	<b>Control of Documents</b>		Page No.:	Page 1 of 5
			Revision No.:	0
	<b>CNU-QP-01</b>	<b>Quality Procedure</b>	Effectivity:	October 27, 2016

## 1.0 PURPOSE:

- 1.1 This document aims to define the policies and procedure for controlling and maintaining the University documents, to ensure that appropriate versions are identified and made available at point of use.
- 1.2 This procedure aims to ensure that documents of external origin are identified and their distribution, controlled.

## 2.0 POLICY

It is the policy of the University to ensure that pertinent documents are properly identified, updated, approved, and made available at points of use. Also, it is the policy of the University to ensure that documents of external origin are identified and controlled during distribution.


## 3.0 DEFINITION OF TERMS:

- 3.1 Controlled Copy – Reproduced copy of the original document, latest issued document; indicated by blue “Controlled Copy” stamp
- 3.2 Documents – as referred to in this procedure, are QMS quality procedures, standard operational instructions, the Quality Manual, and other procedures/standard/form indicated in the Document Master list
- 3.3 Document Controller (DC) – Individual/s assigned to oversee the implementation of the Document Control procedure
- 3.4 Document Custodian – Officer or staff assigned to maintain controlled copies of documents
- 3.5 Document Master list – A list of the documents being controlled by a Document Controller in terms of creation, approval, revision, distribution, access, and use
- 3.6 DFF – Document Feedback Form. A form used to suggest any revision to an existing document or manual.
- 3.7 External Documents – Documents generated from external sources
- 3.8 Internal Documents – Documents generated from QMS implementation and relevant to the university operations
- 3.9 Obsolete Copy – Superseded document, indicated by red “Obsolete Copy” stamp


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3.10 Original Copy – Original document bearing approvals in blue ink, maintained by the DC

3.11 Originator/Process Owner – Person who initiated document creation/revision who shall fill-out the “Prepared by” portion of the document

3.12 Uncontrolled Copy – Reproduced copy of a controlled copy document strictly for reference use, indicated by blue “Uncontrolled Copy” stamp

#### 4.0 SCOPE:

4.1 This procedure applies to all documents required by the UNIVERSITY’s Quality Management System as indicated in the Document Master list.

4.2 This procedure also covers the monitoring and/or distribution of externally generated documents.

#### 5.0 RESPONSIBILITIES:

5.1 PA for Quality Assurance – Reviews the established procedures in line with the requirements complied by the University and recommends the same for approval and implementation.

5.2 Document Controllers – Ensures that all documents are properly identified, updated, approved and made available at relevant areas for use. The DC is also responsible for the maintenance and implementation of this procedure on Control of Documents.

5.3 Document Custodians – Coordinates the implementation of this procedure within their respective group or center. Ensures that obsolete documents are identified and prevented from unintended use.


#### 6.0 PROCEDURE DETAILS:

Ref. No.	Key Activities	Responsibilities
6.1	Creation/revision and identification of documents	Originator
6.2	Review and acceptance of draft documents	Concerned Officer/ Process Owner
6.3	Approval of documents	PA for QA
6.4	Registration and stamping of documents	Document Controller
6.5	Distribution of approved documents	Document Controller
6.6	Maintenance of Controlled Copies	Document Custodians
6.7	Document Revision/Updating	Originator
6.8	Control of External Documents	Document Custodians
6.9	Control of Electronic Document	Document Controller


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## 6.1 Creation/Revision and Identification of Documents

If a need to create/revise a document arises, the Document Feedback Form (DFF) is used. An Originator prepares the DFF, together with the draft document. Draft documents shall be labeled (watermark, if possible) with the word “DRAFT” and should not be used in operations unless it is officially approved. The Originator may obtain a document code from the DC to initially identify/classify the document according to the established document coding system.

## 6.2 Review and Approval of Documents

Upon preparation of the DFF and Draft Documents, these are routed to the concerned officer/process owner for review and acceptance. After the review, said officers/process owners endorse the draft document, together with the accomplished DFF, to the PA for QA for approval. Approved documents bear the signature of approving authorities in blue ink.

## 6.3 Registration and Stamping of Documents

6.3.1 Upon approval of the document, the DC confirms the revision of the document or assigns a new unique identification number according to the following classification:

- |                                     |                       |
|-------------------------------------|-----------------------|
| a. Quality Manual                   | - CNU-QM              |
| b. Quality Procedure                | - CNU -QP-XX          |
| c. Standard Operational Instruction | - CNU -SOI-XX         |
| d. Form                             | - (CNU)-SOP/QP-XX Fnn |

*note: xx and nn are series numbers starting with 01*

6.3.2 Project-related policies follow the existing numbering system supplied by the office.


6.3.3 The DC enters the details, of the document, in the Document Masterlist and keeps the master copy. The DC reproduces the master copy according to the number of custodians specified in the Distribution List. All copies of the document are stamped with “Controlled Copy” in blue ink prior to distribution.

6.3.4 Document Control Stamps are maintained and used by the Document Controller.


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#### 6.4 Distribution and Maintenance of Controlled Copies

- 6.4.1 Distributed controlled copies of documents are recorded in the Document Distribution List by the DC. Upon receipt, the Document Custodian initials the controlled copy of document, in blue ink, and signs on the Distribution List.
- 6.4.2 If other than the controlled copy, a copy of the document is requested, said request is approved by the Document Controller. If approved, the Document Custodian may reproduce a "controlled copy" and stamp the copy with "Uncontrolled Copy", in blue ink, prior to release or distribution. The recipient initials the uncontrolled copy in blue ink.

#### 6.5 Document Modification/Revision/Update

- 6.5.1 If there is a need to update, modify, or revise a QMS document, the DFF is used. Changes made to the document are typed in *italics* for easy identification. The nature of revision is reflected in the "Nature of Revision" portion of the document page. If about 50% or more of the pages is affected by revision/change, the revision/change is classified as "Complete Rewrite". In such case, revision number of all pages of the document shall follow the highest revision number of that document.
- 6.5.2 Review and approval of a revised document follow the guidelines set under Section 6.2 of this procedure. The Document Controller updates the Revision History page, which forms part of each document.
- 6.5.3 Upon distribution of the revised/updated document, obsolete copies are retrieved and stamped with "Obsolete Copy" in red ink. The Document Controller maintains the latest original copy of the obsolete document. Obsolete controlled copies are disposed in accordance with the procedure on Control of Records.

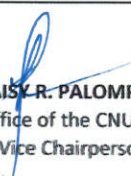
#### 6.6 Control of Externally-Generated Documents


- 6.6.1 Document Controller/s use the External Document Distribution List to register and monitor the receipt and distribution of externally generated documents.
- 6.6.2 Recording is done immediately upon receipt and turnover of documents to concerned unit and/or individual. The responsibility for the maintenance and updating of the External Document Distribution List is entrusted to the College/Department/Division/Unit. Externally generated documents received through e-mail are likewise recorded in the External Document Distribution List.

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## 6.7 Electronic Copies of Documents

6.7.1 Electronic copies of documents are not used as reference for implementation since there is no assurance of being the latest version of the document. Electronic files of Original Copies are edited, copied, and printed only by the Document Controller to protect from unauthorized copy and use.

6.7.2 The Document Controller authorizes uploading and downloading of documents onto and from the intranet. Access to controlled documents available in the intranet is regulated through the use of an access code and password provided by the DC. Access to controlled documents available in the intranet may be extended to other users.


## 7.0 REFERENCES:

- |                    |                                       |
|--------------------|---------------------------------------|
| 7.1 CNU-QP-02      | - Control of Records                  |
| 7.2 CNU -QP-01 F01 | - Document Masterlist                 |
| 7.3 CNU -QP-01 F02 | - External Document Distribution List |
| 7.4 CNU -QP-01 F03 | - Document Distribution List          |
| 7.5 CNU -QP-01 F04 | - Document Feedback Form              |


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	<b>CNU-QP-02</b>	<b>Quality Procedure</b>	Effectivity:	October 27, 2016

## 1.0 PURPOSE:

This document aims to define and provide the controls needed in the use, maintenance, and disposal of records.

## 2.0 POLICY

To ensure conformity to the requirements and ensure effective operation of the CNU's quality management system, it is the policy of the university to ensure that pertinent records are established, organized, maintained, and properly disposed in accordance with the guidelines provided in the control of records.

## 3.0 DEFINITION OF TERMS:

- 3.1 Active Records - Records within the active retention period
- 3.2 Inactive Records - Records within the inactive retention period
- 3.3 Records Custodian - Identified individuals from each unit held responsible for the maintenance, filing and safekeeping of records, as indicated in the  
Records Matrix.

## 4.0 SCOPE:

- 4.1 This procedure applies to all records related to QMS and CNU operations, which are indicated in the Records Matrix.
- 4.2 This procedure also covers the handling of externally generated data during execution of SOP/SOIs, as well as, those data provided by clients/customers.

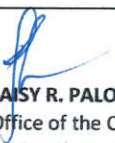
## 5.0 RESPONSIBILITIES


- 5.1 Quality Management Representative - ensures that the Records Custodians adhere to the requirements of this procedure.
- 5.2 Designated Officers - ensure that the data and information provided are sufficient, as required in the relevant document or form.
- 5.3 Records Officer - ensure that active records relative to QMS are properly maintained.
- 5.4 Records Officer - is responsible for the maintenance and disposition of inactive records.
- 5.5 Records Custodian - is responsible for the proper collection, storage, protection, retrieval, retention, and disposition of relevant or active records.

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	<b>CNU-QP-02</b>	<b>Quality Procedure</b>	Effectivity:	October 27, 2016

## 6.0 PROCEDURE DETAILS:

Ref. No.	Key Activities	Responsibilities
6.1	General procedure	
6.2	Collection and identification	Records Custodian
6.3	Review and/or approval of records, as appropriate	Concerned designated officer
6.4	Storage and protection	Records Custodian
6.5	Retrieval and retention	Records Custodian
6.6	Disposition of current/active records	Records Custodian
6.7	Maintenance and disposition of inactive records	Records Custodian

### 6.1 General

- 6.1.1 Records are legible, identifiable and easily retrievable.
- 6.1.2 Records can be in the form of any type of media such as hard copy or electronic file.
- 6.1.3 If necessary, records are reviewed and/or approved prior to issue.
- 6.1.4 Records indicate the person/s who authorizes its use.

### 6.2 Collection and Identification

- 6.2.1 Records are identifiable through any or combination of the following information, as appropriate:
  - a. Title of Record
  - b. Date(s)
  - c. Name of signatory (ies)
  - d. Document Code
  - e. Revision status
  - f. Reference Document
  - g. Control number
- 6.2.2 Records are collected upon availability from their source, for appropriate filing by the Records Custodian or concerned process owner. Only marking pens are used on records. Pencil markings are avoided and may be considered unofficial.
- 6.2.3 In case of erasure or correction, the corrected data bears the initials of the person who corrected it.

For example: ~~6312~~ 7564 *ADK*

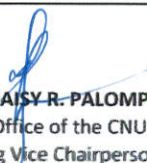
### 6.3 Review and Approval of Records

- 6.3.1 Some records require the signature of authorized individuals. The reviewer ensures that said records are legible and contain sufficient information as basis for its endorsement or approval. Hence, some records without the signature of approving authorities may be treated "unofficial."


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#### 6.4 Storage and Protection

6.4.1 Records are kept in appropriate locations to minimize physical deterioration, damage, and loss. As such, records may be protected in accordance with the following:

- a. Use of expanded folders, protective sheets, and/or ring binders;
- b. Stored in shelves or steel cabinets to prevent from deterioration;
- c. Regular back-up of e-files; and,
- d. Access restriction, through password to prevent from unauthorized use.

#### 6.5 Retrieval and Retention

6.5.1 To ensure easy retrieval, filing cabinets, shelves, boxes, folders, and envelopes are labeled according to the established filing system. Likewise, a Records Matrix is maintained indicating information, such as: Record Title, Retention Period and Record Custodian for both active and inactive records.

6.5.2 Records, borrowed by other offices or workgroups, are traced using logbooks or log sheets.

#### 6.6 Maintenance and Disposal

6.6.1 Maintenance and disposal of records are done in accordance with the Records Matrix. Turnover of inactive records as scheduled and recorded in a specific logbook of the concerned individual or office.

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

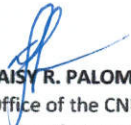
### 7.0 REFERENCES:

7.1 See 8.0 Records Matrix


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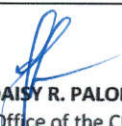
## 8.0 RECORDS MATRIX


TITLE	RETENTION		CUSTODIAN	
	Active	Inactive	Active	Inactive
<b>Sample only....</b>				
TOR	Upon Closure (+2yrs)	Permanent	PM	Records Office/ COO
Invitation to BID	Upon Closure (+2yrs)	Permanent	PM	Records Office/ COO
Letter of Intent	Upon Closure (+2yrs)	Permanent	PM	Records Office/ COO
Letter of Inquiry from client	Upon Closure (+2yrs)	Permanent	PM	Records Office/ COO
Client Referral Acceptance & Monitoring Form	Upon Closure (+2yrs)	Permanent	PM	Records Office/ COO
Inquiry Receipt and Endorsement Form	Upon Closure (+2yrs)	Permanent	PM	Records Office/ COO
Contact Report	Upon Project Closure (+2yrs)	Permanent	PM	Records Office/ COO
Client Profile/ Background Info	Upon Project Closure (+2yrs)	Permanent	PM	Records Office/ COO
Project Proposal	Upon Project Closure (+2yrs)	Permanent	PM	Records Office/ COO
Prescribed Project Proposal from client	Upon Project Closure (+2yrs)	Permanent	PM	Records Office/ COO
Logframe	Upon Project Closure (+2yrs)	Permanent	PM	Records Office/ COO
Workplan	Upon Project Closure (+2yrs)	Permanent	PM	Records Office/ COO
Finplan	Upon Project Closure (+2yrs)	Permanent	Finance Center/ Accounting	Records Office/ COO
Transmittal letter	Upon Project Closure (+2yrs)	Permanent	PM	Records Office/ COO

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	<b>Control of Nonconformity</b>		Page No.:	Page 1 of 3
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	<b>CNU-QP-03</b>	<b>Quality Procedure</b>	Effectivity:	October 27, 2016

## 1.0 PURPOSE

This document defines the policies and guidelines to identify and control nonconforming products/services during the university operations and QMS scope.

## 2.0 POLICY

CNU shall provide services to its clients in accordance with their specified requirements. As such, it is the policy of the university to ensure that all services that do not conform to requirements are identified, evaluated, and resolved in accordance with the guidelines as provided in this document.

## 3.0 DEFINITION OF TERMS:

- 3.1 NC - Nonconformity. Deviation from a specified requirement that need immediate action.
- 3.2 OFI - Opportunity for Improvement. A lapse in the system that causes minor errors or may cause potential problems in CNU operations and therefore may need to be improved.
- 3.3 RFA - Request for Action form. This is used to initiate and record the identified NC/OFI and monitor the status and actions taken relative to the NC/OFI.
- 3.4 Disposition - Actions to be taken to nonconformities
- 3.5 Control Measures - Actions to be taken to prevent occurrence of an identified Nonconformity

## 4.0 SCOPE

This document applies to all products/services provided by the university for its clients, where nonconformities may arise during its operation or QMS scope.


## 5.0 RESPONSIBILITIES

- 5.1 QAO or any process owner/staff – Identifies the nonconformity and initiates the control and disposition measures, in coordination with assigned Supervisor or authorized officer. He or she Records the information/data related to nonconformity as per Corrective and Preventive Action Procedure
- 5.2 QAO or any process owner/staff – Identifies nonconformities, establishes the control methods, defines responsibilities and authorities, and reviews and approves the necessary action to address the identified nonconformity.


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## 6.0 PROCEDURE DETAILS

Ref. No.	Key Activities	Responsibilities
6.1	Identification of nonconformity	QAO or any process owner/staff
6.2	Verification	Process owner/staff
6.3	Resolution	Process owner/staff
6.4	Implementation of Appropriate Action	Refer to Control of Nonconformity Matrix
6.5	Verification of Action Taken	IQA Team/Department Head / CNU Head

### 6.1 Identification of nonconforming products/services

Nonconforming products/services may arise, from CNU operation or QMS scope, when deviation(s) from the following activities and/or identified documented information during execution:

- University Code
- ARTA Documents
- SPMS Manual
- Research Manual
- Extension Manual
- Colleges' Manual of Operations
- Student Handbook
- Faculty Manual
- Administrative Manual
- Collective Negotiation Agreement
- Other Manuals/Guidelines

Upon identification, such nonconformity are recorded using the RFA form. Refer to (CNU)-QP-04 Corrective and Preventive Action Procedure.

### 6.2 Verification of Nonconformity

All documented nonconformities are referred to the QAO with the process owner/staff, for verification and analysis of the nonconformity, using appropriate problem solving tools/techniques. The process owner/staff, depending on the nature of nonconformity, may initiate a meeting with concerned individuals to facilitate the verification and identification of root cause.


### 6.3 Resolution of nonconformity

After problem analysis, the necessary corrective/preventive action are formulated and recorded in the RFA form. Whenever possible, the target date for completion of "Action to be Taken" are indicated in the RFA, as basis for the subsequent follow-up and verification of action taken and result.


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6.4 Follow-up on Action Taken

With reference to the submitted RFA, the QAO and IQA Team, may conduct follow-ups on “action to be taken” and perform some verification to ensure that appropriate action have been taken to address the identified nonconformity. If the implemented resolution or control measure, to address the identified nonconformity, is found to be more effective and/or efficient, such approach may be adopted to update the established Control of Nonconformity Matrix. Revision of such Matrix follows the Document Control Procedure.


6.5 The matrix below describes the disposition and/or control measures applicable to identified NCs.

CONTROL OF NONCONFORMITY MATRIX

Nature of Nonconformity	Disposition/Control Measures	Responsibility
Delays on target dates for deliverables	<ul style="list-style-type: none"> <li>• Inform Client</li> <li>• Revise Workplan</li> </ul>	
Billing errors	<ul style="list-style-type: none"> <li>• Retrieve the Billing Statement</li> <li>• Reissue BS with covering explanation</li> </ul>	
Inability to notify customer re changes in planned arrangements	<ul style="list-style-type: none"> <li>• Issue written explanation/apologies</li> </ul>	
Errors in publication	<ul style="list-style-type: none"> <li>• Publish errata</li> </ul>	
Deviation from established Code of Conduct	<ul style="list-style-type: none"> <li>• Investigate</li> <li>• Refer to superior/ manager for immediate appropriate action</li> </ul>	
Documentation errors <ul style="list-style-type: none"> <li>• Reports</li> <li>• Certificates</li> <li>• Handouts</li> <li>• Correspondence</li> </ul>	<ul style="list-style-type: none"> <li>• Retrieve</li> <li>• Revise</li> <li>• Resend</li> </ul>	

7.0 REFERENCES:

- 7.1 CNU-QP-01 - Control of Documents
- 7.2 CNU-QP-04 - Corrective and Preventive Action Procedure
- 7.3 CNU-QP-04 F01 - Request for Action Form
- 7.4 CNU University Code

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	<b>CNU-QP-04</b>	<b>Quality Procedure</b>	Effectivity:	October 27, 2016

## 1.0 PURPOSE

This document provides the policies and procedure to initiate and record corrective and preventive actions taken by the CNU to eliminate causes of nonconformities and support the intention of continual improvement.

## 2.0 POLICY

The delivery of the university's products and services necessitates that specified requirements of customers/clients are satisfied in accordance with service agreement. As such, it is the policy of the university to identify, control and prevent recurrence/occurrence of products/services that do not conform to specified requirements. It is likewise the policy of the university to implement corrective and preventive actions to continually improve the effectiveness of the established quality management system.

## 3.0 DEFINITION OF TERMS:

- |                       |  |
|-----------------------|--|
| 3.1 NC                | - Nonconformity. Deviation from a specified requirement that need immediate action.  |
| 3.2 OFI               | - Opportunity for Improvement. A lapse in the system that causes minor errors or may cause potential problems in the university operations and therefore may need to be improved.                  |
| 3.3 Corrective Action | - Action to eliminate the cause of a detected NC/OFI or other undesirable situation. Corrective action is taken to prevent recurrence. There can be more than one root cause for a NC/OFI.         |
| 3.4 Preventive Action | - Action to eliminate the cause of a potential nonconformity or other undesirable situation. Preventive action is taken to prevent occurrence. There can be more than one root cause for a NC/OFI. |
| 3.5 RFA               | - Request for Action form. This is used to initiate and record the identified NC/OFI and monitor the status and actions taken relative to the NC/OFI.  |
| 3.6 Initiator         | - An CNU officer or staff who initiated the RFA.   |
| 3.7 IQA               | - Internal Quality Audit. A procedure to evaluate the effectiveness of the QMS.  |

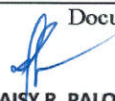
## 4.0 SCOPE

This procedure covers all corrective and preventive actions identified when nonconformity is encountered/anticipated through internal audits, customer complaints, problems encountered/anticipated during CNU operation or QMS scope and any event that could affect the QMS.

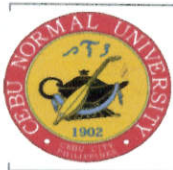
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Quality Procedure

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### 5.0 RESPONSIBILITIES

- 5.1 The Quality Management Representative is responsible for ensuring the proper implementation of this procedure.
- 5.2 The Heads ensure that appropriate actions are carefully reviewed, approved, and implemented without undue delay to eliminate the causes of nonconformities. They are also responsible for ensuring the effectiveness of actions taken.
- 5.3 The Initiator is responsible for conducting follow-up activities to verify the completeness and the effectiveness of the actions taken.
- 5.4 The QMR may initiate requests for actions upon identification of NC or OFI.
- 5.5 IQA Auditors are authorized to initiate RFA through their Audit Team Leader.
- 5.6 The IQA Team Leader maintains a registry of issued RFA.

### 6.0 PROCEDURE DETAILS

#### 6.1 Identification of Nonconformities

Nonconformities are identified through or during conduct or as a result of the following:

- 6.1.1 Operations;
- 6.1.2 Benchmarking;
- 6.1.3 Analysis of similar processes;
- 6.1.4 Evaluation of previous outputs/activities relative to the operations;
- 6.1.5 QMS audits;
- 6.1.6 Customer feedback; and,
- 6.1.7 Supplier evaluation.

#### 6.2 Documenting and Reporting of Nonconformities

Identified nonconformities should be recorded on the RFA Form.

6.2.1 Prior to issuance of RFA, the form is assigned a serial number as follows:


AAA-XX-YY

Sequence number  
Year  
Origin  
CDDSSS - SSSD department

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OIC, Office of the CNU President  
Acting Vice Chairperson



## Corrective and Preventive Action

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Quality Procedure

Effectivity:

October 27, 2016

6.2.2 RFA form contains information that includes, but not limited to:

- Description of potential or actual nonconformity/nonconformance/OFI;
- Root-cause analysis, if applicable;
- Proposed action;
- Individuals responsible for initiating and implementing action;
- Target completion date; and,
- Follow-up action date.

### 6.3 Corrective and/or Preventive Action Implementation

6.3.1 The individual or unit/group responsible for the identified nonconformity identifies its root cause and implement appropriate action in a timely manner. The identified root cause is recorded in the appropriate section of the RFA.

6.3.2 For actions to be effective, they should be focused on addressing the root-cause rather than the detected NC/OFI.

6.3.3 The reviews and approves the actions indicated in the RFA, prior to their implementation.

### 6.4 Verification of Actions Taken

6.4.1 Details of the actions taken and the verification results are written on the follow-up portion of the RFA.

6.4.2 Once the target completion date is due, the IQA Team Leader/Initiator verifies the action taken and records this in the RFA.

6.4.3 If verification necessitates additional action plan or follow-up, the next follow-up date is agreed upon.

6.4.4 To ensure that needed actions are prevented from unnecessary delays, follow-ups shall be limited to only three times wherein the CNU Head conducts the third and final follow-up.

### 6.5 Effectiveness of Actions Taken

6.5.1 Effectiveness of actions taken is discussed and verified during --- meetings wherein information relevant to RFAs is considered.

6.5.2 Records of review on effectiveness of actions taken are maintained per department.

6.5.3 Status of actions taken is included in the agenda and is discussed during management reviews.


## 7.0 REFERENCES:

- |                   |   |                          |
|-------------------|---|--------------------------|
| 7.1 CNU-QP-04 F01 | - | Request for Action Form  |
| 7.2 CNU-QP-03     | - | Control of Nonconformity |
| 7.3 CNU-QP-05     | - | Internal Quality Audit   |


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	<b>CNU-QP-05</b>	<b>Quality Procedure</b>	Effectivity:	October 27, 2016

## 1.0 PURPOSE:

- 1.1 To establish, document, and maintain a procedure for the CNU's Internal Quality Audit (IQA).
- 1.2 To define the system for the planning, preparation, execution, follow-up, and reporting of IQA activities in determining whether:
  - 1.2.1 The QMS conforms to the planned arrangements, to the requirements of ISO 9001, and to the established quality management system; and,
  - 1.2.2 The QMS is effectively implemented and maintained.

## 2.0 SCOPE:

- 2.1 This procedure applies to the CNU's quality management system whose processes directly affect the quality of services delivered to the customer.

## 3.0 DEFINITION OF TERMS:

- 3.1 Audit - Systematic, independent, and documented process for obtaining evidence and evaluating it objectively, to determine the extent to which criteria are fulfilled.
- 3.2 Audit Criteria - Set of policies, procedures, or requirements, used as reference against which audit evidence is compared
- 3.3 Audit Evidence - Records, statements of facts or other information, which are verifiable and relevant to the audit criteria. It can be qualitative or quantitative
- 3.4 Audit Findings - Results of the evaluation of the collected audit evidence against audit criteria
- 3.5 NC - Nonconformity, Non-fulfillment of requirement
- 3.6 Disposition - Actions to be taken to address nonconformities
- 3.7 Control Measures - Measures to be taken to prevent occurrence of an identified
- 3.8 RFA - Request for Action form
- 3.9 OFI - Opportunity for Improvement; Statement of fact or condition that does not signify a failure in the system but may be enhanced
- 3.10 QAO - Quality Assurance Officer

## 4.0 PROCEDURE DETAILS:


### 4.1 Responsibilities


- 4.1.1 The QAO is responsible for ensuring that a complete audit on the quality management system takes place at least once a year.
- 4.1.2 The IQA Team Leader is responsible for ensuring the proper implementation of this procedure.
- 4.1.3 The process owners are responsible for ensuring that appropriate actions, with regard to audit findings are taken without undue delay to eliminate their causes.

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- 4.1.4 The auditor(s) who carried out the audit, which resulted in raising audit findings, is responsible for conducting follow-up activities to verify the completeness and the effectiveness of the actions taken.
- 4.1.5 Auditor(s) are responsible for preparing the necessary tools and Audit Checklist to be used for the Audit.

#### 4.2 Planning the Audit

- 4.2.1 An Annual Audit Plan is prepared by the IQA Team Leader before the start of a calendar year.
- 4.2.2 The Annual Audit Plan contains the schedule for a twelve-month period during which the whole of the quality management system will be audited, at least once.
- 4.2.3 In addition to the planned audits, unplanned internal audits may be initiated by the QAO, if deemed necessary. Decisions for initiating unplanned internal audits should be based on:
- unusual increase of quality related problems,
  - introduction of new products and services,
  - changes on the quality system, personnel and processes, and,
  - customer's request.
- 4.2.4 The Annual Audit Plan is reviewed and approved by the President prior to its implementation.
- 4.2.5 Copies of the Annual Audit Plan are disseminated to all concerned departments through a memorandum prepared by the QAO.
- 4.2.6 Prior to conducting an audit, both planned and unplanned audit require a notification, to be given at least a week before the conduct of audit, to affected functions. Notification of an audit shall be in the form of an Audit Schedule prepared by the IQA Team Leader.
- 4.2.7 An Audit Schedule shall include the:
- purpose of the activity;
  - audit scope;
  - departments to be audited with their designated representatives;
  - assigned auditors; and,
  - date and time of the audit.
- 4.2.8 Auditors, who are tasked to conduct the audit shall be selected from the pool of qualified personnel listed on the Memorandum Order duly signed by the President. Auditors registered on the list are trained and qualified in accordance with appropriate education, training, skill, and experience, as suggested in ISO 19011:2002.


#### 4.3 Preparation for the Audit

- 4.3.1 Upon notifying auditors and auditees, necessary documentation (e.g. Quality Manual, Manual of Operations, QMS records) are reviewed by auditors.


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- 4.3.2 Taking into account the audit scope, objectives, and the information gained from the review of various documents and records, Audit Checklists are developed.
- 4.3.3 The checklist is used flexibly. It is not used as a questionnaire which, when completed, signals the end of the interview. During the audit, the auditor may add to the checklist, depart from it, and return later, or may decide not to cover some items.

#### 4.4 Conducting the Audit

- 4.4.1 An opening meeting is conducted prior to actual audit to reconfirm audit schedule, basis for the audit, and audit participants. The meeting is usually an informal one with no record being kept except those necessary for the smooth conduct of the audit.
- 4.4.2 An Audit proper must have the following activities:
- Establishment of facts by interviewing personnel, reviewing documents, observing processes, and verifying records.
  - Recording of facts as evidence of the audit.
  - Evaluation of facts to determine the objective evidence of a nonconformity.
  - Classifying audit findings as to NC or OFI.
- 4.4.3 Closing meeting is conducted to present audit findings to the Deans/Directors/Heads of Offices of the audited area. RFAs are issued to the Deans/Directors/Heads of Offices after the closing meeting.

#### 4.5 Reporting of Audit Findings

- 4.5.1 Audit findings, are documented on the Request for Action (RFA) form.
- 4.5.2 Audit follow-up is conducted on or after the target implementation/completion date, to verify whether the appropriate action is effectively implemented.
- 4.5.3 Details of the actions taken and the verification results are written on the follow-up portion of the RFA.
- 4.5.4 In case of a rescheduled follow-up, the auditor ensures that the new follow-up date is properly recorded in the RFA.
- 4.5.5 "Closed" RFAs are returned to the IQA Team Leader.
- 4.5.6 An Audit Summary Report is prepared by the IQA Team Leader and submitted to the QAO for approval.
- 4.5.7 To provide evidence of a systematic audit and for useful references, the IQA Team Leader maintains all relevant records of concluded internal audits.
- 4.5.8 Results of internal audits are discussed and presented during management review meetings.


#### 4.6 Verification of Actions Taken

- 4.6.1 RFAs are forwarded to the IQA Team Leader, who assigns control numbers for monitoring purposes. The IQA Team Leader maintains a registry of all RFAs.

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# FORMS

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## MASTERLIST OF DOCUMENTED INFORMATION

**Issue No.:**

[illegible]

Prepared by:

Noted by:

Document Controller / Date

QMR / Date





## EXTERNAL DOCUMENT DISTRIBUTION LIST

**Issue No.:**

[illegible]

Prepared by:

Noted by:

Document Controller / Date

QMR / Date







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Suggested / Proposed Revision:

This part must be filled-up by the Document Controller in coordination with concerned Process Owner and Approving Authorities

Received  
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Feedback/Actions taken/Disposition:

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REQUEST FOR ACTION  
CNU-QP-04 FO1

RFA No.:

DESCRIPTION

☐ Nonconformity

☐ OFI

DETAILS

Action request as a result of:

☐ Internal Quality Audit    ☐ Service Realization Process    ☐ Others:

REFERENCES (manuals, procedures, policies, , etc.)

Area / Division / Office:

Initiator	Signature over printed name / date	Issued by:	Signature over printed name / date	Issued to:	Signature over printed name / date
-----------	---------------------------------------	---------------	---------------------------------------	---------------	---------------------------------------

Definition:  
NC - Nonconformity. Deviation from a specified requirement that need immediate action.  
OFI - Opportunity for Improvement. A lapse in the system that causes minor errors or may cause potential problems and therefore may need to be improved  
Note: The agency head or his/her delegate conducts the final follow-up on unaccomplished corrective/preventive action.





REQUEST FOR ACTION  
CNU-QP-04 FO1

RFA No.:

Position, Division	Position, Division	Position, Division
--------------------	--------------------	--------------------

ANALYSIS (Root Cause)

DISPOSITION / ACTION

Correction	Target date: _____	Corrective /Preventive Action (must address root cause): Target date: _____
------------	--------------------	--

Prepared by: \_\_\_\_\_ Signature over printed name / date  
Position, Division

Approved by: \_\_\_\_\_ Signature over printed name / date  
Position, Division

FOLLOW-UP ON ESTABLISHED ACTION (refer to DISPOSITION / ACTION)

Date	Result / Additional Action Plan (if unresolved)	Remarks	Auditor / Initiator	Auditee / Person who prepared the disposition / action plan
Initial/ First				
Second				
Final				

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Definition:  
NC - Nonconformity. Deviation from a specified requirement that need immediate action.  
OFI - Opportunity for Improvement. A lapse in the system that causes minor errors or may cause potential problems and therefore may need to be improved  
Note: The agency head or his/her delegate conducts the final follow-up on unaccomplished corrective/preventive action.

AUDIT CHECKLIST

IQA No.:

Auditee/s			Division/Section/Group		Page of	
Audit Type			Date of Audit	Time		Auditor/s
<input type="checkbox"/> IQA	<input type="checkbox"/> Follow-up	<input type="checkbox"/> Supplier		Start	End	

AUDIT CRITERIA (Define the requirement that must be satisfied i.e. customer requirements, regulatory requirements, process requirements, ISO 9001 requirements, etc.)	DESCRIPTION	AUDIT NOTES/REMARKS (Describe your observations on the extent of conformance with the specified requirements)

CNU-QP-05 F1, Rev. 0

\* DESCRIPTION

C	Conformity, Requirement has been met; No action required	NA	Not Applicable, No action required
NC	Nonconformity Failure to meet one requirement of a clause of ISO 9001:2000 or set criteria; a lapse in the system that needs improvement.	OFI	Opportunity for Improvement Statement of fact or condition that does not signify a failure in the system but need to be addressed



[illegible]