MERU NATIONAL POLYTECHNIC

QUALITY MANAGEMENT SYSTEM BASED ON ISO 9001:2015

MANDATORY PROCEDURES MANUAL

MNP/MPM/MR/002

Authorized by:_____ Principal	Date: 16TH JUNE 2016
Issued by:_____ Management Representative	Date: 16TH JUNE 2016

DOCUMENT VERSION CONTROL SHEET

Issue No.	Issue Date	Description of Change	Authored / Revised by	Approved By
Issue 1 Version 0	13-May-2011	Document creation	MR	Principal
Issue 2 Version 0	16-June-2016	Overhaul of the Procedure Manual to meet the requirements of ISO 9001:2015	MR	Principal

TABLE OF CONTENTS

PROCEDURE NUMBER 1: CONTROL OF DOCUMENTED INFORMATION

1.0 GENERAL

1.1 PURPOSE

To have a defined way of controlling documented information.

1.2 SCOPE

Applies to the control of all documented information established or determined to be necessary for the effective implementation of the Quality Management System in the Polytechnic.

1.3 REFERENCES

ISO 9001:2015 Clauses 6.3 and 7.5

1.4 TERMS AND DEFINITIONS

Refer to the list of Terms and Definitions.

1.5 RESPONSIBILITY

The MR shall ensure adherence and maintenance of this procedure.

1.6 INTERFACES

During the implementation of the process the MR shall work hand in hand with

a) The Principal`s office for approvals and guidance
b) All Departments in the Polytechnic for implementation, guidance, consultation and compliance

1.7 PERFORMANCE TARGET

The performance shall be measured through the overall performance of the department based on;

PERFORMANCE TARGET	MONITORING AND MEASUREMENT
Complete Quality Management System as per ISO 9001:2015	a) QMS Forms b) ISO 9001:2015
Complete Document Identification	a) Indexed filling b) Master document list
100% Document review process adherence	Approved Review forms
Accurate Record Maintenance	Completed forms and registers

1.8 RESOURCES

The resources to be used in the process are listed below:-

a) Personnel.

b) Finances.

c) Time.

1.9 INPUTS AND OUPUTS

INPUTS	OUTPUTS
Documented information	Approved QMS documents
Requests for review	Reviewed QMS
Forms and registers	Completed forms and registers
	Improvement decisions

2.0 METHOD

2.1 Document generation and approval prior to use

2.1.1 QMS documents in the Polytechnic shall be established by the respective process owners in consultation with the respective users in reference to the operations of the Polytechnic.

2.1.2 After establishment of any QMS document, the process owner shall forward it to the MR for consideration.

2.1.3 After the finalization, the QMS document shall be authorized for use as follows through signing on the space provided:-

a) The Quality Policy, Mandatory Procedures and any other cross cutting documents shall be approved and authorized for use by the Principal,

b) Departmental Procedure Manuals, Work Instructions and Forms shall be approved and authorized for use by the respective Heads of the Departments.

c) The MR shall approve and retain copies of all quality objectives, risk registers, opportunities and context documents.

2.2 Document Identification

2.2.1 QMS documents shall be identified through indexing. The indexing shall be in three parts as follows:

a) *The First part shall be MNP denoting Meru National Polytechnic followed by a slash (/)*
b) *The second part shall be assigned the initials of the document/manual.*
c) *The third part shall be assigned initials denoting the document origin (Department/Office/Section) of the document followed by a slash (/).*
d) *The fourth part shall be a number to denote the number of documents in the Department/Office/Section of origin.*

Notes

a) *The documents shall also bear the version and the logo of the Polytechnic.*
b) *Departmental documents including quality objectives and context shall be identified by the name of the department, title /description of the document, author and dates.*

Example: *Indexing the Quality Policy*: **MNP/QP/MR/01** *denoting that the document is the Quality Policy and it is controlled from the Management Representative's Office and it is the first document in the MR's office.*

2.3 Document Packaging

2.3.1 QMS documents shall be packaged into procedures, manuals, procedures manuals Formats/Registers as applicable.

2.3.2 Hard copy QMS documents shall be bound in booklets irrespective of the number of pages except the Quality policy which shall be published, and displayed at conspicuous strategic points within the precincts of the Polytechnic

2.3.3 Soft copy QMS documents shall be packaged in CDs and in protected Portable Document Format (PDF).

2.4 Document Issuance and Circulation

2.4.1 After approval of the QMS documents, the Management Representative shall be responsible for their issuance. Copies of all

QMS documents shall be issued to the process owners in each department.

2.4.2 In issuing, the MR shall fill in a document issuance form which shall also be signed by the recipient to acknowledge receipt.

2.4.3 The Process Owner(S) shall then using a departmental circulation list circulate the documents to the departmental staff as applicable.

2.4.4 The respective process owner shall within a week of receiving the documents furnish the MR with a copy of the filled – in circulation list.

2.5 Document review, Updating and Re-approval

2.5.1 Quality Management System document review and update can be initiated in any of the following but not limited to:

a) Staff identifying un-practicability of a procedure

b) Customer complaint on service delivery traceable to a procedure

c) Recommendations from a Quality Audit

d) Change of policies affecting the operation of the Polytechnic

e) The Management Representative every two years for scheduled review.

2.5.2 Any recommendation for change shall be forwarded to the MR through respective Heads of Department/Office/Section by filling a Quality Management System document review form.

2.5.3 The MR shall in liaison with the respective process owner validate the need for review or update before effecting any changes.

2.5.4 Reviewed and updated document(s) shall require re - approval for use as original documents.

2.5.5 Records of changes made in the documents shall be maintained in the Document Version Control Sheet on each document.

2.5.6 After any review or update, the MR shall withdraw the previously issued documents and re–issue the revised documents using the document issuance form.

2.5.7 The MR shall as per internal communication procedure communicate to the process owners the invalidation of any previously issued

documents and issue a withdrawal form and direct the process owner to submit them for disposal.

2.5.8 In the event that any QMS document declared obsolete is retained for any purpose by the user, the MR shall ensure that such documents are marked "Obsolete"

2.6 Identification and control of documents of external origin

Any external documents deemed necessary for the effective implementation of the QMS shall be controlled from the MR's office and indexed as follows:-

a) *First part shall be MNP denoting Meru National Polytechnic followed by a slash (/)*
b) *The second part shall be EXT denoting external document followed by a slash (/)*
c) *The third part shall be assigned initials of the Department/Office/Section denoting the user of the document followed by a slash (/).*
d) *The last part shall be a number allocated to indicate number of documents received*

Example: *Indexing the PPRA Guidelines*: **MNP/EXT/PROC/01** *denoting that the document belongs to the Polytechnic, its external, it is controlled from the Procurement department office; it is an external document and is the first document controlled from that office.*

NB: For the external documents, serializing shall be done before issuance

2.7 Document Protection

2.7.1 All QMS documents shall be stored in electronic and physical forms.

2.7.2 For all electronically stored documents, they shall be protected through use of passwords and encryptions.

2.7.3 Hard copies shall be retained in such a manner as to ensure their protection from any form of hazards.

2.7.4 The Management Representative shall establish and maintain a master document list for all internally developed QMS documents.

2.8 Revision and Version Status of QMS Documents

2.8.1 After every amendment, the document shall be issued under a new version starting with version 0 while an Issue level change shall be made when the effected changes constitute a fundamental shift on the content. In such cases, the documents shall be issued as the succeeding version starting from Version 0. This shall be indicated in the footer section of every QMS document.

2.8.2 Typographical changes shall not warrant change to the version number of a document.

2.9 Management of Records

2.9.1 The Polytechnic shall maintain records to provide objective evidence of the conformity, implementation, and effective operation of its Quality Management System.

2.9.2 The various records to be generated and maintained are as determined in the various procedures of the Polytechnic.

2.9.3 The records to be maintained include:

a) Completed forms and registers
b) Minutes
c) Plans
d) Correspondences
e) Academic records

2.10 Records identification

Registers and forms used to generate records in the Polytechnic shall be identified through indexing as detailed below:-

2.10.1 For records from the government printer, the identification given by the government printer shall be used.

2.10.2 For forms generated internally, identification shall be through indexing as follows:-

a) The first part shall be given the initials MNP to denote Meru National Polytechnic followed by a slash (/)
b) The second part shall be given the initials of the Department/Section/Office of origin followed by a slash (/) e.g. MR to denote the Management Representative office
c) The third part shall be assigned a serial number starting with F 001 to denote the sequence of generation.

For example MNP/MR/F 001 to denote the document review form whose custodian is the Management Representative.

2.10.3 Registers shall be labeled and indexed as follows:-

a) The first part shall be given the initials MNP to denote Meru National Polytechnic followed by a slash (/)
b) The second part shall be given the initials of the Department/Section/Office of origin followed by a slash (/) e.g. MR to denote the Management Representative office
c) The third part shall be a number assigned to registers chronologically based on the subject.
d) The fourth part shall be assigned a volume number starting with **VOL 1** to denote the sequence of establishment.

For example the document issuance register maintained by the MR shall be identified as follows: - **MNP/MR/01/VOL 1.**

2.11 Storage and Filing of Records

2.11.1 The respective officers where registers are established shall ensure the storage of the registers in such places that shall assure protection against such hazards as water and direct sunlight.

2.11.2 Records established in forms shall be filed as per the registry guidelines.

2.11.3 Records maintained in soft copy shall be protected by use of passwords and backed up as per the backup procedure.

2.12 Retrieval of Records

Retrieval of records shall be as per the registry guidelines.

2.13 Retention and Disposal of Records

2.13.1 Records maintained in the Polytechnic shall be retained for such periods as prescribed in Polytechnic records' retention and disposition schedule and other applicable laws.

2.13.2 Records disposition shall be as per Polytechnic records' retention and disposition schedule and other applicable laws.

3.0 REPORTS AND RECORDS

3.1 Document issuance form.

3.2 Departmental circulation list.

3.3 Quality Document Review form.

3.4 Master document list.

3.5 Document Withdrawal form.

PROCEDURE NUMBER 2: INTERNAL QUALITY AUDITING

1.0 GENERAL

1.1 PURPOSE

The purpose of this procedure is to ensure effectiveness in undertaking Internal Quality Audits.

1.2 SCOPE

This procedure applies to all internal Quality Audits conducted in the Polytechnic.

1.3 TERMS AND DEFINITIONS

Refer to the list of terms and definitions.

1.4 REFERENCES

a) ISO 9001: 2015 Clause 9.2

b) ISO 19011: 2011 – Guidelines for auditing Management Systems.

1.5 RESPONSIBILITY

The MR shall ensure that this procedure is adhered to and maintained

1.6 INTERFACES

During the implementation of the process the MR shall work hand in hand with

a) Board of Governors for policy Direction

b) The Principal for approvals, guidance, consultation and ensuring adherence

c) All Departments in the Polytechnic for compliance, support and implementation

1.7 PERFORMANCE TARGET

The performance shall be measured through the overall performance of the department based on;

PERFORMANCE TARGET	MONITORING AND MEASUREMENT
Conducting an internal quality audit twice a year	a) Audit notification b) Audit programme c) Appointment of auditors and Team leader d) Audit checklist e) Audit report f) Management review meeting minutes

1.8 RESOURCES

The resources to be used in the process are listed below:-

a) Personnel

b) Finance

c) Time

1.9 INPUTS AND OUTPUTS

INPUTS	OUTPUTS
Audit programme Audit criteria Auditors Audit forms and checklists	Approved programme Audit report Completed forms Correction and corrective actions Improvement decisions

2.0 METHOD

2.1 Planning for quality audits

2.1.1 The Polytechnic shall undertake 2 internal Quality Audits at planned intervals of 6 months.

2.1.2 The MR shall prepare an internal audit programme for the whole succeeding year within the last month of the current year.

2.1.3 In preparing the programme, the MR shall consider:

a) Status and importance of the processes

b) Areas to be audited

c) Results of the previous audits.

d) Polytechnic calendar of events.

2.1.4 The MR shall forward the programme to the Principal for approval.

2.1.5 At the onset of any year, the MR shall circulate the programme to all the process owners and internal Quality Auditors for information.

2.2 Selection of auditors and preparation for audits

2.2.1 At least one month to the Internal Audit dates, the MR shall;

a) Issue a general audit notification to the auditees

b) Appoint an audit team and a team leader from the Polytechnic pool of trained auditors.

2.2.2 In appointing the team, the MR shall consider:-

a) Areas to be audited and complexity of the processes,

b) Number of audit days.

2.2.3 The audit team leader shall prepare for the audit by preparing an audit plan and sending it to the auditees at least seven days to the audit.

2.2.4 The internal quality auditors will prepare the checklist of the areas to be audited.

2.3 Conduct of audits

2.3.1 During the audit period, the team leader shall ensure that the audit timetable is adhered to and ensure that:-

a) All audit findings are recorded in the audit findings report forms.

b) The auditee acknowledges the audit findings by signing the audit findings report form.

2.3.2 The team leader shall further ensure that for the nonconformities raised during the audit are recorded in the nonconformity report form(s) and acknowledged by the auditee in the closing meeting.

2.3.3 The MR shall oversee the audit exercise and handle any issues arising during the exercise.

2.4 Audit reporting and analysis

2.4.1 The audit team leader shall ensure that a report of the audit is prepared and submitted to the MR, the auditees and the Principal within five working days of the audit**.**

2.4.2 After receipt of the Audit Report, the MR shall analyse the audit findings and prepare an audit analysis report identifying areas of common deficiency in the areas audited.

2.4.3 The MR shall table the audit analysis report in the subsequent Management Review forum for deliberations.

2.5 Corrective action follow-up

2.5.1 Corrective action determined in the Polytechnic shall be undertaken within fourteen working days or such other periods as agreed between the auditee and auditors of the audit during the closing meeting.

2.5.2 The MR in liaison with the audit team shall ensure the Process owner for any area where nonconformities are identified during the audit undertakes necessary corrections (as applicable) and corrective actions within the stipulated time.

2.5.3 At the lapse of the fourteen working days or such other periods as agreed between the auditee and auditors, the MR in liaison with the Audit Team Leader shall ensure the audit team conducts an audit follow up to determine whether the process owners have implemented the correction and corrective actions.

2.5.4 After the follow up, the audit team leader shall ensure that a follow up report is prepared and submitted to the MR for information and action.

2.5.5 During the subsequent audit, the MR shall ensure that the audit team carries an audit close out to determine the effectiveness of corrective actions implemented and complete the corrective action report form.

2.6 Management review

2.6.1 As per the management review meetings schedule, the MR in liaison with the Principal shall as per the meetings procedure, convene the Management Review Forum. The agenda of the forum shall be as outlined in Clause 9.3.2 of ISO 9001:2015.

2.6.2 The MR shall table the audit analysis report as the agenda of the forum for deliberation.

2.6.3 The respective process owner shall report on their processes performance and conformity of products and services including,

effectiveness of actions to address risks and opportunities and corrective actions raised.

2.6.4 The Management Review forum shall deliberate on the agenda and make resolutions guided by clause 9.3 of ISO 9001:2015.

2.6.5 The MR shall maintain all the audit records generated during the audit cycle as per the control of documented information procedure number 1 in this manual.

3.0 REPORTS AND RECORDS

3.1 Audit checklists.

3.2 Nonconformity report forms.

3.3 Audit findings forms.

3.4 Audit report.

3.5 Audit follow up report.

PROCEDURE NUMBER 3: CONTROL OF NONCONFORMING OUTPUTS

1.0 GENERAL

1.1 PURPOSE

The purpose of this procedure is to ensure effectiveness and timeliness in dealing with nonconforming outputs.

1.2 SCOPE

This procedure applies to all nonconforming outputs in the Polytechnic.

1.3 REFERENCES

ISO 9001:2015 Clause 8.7

1.4 TERMS AND DEFINITIONS

Refer to the list of terms and definitions.

1.5 RESPONSIBILITY AND AUTHORITY

The MR shall ensure that this procedure is adhered to and maintained.

1.6 INTERFACES

During the implementation of the process the MR shall work hand in hand with

a) Principal`s Office for approvals ,guidance and consultations
b) All Departments in the Polytechnic to ensure adherence, guidance and consultation

1.7 PERFORMANCE TARGET

The performance shall be measured through the overall performance of the department based on;

PERFORMANCE TARGET	MONITORING AND MEASUREMENT
100% adherence to Control of nonconforming output processes	Analysis of Nonconforming output register

1.8 RESOURCES

The resources to be used in the process are listed below:-

a) Personnel

b) Finance

c) Time

1.9 INPUTS AND OUTPUTS

INPUTS	OUTPUTS
Nonconforming outputs' reports	Concessions/approvals Nonconforming outputs registers Satisfied customers

2.0 METHOD

2.1 This procedure shall start with;

a) Any member of staff identifying a nonconforming outputs during service provision.

b) The identification of nonconforming outputs during an audit.

c) Receipt of customer complaints on nonconforming outputs.

2.2 On identification or receipt of information on a nonconforming output, the officer shall as per the internal communication procedure inform respective HOD immediately.

2.3 On receipt of the communication, the HOD shall establish the validity of the alleged nonconforming output based on the evidence provided.

2.4 In case the alleged nonconforming output is not valid; the HOD shall dismiss it and communicate to the originator with reasons for the dismissal.

2.5 If the alleged nonconforming output is valid, the HOD shall deal with the nonconforming output by any of the following ways:-

a) Correction and re-verification for conformity prior to delivery,

b) Return of the nonconforming outputs for correction in case the outputs are identified after delivery,

c) Halting the production or service provision until appropriate actions are taken,

d) Seeking authorization for acceptance from the respective Deputy Principal/Principal and where need be the customer and relevant authorities, or

e) Informing the customer of the actions taken in case a nonconforming output is identified by the Customer.

2.6 To avoid recurrence of the nonconforming output, the MR shall ensure that the nonconformity is dealt with as per the nonconformity and corrective action procedure number 4 in this manual.

2.7 The HODs shall maintain a record of all nonconforming outputs in the nonconforming outputs register.

3.0 REPORTS AND RECORDS

3.1 Nonconforming outputs register.

PROCEDURE NUMBER 4: NONCONFORMITY AND CORRECTIVE ACTION

1.0 GENERAL

1.1 PURPOSE

The purpose of this procedure is to ensure effectiveness and consistency in handling nonconformities to eliminate recurrence in the Polytechnic.

1.2 SCOPE

This procedure applies to the handling of all nonconformities identified in the Polytechnic.

1.3 REFERENCES

ISO 9001: 2015 Clause 10.2

1.4 TERMS AND DEFINITIONS

Refer to the list of terms and definitions.

1.5 RESPONSIBILITY AND AUTHORITY

The MR shall ensure that this procedure is adhered to and maintained.

1.6 INTERFACES

During the implementation of the process the MR shall work hand in hand with

a) Principal`s Office.
b) Polytechnic Council.
c) All Departments in the Polytechnic.

1.7 PERFORMANCE TARGET

The performance shall be measured through the overall performance of the department based on;

PERFORMANCE TARGET	MONITORING AND MEASUREMENT
100% Effectiveness of Corrective Action	Analysis of CAR forms and Corrective action notices

1.8 RESOURCES

The resources to be used in the process are listed below:-

a) Personnel

b) Finance

c) Time

1.9 INPUTS AND OUPUTS

INPUTS	OUTPUTS
Nonconformities	Corrections and corrective actions
	Improvement decisions

2.0 METHOD

2.1 This procedure shall either start with:-

a) Detection of nonconformity by Auditors during audits;

b) Receipt of information of a nonconformity from a customer or;

c) Detection of a non-conformity by any officer in the course of service delivery.

2.2 Reviewing and analyzing nonconformities

2.2.1 On identifying a nonconformity or receipt of information on a nonconformity, the officer shall as per the internal communication procedure inform the concerned HOD who in liaison with MR shall review the nonconformity to determine its validity.

2.2.2 In reviewing and analyzing the nonconformity to establish its validity, the MR and the HOD/ shall consider:-

a) Evidence provided

b) The effect of the nonconformity on service provision.

2.2.3 In case the nonconformity is not valid, the reviewing officers shall drop the matter and as per the internal and/or the external communication procedures communicate the same to the originator with reasons thereof.

2.2.4 In the event that the nonconformity is valid, the MR shall fill a Corrective Action Notice (CAN) and submit it to the officer where the nonconformity has been detected.

2.3 Determining the causes of nonconformities

2.3.1 On receipt of the CAN, the officer shall in liaison with immediate supervisor determine the root causes of the non-conformity and propose the necessary actions to be undertaken to eliminate them.

2.3.2 On filling the CAN the officer shall forward it to the MR who shall undertake any analysis to determine if similar nonconformities exist or could potentially occur and update the CAN accordingly in consultation with the HOD where the nonconformity has been identified.

2.4 Implementing the actions needed

The management of the area affected shall:-

a) Ensure that actions are taken to control and correct the nonconformity,

b) Ensure any consequences as a result of the nonconformity are dealt with,

c) Ensure implementation of the corrective actions to eliminate the causes of the nonconformity,

d) Update risks and opportunities and propose changes to the QMS if necessary, and

e) Ensure records are maintained as evidence of implementing the corrections and corrective action.

2.5 Follow up on Implementation of Corrective Actions

2.5.1 The MR shall ensure follow-up to check the implementation of corrections and corrective actions as stated in CAN.

2.5.2 In the event that corrective action has not been implemented, inform the respective DP and where need be the Principal for further action.

2.6 Reviewing the effectiveness of the corrective action taken

2.6.1 The MR shall ensure review of the effectiveness of corrective actions taken during subsequent internal audits.

2.6.2 In the event that the actions taken are not effective, the internal auditor shall issue a new CAN to the HOD.

2.6.3 If the action taken is effective, the auditor shall close out the nonconformity and forward the completed CAN to the MR for filing.

2.7 Dealing with Nonconformities identified during External Audits

2.7.1 Upon receipt of the nonconformities report from the external auditors, the MR shall in liaison with the respective HOD determine appropriate corrections and root causes to address the nonconformities and complete the auditors' report.

2.7.2 After endorsement of the actions to address the nonconformities by the external auditors, the MR in liaison with the respective HOD shall ensure implementation of the corrections and corrective actions.

2.7.3 The MR shall ensure review of the effectiveness of corrective actions as per clause 2.6 above.

3.0 REPORTS AND RECORDS

3.1 Corrective Action Notices.

3.2 Report on status of corrective actions.