Quality Assurance Operations Manual

1st Revision, 2018 Edition

Republic of the Philippines
CEBU NORMAL UNIVERSITY
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OPERATIONS MANUAL

Quality Assurance Operations Manual No. 01
BOR Resolution No. 120 series 2018

Preface

Measuring one's capability to promote excellence is an enduring process to meet certain standards of evaluation wherein specific level of quality is determined to provide substantial information for the intended community and global market. Quality Assurance is the process of verifying whether products or services meet or exceed customer expectations. It is a process-driven approach with specific steps to help define and attain goals (Ruiz, Sabio, 2012).

In Cebu Normal University where quality and excellence are a matter of significance, the management strives to preserve and uphold these standards. The CNU community to the best of its capacity undertakes quality management and quality control through accreditations and certifications. It submits itself and its programs to external accreditations by the Accrediting Agency of Chartered Colleges and Universities of the Philippines (AACCUP), Inc; Commission on Education Institutional Sustainability Assessment and to certifications conducted by the International Standards Organization (ISO).

In this respect, the Office of the Presidential Assistant for Quality Assurance is tasked to:

a. Work closely with top management in setting up and strengthening quality assurance structures and mechanisms;
b. Spearhead accreditation activities in coordination with the academics and research division;
c. Coordinate with colleges and units in carrying out self-evaluation and assessment of the academic programs and services offered by the university;
d. Ensure integration of recommendations from partner accrediting agencies in the university's annual plans and monitors their full implementation;
e. Implement a document management system to ensure accuracy and readiness of information for purposes of quality assurance activities;
f. Ensure that requirements set by CHEd along the area of quality assurance are met with required standards (Cebu Normal University, 2018)

g. Ensure that the quality management system is compliant to statutory, regulatory and international standards requirements.

In order to fulfill these tasks the office of quality assurance deemed it necessary to create an operations manual to provide a detailed written documentation which clearly describes the controls for each element of the Quality Assurance Program as to who, what, when, where and how the program is being implemented. Furthermore, this manual will link closely with the other university – generated manuals the quality system policies and procedures on all activities of instruction, research and extension as embodied in the CNU quality policy.

Approval

Reviewed by the Administrative Council through Resolution No. 64 series 2018

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Approval of the Board of Regents

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Distribution

University President
Vice Presidents
Presidential Assistants
Unit Process Owners
Quality Assurance Officers
Internal Quality Auditors

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QUALITY
ASSURANCE

CNU QUALITY POLICY

Cebu Normal University commits itself to deliver excellence in education, research and extension services towards global competitiveness, to meet the increasing levels of customer demand, statutory, regulatory and international standards through continuous quality improvement and good governance.

To ensure compliance to the commitment, relevant and responsive virtual and/or physical monitoring, review and upgrading of service delivery is implemented.

BOR Resolution No. 119 Series 2017

Prepared by:	Reviewed by:	Approved by:
Ma. Mayla Imelda M. Lapa Presidential Assistant for Quality Assurance	[refer to Admin Council Resolution page iv] **Administrative Council** Cebu Normal University	**Dr. Filomena T. Dayagbil** Chairperson, CNU Administrative Council; SUC President

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Quality Policy	QA Operations Manual	01	December 2017	BOR	12/17/18	1 of 1

CNU QUALITY OBJECTIVES

QO1: Increase average passing percentage of board examination programs by 20% of the national passing.

QO 2: Ensure 80% cohort survival of graduates in the undergraduate programs.

QO 3: Increase number of publication in refereed reputable journals.

QO 4: Increase technical advisory extension services that are responsive and timely to the needs of the community.

QO 5: Timely completion of financial accountability reports.

QO 6: Increase customer satisfaction index in all services of the university through fast-tracking of services in compliance with service delivery charter (ARTA).

QO 7: Institute timely risk management protocol in order to mitigate effects of risks in its various process deliveries.

QO 8: Ensure confidentiality of records and/or information in compliance with the provisions of relevant statutory requirements (DPA).

BOR Resolution No. 119 Series 2017

Prepared by:	Reviewed by:	Approved by:
Ma. Mayla Imelda M. Lapa Presidential Assistant for Quality Assurance	[refer to Admin Council Resolution page iv] **Administrative Council** Cebu Normal University	**Dr. Filomena T. Dayagbil** Chairperson, CNU Administrative Council; SUC President

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Quality Objectives	QA Operations Manual	01	December 2017	BOR	12/17/16	1 of 1

CNU Strategic Directions

Sustaining Quality and Relevance

1. Blended Instruction
2. Faculty and Student Exchange Program
3. Streamlining of processes
4. Internationally – based faculty and Staff Development
5. Strong Industry and Academe Interface
6. Student mobility program
7. Pursuing Quality Assurance Mechanisms

Enhancing Research, Development and Innovation

1. Establishment of research Institutes
2. Research – based purposive Faculty and Staff development.
3. Cutting edge research papers
4. Journal Incentivization program
5. Citation Index
6. Generating Patents, Inventions, Copyrights
7. Establishment of Research Ethics Committee

Expanding Community Engagement and Linkages

1. Strengthen partnerships with International and national Agencies
2. Expand Needs – Based Extension projects
3. Generate Externally – funded Extension Projects
4. Pursue Policy development initiatives for Internationalization

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CNU Strategic Directions	QA Operations Manual	00	June 1, 2018	12/17/18	1 of 1

Digitization and automation of Operations

1. Implement content management systems (HRIS, Online enrolment, Faculty Evaluation, etc)
2. Streamlining of university website

Maximizing Resource Generation and Utilization

1. Create training centers for short – term courses
2. Implement other income generating projects

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Amendments and Revisions

Reviews

This operations manual will be reviewed periodically and when deemed necessary in order to update with the current trends and demands of the university.

However, Management reviews of operations are continuous, and any problems indicated with the Quality Program or its implementation will be addressed and corrected as directed by Management.

Revision Control

This manual will be revised by Quality Assurance as required. Whenever revisions occur, all holders of controlled copies will be distributed copies of the applicable revised pages, including a new revision page describing the changes.

Release No.	Date	Revision Description	Approval
Rev 00	August 2018	Quality Assurance Manual 2018	Dr. F. Dayagbil

Prepared by:

Ma. Mayla Imelda M. Lapa
Presidential Assistant for Quality Assurance

Reviewed by:
[refer to Admin Council Resolution page iv]
Administrative Council
Cebu Normal University

Approved by:

Dr. Filomena T. Dayagbil
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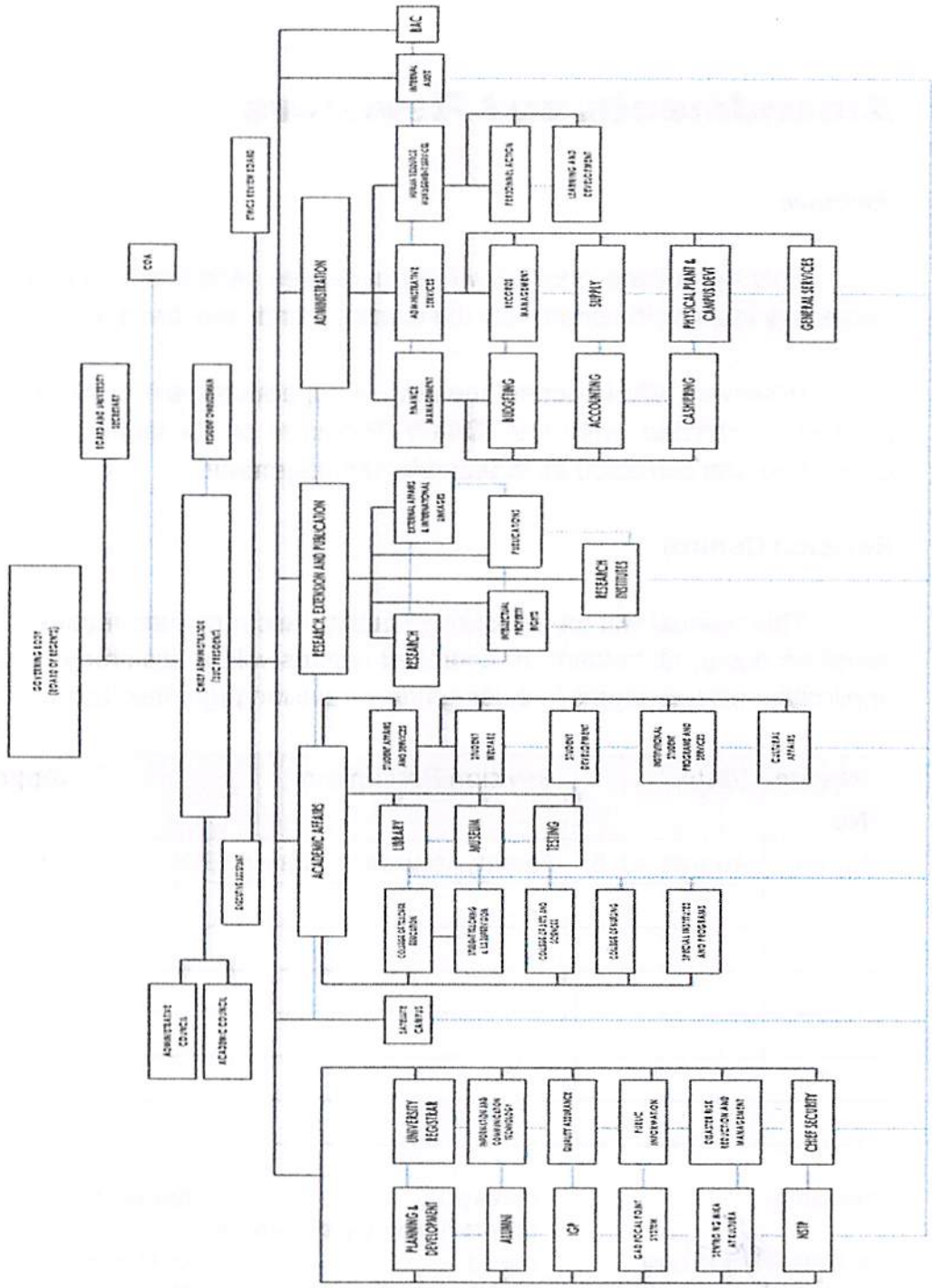
REVISED CNU ORGANIZATIONAL STRUCTURE



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QUALITY ASSURANCE ORGANIZATIONAL STRUCTURE

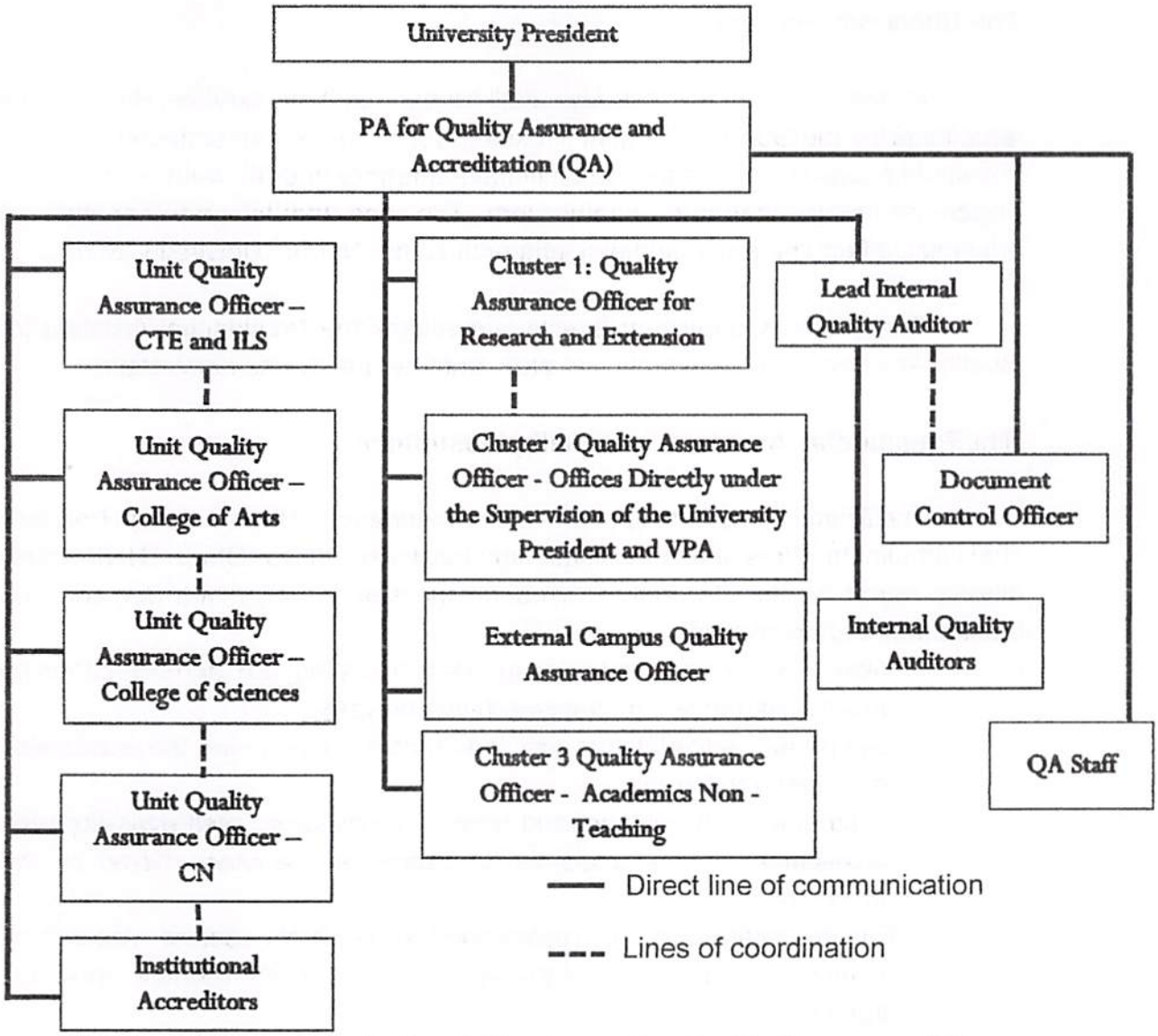

Figure 1. Organizational Structure of the Quality Assurance Office

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ORGANIZATIONAL DUTIES AND RESPONSIBILITIES

The University President

As the head of the agency shall render full-time service. He shall be appointed by the Board of Regent/Trustees, upon the recommendation of a duly constituted search committee. He shall have a term of four (4) years and shall be eligible for reappointment for another term: Provided, that this provision shall not adversely affect the terms of the incumbents (Cebu Normal University, 2018).

The university president directly supervises the Presidential Assistant for Quality Assurance and indirectly the staff, and the quality assurance team.

The Presidential Assistant for Quality Assurance

The Board of Regents upon the recommendation of the University President shall appoint the Presidential Assistant for Quality Assurance Officer. He/She shall directly report to the University President and shall function with the following duties and responsibilities[1]:

1. Work closely with top management in setting up and strengthening quality assurance structures and mechanisms;
2. Spearhead accreditation activities in coordination with the academics and research division;
3. Coordinate with colleges and units in carrying out self-evaluation and assessment of the academic programs and services offered by the university;
4. Ensure integration of recommendations from partner accrediting agencies in the university's annual plans and monitors their full implementation;

[1] De la Salle University Quality Assurance Manual as cited in (Cebu Normal University, 2018)

5. Implement a document management system to ensure accuracy and readiness of information for purposes of quality assurance activities;
6. Ensure that requirements set by CHEd along the area of quality assurance are met with required standards.

Quality Assurance Officers

Cluster Quality Assurance Officer for Research and Extension (CQAORE)

The University President, upon the recommendation of the PA for Quality Assurance and Vice President for Research, Extension and Publication, shall appoint the Quality Assurance Officer for Research and Extension. The Cluster Quality Assurance Officer for Research and Extension will be a key member of the University's Quality Assurance Team. The CQA Officer will be responsible for assisting the PA for Quality Assurance in the oversight of research and extension quality services in the University. As a member of the faculty he/she shall have a deloading of full time equivalency (FTE) as prescribed by the University President. He/She shall report to the Vice President for REP and shall function with the following duties and responsibilities

1. Provision of assistance to the research and extension heads in the planning and implementation of quality assurance initiatives.
2. To act as a point of contact for questions and requests for advice about research and extension quality assurance initiatives, and the main point of contact for queries and requests from accreditation working team.
3. To contribute to, and fully participate in the process of ensuring that research and extension maintains excellence in fulfilling its legal mandate for research innovations and initiatives and extension services;
4. To assist in the collation, analysis and dissemination of research and extension client's satisfaction survey results and implement actions in response to client survey results.
5. To assist in the various processes surrounding research and extension core process review, revisions and enhancements and write reports thereof.

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6. To assist in maintaining the official repository of the research and extension documents submitted from these units;
7. Coordinate with the Training Office for research and extension training initiatives.
8. Ensure that requirements set by CHEd and partner accrediting and certifying agencies along the area of quality assurance in research and extension services are met according to required standards.
9. To undertake such other duties as may be reasonably expected.

Unit Quality Assurance Officer (UQAO)

The University President upon the recommendation of the PA for Quality Assurance and the College Dean shall appoint the College Quality Assurance Officer. The Unit Quality Assurance (UQA) Officer will be a key member of the University's Quality Assurance Team. The UQA Officer will assist the unit head in the oversight of the unit's quality assurance undertakings. He/She shall have a deloading of full time equivalency (FTE) as prescribed by the University President. He/She shall directly report to the Unit Head and shall function with the following duties and responsibilities (University of Glasgow, n.d)

1. Provide leadership in the development, implementation and monitoring of quality assurance processes across the unit/s he/she coordinates in line with University expectations and the requirements of external bodies.
2. Have particular responsibility for the monitoring of the units' core process and its implementation.
   2.1. Act as internal auditor ensuring that core process protocols are observed, implemented, evaluated and monitored
   2.2. Work closely with the process owner (unit head/dean) in identifying individuals that can be delegated to work on program areas for accreditation
   2.3. May be assigned an area to work on, if necessary, during accreditation activities as a faculty member of the program for accreditation

2.4. Act as internal accreditor to initially inspect and check on the compliance to the benchmark statements

3. Work with the University's Quality Assurance Team headed by the PA for QA, to improve the consistency of quality processes within the unit to enhance the students' learning experience.
4. Promote good practice arising from quality assurance and enhancement activity.
   4.1. Act as document control officer in the unit of assignment
      4.1.1. Ensuring that documents used in the implementation of core processes are reviewed and approved
      4.1.2. Transmit new/revised/updated documented information to the document control officer for coding and control
      4.1.3. Retain control copies of coded documents
      4.1.4. Monitor and track the distribution of quality documents
      4.1.5. Ensure that quality documents are used for its intended purpose
   4.2. Act as quality documented information custodian ensuring efficient document management i.e. document safety, retention, updating, and disposition. Document custodianship applies to all copies of controlled documents, accreditation documents among others.
5. Monitor client satisfaction survey within the unit/s and implement initiatives that responds to client demands.
6. Become a member of the curriculum committee (College) to ensure quality assurance in curriculum review, revision, implementation and evaluation and to write reports thereof.
7. Become a member of the unit's core process review committee to ensure quality assurance in the review, revision, implementation and evaluation of core processes and to write reports thereof.
8. Submit quality assurance reports to the Quality Assurance office.
9. To undertake such other duties as may be reasonably expected with the agreement of the College Dean.

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Cluster Quality Assurance Officer for Offices Directly under the Supervision of the University President and the Vice President for Administration

The University President, upon the recommendation of the PA for Quality Assurance and Vice President for Administration, shall appoint the Cluster Quality Assurance Officer. The Cluster Quality Assurance (CQA) Officer will be a key member of the University's Quality Assurance Team. The CQA Officer will assist the unit heads in the oversight of the unit's quality assurance undertakings. As a member of the faculty he/she shall have a deloading of full time equivalency (FTE) as prescribed by the University President. He/She shall have the following duties and responsibilities

1. Provide leadership in the development, implementation and monitoring of quality assurance processes across the clustered units in line with University expectations and the requirements of external accrediting bodies.
2. Have particular responsibility for the monitoring of the clustered units' core process and its implementation.
3. Work with the University's Quality Assurance Team headed by the PA for QA, to improve the consistency of quality processes within the clustered units to enhance the client experience.
4. Promote good practice arising from quality assurance and enhancement activity.
5. Monitor client satisfaction survey within the clustered units and implement initiatives that responds to client demands.
6. Become a member of the unit's core process review committee to ensure quality assurance in the review, revision, implementation and evaluation of core processes and to write reports thereof.
7. Submit quality assurance reports to the Quality Assurance office.
8. In coordination with the university technicians, i.e. IT technicians, mechanical technicians, other technical staff, ensure that technical equipment i.e software or hardware are functional and in good running order.

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External Campus Quality Assurance Officer (ECQAO)

The University President upon the recommendation of the PA for Quality Assurance and the College Dean shall appoint the External Campus Quality Assurance Officer. The External Campus Quality Assurance (ECQA) Officer will be a key member of the University's Quality Assurance Team. The ECQA Officer will assist the campus director in the oversight of the campus' quality assurance undertakings. He/She shall have a deloading of full time equivalency (FTE) as prescribed by the University President. He/She shall directly report to the Campus Director and shall function with the following duties and responsibilities (University of Glasgow, n.d)

1. Provide leadership in the development, implementation and monitoring of quality assurance processes across the campus he/she coordinates in line with University expectations and the requirements of external bodies.
2. Have particular responsibility for the monitoring of the campus' core process and its implementation.
3. Work with the University's Quality Assurance Team headed by the PA for QA, to improve the consistency of quality processes within their campus to enhance the students' learning experience.
4. Promote good practice arising from quality assurance and enhancement activity.
5. Monitor client satisfaction survey within the campus and implement initiatives that responds to client demands.
6. Become a member of the curriculum committee (College) to ensure quality assurance in curriculum review, revision, implementation and evaluation and to write reports thereof.
7. Become a member of the campus core process review committee to ensure quality assurance in the review, revision, implementation and evaluation of core processes and to write reports thereof.
8. Submit quality assurance reports to the Quality Assurance office.
9. To undertake such other duties as may be reasonably expected with the agreement of the Campus Director.

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Lead Internal Quality Auditor

The Lead Internal Quality Auditor is a designated position to a faculty member who had undergone lead auditors' training course by an independent auditing body. He/She shall have full time equivalency deloading as prescribed by the University President. He/She shall report directly to the PA for Quality Assurance. He/She shall have the following functions and responsibilities (Bizmanualz, Inc, 1999-2017):

1. Management of a team of Internal Quality Auditors in the performance of internal audits, ensuring that internal audits comply with applicable standards, regulations, and guidance (e.g., ISO 19011; 9001) and that resulting reports are fair, impartial and useful.
2. Selection of competent internal auditors and providing the auditors with information and other resources they need to carry out the quality audit in coordination with the PA for Quality Assurance.
3. Maintains and updates the quality management system, including procedure enhancements, revision changes, and overall process control.
4. Evaluate core processes for compliance with quality requirements (statutory, regulatory, institutional and international standards).
5. Periodically inspect and calibrate auditing tools and internal quality auditors.
6. Assist in the development of audit plans, audit schedules.
7. Participate in quality audits (and lead a team of quality auditors, when needed).
8. Identify processes, situations, etc., where organization is meeting requirements, as well as identify opportunities for improvement.
9. Assist audit team in developing audit reports; present audit reports to top management and/or process, as needed.
10. Assist with follow-up audits, as required.
11. May develop internal auditing/testing parameters.
12. Works in conjunction with auditees during internal audits.

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Document Control Officer

The Document Control Officer is a designated position to a faculty member who is in-charge with controlling the quality process documents generated by the core process owners. He/She shall have full time equivalency deloading as prescribed by the University President. He/She report directly to the PA for Quality Assurance and has a coordinative relationship with the Lead Internal Quality Auditor. He/She shall have the following functions and responsibilities (Schrijver, 2018):

1. Manage core process quality documents while also ensuring their accuracy, quality and integrity.
2. Ensure Document Management according to established procedures or standards (documents numbering, formats, issuance, review, dispatch, recording and archiving).
3. Develop and maintain the Document Management System by storing, managing and tracking core process quality documents.
4. Scan, image, organize and maintain documents, adhering to the document lifecycle procedures, and archive inactive quality records in accordance with the records retention schedule.
5. Help the institution adhere to record policies, safeguard information and retrieve data more effectively.
6. Manage all flows of documents either in electronic form or on paper support.
7. Process incoming documentation (registration in the Document Management System, internal distribution, archiving).
8. Process outgoing documentation (transmit to Client and Suppliers/3rd parties).
9. Makes sure that controlled copies of latest approved quality documents, plans and curricula are retained and stored as internal file.
10. Ensure all updated and approved documents are correctly identified, distributed and filed/stored
11. Assist in the preparation, collation and issuance of reports and registers as may be required by the quality management system.

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12. Monitor quality documents review and approval in accordance with agreed schedule.
13. Monitor documentation progress in coordination with the different process owners.
14. Ensure the use of standardized forms and templates in the generation of quality reports and documentation
15. Establish and maintain the Master Document Register in coordination with the different process owners.
16. Collate, produce and submit QA Documentations when required.

Internal Quality Auditors

The University President upon the recommendation of the PA for Quality Assurance and the Lead Internal Quality Auditor shall appoint the internal quality auditors. He/She must be an experienced member of the organization who shall confirm the core processes units' documentation meets statutory, regulatory, international and institutional standards requirement, and that day-to-day operations follow the documentation (Dawson, 2015). He/She reports directly to the Lead Internal Quality Auditor. He/She shall perform the following

1. Obtain and assess objective evidence fairly.
2. Remain true to the purpose of the audit without fear or favor.
3. Evaluate constantly the effects of audit observations and personal interactions during an audit.
4. Treat concerned personnel in a way that will best achieve the audit purpose.
5. Perform the audit process without deviating due to distraction.
6. Commit full attention and support to the audit process.
7. React effectively in stressful situations.
8. Arrive at generally acceptable conclusions based on audit observations.
9. Remain true to a conclusion despite pressure to change that is not based on evidence.
10. Assist and work in conjunction with auditees and other auditors during an internal audit.
11. Discuss with the auditee the findings of the audit.

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12. Monitor and verify corrections and corrective actions undertaken by the auditee for effectiveness of the plan.

Institutional Accreditors

The Institutional Accreditors have the rank from assistant professor to full professors who are trained by the Accrediting Agency for Chartered Colleges and Universities in the Philippines (AACCUP), where CNU is a member-institution. He/She performs the following:

1. Participate in the internal accreditation of programs for AACCUP survey visit.
2. Use the AACCUP survey instrument to ensure that the program for AACCUP visit has complied with the accreditation requirements of the team's previous visit recommendations and the tool's benchmark statements.
3. Make a report on observations and findings resulting from the internal accreditation and furnish such report the office of the quality assurance.

Quality Assurance Staff

The quality assurance staff is a non-academic member of CNU community who is hired by the HRM office and assigned to the Quality Assurance Office. He/She shall report to and be supervised directly by the PA for Quality Assurance and shall perform the following functions

1. Assist the QA officers in the implementation of quality assurance initiatives, activities and undertakings, while acting as secretariat to these activities when so assigned.
2. Take part in the quality assurance initiative as part of the planning committee performing secretarial functions, documentation activities and the like.

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3. Respond to office queries, answer telephone calls, accept and take note endorsements/communications/documents from other offices.
4. Take part in the safety and security of official records and documents in the quality assurance office.
5. Transmit inter-office communications within and outside the university when so delegated.
6. Act as office clerk and/or secretary as the case may be.
7. Perform other tasks as may be necessary for quality assurance.

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INTERACTION BETWEEN QUALITY ASSURANCE AND OTHER DELIVERY UNITS OF THE UNIVERSITY

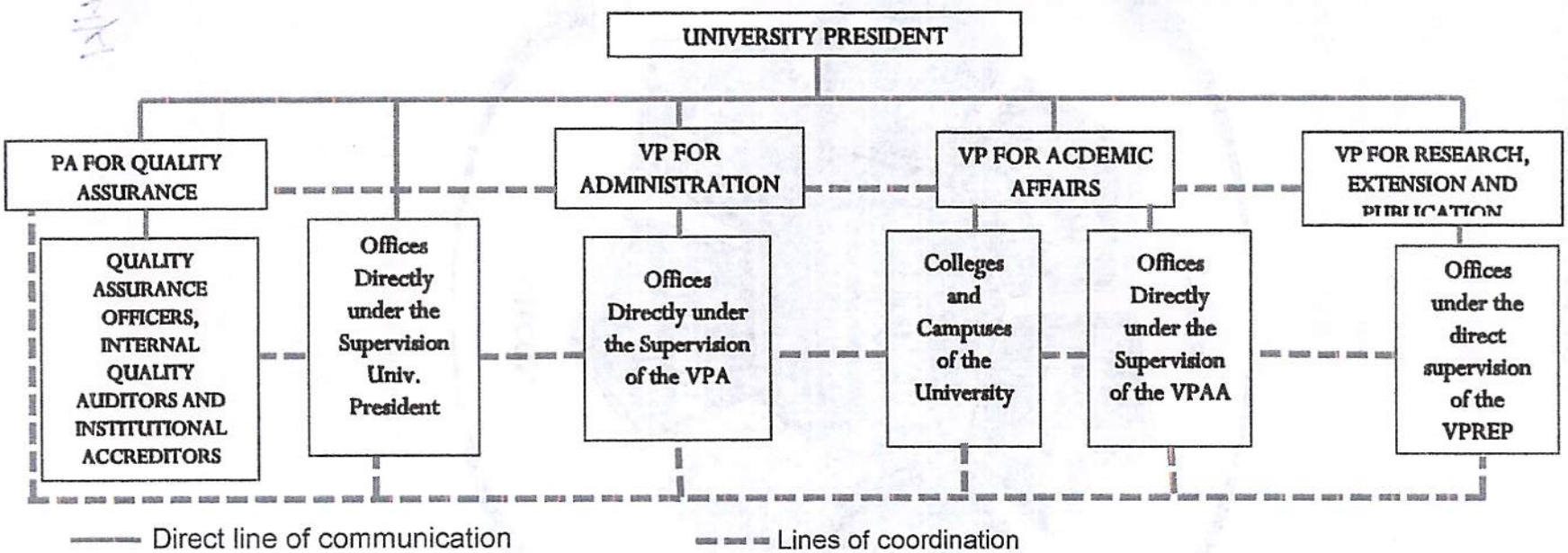

Figure 2. Interaction of the Quality Assurance Office with the other Delivery Units of the University

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QUALITY ASSURANCE FRAMEWORK

The quality assurance framework will serve as guide in ensuring that quality is observed and enforced in all processes within the context of Cebu Normal University organization. It can be used as a tool to enhance effectiveness and efficiency in service delivery within and among the organizations various delivery units to its clientele to achieve the organization's desired outcomes.

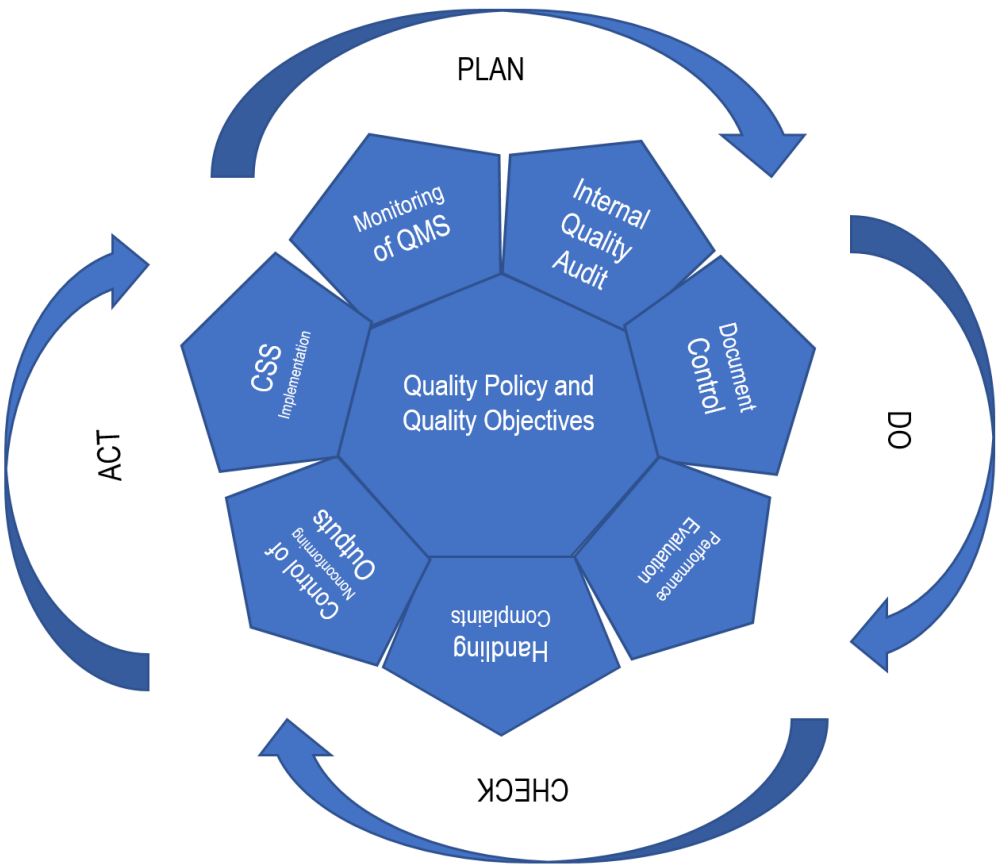

Figure 3. Quality Assurance Framework

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Section Title	Document Type	Revision No.	Revision Date	Effective date	Page
QA Framework	QA Operations Manual	00	June 1, 2018	8/7/18	1 of 3

The quality assurance framework is like a blooming flower. It blooms to meet quality assurance requirement. A flower blooms as time goes by, just like quality, it gets better as time goes by through continuous quality improvement. The framework may also be viewed as a spinning wheel. The spinning inner wheel is enclosed in another outer spinning wheel. The framework reflects that in every facet of the inner spinning wheel the Plan-Do-Check-Act cycle is executed to continuously improve every undertaking in each of the component of the framework.

The central focus of the framework are the quality policy and the quality objectives of the university. The framework ensures that the quality policy is observed by all concerned and that the quality objectives are met throughout the quality assurance cycle. The middle layers of the framework signify the core processes of the quality assurance office, namely, Customer Satisfaction Survey (CSS) implementation, Monitoring of the Quality Management System (QMS), Internal Quality Audit (IQA), Document Control, Control of Nonconforming Outputs, Handling of Complaints; and Performance Evaluation. The outer layer of the framework reflects the Plan – Do – Check – Act Cycle that is integrated into the ISO process approach.

Customer Satisfaction Survey (CSS) Implementation. This core process focused on measuring how well the units deliver the required services. The survey is done after the client had availed of the services offered by the unit. The result of the survey is then collated, analyzed and used to improve delivery of services in the unit.

Monitoring of the Quality Management System (QMS). QMS monitoring is done by the QA office as well as by the unit heads/delivery unit heads. It is done to check on the operation of the QMS as evidenced by records, CSS results, proofs of implementation of QMS, minutes of the meetings, and proofs of continuous quality improvements.

Internal Quality Audit (IQA). Internal quality audits (IQA) or "first party audit" is done by the organization's internal auditors. This audit is done to check whether the QMS conforms to CNU's QMS requirements, ISO QMS requirements and whether the QMS is effectively implemented and maintained.

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Documents Control. Control of documented information whether in hard copy or electronic file. These documents are those required by ISO standards and those determined by the organization as deemed necessary for the effective implementation of the QMS. This control also disseminates guidelines on creating and updating of documents as well as its availability and suitability for use, protection, distribution, storage, control of changes, retention and disposition. Document control is not limited to those mentioned but also extend to activities which may be essential to access, retrieval and use of documents.

Control of Nonconforming Outputs. This core process deals with the control of outputs/services that do not conform to standards or quality requirements. It involves identification of these outputs/services and controlling it to prevent unintended use or delivery. Identification of nonconforming outputs is done through internal audits, accreditation survey visits by external evaluators and certifying bodies. Their observations/recommendations will be used to improve service delivery and outputs.

Handling of Complaints. Internal and External client complaints are handled by the QA. These complaints are extracted from the CSS instrument after it is filled out by the client. Once complaints are extracted an investigation will be initiated to compile details of the complaints. Once details are completed, copy of the complaint will be forwarded to the concerned unit for root cause analysis and formulation of corrective action. QA files official report and monitors implementation of corrective action.

Performance Evaluation. This is instituted to ensure compliance to nonconformity reports, institutional, statutory and regulatory requirements. QA identifies and monitors trends and patterns in the QMS, effectiveness of implementation and conformity to planned activities.

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QUALITY ASSURANCE CORE PROCESSES

CUSTOMER SATISFACTION SURVEY IMPLEMENTATION

Core Process	Process Flow
Source of Input: CNU Unit clients: Internal and External	CNU Unit internal and/or External Client ⇩ Transact business with any CNU unit ⇩ Completes transaction ⇩ Fills out CSS form given by unit staff or gets CSS form from its receptacle ⇩ Drops duly filled out CSS form into the drop box outside the unit ⇩ QAO clerk collects the dropped CSS forms from the unit drop box ⇩ QAO clerk encodes the collected CSS into the QAO official computer ⇩ PA for QA/Lead Auditor verifies the encoded CSS results ⇩ QAO staff returns the encoded CSS forms to the unit process owners ⇩ QAO staff generates the CSS results ⇩
Input: Duly Filled up Customer Satisfaction Survey (CSS) Form	
Input Control Measure Remind customer to fill up CSS form after they finish their transaction with any offices in CNU	
Process Activities 1. After delivery of service, staff provides a CSS form and asks the client to completely fill-up and insert the CSS form on the locked drop box. 2. At the end of the month, the QA office (QAO) collects the filled-up CSS forms from the locked drop box of the CNU units and encodes before the 15th of the following month. 3. QA Office returns the encoded CSS to the process owners before the end of the succeeding month.	

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Core Process	Process Flow
4. Process owner files the encoded filled-up CSS forms upon return. 5. On the 22nd of the following month, QAO staff generates CSS reports from the system and distributes to all concerned units. 6. Process owner receives and discusses the CSS reports with their respective unit members and generates reports of the discussion. 7. Process owner files the CSS report and transmits discussion reports to the QAO 8. QAO integrates the CSS reports and discussion reports into the management review agenda.	PA for QA/Lead auditor verifies the encoded CSS results ⇩ QAO staff generates and transmits the generated CSS reports to the process owners ⇩ Process owner discusses the CSS reports with their unit members ⇩ Process owner generate report of the discussion and transmit such to the QAO ⇩ QAO receives the discussion report and integrate such into the management review agenda ⇩ QAO generates a consolidated CSS report and process owner discussion report
Risks 1. No CSS results 2. Uncollected CSS forms 3. Unencoded CSS results 4. Mis-encoded CSS results 5. CSS results not received by process owner 6. No discussion result forwarded to QAO 7. CSS discussion reports not integrated into the management review agenda.	
Risk Control 1. Include in unit meetings the reminder to give CSS form every after client transaction; Personnel catering to the request bring with them the CSS form to be filled out by client	

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Core Process	Process Flow
2. Assign the QAO clerk to collect CSS forms from CNU units weekly. 3. Assign the QAO clerk to encode the collected CSS forms immediately after collection. 4. Encoded CSS results will be verified by the PA for QA/lead auditor after encoding. 5. QAO copy of the delivered CSS report will be signed by the unit receiving officer. Logbook of transmittals will also be signed by the unit receiving officer. 6. Follow up submission of process owners on their discussion report re: CSS report 7. Review all CSS reports prior to creating the management review agenda	
Output/s 1. Filed CSS discussion reports 2. Consolidated CSS Discussion Reports 3. Top management review agenda with CSS result inclusion.	
Receiver of Output Office of the University President	

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MONITORING OF THE QUALITY MANAGEMENT SYSTEM (QMS)

Core Process	Process Flow
Source of Input Process Owners	Inputs ⇩ Internal Auditor (IA) visits the unit to be monitored ⇩ Courtesy call to the unit process owner ⇩ IA gathers documents and records to be checked ⇩ Observes transaction flow in the visited unit ⇩ Interviews unit head/process owner, if necessary ⇩ (IA) diligently notes the findings of the interview and observation ⇩ IA discusses the findings to the point person in-charge/process owner ⇩ IA ensures that the process owner/point person in-charge acknowledges the findings and actions to be taken ⇩ IA monitors the implementation of actions taken by the unit. ⇩ Evaluates with the process owner the effect of the actions taken ⇩ IA makes report of all the findings with corresponding action taken and its effect. ⇩
Input 1. Outputs of Processes 2. CSS results 3. Nonconformities 4. Complaints 5. Minutes of Meetings (i.e. CSS results discussion) 6. Risk assessment review 7. Core process review 8. QMS evaluation 9. Audit plan	
Input Control Measures Evaluate carefully the inputs to determine priority focus of monitoring	
Process Activities 1. Internal Auditor arrives at the unit to be monitored and makes courtesy call/appearance to the person-in-charge 2. Internal Auditor gathers documents and records to be checked which are not limited to — records, CSS results, proofs of implementation of QMS, minutes of meetings, similar documents 3. Internal Auditor observed the implementation of core processes in the unit without distracting daily routine/transactions.	

Core Process	Process Flow
4. Internal Auditor interviews unit head/process owner, if necessary. 5. Internal Auditor explains the findings to the point person-in-charge/process owner. 6. Internal Auditor monitors the actions taken by the unit. Evaluates with the process owner the effect of actions taken. 7. Internal Auditor prepares report of all findings noted with the corresponding actions taken by the units concerned and its effectiveness and forwards it to the lead auditor for review and approval. 8. Lead auditor gives copy of the report to the PA for QA and the process owner.	Forwards the report to the Lead Auditor for review and approval ⇩ Lead auditor gives a copy of the report to the PA for QA and process owner.
Risk/s 1. No available internal auditor to do the monitoring/interview/visit. 2. QA officer no idea on what to monitor. 3. Incomplete recording of findings from the interview. 4. Findings not discussed with the process owner/point person 5. Output receiver unable to receive a copy of the findings.	
Risk Control Maintain a pool of internal auditors that are QMS trained with the latest version of the standard Internal Auditor reads carefully the documents and records presented and gathered after orientation by the Lead Auditor.	

Core Process	Process Flow
Records diligently findings from the interview. Ensures that point person acknowledges findings and actions to be taken. Monitors proof of implementation from last monitoring. Ensures that PA for QA and process owner has received the findings.	
Output Findings of the visit	
Receiver of Output Process owner PA for QA	

INTERNAL QUALITY AUDIT

Core Process	Process Flow
Source of Input QMS Documentation **Input** ISO 9001:2015 Guidelines for auditing management system **Input Control Measures** Use of most recent version of standard, statutory, and regulatory requirements **Process Activities** 1. Establish audit program objectives 2. Audit program and planning 3. Communicate with all concerned the IQA program and plan 4. Implement audit program and plan 5. Perform internal audit flow 5.a Initiate the audit 5.b Prepare audit activities 5.c Conduct audit activities 5.d Prepare and distribute audit report 5.e Complete the audit 5.f Conduct audit follow-up 6. Monitor the program 7. Review and improve the program	Establishment of the audit program and plan ⇩ Transmittal of the audit program and plan to process owners and internal auditors ⇩ Implementation of the audit program and plan ⇩ Personal calls to process owners to confirm feasibility and auditee one week after issuance of audit plan ⇩ Initiation of the audit ⇩ Preparation of audit activities ⇩ Meeting with process owners and internal auditors on the planned 1st party audit: assignments, review, and preparation of audit tools ⇩ Conduct of audit activities ⇩ Opening meeting and conduct of audit as scheduled ⇩ Preparation of audit reports ⇩ Deliberation of audit findings by the whole audit team ⇩ Generation of audit reports (NCAR) @ least 72 hours after closing of the audit ⇩ Distribution of audit report ⇩

Core Process	Process Flow
Risks No agreed audit program objectives Audit program and plan not communicated to all concerned parties (internal auditor and process owner) • Process owners don't have an idea of the planned audit. • Internal auditors not available to do the audit • Audit activities not conducted as planned Audit report not prepared. Audit follow up not done Auditors lack the necessary skills to conduct the audit or did not follow audit protocol.	Process owner generates root cause analysis; correction and corrective action plan ⇩ Internal auditor monitors implementation of correction and corrective action ⇩ Completion of the audit report ⇩ Audit follow – up visit on agreed dates 1st visit: verification of correction and corrective action 2nd visit: verification of effectiveness of the action plan ⇩ Program monitoring • Internal auditor evaluation: auditee, self and QAO • Evaluation of the conduct of internal audit ⇩ Program review and improvement
Risk Control Meeting with the internal auditors and the process owners on the planned 1st party audit. Ensure that the program objectives and program are agreed with the process owners and the internal auditors. Copy of Memorandum distributed one month before the planned audit to the process owners Personal call to the process owners to confirm feasibility and availability of auditee one week prior to the implementation of the audit program plan Conduct IQA meeting for assignments, review and preparation of audit tools Attendance to the Opening Meeting, Conduct audit as per schedule	

Core Process	Process Flow
Internal Quality Audit Report (reflecting time started and ended) Minutes of the deliberation of audit findings to be done by the whole 1st party audit Team QA office issues NCAR form within 7 working days from the time of closing meeting Facilitates correction (if applicable) within 24 hours to one week from the time of audit depending on feasibility of correction needed • Facilitates Root Cause Analysis and Corrective Action within 15 days (minor) and 30 days (major) • For minor NCs not addressed within 15 days, will be raised as Major NC. • Compliance to timeframe as per OPCR Agreed dates (verification for implementation-1st follow-up and effectiveness-2nd follow-up) of follow-up reflected in the NCAR form Reflected in the OPCR target to have no outstanding NC. Monitoring tools for conduct of audit (Competence Evaluation Form for Auditors) – to be evaluated by QAO, self-evaluation and auditee. Feedback of result of evaluation for auditors' and process improvement by QAO Head.	

Core Process	Process Flow
Output Audit Program Objectives Established, Audit Program and Plan Audit Checklist Attendance Sheets IQA Report NCAR issuance Closed NCARs Actual Evaluation of the audit done Quality Improvement Plan based on feedback	
Receiver of Output Auditee Top Management External Auditor	

DOCUMENT CONTROL

Core Process	Process Flow
Source of Input Statutory Requirements Regulatory Requirements International Standards	Quality Assurance Officer becomes a member of the core process review committee and the generation of documented information ⇩ Documented information generation ⇩ Approval of the documented information by the unit head ⇩ Submission of the documented information to QA office ⇩ DCO codes the documented information ⇩ DCO returns the coded documented information to process owner ⇩ Process owner reproduce/use documented information in its operations ⇩ Process owner tracks the distribution of the documented information ⇩ Review and revision of documented information by the Process Owner ⇩ Compliance with documented information protocol ⇩ QA office and Process owner maintain master list of documented information.
Input Manuals of Operation Standard Operating Procedures/Protocols (SOP) Work instructions Process Flow Quality Plans Blueprint documents	
Input Control Measures Documentation of all core processes in all units through the standard documentation template. Approval of the documented information by the unit heads Submission of a copy of the approved documented information to the office of the quality assurance (document control officer)	
Process Activities 1. Generation of documented information by the process owners/assignee. 2. Approval of the documented information by the unit head (using the standard documentation template) with the following contents 2.1. Purpose 2.2. Scope 2.3. Reference 2.4. Responsibility map 2.5. Document code	

Core Process	Process Flow
3. Submission of the documented information to the office of the quality assurance (document control officer). 4. Document control officer (DCO) codes the documented information. 5. DCO retains a copy of the coded documented information as file copy (controlled copy). 6. DCO returns the coded documented information to the process owner. 7. Process owner reproduce the coded documented information for distribution and use in its operations. 8. Process owner tracks the distribution of the document and keeps a file on hand for QMS inspection. When appropriate and relevant, documents display a distribution list. 9. Document changes are reviewed and authorized by the same authority that issued the original document. Revised portions of documents are distributed with a change brief following the foregoing procedure and obsolete documents are removed. 10. Each unit and the QAO maintain a master list of documented information specifying the latest issues and revisions of its documents.	

Core Process	Process Flow
Risks Documented information not approved by the unit head QAO no copy of the documented information Distributed documented information not coded DCO unable to return the coded documented information. Process owner unable to track distribution of the documented information. Document revisions implemented missing the document control process flow. Master list of documented information not available.	
Risk Control Quality assurance officer (QAO) to become a member of the core process review committee and in the generation of documented information to ensure compliance to documentation protocol and submit such to the QA office. Documented information can only be used after due approval by the unit head. All documented information when used for core operations must bear its individual identifier (code).	

Core Process	Process Flow
Assign a DCO to generate the codes of the submitted documented information, retain and maintain its file. Institute the generation of a master list for all documented information by the QAO.	
Output Coded documented information	
Receiver of Output Core process owner QA office Clients	

CONTROL OF NONCONFORMING OUTPUTS

Core Process	Process Flow
Source of Input Clients: Internal and external Interested parties External providers QAO Head	Documentation of the detected nonconformity; signed nonconformity report and attachments as proof of NC ⇩ Submission of nonconformity report to QAO Head ⇩ QA officer assigned to review and confirm the detected nonconformity ⇩ Transmittal of the conconformity report to the process owner ⇩ Receipt of the conconformity report by the process owner ⇩ Process owner conducts root cause analysis and documents the result ⇩ Process owner plans correction/corrective action ⇩ Process owner implements corrective measures according to action plan activities ⇩ QA Officer monitors the action plan activities ⇩ QA Officer verifies the effectiveness of implementation of the corrective action ⇩
Input Nonconforming services report of compliance to requirements of QMS Reports of interested parties Reports of external providers/clients	
Input Control Measures 1. Documentation of the detected nonconformity 2. Review of the Nonconformity Report 3. Conduct of Root cause analysis 4. Perform correction/corrective action 5. Verification of the implementation of action plan activities 6. Determination of the effectiveness of implementation and conformity to the planned activities	

Core Process	Process Flow
Process Activities 1. Documents the detected nonconformity in the Nonconformity Report form 2. Submit Nonconformity report to QAO Head 3. QA officer is assigned to review and confirm the detected nonconformity 4. Receipt of the Nonconformity Report by the process owner 5. Process owner conducts root cause analysis 6. Process owner plans correction/corrective action 7. Process owner implements correction/ corrective measures according to action plan activities 8. QA Officer/Internal Auditor monitors the action plan activities 9. QA Officer/IA verifies the effectiveness of implementation of the corrective action/ correction 10. QA Officer submit Nonconformity report outcome for inclusion in the Management review	QA Officer generates report of outcome of action/s taken based on the monitoring of implementation of planned activities and on-going QMS improvement ⇩ QA Officer submit Nonconformity report outcome for inclusion in the Management review

Core Process	Process Flow
Risks Nonconformity report unsigned; no proof of the NC Root cause analysis not documented No plan for correction or corrective action No report of the monitoring and verification generated by the QA officer	
Risk Control Signed Nonconformity Report and attachments as proof of the NCs Root cause analysis documents Correction /Corrective action plan Report of outcome of action/s taken based on the monitoring of implementation of planned activities and on-going QMS improvement Report on the degree of effectiveness of implementation of action taken and submit it to Management for decision	
Output Report of the quality of product/ service effectively given corrective action and improvements	
Receiver of Output Top management	

HANDLING OF COMPLAINTS

Core Process	Process Flow
Source of Input Internal/External Client	QA Officer receives a customer with a complaint (from the officer of the day) ⇩ QA officer interviews the customer to solicit details of the complaint and records it diligently ⇩ QA Officer/Complainant documents in the "complaint form" the details of the complaint based on the interview and signs the accomplished complaint form ⇩ QA officer provides appropriate correction to address customer complaint ⇩ ⇩ If resolved, QA Officer documents correction on the complaint form. If not resolved, QA Officer explains to the customer that the case will be elevated to the management and documents the correction on the complaint form. ⇩ ⇩ QA Officer forwards copy of the complaint form to QA Office. ⇩ ⇩ QAO examines the complaint and informs the concerned unit for investigation and root cause analysis of the complaint as necessary. If the issue reflects non-conformity to a process, initiates and issues NCAR to concerned unit. ⇩
Input Complaint	
Input Control Measures Reminds customer to completely fill-up CSS form/complaint form and insert on the locked CSS drop box.	
Process Activities 1. QA Officer receives a customer with a complaint (from the officer of the day) 2. QA officer interviews the customer to solicit details of the complaint 3. QA Officer/Complainant documents in the "complaint form" the details of the complaint based on the interview and signs the accomplished complaint form 4. QA officer provides appropriate correction to address customer complaint 5. If resolved, QA Officer documents correction on the complaint form. If not resolved, QA Officer explains to the customer that the case will be elevated to the management and documents the correction on the complaint form. 6. QA Officer forwards copy of the complaint form to QA Office.	

Core Process	Process Flow
7. QAO examines the complaint and informs the concerned unit for investigation and root cause analysis of the complaint as necessary. Under warranted circumstances; the complaint will be elevated to: 7.1. Grievance committee of the Institution for internal clients 7.2. 888 Committee of the institution for external clients If the issue reflects non-conformity to a process, initiates and issues NCAR to concerned unit. 8. Concerned unit formulates corrective action based on root cause analysis and submits report to QA office. 9. Concerned unit implements formulated corrective action/correction. 10. QA Officer monitors the action plan activities. 11. QA Officer verifies the effectiveness of implementation of the corrective action. 12. QA Officer provides official report to QA office. 13. QA office files official report.	Concerned unit do investigation and root cause analysis based on the copy of the complaint forwarded to their office ⇩ Concerned unit formulates corrective action based on root cause analysis and submits minutes of their meeting to QA office. ⇩ Concerned unit implements formulated corrective action. ⇩ QA Officer monitors the action plan activities. ⇩ QA Officer verifies the effectiveness of implementation of the corrective action. ⇩ QA Officer provides official report to QA office. ⇩ QA office files official report.
Risks Client complaints not documented No action taken by the concerned unit	

Core Process	Process Flow
Risk Control Record diligently findings from the interview. Ensure that the accomplished complaint form is acknowledged by complainant. Ensure that the concerned unit will do investigation and root cause analysis based on the copy of the complaint forwarded to their office. Unit concerned furnish the QA office minutes of their meeting reflecting • Root cause analysis • Plan correction/corrective action	
Output Official Complaint Report	
Receiver of Output QAO Head review the report before submission to the Unit Head	

QMS PERFORMANCE EVALUATION

Core Process	Process Flow
Source of Input Unit Heads Process Owners Lead auditor QAO Head	Data presentation during QAO meeting ⇩ Data analysis. ⇩ Identification of data critical to QMS implementation. ⇩ Generation of action plan and monitoring program to address findings that affects the QMS. ⇩ Implementation of action plans. ⇩ Monitoring until affected QMS is resolved including continuing analysis to note the recurrence of same issue and other findings affecting QMS.
Input Reports of Nonconformity to QMS Customer satisfaction feedback data Monitoring records of CQI / implementation of corrective actions Audit report Reports of risks management /opportunities for improvements Client complaints Evaluation report of external auditors/providers Management reviews	
Input Control Measures 1. Reviews of compliance to nonconformity reports 2. Compliance with applicable legal requirements and other requirements needed for the provisions of customer services of the organization.	

Core Process	Process Flow
3. Generates data. 4. Identifies and monitors reports of trends or patterns in QMS problems. 5. Determines the effectiveness of implementation and conformity to the planned activities. 6. Carry-out regular management reviews to ensure the overall effectiveness and continual improvement of the QMS, allocate sufficient resources and identify on-going improvement objectives.	
Process Activities 1. Data presentation during QAO meeting 2. Data analysis. 3. Identification of data critical to QMS implementation. 4. Generation of action plan and monitoring program to address findings that affects the QMS. 5. Implementation of action plans. 6. Monitoring until affected QMS is resolved including continuing analysis to note the recurrence of same issue and other findings affecting QMS.	
Risks No records of QMS performance	

Core Process	Process Flow
Risk Control Records of CQI/implementation of planned activities of corrective action. Generated data to be analyzed (CS feedback, audit reports, client complaints, risks management, and evaluation of external auditors). Report of implementation of accomplished activities and on-going QMS improvement.	
Output Assessment on how well QMS system operates with focus on objective evidence of conformity Report on overall effectiveness of implementation of planned activities, corrective actions and continual improvement of the QMS	
Receiver of Output Top management	

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APPENDICES

APPENDIX A
CUSTOMER SATISFACTION SURVEY IMPLEMENTATION

Source Input	Input	Input Control	Process Activities	Risks	Process Control/Risk Control	Outputs	Output Receiver
CNU Unit Clients Internal External	Duly Filled up Customer Satisfaction Survey (CSS) Form (Client Feedback Form)	Remind customer to fill up CSS form after they finish their transaction with any office in CNU	1. After delivery of service, the staff provides a CSS form and ask the client to completely fill up and insert the CSS form in the locked drop box	No CSS result	Include in unit meetings the reminder to give CSS form every after client transaction; Personnel catering to the request bring with them the CSS form to be filled out by client	Filed CSS results and discussion reports Consolidated CSS results and discussion reports Top management review agenda with CSS inclusion	Office of the University President
			2. At the end of the month, the QA office (QAO) collects the filled-up CSS forms from the locked drop box of the CNU units and encodes before the 15th of the month	uncollected CSS forms	Assign QAO clerk to collect CSS from the CNU units weekly		
				unencoded CSS forms	QAO clerk encodes immediately the CSS results after collection		
				Mis-encoded CSS forms	Encoded results will be verified by the PAQA or the lead auditor		
			3. QAO return the encoded CSS to the process owners before the end of the succeeding month	Not returned CSS results	Schedule and monitor the return of the CSS results to the PO		
			4. Process owner (PO) files the encoded filled-up CSS forms upon return	CSS results not received by PO	QAO copy of the delivered CSS result will be signed by the unit receiving officer. Logbook of transmittals will also be signed by the unit receiving officer.		

Source Input	Input	Input Control	Process Activities	Risks	Process Control/Risk Control	Outputs	Output Receiver
			5. On the 22nd of the following month, QAO staff generates CSS reports from the system and distributes to all concerned units	CSS reports not generated	Schedule the report generation and distribution of CSS reports		
			6. PO receives and discusses the CSS report on their respective units and generates report of the discussion and transmit to QAO	PO did not receive the CSS report	QAO copy of the delivered CSS result will be signed by the unit receiving officer. Logbook of transmittals will also be signed by the unit receiving officer.		
				No discussion done	Follow up submission of PO of their discussion report re: CSS result		
				No discussion report generated and forwarded to QAO			
			7. PO files the CSS result together with the report				
			8. QAO integrates the CSS reports and discussion reports into the top management review protocol/agenda	CSS discussion reports not integrated into the top management review protocol/ agenda	Review all CSS results prior to creating the management review agenda.		

APPENDIX B

CUSTOMER SATISFACTION SURVEY IMPLEMENTATION PROTOCOL

Process Activity	Work Instruction	Time Frame	Responsibility Map	Resources	Document
1. After delivery of service, the staff provides a CSS form and ask the client to completely fill up and insert the CSS form on the locked drop box	1.1. The client completes the transaction with the CNU unit	15 - 30 mis	R - unit staff entertaining the client A - immediate head C - Unit head, unit staff immediate head I - transacting client, top management	Ballpen Bond paper Drop box Lock and key Informed unit staff	CSS form
	1.2. Unit staff (US) catering to the transaction gives the client a CSS form to be filled up	1 min			
	1.3. Unit staff instructs the client to drop the filled up CSS form in the box outside of the unit	1 min			
	OR				
	1.2. Client gets the CSS form from the receptacle outside the unit he/she is transacting with	1 min			
	1.3. Drops the filled up CSS form into the drop box outside the unit	Less than 1 min			
2. At the end of the month, the QA office (QAO) collects the filled-up CSS forms from the locked drop box of the CNU units and encodes before the 15th of the month	2.1. QAO clerk goes to the different CNU units weekly within the evaluation month	10 mins going to the different units	R - QAO clerk A - PAQA/Lead Auditor C - process owners QAO clerk I - process owners	Drop box padlock keys Collection envelope QAO clerk Time Official QAO computer PAQA/Lead auditor	CSS forms
	2.2. QAO clerk opens the locked drop box outside the different units according to the sequencing list	1 min			
	2.3. QAO clerk collects the filled out CSS forms from the box and placed it inside the collection envelope	2 mins			
	2.4. Locks the drop box after collection	1 min			
	2.5. QAO clerk immediately returns to the office after collection	15 mins after last office			

Process Activity	Work Instruction	Time Frame	Responsibility Map	Resources	Document
2. At the end of the month, the QA office (QAO) collects the filled-up CSS forms from the locked drop box of the CNU units and encodes before the 15th of the month	2.6. QAO clerk immediately encodes the CSS results into the QAO official computer	immediately after arrival at QAO			
	2.7. Encoded results will be verified by the PAQA/Lead auditor	immediately after encoding is concluded			
3. QAO return the encoded CSS to the process owners before the end of the succeeding month	3.1. QAO clerk places the encoded CSS results into a short brown envelope	15 minutes for all results	R - QAO clerk A - PAQA/Lead Auditor C - process owners QAO clerk I - process owners	Short brown envelope QA sticker seal Ballpen QA clerk Verifying officer Time	Encoded CSS results placed in the envelope
	3.2. Seals the envelope using the QA office sticker seal placed on the flap of the envelope	1 min			
	3.3. Encoder and verifier affixed their names and signatures outside the sealed envelope	1 min			
	3.4. QAO clerk transmits the sealed envelope to the PO before the end of the succeeding month	10 mins to reach per office			
4. Process owner (PO) files the encoded filled-up CSS forms upon return	4.1. Unit officer receives the sealed CSS results	1 min	R - receiving officer A - Immediate head C - process owner I - unit head	Receiving officer Time Ballpen	Sealed envelope with encoded CSS result Transmittal logbook
	4.2. Receiving officer affixes his/her name and signature in the QAO copy of the CSS results and in the transmittal logbook	1 min			
	4.3. Process owners files the encoded CSS results upon receiving				

Process Activity	Work Instruction	Time Frame	Responsibility Map	Resources	Document
5. On the 22nd of the following month, QAO staff generates CSS reports from the system and distributes to all concerned units	5.1. On or before the 22nd of the following month, QAO staff generates the CSS report/s and affixed name and signature	5 mins per report	R - QAO staff A - PAQA/Lead auditor C - unit staff I - process owner	Time QAO staff Official QAO computer printer Printer ink Bond paper Envelope Sticker seal	CSS report * verified * signed * sealed
	5.2. PAQA/Lead auditor verifies the report/s and affixed name and signature	5 mins per report			
	5.3. QAO staff places the report in an envelope and sealed using the QA sticker seal placed on the flap of the envelope	2 mins			
	5.4. QAO staff distributes the sealed CSS reports to the POs before the end of the month	10 mins to reach PO			
6. PO receives and discusses the CSS report on their respective units and generates report of the discussion and transmit to QAO	6.1. Unit officer receives the sealed CSS report	1 min	R - process owner A - immediate head C - process owner, immediate head, unit staff I - unit staff	Time Receiving officer Process owner Unit staff Documentation materials	CSS report Discussion report
	6.2. Receiving officer affixes his/her name and signature in the QAO copy of the CSS report and in the transmittal logbook	less than a min			
	6.3. PO discusses the CSS report with the unit staff	within 15 days from receipt			
	6.4. PO generates report of the discussion	after discussion			
	6.5. PO transmits the discussion report to the QAO	before the end of the following month			
7. PO files the CSS report					

Process Activity	Work Instruction	Time Frame	Responsibility Map	Resources	Document
8. QAO Integrates the CSS reports and discussion reports into the top management review agenda	8.1. QAO receives the discussion report/s from the POs	1 min	R - PAQA A - Univ Pres C - Univ Pres I - Top management	QAO official computer Printer with Ink Time PAQA	Top management agenda
	8.2. QAO collates and analyzes the discussion reports	within 7 days			
	8.3. Integrates the reports into the top management review agenda	a month prior to Top Management Review			

Definition of terms

CSS forms: forms filled out by the client, dropped in the drop box, collected by QAO staff weekly and/or end of the month

CSS results: the processed CSS forms, placed in a sealed envelope, and returned to the process owners for filing in their respective units

CSS reports: document that is computer generated, the result data processing of the CSS results placed in a sealed envelope, transmitted to the process owner for discussion with their staff

Discussion report: minutes of the discussion that the process owner performed with their staff in reference to the transmitted CSS report

Top management agenda: list of items for discussion by the top management during the top management review procedure.

Republic of the Philippines

CEBU NORMAL UNIVERSITY

Osmeña Blvd. Cebu City, 6000 Philippines

CLIENT FEEDBACK

Dear valued client,

Thank you for choosing CNU to cater to your needs. Your satisfaction in our services is important to us. Your feedback will help us enhance our service delivery with your future transactions. Share with us your experience by filling out this form. Thank you.

Date: _____ Time: _____

Kindly place a check (/) mark where it is necessary.

Client Type:
☐ Internal Client ☐ External Client
☐ Faculty ☐ Student ☐ Parent ☐ Others, specify _____
☐ Employee ☐ Alumni ☐ Guest

Office/College of transaction: _____

Transactions availed
☐ Requisition of documents ☐ Follow up of documents
☐ Submission of documents ☐ Releasing of documents
☐ Inquiry ☐ Consultation
☐ Testing and Evaluation ☐ Guidance and Counselling
☐ Selling products ☐ Buying products/services
☐ Checking and maintenance ☐ Repair services, specify: _____
☐ Others, specify: _____

Please rate the quality of service you had received. Place a check (/) mark on the box that represents your evaluation.
Rating scale: 4 – Excellent 3 – Better 2 – Good 1 – Needs Improvement

Criteria	4	3	2	1
1. Courtesy of the service provider.				
2. Helpfulness and accommodation of the service provider.				
3. Promptness in attending to your needs.				
4. Efficiency in completing transaction/s.				
5. Overall experience.				

Comments and Suggestions:

_____

_____

_____

If at a later time you have additional feedback, you may call the Office of the Quality Assurance @ Tel No. (032) 254-1452 local 157 or Email: qa@cnu.edu.ph

APPENDIX D
INTERNAL QUALITY AUDIT

Source Input	Input	Input Control	Process Activities	Risks	Process Control/ Risk Control	Outputs	Output Receiver
QMS Documentation	ISO 9001:2015 Guidelines for auditing management system	Use of most recent version of standard, statutory, and regulatory requirements	1. Establish program objectives	No agreed audit program objectives and audit program plan	Meeting of the Internal auditors and the process owners on the planned first party audit	Audit Program Objectives Established, Audit Program and Plan Audit Checklist Attendance Sheets IQA Report NCAR Issuance Closed NCARs Actual Evaluation of the audit done Quality Improvement Plan based on feedback	Auditee Top Management External Auditor
			2. Audit program and planning				
			3. Communicate with all concerned the IQA program plan	Audit program and plan not communicated to all concerned parties (internal auditors and process owners)	Ensure that program objectives and program are agreed with the process owners and internal auditors		
				* PO don't have an idea of the audit plan	IA and PO affixed their signatures in the audit program and objectives		
				* IA not available to do the audit			
					Copy of program plan distributed one month before the planned audit to the process owners		

Source Input	Input	Input Control	Process Activities	Risks	Process Control/Risk Control	Outputs	Output Receiver
			4. Implement audit program and plan	Audit activities not conducted as Planned	Personal call to process owners to confirm feasibility and availability of auditee one (1) week prior to the implementation of the audit program plan		
			5. Perform internal audit flow 5.1. Initiate the audit 5.2. Prepare audit activities		Conduct IQA meeting for assignments, review and preparation of audit tools		
			5.3. Conduct audit activities	No internal auditor participation	Attendance to the opening meeting Conduct audit as scheduled		
			5.4. Prepare and distribute audit reports	Audit reports not prepared	Memo reminders will be sent to IAs IQA reports reflecting time and date started and ended QA issues NCAR form 7 working days from the time of closing meeting		
			5.5. Complete the audit		Facilitates correction (if applicable) within 24 hours to one week from the time of audit Facilitates RCA and corrective action within 15 days (minor NC) and 30 days (major NC) Agreed dates (verification for implementation-1st follow-up and effectiveness-2nd follow-up) of follow-up reflected in the NCAR form		
			5..6. Conduct audit follow - up	Audit follow-up not done			

Source Input	Input	Input Control	Process Activities	Risks	Process Control/Risk Control	Outputs	Output Receiver
			6. Monitoring, review and improvement of the program	Non conduct of program monitoring review and improvement	Minutes of the deliberation of audit findings done by all the members of the 1st party audit Minor NCs not addressed within 15 days will be raised as major NC Compliance to timeframe as per OPCR Reflected in the OPCR target the number of units with no outstanding NC. Monitoring tools for conduct of audit (Competence Evaluation Form for Auditors) - to be evaluated by QAO, self-evaluation and auditee. Feedback of result of evaluation for auditors' and process improvement by QAO Head.		

APPENDIX E
INTERNAL QUALITY AUDIT PROTOCOL

Process Activity	Work Instruction	Time Frame	Responsibility Map	Resources	Document
1. Establish program objectives	1.1. QA office issues notice for a meeting to internal auditors and process owners 1.2. Meeting agenda to include audit objectives 1.3. Presentation of latest audit results 1.4 Solicit contributions for audit objectives	one month prior to 1st party audit	R - Lead Auditor A - PA QA C - process owners, internal auditors I - process owners. internal auditors	Food Paper Printer ink Printers Computer set	Established audit program objectives reflecting the signatures of the POs and IAs Notice of meeting duly noted by the Univ Pres
2. Audit program and planning	2.1. QA office issues notice of meeting to IAs and POs 2.2. Agenda on planned audit activity 2.3. Presentation of the audit program plan 2..4. Discussion on unit/s for visit	one month prior to 1st party audit	R - Lead Auditor A - PA QA C - process owners, internal auditors I - process owners. internal auditors	Food Paper Printer ink Printers Computer set	Established audit program objectives reflecting the signatures of the POs and IAs Notice of meeting duly noted by the Univ Pres
3. Communicate with all concerned the IQA program plan	3.1. Confirmation of the schedule of the audit visit to the process owners and the Internal auditors 3..2. Finalization of the schedule of the audit program plan	45 days prior to program plan issuance	R - Lead Auditor A - PA QA C - process owners, internal auditors I - process owners. internal auditors	Paper Printer ink Printers Computer set	Confirmed and approved program plan

Process Activity	Work Instruction	Time Frame	Responsibility Map	Resources	Document
	3.3. Issuance of a copy of the audit program plan to the process owners and the Internal auditors after its approval by the University President	one month prior to the planned audit visit			
	3.4. PO and IA affixed their signature on the QAO copy of the program plan to signify receipt thereof				
4. Implement audit program and plan	4.1. Personal call to process owners to confirm feasibility and availability of auditee one prior to the implementation of the audit program plan	7 days	R - Lead Auditor A - PA QA C - process owners, internal auditors I - process owners. internal auditors	Paper Printer ink Printers Computer set	Confirmed schedule of the planned audit
	4.2. Confirmation of the availability of the internal auditor/s prior to the implementation of the audit program plan	14 days			
5. Perform internal audit flow 5.1. Initiate the audit	5.1.1. Conduct of IQA meeting	30 - 45mins	R - Lead Auditor A - PA QA C - Internal Auditors I - process owners.	Paper Printer ink Printers Computer set Time	Closed out NCAR Memo reminders
	5.1.2. Review of the latest audit results vis-à-vis audit objectives				
	5.1.3. Assignment of internal auditors vis-à-vis units to visit				
5.2. Prepare audit activities	5.2.1. Preparation of the audit instrument/guide based on the findings of the latest audit visit vis-à-vis established program objectives	15 days prior to IQA	R - Internal Auditor A - Lead Auditor C - PA QA I - process owners.		Internal audit instrument/guide
	5.2.2. Review of the audit guide by the Lead auditor	one day			

Process Activity	Work Instruction	Time Frame	Responsibility Map	Resources	Document
5.3. Conduct audit activities	5.3.1. IAs attend opening meeting 5.3.2. IAs assignment reiterated and reminders for the visit issued	30 - 45 mins	R - Lead Auditor A - PA QA C - Internal Auditors I - process owners.	Audit Plan	attendance to the IQA meeting
5.4. Prepare and distribute audit reports	5.4.1. IAs prepare the audit report after the conclusion of the visit	one hour	R - Internal Auditor A - Lead Auditor C - PA QA I - process owners.	Paper Printer ink Printers Computer set Time	audit report NCAR forms
	5.4.2. Audit reports generated reflecting date and time audit/s were started and concluded				
	5.4.3. Submit such audit report to the Lead Auditor	24 hrs after closing			
	5.4.4. QA office issues memo reminders to IAs whose audit reports were not submitted on agreed due date	24 hrs after closing			
	5.4.5. QA office issues NCAR to process owners seven (7) working days after the closing meeting	7 working days after closing			
5.5. Complete the audit	5.5.1. IA visits the audited unit to facilitate correction	24 hrs to one week from time of audit	R - Internal Auditor A - Lead Auditor C - PA QA I - process owners.		NCAR forms
	5.5.2. IA closes the NCAR after the visit	24 hrs after the correction verification			
	5.5.3. IA submits the closed out NCAR to the Lead Auditor	24hrs after closed out			
5..6. Conduct audit follow - up	5.6.1. Facilitate RCA and corrective action implementation	Minor NC: 15days Major NC: 30days	R - Internal Auditor A - Lead Auditor C - PA QA I - process owners.	Paper Printer ink Printers Computer set Time	RCA Corrective action plan Closed out NCAR
	5.6.2. Conduct of follow - up visit for verification (1st visit) and evaluation of effectiveness (2nd visit)	agreed dates			

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Process Activity	Work Instruction	Time Frame	Responsibility Map	Resources	Document
	5.6.3. Reflect these visits in the Internal Auditors report as appended to the closed out NCAR	7 days after last monitoring and visit			
6. Monitoring, review and improvement of the program	6.1. Review of the minutes of the deliberation of audit findings conducted by all members of the 1st party audit	one month after all reports are submitted	R - Lead Auditor A - PAQA C - Internal Auditors I - Process owners, Internal Auditors	Paper Printer ink Printers Computer set Time	Minutes of audit findings deliberation IA reports Competence Evaluation Form for Auditors Evaluation reports with the affixed signature of the Internal Auditor confirming receipt of the feedback OPCR reflecting actual accomplishment vis-à-vis targets
	6.2. Raising minor NCs not addressed within 15 days into Major NC				
	6.3. Review of the results of monitoring tools evaluated by the QAO, self and auditee (Competence Evaluation Form for Auditors)				
	6.4. Review results of evaluation for auditors and improvement by QAO Head				
	6.5. Give auditors feedback of their evaluation results				
	6.6. Compliance to timeframe as reflected in the OPCR				
	6.7. Reflected in the OPCR target the number of units with no outstanding NCs				

APPENDIX F
QUALITY MANAGEMENT SYSTEM (QMS) MONITORING

Source Input	Input	Input Control	Process Activities	Risks	Process Control/ Risk Control	Outputs	Output Receiver
Process Owners	Outputs of Processes CSS results Nonconformities Complaints Minutes of Meetings (i.e. CSS results discussion) Risk assessment review Core process review QMS evaluation Audit plan	Evaluate carefully the inputs to determine priority focus of monitoring	1. Internal Auditor arrives at the unit to be monitored and makes courtesy call/ appearance to the person-in-charge	No available internal auditor to do the monitoring/ interview/visit.	Maintain a pool of internal auditors that are QMS trained with the latest version of the standard	Collated results of the QMS monitoring and evaluation	PA for QA
			2. Internal Auditor gathers documents and records to be checked which are not limited to -- records, CSS results, proofs of implementation of QMS, minutes of meetings, similar documents	IA officer no idea on what to monitor.	Orientation of the IA prior to the visit. Discussion of the inputs during the orientation. Preparation of the audit guide based on the inputs. Internal Auditor reads carefully the documents and records presented and gathered after orientation by the Lead Auditor.		
			3. Internal Auditor observed the implementation of core processes in the unit without distracting daily routine/ transactions.	Limited auditor's skills in the conduct of internal audit	Re-tooling/Knowledge updating of Internal Auditors		
			4. Internal Auditor interviews unit head/process owner, if necessary.	Incomplete recording of findings from the interview.			

Source Input	Input	Input Control	Process Activities	Risks	Process Control/ Risk Control	Outputs	Output Receiver
			5. Internal Auditor explains the findings to the point person-in-charge/process owner.	Findings not discussed with the process owner/point person	Process owner/point person signs the initial report of the findings evidence that the findings had been discussed with them		
			6. Internal Auditor monitors the actions taken by the unit. Evaluates with the process owner the effect of actions taken.	No monitoring and evaluation	Monitoring and evaluation schedule will be the last working day of the month after the process owner signs the receipt of the QMS findings (correction) and every last day of the succeeding month (to evaluate corrective action)		
			7. Internal Auditor prepares report of all findings noted with the corresponding actions taken by the units concerned and its effectiveness and forwards it to the lead auditor for review and approval.	No reports done	IA makes the report 7 days after the last monitoring visit Reminder memos will be issued to IA		
			8. Lead auditor gives copy of the report to the PA for QA and the process owner.	Output receiver unable to receive a copy of the findings.	Deadline for submission of collated QMS monitoring results will be 5 working days after the conclusion of the monitoring		

APPENDIX G
QUALITY MANAGEMENT SYSTEM MONITORING PROTOCOL

Process Activity	Work Instruction	Time Frame	Responsibility Map	Resources	Document
1. Internal Auditor arrives at the unit to be monitored and makes courtesy call/ appearance to the person-in-charge	1.1. PA QA together with the Lead Auditor (LA) review the current pool of internal auditors	at least 2 mos before the planned QMS monitoring	R - Lead Auditor A - PA QA C - Internal auditor, process owners I - Process owners, unit staff, VPs, QA officers University President	Time Paper Ballpens Computer set Printers Printer Inks Food	Designation from the University President Signed confirmation of the Internal Auditors and Process owners of their availability Internal audit guide
	1.2. Internal Auditor (IA) is assigned to a unit that he/she will be visiting for QMS monitoring	One (1) month before the planned QMS monitoring			
	1.3. IA is issued a memorandum by the PA QA duly noted by the University President on his/her unit assignment				
	1.4. Lead Auditor checks the availability of the internal auditors for QMS monitoring	15 days before the planned QMS monitoring			
	1.5. LA notifies the process owner of the scheduled audit 1.5.1. checks for their availability 1.5.2. agree on the time for the visit				
	1.6. Opening meeting	30 - 45 mins			
	1.7. Discussion of the inputs during the orientation	15 mins per internal auditor			
	1.8. Internal auditor reads the audit guide and presents plan on the flow of internal audit visit				
	1.9. IA visits the assigned unit to begin the audit (QMS monitoring)	10 mins to reach the unit for visit			
	1.10. Greets the process owner and states the purpose of the visit	10 – 15 mins			

Process Activity	Work Instruction	Time Frame	Responsibility Map	Resources	Document
2. Internal Auditor gathers documents and records to be checked which are not limited to — records, CSS results, proofs of implementation of QMS, minutes of meetings, similar documents	2.1. IA samples transaction documents for verification against unit protocol	flexible	R - Internal Auditor A - Lead Auditor C - PA QA, Process owner I - Unit staff	Time Ballpens Note pads	Internal audit guide Unit Protocol/Core Process
3. Internal Auditor observed the implementation of core processes in the unit without distracting daily routine/ transactions.	3.1. Observes the flow of the transactions in the unit and checks whether transactions follow the unit protocol without disrupting the unit process flow	flexible	R - Internal Auditor A - Lead Auditor C - PA QA, Process owners I - Unit staff	Time Ballpens Note pads	Internal audit guide Unit Protocol/Core Process
	3.2. IA notes observations in the audit guide				
4. Internal Auditor interviews unit head/ process owner, if necessary.	4.1. IA interviews the process owner for verification of transaction using the audit guide	flexible	R - Internal Auditor A - Lead Auditor C - PA QA, Process owners I - Unit staff	Time Ballpens Note pads	Internal audit guide Unit Protocol/Core Process
	4.2. IA notes interview results in the audit guide				
5. Internal Auditor explains the findings to the point person-in-charge/process owner.	5.1. Internal auditor discusses findings of the audit with the process owner/point person-in-charge	15 - 30 mins	R - Internal Auditor A - Lead Auditor C - PA QA, Process owners I - Unit staff	Time Ballpens Note pads	Internal audit guide
	5.2. Process owner may affirm, verify and further explains the findings discussed by the internal auditor				

Process Activity	Work Instruction	Time Frame	Responsibility Map	Resources	Document
	5.3. Process owner/point person signs the initial report of the findings evidence that the findings had been discussed with them	1 min			
6. Internal Auditor monitors the actions taken by the unit. Evaluates with the process owner the effect of actions taken.	6.1. Process owner conducts root cause analysis of the NCs cited by the IA	within 15 days after receipt of the NCAR	R - Internal Auditor A - Lead Auditor C - PA QA, Process owners I - Unit staff	Time Ballpens Note pads Computer set Printers Printer Inks Paper	NCAR RCA IA monitoring sheet
	6.2. PO plans for correction and corrective action of the NCs cited by the IA	Correction: Immediate to one week implementation Corrective action: within 15 days after RCA			
	6.3. IA arranges with the PO for the monitoring and evaluation schedule for the correction and corrective action implementation	Correction: last working day of the following month of NCAR receipt Corrective action: every last day of the following month of NCAR receipt			
7. Internal Auditor prepares report of all findings noted with the corresponding actions taken by the units concerned and its effectiveness and forwards it to the lead auditor for review and approval.	7.1. IA closes the NCAR form	7 days after the last monitoring and evaluation visit	R - Internal Auditor A - Lead Auditor C - PA QA I - QA Officer	Time Ballpens Paper Computer set Printers Printer Inks	NCAR IA monitoring sheet Internal Auditors report
	7.2. IA prepares report of all findings noted with corresponding actions taken and its effectiveness				
	7.3. Forwards such report to the Lead Auditor for review and approval				

Process Activity	Work Instruction	Time Frame	Responsibility Map	Resources	Document
8. Lead auditor gives copy of the report to the PA for QA and the process owner.	8.1. LA receives the Internal auditor's report		R - Lead Auditor A - PA QA C - Internal auditor I - University President	Time Ballpens Paper Computer set Printers Printer Inks	Internal audit analysis
	8.2. Reviews and approves the report.	3 working days			
	8.3. Gives a copy of the report to the process owner	15 days after receipt of the report			
	8.3. LA collates, summarizes and analysis the approved internal auditors reports				
	8.4. LA prepares analysis of the collated reports				
	8.5. Submits the analysis to the PA QA for approval				
	8.6. PA QA submits the internal audit analysis to the University President	3 days after receipt of the report			

APPENDIX H
DOCUMENT CONTROL

Source Input	Input	Input Control	Process Activities	Risks	Process Control/Risk Control	Outputs	Output Receiver
Statutory Requirements Regulatory Requirements International Standards	Manuals of Operation Standard Operating Procedures/ Protocols (SOP) Work instructions Process Flow Quality Plans Blueprint documents	Documentation of all core processes in all units through the standard documentation template. Approval of the documented information by the unit heads Submission of a copy of the approved documented information to the office of the quality assurance (document control officer)	1. Generation of documented information by the process owners/assignees		QA officer to become a member of core process review committee and in the generation of the documented information to ensure compliance to documentation protocol and submit such to QA office	Coded documented information	Core process owners QA office Clients
			2. Approval of the documented information by the unit head (using the standard documentation template) with the following contents 2.1. Purpose 2.2. Scope 2.3. References 2.4. Responsibility map 2.5. Document code	Documented information not approved by the unit head	Documented information can only be used after due approval by the unit head		
				standard documentation template not followed	[refer to risk control first entry]		

Source Input	Input	Input Control	Process Activities	Risks	Process Control/Risk Control	Outputs	Output Receiver
			3. Submission of the documented information to the Office of Quality Assurance (document officer)	QAO no copy of documented information	[refer to risk control first entry]		
			4. Document officer codes the submitted documented information	Distributed documented information not coded	All documented information when used for core operations must bear its individual identifier (code)		
			5. DCO retains a copy of the coded documented information as file copy (controlled copy)	No QA office file of the documented information	Assign a DCO to generate the codes of the submitted documented information, retain and maintain its file		
			6. DCO returns the coded documented information to the process owner	DCO unable to return to the process owner the coded documented information	Return documented information to process owners 7 working days after received by the office		
					Track submissions and release of core process documented information from DC office		
			7. Process owner reproduce the coded documented information for distribution and use in its operation				
			8. Process owner tracks the distribution and release documented information and keeps a file on hand for QMS inspection. When appropriate and relevant documents display a distribution list.	Process owner unable to track distribution of documented information	Logbook for the release and distribution of documented information		

Source Input	Input	Input Control	Process Activities	Risks	Process Control/Risk Control	Outputs	Output Receiver
			9. Document changes are reviewed and authorized by the same authority that issued the original document. Revised portions of documents are distributed with a change brief following the foregoing procedure and obsolete documents are removed.	Document revisions implemented missing the document control process flow	QA office through the QA officer monitors the occurrence of documented information changes in their respective unit assignment		
			10. Each unit maintains a masterlist of documented information specifying the latest issues and revisions of its documents	Masterlist of documented information not available	Institute the generation of masterlist of documented information by the QA office		

APPENDIX I
DOCUMENT CONTROL PROTOCOL

Process Activity	Work Instruction	Time Frame	Responsibility Map	Resources	Document
1. Generation of documented information by the process owners/ assignees	1.1. Process owner with the QA officer reviews current documented information for appropriateness for use in the core operations	Periodic	R - Unit Staff A - Unit Head C - QA officer I - Unit staff	Paper Printer ink Printers Computer set Time	Revised documented information
	1.2. Core process owner - initiated changes when necessary				
	1.3. Unit staff generates the revision of the documented information	after review and revision activities			
	OR				
	1.1. Unit develops new documented information as appropriate to unit core process	When necessary			
	1.2. Unit staff generates the new documented information	after review and revision activities			
2. Approval of the documented information by the unit head (using the standard documentation template) with the following contents 2.1. Purpose 2.2. Scope 2.3. References 2.4. Responsibility map 2.5. Document code	2.1. Unit staff generates the revised/brand new documented information using the standard documentation template.	2 days after review and revision	R - Unit Staff A - QA Officer C - Unit head, Unit Staff I - Unit staff, QA Office	Paper Printer ink Printers Computer set Time	Approved New/Revised Documented information
	2.2. submits the generated documented information to the QA officer for review	one day after its generation			
	2.3. QA officer forwards the generated documented information to the unit head for approval	2 days after receipt of the document			
	2..4. Unit head approves the generated documented information	2 days after receipt of the document			

Process Activity	Work Instruction	Time Frame	Responsibility Map	Resources	Document
3. Submission of the documented information to the Office of Quality Assurance (document officer)	3.1. QA officer after approval of the new/revised documented information, endorses such to the QA office (document control officer)	within 24 hours of its approval	R - QA Officer A - Document Control Officer C - Unit Head I - Unit Head, PAQA, Lead Auditor	Time	Approved New/Revised Documented Information
	3.2. QA officer/document control officer logs the submission of the document into the document control logbook	immediately after submission			
4. Document officer codes the submitted documented information	4.1. Document officer upon receipt of submission reviews the documented information masterlist of the unit	max 2 days after receipt	R - Document Control Officer A - PA QA C - Lead Auditor I - Unit Head	Time	Coded documented information
	4.2. Enters the documented information into the unit masterlist and specifies: 4.2.1. new documented information 4.2.2. revised documented information and reflects the revision number				
	4.3. Generates the document code for the submitted documented information				
5. DCO retains a copy of the coded documented information as file copy (controlled copy)	5.1. DCO ascribes the code into the documented information	immediately	R - Document Control Officer A - PA QA C - Lead Auditor I - Unit Head	Time	Coded documented information as controlled copy
	5.2. Generates a copy of the coded documented information	max 30 mins after coding			
	5.3. Retains a copy of such				
	5.4. Files the coded documented information into the file binder of the unit as controlled document				

Process Activity	Work Instruction	Time Frame	Responsibility Map	Resources	Document
6. DCO returns the coded documented information to the process owner	6.1. DCO generates the coded information for the unit process owners as uncontrolled documents 6.2. Issues the uncontrolled document to the process owners 6.3. Tracks the submission and release of uncontrolled documents through the document control logbook	7 working days after receipt by the office	R - Document Control Officer A - PA QA C - Lead Auditor I - QA officer, process owner, unit staff	Time Computer set Printer Printer ink	Coded documented information as uncontrolled copy
7. Process owner reproduce the coded documented information for distribution and use in its operation			R - Process owner		Reproduced documented information
8. Process owner tracks the distribution and release documented information and keeps a file on hand for QMS inspection. When appropriate and relevant documents display a distribution list.	8.1. embed distribution list into the documented information, if possible		R - Process owner		Logbook for tracking release of documented information

Process Activity	Work Instruction	Time Frame	Responsibility Map	Resources	Document
9. Document changes are reviewed and authorized by the same authority that issued the original document. Revised portions of documents are distributed with a change brief following the foregoing procedure and obsolete documents are removed.	9.1. QA officer sitting as part of the core process review committee monitors the occurrence of documented information changes in their respective units	during the review	R - QA Officer A - Document control officer C - Lead Auditor I - PA QA	Time	Controlled obsolete documents
	9.2. QA officer informs the process owner on the procedure for instituting the changes and monitors its compliance	immediately after the review			
	9.3. QA officer ensures that obsolete documents are controlled				
	9.4. QA officer endorses such changes to the document control officer for monitoring and tracking				
10. Each unit maintains a masterlist of documented information specifying the latest issues and revisions of its documents			R - Unit Head A - QA Officer		Masterlist of documented information

APPENDIX J
CONTROL OF NONCONFORMING OUTPUTS

Source Input	Input	Input Control	Process Activities	Risks	Process Control/ Risk Control	Outputs	Output Receiver
Clients: Internal and External Interested Parties External Providers QAO Head	Nonconforming services report of compliance to requirements of QMS Reports of interested parties reports of external providers/clients	Documentation of the detected nonconformity review of the nonconformity report conduct of root cause analysis perform correction/ corrective action verification of the implementation of action plan activities determination of the effectiveness of implementation and conformity to the planned activities	1. Documentation of the detected nonconformity into the nonconformity report form	Nonconformity report unsigned No evidence of the nonconformity	Signed nonconformity report and attachments as proof of the NC	Report of the quality of products/service effectively given corrective action and improvement	Top management
			2. Submit nonconformity report to the QAO Head				
			3. QA officer assigned to review and confirm the detected nonconformity	No QA officer review and confirmation	Memo to QA officer to do the review and investigation		
			5. Process owner conducts root cause analysis	Root cause analysis not documented	Root cause analysis documents		
			6. Process owner plans correction/corrective action	no plan for correction or corrective action	Correction/corrective action plan		

Source Input	Input	Input Control	Process Activities	Risks	Process Control/Risk Control	Outputs	Output Receiver
			7. Process owner implements correction/corrective measures according to action plan activities				
			8. QA officer or Internal Auditor monitors the action plan activities	No report on the monitoring and verification generated by the QA officer/ Internal Auditor	Report of outcome of action/s taken on the monitoring and implementation of planned activities and on-going QMS improvement		
			9. QA officer or Internal Auditor verifies the effectiveness of implementation of the correction/corrective action		Report on the degree of effectiveness of implementation of action taken and submit it to management for decision		
			10. QA submit Nonconformity report outcome for inclusion in the Management review				

APPENDIX K
CONTROL OF NONCONFORMING OUTPUTS PROTOCOL

Process Activity	Work Instruction	Time Frame	Responsibility Map	Resources	Document
1. Documentation of the detected nonconformity into the nonconformity report form	1.1. Input sources reports on the nonconformity directly or indirectly experienced	variable or after QMS monitoring	R - Input source A - QAO Head C - QA Officer, Internal Auditor I - Process owner/unit head	Paper ballpen	Signed nonconformity report
	1.2. Input source signed the nonconformity report and provide attachments (evidences) for the claim				
2. Submit nonconformity report to the QAO Head	2.1. Input source submits the signed nonconformity report form and relevant attachments	variable	R - Lead auditor A - QAO Head C - QA Officer, Internal Auditor I - Process owner/unit head	Paper ballpen	Signed nonconformity report
	2.2. QAO Head acknowledges the submission and issues acknowledgement receipt to the input source	immediately after receipt			
	2.3. Reviews the nonconformity report and decides on its relevance to the QMS	immediately after submission			
	2.4. Forwards such report to the lead quality auditor	After review			
3. QA officer assigned to review and confirm the detected nonconformity	3.1. QA officer informed of the occurrence of the reported nonconformity	within 24 hours from QA office review	R - QA Officer A - Lead Auditor C - QAO Head I - Process owner	Paper Ballpen Computer set Printer Printer ink	QA officer report NCAR
	3.2. Memo to review and investigate issued to the QA officer				
	3.3. QA officer generates report of the review and investigation	within 7 days from receipt of the memo			
	3.4. When warranted, the investigated nonconformity will be converted into QMS nonconformity and written into the official NCAR and signed by the QA officer	within 7 days after report submission			

Process Activity	Work Instruction	Time Frame	Responsibility Map	Resources	Document
4. Receipt of the nonconformity report by the process owner	4.1. QA office issues NCAR duly signed by the investigating QA Officer	7 days after report submission	R - QA Officer A - Lead Auditor C - QAO Head I - Process owner	Paper Ballpen Computer set Printer Printer ink	NCAR QA office logbook
	4.2. Process owner receives the NCAR and signs the transmittal logbook	10 mins to reach the Office 10 mins for signature			
	4.3. QA Office records the receipt of the NCAR	immediately upon QA staff's return to QA office			
	4.4. QA office schedules a follow up date with the process owner according to the IQA protocol	agreed schedule			
5. Process owner conducts root cause analysis	5.1. Process owner conducts root cause analysis	within 15 days from receipt of NCAR	R - Process owner A - QA Officer C - Lead auditor I - QAO Head	Paper Ballpen Computer set Printer Printer Ink Time	Root cause analysis report
	5.2. Process owner makes report of the conducted root cause analysis	immediately after its conduct			
6. Process owner plans correction/corrective action	6.1. PO plans for correction/corrective action	immediately after RCA Correction: immediate to one week implementation Corrective action: within 15 days after RCA	R - Process owner A - QA Officer C - Lead auditor I - QAO Head	Paper Ballpen Computer set Printer Pirnter Ink Time	Correction/ corrective action plan

Process Activity	Work Instruction	Time Frame	Responsibility Map	Resources	Document
7. Process owner implements correction/ corrective measures according to action plan activities	7.1. Implements correction/ corrective action plan	Correction: immediate to one week implementation Corrective action: within 15 days after RCA	R - Process owner A - QA Officer C - Lead auditor I - QAO Head	Paper Ballpen Computer set Printer Pimter ink Time	Record/report on correction/ corrective action plan implementation
8. QA officer or Internal Auditor monitors the action plan activities	8.1.QA officer/IA arranges with the PO for the monitoring and evaluation schedule for the correction and corrective action implementation	Correction: last working days of the following month of NCAR receipt Corrective action: every last day of the following month of NCAR receipt	R - QA Officer A - Lead Auditor C - QAO Head I - Process owner	Paper Ballpen Computer set Printer Printer ink Time	Record/report on correction/ corrective action plan implementation
	8.2. QA Officer/IA visits the PO during the agreed monitoring and evaluation schedule				
9. QA officer or Internal Auditor verifies the effectiveness of implementation of the correction/corrective action	9.1. Conduct of follow - up visit for verification (1st visit) and evaluation of effectiveness (2nd visit)	agreed dates	R - QA Officer A - Lead Auditor C - QAO Head I - Process owner	Paper Ballpen Computer set Printer Printer ink Time	verification report QA officer/IA's report
	9.2. Reflect these visits in the Internal Auditors/QA officer's report as appended to the closed out NCAR	7 days after last monitoring and evaluation			
10. QA submit Nonconformity report outcome for inclusion in the Management review	10.1 Lead auditor reviews and approves the submitted reports	Within 3 working days	R - Lead Auditor A - QAO Head C - QA Officer I - Top Management	Paper Ballpen Computer set Printer Pimter ink Time	QA officer/IA's report
	10.2. Gives a copy of the report to the process owner and QAO Head				
	10.3. QAO Head submits copy of the report to top management	3 working days after receipt of the report			

APPENDIX L
HANDLING COMPLAINTS

Source Input	Input	Input Control	Process Activities	Risks	Process Control/ Risk Control	Outputs	Output Receiver
Internal/ External Clients	Complaint	Remind customer to completely fill up CSS form/complaint form and insert in the locked CSS drop box	1. QA officer receives a customer with a complaint			Official Complaint Report	QAO Head review the report before submission to the Unit Head
			2. QA officer interviews the customer to solicit details of the complaint				
			3. QA officer/ complainant documents in the complaint form the details of the complaint based on the interview and signs the accomplished complaint form	Client complaints not documented	Record diligently findings from the interview. Ensure that the accomplished complaint form is acknowledged by complainant.		
			4. QA Officer provides appropriate correction to address client complaints				
			5. If resolved, QA officer documents correction on the complaint form. If not resolved, QA officer explains to the client that the case will be elevated to the management and documents the correction on the complaint form.				
			6. QA officer forwards a copy of the complaint form to the QA Office				

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Source Input	Input	Input Control	Process Activities	Risks	Process Control/ Risk Control	Outputs	Output Receiver
			7. QAO examines the complaint and informs the concerned unit for investigation and root cause analysis of the complaint as necessary. If the issue reflects non-conformity to a process, initiates and issues NCAR to concerned unit.	No action taken by the concerned unit	Ensure that the concerned unit will do investigation and root cause analysis based on the copy of the complaint forwarded to their office.		
			8. Concerned unit formulates corrective action based on root cause analysis and submits report to QA office.		Unit concerned furnish the QA office minutes of their meeting reflecting * Root cause analysis * Correction/ Corrective action plan		
			9. Concerned unit implements formulated corrective action/correction.				
			10. QA Officer monitors the action plan activities.				
			11. QA Officer verifies the effectiveness of implementation of the corrective action				
			12. QA Officer provides official report to QA office.				
			13. QA office files official report.				

APPENDIX M
HANDLING COMPLAINTS PROTOCOL

Process Activity	Work Instruction	Time Frame	Responsibility Map	Resources	Document
1. QA officer receives a customer with a complaint	1.1. Customer will be received by the QA officer in a safe place and private enough so as not to cause disruption of the units core process activities	immediately	R - QA Officer A - Unit Head C - Unit staff I - Customer	Time Space for the interaction	Notice of complaint
	1.2. QA officer maintains a welcoming and nonjudgmental attitude to allow the complaining customer to verbalize concerns				
	1.3. QA officer notes the name of the customer and the concern				
2. QA officer interviews the customer to solicit details of the complaint	2.1. QA officer sits the customer in a safe and private place	immediately	R - QA Officer A - Unit Head C - Unit staff I - Customer	Time Space for the interaction Paper Ballpen	filled up complaints form
	2.2. QA officer verifies form the customer the desire to write or just talk about the concern				
	2.3. QA officer allows the customer to describe the details of the concerns without interrupting the narration				
	2.3. QA officer prompts customer for clarifications on the concern, when necessary				
	2.4. QA officer notes the details of the concern				
3. QA officer/ complainant documents in the complaint form the details of the complaint based on the interview and signs the accomplished complaint form	3.1. QA officer again asks the customer to write the details of the concern, if customer refuses, QA officer informs the customer that a written complaint form will be needed for proper action and that officer will write the details and customer will sign the form	during the narration of the details of the concern	R - QA Officer A - Unit Head C - Unit staff I - Customer	Time Space for the interaction Paper Ballpen	Accomplished complaint form
	3.2. QA officer accomplishes the complaint form and signs it in behalf of the customer, if customer refuses to sign				

Process Activity	Work Instruction	Time Frame	Responsibility Map	Resources	Document
4. QA Officer provides appropriate correction to address client complaints	4.1. QA officer institutes correction to the customer concern according to capacity/capability	upon receipt of the accomplished complaint form	R - QA Officer A - Unit Head C - Unit staff I - Customer	Time Space for the interaction Paper Ballpen	Report on correction and its effectiveness
	4.2. Evaluates effect of the correction with the customer				
5. If resolved, QA officer documents correction on the complaint form. If not resolved, QA officer explains to the client that the case will be elevated to the management and documents the correction on the complaint form	5.1. Resolved concern, QA officer documents the correction on the complaint form	Immediately	R - QA Officer A - Unit Head C - Unit staff I - Customer	Time Space for the interaction Paper Ballpen	Compliant form with correction and evaluation of its effectiveness
	5.2. Evaluates with the customer the effectiveness of the correction and documents it in the complaint form				
	5.3. Unresolved concerns, QA officer explains to the customer the concern will be elevated to management.	within 24 to 48 hours of receipt of the complaint			Compliant form with corrective action and endorsement to management
	5.4. Documents the correction in the complaint form.				
6. QA officer forwards a copy of the complaint form to the QA Office	6.1. QA officer notes corrective action in the complaint form	within 24 to 48 hours of receipt of the complaint	R - QA staff A - QA Officer C - Lead Auditor, QAO Head I - Unit Head, Customer	Time Paper Ballpen	Complaint form with corrective action and endorsement to management
	6.2. Makes endorsement to QA office providing further details of customer concern				
	6.3. Receive acknowledgement of the endorsed complaint form	Immediately after endorsement			

Process Activity	Work Instruction	Time Frame	Responsibility Map	Resources	Document
7. QAO examines the complaint and informs the concerned unit for investigation and root cause analysis of the complaint as necessary. If the issue reflects non-conformity to a process, initiates and issues NCAR to concerned unit.	7.1. QA receives the complaint form	within 3 days after receipt of the form	R - Lead Auditor A - QA Head C - QA officer I - Process owner	Time NCAR form SOPs Protocol Statutory, regulatory and international standards University Code Unit Manual of Operations	NCAR
	7.2. Examines the complaint for QMS nonconformity				
	7.3. QA issues NCAR to process owner for root cause analysis and corrective action plan				
	7.4. sets agreed deadline with process owner for their compliance				
	7.5. QA office informs QA officer of NCAR issuance				
8. Concerned unit formulates corrective action based on root cause analysis and submits report to QA office.	8.1. Process owner conducts root cause analysis	within 15 days from receipt of NCAR	R - Process owner A - QA officer C - QA officer I - unit staff	Time Paper Printer Printer Ink Computer set	Corrective action plan
	8.2. Process owner plan for corrective action	Corrective action: within 15 days after RCA			
	8.3. Process owner submits corrective action plan to QA office	within the stipulated days			
9. Concerned unit implements formulated corrective action/ correction.	9.1. Process owner implements planned corrective action	Corrective action: within 15 days after RCA	R - Process owner A - QA officer C - QA officer I - unit staff	Time Paper Printer Printer Ink Computer set	Effectiveness of the corrective activities report
	9.2. Evaluates effectiveness of corrective action activities with the QA officer.				
	9.3. Process owner makes report on the effectiveness of the corrective action activities.				

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Process Activity	Work Instruction	Time Frame	Responsibility Map	Resources	Document
10. QA Officer monitors the action plan activities.	10.1. QA officer monitors implementation of the corrective action plan	agreed dates	R - QA officer A - Lead auditor C - Process owner I - QAO head	Time	record of visits of the QA officer
	10.2. QA officer together with the process owner evaluates the effectiveness of the corrective activities				
11. QA Officer verifies the effectiveness of implementation of the corrective action	11.1. QA officer visits the process owner 11.1.1. First visit - verification of the corrective activities 11.1.2. Second visit - evaluation on the effectiveness of corrective activities	agreed dates	R - QA officer A - Lead auditor C - Process owner I - QAO head	Time	record of visits of the QA officer
12. QA Officer provides official report to QA office.	12.1. QA officer records visits to process owner	every visit	R - QA officer A - Lead auditor C - Process owner I - QAO head	Time Paper Printer Printer Ink Computer set	record of visits of the QA officer evaluation report/s
	12.2. makes report on the evaluation of corrective actions	7 days after last monitoring and evaluation			
13. QA office files official report.	13.1. QA office issues acknowledgment receipt of the evaluation report submitted by the QA officer	immediately	R - QA staff A - Lead auditor C - QAO Head I - QA officer	Paper Printer Printer Ink Computer set	complete evaluation report
	13.2. evaluates the submitted report for completeness				
	13.3. files the report as reference for top management review				

APPENDIX N

QUALITY MANAGEMENT SYSTEM (QMS) EVALUATION

Source Input	Input	Input Control	Process Activities	Risks	Process Control/ Risk Control	Outputs	Output Receiver
Unit Heads Process Owners Lead auditor QAO Head	Reports of Nonconformity to QMS Customer satisfaction feedback data Monitoring records of CQI/ implementation of corrective actions Audit report Reports of risks management/ opportunities for improvements Client complaints Evaluation report of external auditors/providers Management reviews	Reviews of compliance to nonconformity reports Compliance with applicable legal requirements and other requirements needed for the provisions of customer services of the organization. Generates data. Identifies and monitors reports of trends or patterns in QMS problems. Determines the effectiveness of implementation and conformity to the planned activities. Carry-out regular management reviews to ensure the overall effectiveness and continual improvement of the QMS, allocate sufficient resources and identify on-going improvement objectives.	1. Data presentation during QAO meeting 2. Data analysis.	No records of QMS performance	Records of CQI/ Implementation of planned activities of corrective action. Generated data to be analyzed (CSS feedback, audit reports, client complaints, risks management, and evaluation of external auditors).	Assessment on how well QMS system operates with focus on objective evidence of conformity Report on overall effectiveness of implementation of planned activities, corrective actions and continual improvement of the QMS	Top management

Source Input	Input	Input Control	Process Activities	Risks	Process Control/ Risk Control	Outputs	Output Receiver
			3. Identification of data critical to QMS implementation.				
			4. Generation of action plan and monitoring program to address findings that affects the QMS.		Report of implementation of accomplished activities and on-going QMS improvement.		
			5. Implementation of action plans				
			6. Monitoring until affected QMS is resolved including continuing analysis to note the recurrence of same issue and other findings affecting QMS.				

APPENDIX O
QUALITY MANAGEMENT SYSTEM (QMS) EVALUATION PROTOCOL

Process Activity	Work Instruction	Time Frame	Responsibility Map	Resources	Document
1. Data presentation during QAO meeting	1.1. Notice of meeting issuance to members of the QA team	semi-annual	R - Lead Auditor A - QAO Head C - QA officers I - QAO staff	Records Computer set software (as necessary) Time	QMS records Collated data
	1.2. Preparation of data from QMS records 1.2.1. reports of nonconformity 1.2.2. customer satisfaction feedback 1.2.3. CQI monitoring records 1.2.4. Implementation of corrective action 1.2.5. audit reports 1.2.6. Risk management reports 1.2.7. Opportunities for improvement reports 1.2.8. Client complaints 1.2.9. Evaluation reports of external auditors 1.2.10. Management reviews	one month before scheduled meeting			
	1.3. Collation of data				
2. Data analysis.	2.1. Presentation of collated data to QA Team	Data given to QA team members one (1) month prior to scheduled QAO meeting for study based on the parameters	R - QA Team members A - Lead auditor C - QAO Head I - QAO staff	Paper software (as necessary) Analysis guide computer set Time Printer Printer ink	Collated data QMS analysis guide
	2.2. Analysis of the data according to the following parameters 2.2.1. What is the frequency of occurrence of these data? 2.2.2. What institutional, regulatory or statutory requirements were not satisfied with these data occurrence? 2.2.3. How effective are the current Risk Management protocol in mitigating the occurrence of these data? 2.2.4. How will these data affect QMS performance?				

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Process Activity	Work Instruction	Time Frame	Responsibility Map	Resources	Document
3. Identification of data critical to QMS implementation.	3.1. Each QA team member brings to the QA team meeting results of the analysis they had done based on the set parameters	10 mins per presentation	R - QA Team members A - Lead auditor C - QAO Head I - QAO staff	Paper software (as necessary) Analysis guide computer set Time Printer Printer ink	Critical QMS data
	3.2. QA member presents critical data that would affect QMS implementation				
	3.3. QA team further analyzes these critical data on the following criteria 3.3.1. What is the trend of data occurrence? 3.3.2. What will be its anticipated effect on QMS implementation? 3.3.3. What risk management protocol can be used to mitigate its anticipated effect? 3.3.4. What other risk management protocol can be generated to mitigate the effect of these data to QMS implementation?	duration of the QA team meeting			
4. Generation of action plan and monitoring program to address findings that affects the QMS.	4.1. Critical data and risk management protocol identified	during QA team meeting	R - Lead Auditor A - QAO Head C - QA officers I - QAO staff	Paper software (as necessary) Analysis guide computer set Time Printer Printer ink	QMS action plan
	4.2. Prioritization of critical data				
	4.3. QA team develops the action plan to mitigate risk occurrence integrating in this plan the identified risk management protocol.				
	4.4. QA team plans on implementation strategy to prevent/avoid recurrence of risk				
	4.5. QA team embed into the action plan the monitoring strategies to evaluate effectiveness of corrective activities				

Process Activity	Work Instruction	Time Frame	Responsibility Map	Resources	Document
5. Implementation of action plans	5.1. Implementation of QMS action plan to units where priority data occurred frequently and where risk management protocol was deemed by the QA team to be weak	within one month of the approval of the action plan	R - Lead Auditor A - QAO Head C - QA officers I - QAO staff, University President, process owner	availability of the process owner and QA officer willingness of the process owner to utilize the action plan strategies Paper Ballpen	QMS action plan
	5.2. Gradually increase the coverage of implementation to address the frequency of occurrence of the priority data in other units				
6. Monitoring until affected QMS is resolved including continuing analysis to note the recurrence of same issue and other findings affecting QMS.	6.1. Assignment of QA officer to monitor and evaluate the effect of the action plan activities on the QMS in the target unit	finalization of the action plan	R - QA officer A - Lead Auditor C - QAO head I - Process owner, University President	availability of the process owner and QA officer willingness of the process owner to utilize the action plan strategies Paper Ballpen	Evaluated QMS action plan
	6.2. Continuous assessment and analysis on the recurrence of the same issue	within the time of implementation			
	6.3. Identification of factors that hindered that affect the effectiveness/efficiency of the planned corrective activity/ies in the target unit				
	6.4. Planning and implementation strategies to mitigate emergent issues affecting the implementation of corrective activities.				

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