BATAAN PENINSULA STATE UNIVERSITY
Balanga City 2100 Bataan

PROCEDURES AND WORK INSTRUCTIONS MANUAL

Approved through
Board Resolution No. 82 series 2016
During the 46th Meeting of the Board of Regents
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Introduction

This document, Quality Procedures and Work Instructions, hereafter referred to as QPWI, contains or references all procedures and work instructions required to ensure the satisfactory operation of Bataan Peninsula State University Quality Management System as described in our Quality Manual. QPWI is divided into sections corresponding to the ISO 9001 Mandatory Procedures. Each section may contain a combination of procedures and work instructions. Procedures will detail the who, how, when, where, and why of a particular function or process undertaken by the organization and have a set structure (purpose, scope, references, definitions, procedure, and documentation). Work instructions are detailed step-by-step instructions that explain how to carry out a particular task. All procedures and work instructions are written in accordance with the Generic Manual on ISO 9001 provided by Government Quality Management Program.

QP1.Control of Documents

Purpose

The purpose of this procedure is to ensure that all documents needed for the quality management system are kept up-to-date and are readily available for use by those who need them.

Scope

This procedure applies to all internal and external documents identified by the university as required by the quality management system.

Definition of Terms

Document	Information and its supporting medium. The medium can be paper, magnetic, electronic or optical computer disc, photograph or a combination thereof

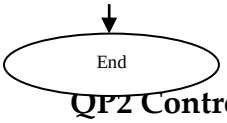
Responsibilities

QMR	Reviews and approves documents included in the Quality Manual; approves the university wide distribution of external documents.
Unit Manager	Reviews and approves internal documents needed by his unit, process or function; approves the distribution of copies of external documents pertaining to his process or function

Procedure Details

Activity	Person Responsible	Details/Functions	References
Start			
Register documents	Document Originator	-prepares document, update notice and submits new or revised document to office Document controller	Document Masterlist (BPSU-QMS-FR-001)
New Document	Office Document Controller		
Review and approve copy distribution		Approval of distribution list	
Distribute document			
Update document	Office Head	Review, modifies as needed and approves copy distribution	

Unit document controller prepares controlled copies of document for distribution to Document Originator



QP2 Control of Records Procedure

Purpose

The purpose of this procedure is to ensure that all records generated by the quality management system are properly maintained and are readily available for use by those who need them.

Scope

This procedure applies to records required by ISO 9001 as well as records identified by the organization as required for the effective management and control of processes.

Record	A document stating results achieved or providing evidence of activities performed. Records can be used to document traceability and to provide evidence of verification, preventive action, and corrective action. Generally records need not be under revision control (Document Control procedure). Records may use different media, including paper, magnetic, electronic or optical computer disc, photograph or combination thereof
Active Records	Records that are currently being maintained, used and controlled. These records are normally kept in desk/workstation drawers or nearby filing cabinets, shelves or racks for easy access and retrieval
Inactive Records	Records that are very rarely or no longer referred to, and which must be transferred to a cheaper place (e.g. the Agency's Records Center). These records have already served their purpose but must be kept just the same for legal requirements or some compelling reasons. They are only destroyed the moment their retention periods have expired
Obsolete Records	Records whose retention periods have expired and which are no longer needed
File	A cabinet with records in it; a folder containing records; a collection of papers involving a specific name or topic; a class of records in a separate group or series of filing drawers
Filing System	A plan for identifying, arranging and finding records. Filing systems may be alphabetical, numerical, chronological, or functional subject-alphabetic classification system (FSACS)
Records Masterlist	A list that identifies the records needed and maintained for the QMS
Records Disposition Schedule	A listing of records series by organization showing, for each record series, the period of time it is to remain in the office area, in the storage (inactive) area, and its preservation or destruction
Retention Period	Refers to the specific period of time established and approved by the National Archives of the Philippines as the life span of records, after which they are deemed ready for permanent storage or destruction. Period of time when records must be kept, usually stated in terms of number of months or

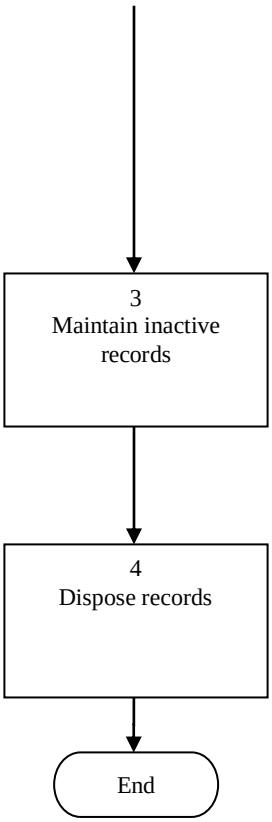
	years, but sometimes expressed as contingent upon the occurrence of an event such as employee termination, contract closure, project completion, etc.

Responsibilities

QMR	Reviews and approves the records retention schedule for records pertaining to mandatory procedures on control of documents, control of records, internal audit, corrective action and preventive action
Unit Manager	Reviews and approves the records retention schedule for records pertaining to his process or function. (At the minimum, in accordance with RMAO).
Document Controller	Ensures that the controls provided in this procedure are effectively implemented throughout the Agency. Maintains the Central Records Retention Schedule.
Unit Document Controller	Ensures that records needed by the Unit are properly maintained and are readily available. Maintains the Unit's Record Retention Schedule and Record Masterlist, listing all the records held by the Unit.
Unit Records Custodian	Classifies records needed by his function or process; recommends retention periods for these records. Maintains active files needed by his function or process; turns-over inactive records to the Records Center, as needed; disposes obsolete records in his area.
Records Officer	Maintains the inactive records turned over to the Records Center; disposes obsolete records in the Records Center. Maintains the Records Center's Record Masterlist.

Procedure Details

Activity	Responsibility	Details	References
Start			
1 Classify Records	Unit Records Custodian	• Identifies the record series and determines the record value and retention period, in coordination with the Unit Document Controller	Records Disposition Schedule (BPSU-QMS-FR-003)
2 Maintain active records	Unit Document Controller Unit Manager	• Updates the Records Disposition Schedule • Approves the Records Disposition Schedule	



Document Controller	• Updates the Central Records Disposition Schedule	
Unit Records Custodian	• Creates and labels files as needed • Sets up and labels active records storage locations as needed • Maintains files of active records in conjunction with his function or process; Maintains the Records Masterlist • Turns files of inactive records over to the Records Center following the retention schedule, using the Turnover List and Disposal Authorization	Records Masterlist _BPSU-QMS-FR-004) Records Disposition Schedule (BPSU-QMS-FR-003) Turnover List and Disposal Authorization (BPSU-QMS-FR-005)
Unit Manager	• Approves the turnover of files	
Records Officer	• Sets up and labels inactive storage locations as needed • Receives inactive files for storage; Maintains the Masterlist of Records • Implements the disposition of records following the retention schedule	Records Masterlist (BPSU-QMS-FR-004) Turnover List and Disposal Authorization (BPSU-QMS-FR-005) Records Disposition Schedule (BPSU-QMS-FR-003)
Unit Records Custodian / Records Officer	• Disposes records in his area following the retention schedule, using the Turnover list and Disposal Authorization; updates the Masterlist of Records	Records Masterlist (BPSU-QMS-FR-004) Turnover List and Disposal Authorization (BPSU-QMS-FR-004) Records Disposition Schedule (BPSU-QMS-FR-003)
Unit Manager	• Approves the disposal of files	

Guidelines

a) Internal forms needed by the Unit shall be designed, developed, distributed for use and/or revised subject to the document control procedure.
b) Control of records shall generally comply with the RA 9470 RMAO.
c) Control of records related to the 6 mandatory procedures shall follow the same procedure as records required by the different units, except that the Records Retention Schedule shall be approved by the QMR.
d) Records Classification
    1. The values of records may be considered through the following perspectives: first, from the Agency's point of view, in terms of their immediate or future utility to the Agency for administrative, legal or fiscal, and second, from the archival point of view in terms of their permanent historical or research value.
    2. Records shall be classified in terms of value as:
        i. Time Value – a record may be appraised as either temporary or permanent value
        ii. Utility Value – a record may be further appraised on the basis of various categories of usefulness.
            - Administrative Value – serves as administrative tools to accomplish the mission of the Agency.
            - Fiscal Value – serves as tools in discharging the financial obligations of the Agency.
            - Legal Value – states legal decisions and opinions, either of a permanent or temporary character.
            - Archival Value – historical or research significance of records or documents, such as the creation and development of an agency, its various policies and procedures.
    3. Records belonging to a group or series shall have the same retention and disposition. Under the FSACS, the record group series is defined by function subject.

e) Maintenance of Active Records
    1. Filing systems may be one of the following:
        i. Alphabetical – records are arranged in dictionary order, by name (individual or organization), subject matter (descriptive feature) or location (geographic).
        ii. Numerical – records are identified by the numbers assigned to them. This is used for records such as invoices and issuances.
        iii. Chronological – records are arranged by time sequence or date (year, month, day)
        iv. Functional Subject – Alphabetic Classification System (FSACS) – records are arranged by function (alphabetical) and their component subjects (alphabetical).

2. Files shall be labeled following the format:

File Title 1	Date 1
File Title 2	Date 2
	Date 3

File Title 1	Records Series Title (FSACS function title)
File Title 2	Record Title (FSACS subject/name title)
Date 1	Coverage Date
Date 2	Date of transfer to the Records Office
Date 3	Disposal date

Employee	Programs	Jan 2009
Employee	Satisfaction Survey Forms	Jan 2010
		Jan 2011

3. Files shall be arranged following the filing system specified in the Records Disposition Schedule.
4. File storage areas shall be identified and labeled. Filing cabinets, shelves, racks, and drawers may be numbered accordingly.

f) Maintenance of Inactive Records
   1. At the end of active retention, files shall be placed in boxes and transferred to the Records Center. Files in a box must belong to only one Unit and must have similar dates of transfer to the Records Center and disposal dates. There should be a Turnover List and Disposal Authorization (TLDA, please define / consider red tagging) with the following information:
      i. Unit Code (see Document Reference Coding or FSACS)
      ii. Box Number (sequential)
      iii. Date of transfer to the Records Office
      iv. Disposal date
   2. File boxes are arranged on racks inside the Records Center. Each slot on the rack has a designated numbered address (rack number, row number, slot number), which is indicated in the Records Masterlist of the Records Center.
   3. A logbook shall be maintained on records borrowed from/returned to the Records Center. The logbook shall indicated the following information:
      i. Borrowing Unit
      ii. Name of Borrower
      iii. Record Title
      iv. Date Borrowed

v. Date Due
vi. Signature of Borrower
vii. Date Returned
viii. Signature of Records Officer

g) Disposal of Records
1. Records shall be disposed when the records have reached their inactive retention period and are deemed obsolete or no longer needed.

QP3 Internal Quality Audit Procedure

Purpose

The purpose of this procedure is to verify whether the quality management system conforms to the planned arrangement, to the requirements of ISO 9001 and the quality management system requirements established by the university, and is effectively implemented and maintained.

Scope

This procedure (the conduct of internal quality audits) applies to the organization's core and support processes included in the quality management system scope.

Definition of Terms

Audit	Systematic, independent and documented process for obtaining audit evidence and evaluating it objectively to determine the extent to which audit criteria are fulfilled.
Audit Programme	A set of one or more audits planned for a specific time frame and directed towards a specific purpose.
Audit Plan	Description of the activities and arrangements for an audit.
Audit Scope	Extent and boundaries of an audit.
Audit Criteria	A set of policies, procedures or requirements.
Audit Evidence	Records, statements of fact or other information which are relevant to the audit criteria and verifiable.
Audit Findings	Results of the evaluation of the collected audit evidence against audit criteria. Findings include conformities, non-conformities and observations/opportunities for improvement.
Audit Conclusion	Outcome of an audit provided by the audit team after consideration of the audit objectives and all audit findings.
Audit Client	Organization or person requesting an audit. This may be Top Management, the QMR, another government Agency, other interested stakeholder.
Auditee	Organization or person being audited.
Auditor	Person with the demonstrated personal attributes and competence

	to conduct an audit.
Audit Team	One or more auditors conducting an audit, supported if needed by technical experts.
Technical Expert	Person who provides specific knowledge or expertise to the audit team. A technical expert does not act as an auditor in the audit team.
Non-conformity	Non-fulfillment of a requirement.
Opportunity for Improvement	An area of the QMS which currently fulfills the requirement but which may be further enhanced to prevent a possible non-conformity.

Responsibilities

QMR	Reviews and approves the annual audit programme. As audit client, identifies priority areas of the quality management system which will be focus of the audit programme.
IQA Chairman	Plans and manages the audit programme; coordinates the audit programme with the audit client and the QMR.
IQA Team Leader	Plans and manages audits assigned to him; coordinates audit plans with the auditee. Conducts audits assigned to him/her.
IQA Team Member	Conducts audits assigned to him/her.
Auditee	Provides audit evidence to the IQA Team; responds to audit findings as needed.

Procedure Details

Activity	Person Responsible	Details/Functions	References
Start			
1.Plan the audit programme	IQA Chairman	-Schedules the different audits for the year; Determines the audit objectives, scope and applicable criteria; identifies the audit team leader and members per audit.	Annual Audit Schedule (BPSU-QMS-FR-006)
2.Manage the auditor pool	QMR IQA Chairman	-Approves the audit programme -Evaluates candidate auditors. -Maintains the directory of auditors -Identifies auditor training needs; coordinates with Personnel Mgt. on training and development	
3.Prepare for audits			
4.Conduct audits			
Review audit results and status			
End			

	requirements.	
IQA Team	-Prepares the audit plan; Prepares audit checklists.	Audit Plan(BPSU-QMS-FR-007)
IQA Team Leader	-Coordinates audit arrangements with the auditee.	
IQA Team	-Gathers audit evidence and evaluate them against the audit criteria. -Reports on audit findings and conclusions	Audit Checklist(BPSU-QMS-FR-008)
Auditee	-Prepares and implements corrective actions on non-conformities, if any.	Request for Action(BPSU-QMS-FR-009) Corrective Action Procedure
IQA Team	-Conducts follow-up audits, if needed	
QMR/IQA Team	-Reviews audit results and status of follow-up audits	IQA Status Report (BPSU-QMS-FR-010)
QMR/Management Team/Auditee	-Reviews audit results and status of corrective actions	

Guidelines

Planning

1. Planning of the Audit Programme shall be done in conjunction with BPSU's annual planning cycle. It shall consider the results of previous audits, trends in process performance, the availability of auditors and auditees.

i. Newly-created or recently-modified processes or functions as well as those which have incurred non-conformities may need to be audited more frequently, until such a time as these processes or functions have stabilized or matured.
ii. Processes or functions which have been showing declining performance may also need to be audited more frequently, until such a time as the performance trend has been reversed.

2. The primary audit criteria for QMS audits shall be based form ISO 9001. The university shall also needs to comply with applicable laws, regulations, and orders, as well as its own documented policies, guidelines and procedures. Depending on the audit scope, these may also be considered as audit criteria.

3. The scope of the audit is determined by the IQA Chairman in coordination with the Audit Client. The scope should include the processes or functions which need to be audited in order to meet the objectives of the audit.

4. The choice of IQA Team Leader and Members depends on the scope of the audit and the criteria to be applied. Leaders and Members are selected from the auditor pool based on their audit competencies, and their availability for the audits (as scheduled).

c) Managing the Auditor Pool

1. Acceptance of candidate auditors into the auditor pool and selection of auditors for specific audit assignments shall consider the following audit competencies:

i. The personal attributes of the (candidate) auditor, including the following:
   - Ethical - fair, truthful, sincere, honest and discreet
   - Open-minded – willing to consider alternative ideas or points of view
   - Diplomatic – tactful in dealing with people
   - Observant – actively aware of physical surroundings and activities
   - Perceptive – instinctively aware of and able to understand situations
   - Versatile – adjusts readily to different situations
   - Tenacious – persistent, focused on achieving objectives
   - Decisive – reaches timely conclusions based on logical reasoning and analysis
   - Self-reliant – acts and functions independently while interacting effectively with others

ii. Knowledge on auditing concepts and methodologies

iii. Auditing Skills – planning, preparation of checklists, gathering of audit evidence (e.g. conducting interviews, reviewing records), evaluating audit evidence against audit criteria, and preparing audit reports.

iv. Knowledge on ISO 9001 requirements and the quality management system of the organization, vis-à-vis audit requirements of the audit client.

2. Auditor performance shall be reviewed considering the following:

i. Feedback from the IQA Team Leader, other auditors, and the auditee.

ii. The quality of audit checklists and audit reports.

3. The competencies and performance of auditors shall be periodically evaluated to identify training and development needs. The IQA Chairman shall coordinate with Personnel Management (HR) to plan and implement a training and development program for auditors.

d) Preparing for the Audit

1. Audit plans shall be prepared for each audit scheduled in the Audit Programme. The audit plan must be prepared at least one (1) month before the scheduled date of the audit, to allow sufficient time for audit preparation and communication between the Team and the auditee(s).

2. The IQA Team shall determine the assigned audit area(s) of each auditor in the Team. Selection of assignments shall ensure that auditors do not audit their own work.

3. Audit plans should be submitted to the auditee (s) at least two (2) weeks before the start of the audit.

1. The audit team shall prepare checklists at least one (1) week prior to the audit. Preparation of checklists may involve a preliminary review of relevant QMS documents and records.

e) Conducting Audits

1. Audit activities shall include the following

i. Opening meeting – to clarify audit scope, objectives and schedule of audit activities.
ii. Gathering of audit evidence – through interviews, review of documentation and records, and observations
iii. Periodic audit team meetings – to discuss initial findings, identify additional audit requirements, and resolve any audit issues; to consolidate and prepare audit reports. Non-conformities found during audits shall be documented using the Request for Action (RFA).
iv. Closing meeting – to present audit findings and conclusions, and to agree on the submission of corrective actions for any non-conformities. The IQA Team Leader signs the RFA on the space "Issued by" ; the concerned auditee signs on the space "Acknowledged by". Alternatively, the QMR may collectively sign the RFAs for the auditees.

2. Auditees shall commit to and apply the necessary corrective actions to any nonconformity found during audit. (See Corrective Action procedure). Auditees must submit a corrective action plan within one (1) month after the closing meeting.

3. Follow-up audit shall be conducted within one (1) month after the completion date of corrective action. The Auditees shall submit documentary evidences to show implementation of the corrective actions. The IQA Team shall review the documentary evidence, and if sufficient, may deem the non-conformity to be closed. Otherwise,a site inspection to verify actual implementation may be conducted, after which the non-conformity may be deemed to be closed.

f) Reviewing Audit Results and Status

1. Within one (1) month after the closing meeting, the QMR shall review the status of the audit with the IQA Chairman. The review shall determine if the audit was able to meet its objective, including the need for any follow-up audit(s).

2. At the Management Review immediately following the audit, the QMR shall discuss with the Management Team the results of the audit, as well as the status of corrective actions on non-conformities. The review of the status of corrective actions shall remain on the Management Review agenda until such time as the corrective actions have been implemented and the non-conformity has been closed. Auditees shall keep the QMR and the IQA Chairman periodically updated on the status of corrective actions, until the corrective actions have been implemented.

QP4. Control of Nonconforming Product/Service Procedure

Purpose

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

Scope

This procedure applies to the products and services provided by the University to its customers included in the University's quality management system.

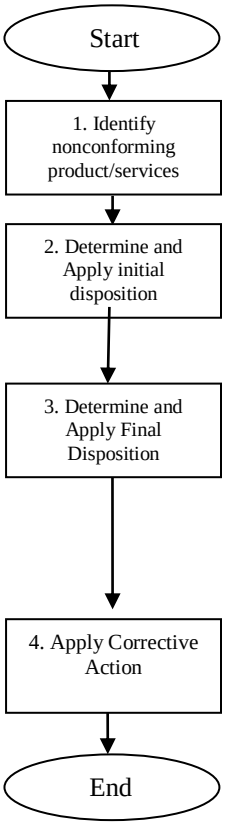
Definition of Terms

Nonconforming product/service	Products or Services that do not fulfill requirements. Products may include physical items, as well as reports and other documents prepared and released in conjunction with services delivery. Examples of physical products are Driver's License ID Cards, Passports, SSS ID Cards, monetary notes and coins. Examples of Services are responding to customer inquiries or complaints, delivering mail, processing a license application. An example of a nonconforming product is monetary notes which are off-color (wrong color shade), or with printing registration errors (graphics not aligned). Mail delivered to the wrong address is a nonconforming service.
Initial Disposition	Action taken to contain the nonconforming product/service and minimize its immediate effect. This may include putting the nonconforming product on hold and setting it aside, or temporarily discontinuing service delivery.
Final Disposition	Action taken to correct the nonconforming product/service, to make it conform to requirements or otherwise prevent its unintended use or delivery. This may include reworking, regarding, repairing or scrapping of nonconforming products, or redoing the service.
Concession	Permission to use or release a product or deliver a service that does not conform to specified requirements. A Concession is generally limited to the delivery of a product that has nonconforming characteristics within specified limits for an agreed time or quantity of that product.
Corrective Action	Action to eliminate the cause of a detected nonconformity (nonconforming product/service) or other undesirable situation, and prevent recurrence.

Responsibilities

Unit Staff	Identify nonconforming product/service and take appropriate action.
Unit Manager	Review nonconforming product/service situation and determine how it may be effectively resolved.
Agency Head	Authorize actions involving high levels of risk to the Agency.

Procedure Details

Activity	Person Responsible	Details/Functions	References
	Unit Staff	-Detects nonconforming product/service. -Receives citizen feedback on nonconforming product/service.	Operating procedures Process Guidelines Product/Service guidelines Citizen Complaint Procedure
		-Isolates nonconforming product, and/or temporarily stops process/service delivery, following the Control of Nonconforming Matrix. -Provides initial response to citizen feedback, as needed.	Operating procedures Process Guidelines Product/Service Guidelines Control of Nonconformity Matrix (BPSU-QMS-FR-011)
	Unit Manager/Agency Head	-Reviews the nonconforming product/service situation, and approves final disposition.	Operating procedures Process Guidelines Product/Service Guidelines Control of Nonconformity Matrix (BPSU-QMS-FR-011)
	Unit Staff	-Obtains product concession, corrects nonconforming product, scraps product, or adjusts or restarts process/service delivery following the Control of Nonconformity Matrix. -Provides final response to citizen feedback, as needed.	
	Unit Staff	-Prepares a Request for Action	Request for Action (BPSU-QMS-FR-009) Corrective Action Procedure

Guidelines

a) Identifying Nonconforming Product/Service

1. Nonconforming products/services may be detected internally by Unit Staff as they perform their functions, through observation, monitoring, inspection, verification and review.

2. Nonconforming products/services may also be detected externally by the customer/citizen, relayed to the Agency through feedback or complaints.

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

b) Determining and Applying Initial Disposition

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

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

i. Tagging or marking the product to identify it as nonconforming
ii. Segregating the product and storing it in a location designated for nonconforming products to prevent it from being mixed with conforming product.
iii. Providing special treatment or handling of the product, to prevent it from further deterioration.
iv. Retrieving or withdrawing the nonconforming product from customer.
v. Temporarily discontinuing the nonconforming service.

3. When the nonconforming product/service is detected just prior to delivery to the customer/citizen or at any time thereafter, the customer citizen shall be informed of the noncom forming product/service.

c) Determining and Applying Final Disposition

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

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

i. Rework – action on a product to make it conform to requirements.

ii. Regrade – alteration of the grade of a nonconforming production order to make it conform to requirements differing from the initial ones.
iii. Repair – action on a nonconforming product to make it acceptable for the intended use.
iv. Scrap – action on a nonconforming product to preclude its originally intended use. This may include recycling or destruction.
v. Concession – obtaining permission (from the Unit Manager, Agency Head and/or the customer) to use or release a product that does not conform to specified requirements.
vi. Re-evaluation/Re-testing to demonstrate conformity to specifications (after repair, regrade, or rework).
vii. Adjusting an ongoing service.
viii. Restarting a service that has been temporarily discontinued.
ix. Redirecting to other services or service providers.

3. Final disposition may require the approval of the Unit Manager and/or the Agency Head, depending on the gravity of the situation and its cost implications.

d) Applying Corrective Action

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

i. the nonconforming product/service is identified via a customer/citizen complaint
ii. monitoring shows that nonconforming product/service are recurring
iii. the frequency and extent of nonconforming product/service are increasing
iv. correction requires that the nonconforming product be reworked or replaced, or for the service to be restarted or redirected, incurring significant cost in time and resources
v. the nonconforming product/service represents legal implications to the organization, the customer/citizen, or both.

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

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

QP5. Corrective Action Procedure

Purpose

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

Scope

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

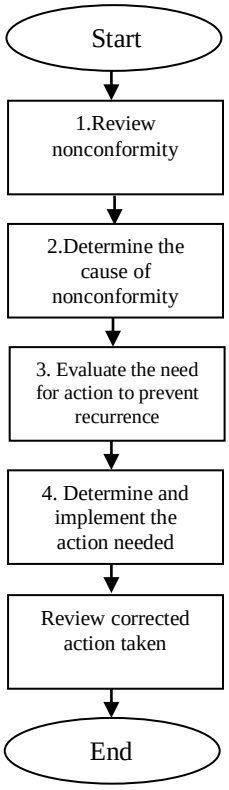
Definition of Terms

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

Responsibilities

Unit Manager	Ensures that actions are taken without undue delay to prevent the recurrence of nonconformities
Unit Staff	Conducts root cause analysis, develops, plans and implements corrective actions.
QMR/Management Team	Ensures the provision of resources for the implementation of corrective actions. Reviews the status and effectiveness of corrective actions.

Procedure Details

Activity	Person Responsible	Details/Functions	References
	Unit Manager	-Receives and reviews the Request for Action -identifies concerned staff who will be involved in corrective action.	Request for Action (BPSU-QMS-FR-009)
	Unit Staff	-Conducts root cause analysis	Request for Action (BPSU-QMS-FR-009)
	Unit Staff	-Assesses the risks associated with a recurrences of the nonconformity	Request for Action (BPSU-QMS-FR-009)
	Unit Staff Unit Manager Unit Staff	-Develops, plans and recommends corrective actions -Approves corrective actions -Implements corrective actions	Request for Action (BPSU-QMS-FR-009)
	Unit Manager/ Management Team/ QMR	-Reviews the implementation status and evaluates the effectiveness of corrective actions.	Request for Action (BPSU-QMS-FR-009) Corrective Action Status Report(GGA-QMS-FR-012)

Guidelines

a) The corrective action procedure shall be triggered by Request for Action form other processes/ procedures in response to identified nonconformities from:

1. Internal quality audits
2. Customer / citizen complaints (from the complaint handling process)
3. qualified nonconforming products/ services (from Control of Non conforming Product / Service)
4. poor business performance results and unacceptable deviations from the organizations programs and plans (from management reviews)

b) Review of Nonconformity

1. the initial review fo the Request of Action shall consider:
    1.1 the extent and impact of the reported non-conformity
    1.2 The processes contributing to and affected by the reported nonconformity

2. The Unit Manager shall identify concerned personnel who need to be involved in corrective action. This may extend to personnel outside his own Unit; coordination with the other concerned units should be established.

c) Determining the Cause of Nonconformity

1. Root cause analysis shall consider the different factors contributing to the non conformity including
    1. Manpower – personal competencies and their ability to consistently perform their functions as required
    2. Machine – the availability of appropriate tools, equipment and facilities to enable effective operations
    3. Methods – the availability and consistent application of appropriate procedures, guidelines products/services and standards
    4. Materials – the availability of the needed materials and supplies to enable effective operations

2. Where several root causes are identified, they shall be prioritized relative to their contribution to the nonconformity

d) Evaluating the Need for Corrective Action

1. Risk assessment shall determine the significance of the nonconformity, considering the following:
    i. the likelihood of recurrence of the nonconformity
    ii. the severity impact of nonconformity to the organization (and to customers and others) should it recur

2. Likelihood can be evaluated in terms of "low", "medium", "high", e.g. the impact to the agency is expected to be "Low".

3. The risk level can be determined by evaluating likelihood and severity together, using a basic Significance Table for assessing risk is shown below:

		Likelihood of Recurrence		
		Low	Medium	High
Severity Of Impact	Low	1	2	4
	Medium	3	5	7
	High	6	8	9

4. Using the significance Table, for example, a nonconformity with a likelihood of "High" will be rated "9". Nonconformities with a rating of 4 and above are considered significant, and shall be subjected to corrective action. Corrections may suffice for non-conformities with a rating of 3 and below

e) Determining and implementing Corrective Action

1. Planning of corrective actions (solutions) shall involve the following
   i. generation of alternative solutions
   ii. the selection of the best solution
   iii. the identification of activities, resources, responsibilities and timeliness needed to implement the selected solution

2. Corrective actions (solutions) shall be approved by the Unit Manager. Corrective actions involving multiple units may require higher – level approval (e.g. from the Agency Head) before implementation

f) Reviewing the Status of Corrective Action

1. The implementation status and effectiveness of corrective actions shall be periodically reviewed and evaluated by the concerned Unit Manager; any issues shall be promptly addressed.
2. Corrective actions shall be collectively reviewed by the Management Team (under management review). Depending on the nature of the solution and the associated nonconformity, monitoring and review shall continue for at least 6 months after implementation after which the corrective action shall be deemed completed.

QP6. Preventive Action Procedure

Purpose

The purpose of this procedure is to ensure that causes of potential nonconformities are identified and eliminated in order to prevent occurrence.

Scope

This procedure applies to potential nonconformities identified during strategic planning, management reviews, audits, and interactions with other public sector organizations.

Definition of Terms

Potential nonconformity	Possible non-fulfillment of a requirement.
Preventive Action	Action eliminate the cause of a potential nonconformity or other undesirable potential situation, and prevent occurrence.

Responsibilities

Unit Manager	Ensures that actions are taken without undue delay to prevent the occurrence of nonconformities
Unit Staff	Conducts root cause analysis, develops, plans and implements preventive actions.
QMR/Management Team	Ensures the provision of resources for the implementation of preventive actions. Reviews the status and effectiveness of preventive actions.

Procedure Details

Activity	Responsibility	Details	Reference
Start			
1 Review potential Nonconformity	Unit Manager	* Receives and reviews the Request for Action. * Identifies concerned staff who will be involved in preventive action.	Request for Action (BPSU-QMS-FR-009)
2 Determine the (BPSU-possible cause of potential non-conformity	Unit Staff	* Conduct root cause analysis	Request for Action QMS-FR-009)

Evaluate the need Action to prevent Occurrence	Unit Staff	* Assesses the risks associated with an occurrence of the potential nonconformity	Request for Action for BPSU- QMS-FR-009)
4 Determine and implement the action needed	Unit Staff Unit Manager Unit Staff	* Develops, plans and recommends *Approves preventive actions * Implements preventive actions.	Request for Action (BPSU- QMS-FR-009)
5 Review preventive Action taken	Unit Manager/ Management Team/QMR	* Reviews the implementation status and evaluates the effectiveness of preventive action	Request for Action (BPSU- QMS-FR-
END			

Guidelines

a) The preventive action procedure shall be triggered by Request for Action from other processes/procedures
in response to identified potential nonconformities from:

1. major changes in the organization, organization processes, and equipment/facilities (from strategic planning)
2. learnings on opportunities for improvement (from interactions with other public sector organizations)
3. observations/opportunities for improvement (from audits)
4. trend analysis on business and administrative performance (from management reviews)

b) Review of Potential Nonconformity

1. The initial review of the Request for Action shall consider:
   i. The extend and impact of the potential nonconformity
   ii. The processes contributing to and affected by the potential nonconformity.

2. The Unit Manager shall identify concerned personnel who need to be involved in preventive action. This may extend to personnel outside his own Unit: coordination with the other concerned Units should be established.

c) Determining the Cause of Potential Nonconformity

1. Root cause analysis shall consider the different factors contributing to the potential nonconformity, including:
    i. Manpower – personnel competencies and their ability to consistently perform their functions as required.
    ii. Machine - the availability of the appropriate tools, equipment and facilities to enable effective operations.
    iii. Methods - the availability and consistent application of appropriate procedures, guidelines and standards.
    iv. Materials - the availability of the needed materials and supplies to enable effective operations.

2. Where several root causes are identified, they shall be prioritized relative to their contribution to the potential nonconformity.

d) Evaluating the Need for Preventive Action

1. Risk assessment shall determine the significance of the potential nonconformity, considering the following:
    i. the likelihood of occurrence of the potential nonconformity
    ii. the severity impact of the potential nonconformity to the organization (and to customer and others) shall it occur.

2. A basic Significance Table for assessing risk is shown below:

		Likelihood of Occurrence		
		Low	Medium	High
Severity of Impact	Low	1	2	4
	Medium	3	5	7
	High	6	8	9

3. Using the Signifance Table, significant nonconformities with a rating of 4 and above shall be subjected to preventive action.

e) Determining and Implementing Preventive Action

1. Planning of preventive actions (solutions) shall involve the following \

    i. generation of alternative solutions
    ii. the selection of the best solution (from the alternatives)
    iii. the identication of activities, resources, responsibilities and timeless needed to implement the selected solution.

2. Preventive actions (solutions) shall be approved by the Unit Manager. Preventive actions involving multiple units may require higher-level approval (e.g. from the Agency Head) before implementation.

f) Reviewing the Status of Preventive Action

1. The implementation status and effectiveness of preventive actions shall be periodically reviewed and evaluated by the concerned Unit Manager ; any related issues shall be promptly addressed.

2. Preventive action shall be collectively reviewed by the Management Team (under management review). Depending on the nature of the solution and the associated potential nonconformity, monitoring and review shall continue for at least 6 months after implementation, after which the preventive action shall deemed completed.

APPENDICES

DOCUMENT MASTERLIST-Internal Documents BPSU-QMS-FR-001

Doc. Ref. Code							Distribution (Office/Unit)				
Org	Unit	Type	Seq	Title	Rev. No.	Rev. Date					

BPSU-QMS-FR-002

DOCUMENT UPDATE NOTICE

DUN No.	
DUN Date	

Document Title	
Origin	

☐ Internal
☐ External

☐ Quality Manual ☐ Specifications ☐ Others (Specify)
☐ Policies ☐ Procedures
☐ Guidelines ☐ Work Instructions
☐ Forms

Doc Ref Code

☐ New ☐ Revision Rev. No.____ ☐ Delition
Eff. Date____

Details

Copy Distribution

Copy Harder	Signature	Copy Holder	Signature

Prepared By	Approved By
Signature over Printed Name/Date	Signature over Printed Name/Date

RECORDS RETENTION SCHEDULE BPSU-QMS-FR-003

Records Series Title	Filing	Records Retention		Disposition
		Active	Inactive	

BPSU-QMS-FR-004

RECORDS Master List

Records Series Title/ Record Title	Retention Date			Location	TLDA No.
	Coverage	Transfer	Disposal		

			BPSU-QMS-FR-005	
TURNOVER LIST AND DISPOSAL AUTHORIZATION				
DEPARTMENT /UNIT	BOX NO.	DISPOSAL DATE	DISPOSAL METHOD	TLDA NO.
RECORD TITLE	CREATION/COV DATE	RECORD TITLE		CREATIO/COV DATE
Prepared by		Prepared By:		
Signature Over Printed Name/Date		Sign Over Printed Name/Date		
RECORDS DESTRUCTION (This position is to be a accomplised before disposal of record.)				
INSTRUCTIONS				
DISPOSAL AUTHORIZATION		**CERTIFICATE OF DIPOSAL**		
Thisa authorizes the destruction of all records above, except those that are crossed out.		**This certifies that the records listed above which have been approved for destruction, have already been destroyed.**		
Prepared by		Prepared By:		
Signature Over Printed Name/Date		Sign Over Printed Name/Date		
Retension Period: Record Copy -Indefinite		**Other Copies -Five (5) years**		

BPSU-QMS-FR-006

ANNUAL AUDIT SCHEDULE

			Audit Month										
Process/Area to be Audited	**Auditee**	**Audit Team**	**1**	2	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**

PREPARED BY:

Name and Signature/Date

Approved By:

Name and Signature

AUDIT PLAN

BPSU-QMS-FR-007

CRITERIA		
SCOPE		
OBJECTIVES		
AUDIT TEAM	**TEAM LEADER**	
	MEMBERS	

Date	Time	Activity	Auditee	Auditors

BPSU-QMS-FR-008

AUDIT CHECKLIST

AREA	Date

Criteria/Item	Findings	C	NC	Remarks

BPSU-QMS-FR-009

RFA NO. _____

RFA DATE _____

REQUEST FOR ACTION

CATEGORY ☐ Product ☐ internal Audit ☐ Supplier Audit
☐ Process ☐ External Audit ☐ Others (Specify)
☐ Client Complaint ☐ Client Audit

CONCERNED AREA

DESCRIPTION OF THE PROBLEM ☐ Actual ☐ Potential

ISSUED BY	ACKNOWLEDGE BY
Name and Signature/Date	Name and Signature/Date

CORRECTION

ROOT CAUSE

CORRECTIVE/PREVENTIVE ACTION

ACTION	Responsibility	Due Date

PREPARED BY: Name and Signature/Date	APPROVED BY: Name and Signature/Date

FOLLOWUP

Date	Details	Verified by