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Revision: 2

Prepared/Reviewed by: Directorate of Quality Assurance.....

Approved by: Vice Chancellor Sign.....

Issued by: Director Quality Assurance Sign.....

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<b>Interested Parties</b>					
<b>#</b>	<b>Interested Party</b>	<b>Internal or External</b>	<b>Summarize expectations or requirements</b>	<b>References</b>	<b>Responsibilities</b>
<b>1</b>	BV	External	Compliance to the standard and QMS	Contract No. KE: 2903371	DQA
	MoE, CUE	External	Compliance to the statutory, regulatory and legal requirements	CUE Standards and guidelines, statutory, regulatory and legal requirements.	DQA
	Staff	Internal	Provision of timely quality services	HR Manual, Citizens Service Delivery Charter, SLAs, University Act 2012 & its revisions, Statutes, Chapter Six of Constitution of Kenya 2010 etc	DQA
<b>2</b>	Students	Internal	Quality teaching/learning, research and community outreach among other services, Compliance with rules and regulations	Students' Admission Handbook, Citizens Service Delivery Charter, SLAs	DQA
<b>4</b>	Top Management	Internal	Timely, accurate and consistent audit reports	Audit programme	DQA
<b>5</b>	Deans, CoDs, Directors and all HoCC	Internal	Timely, accurate and consistent audit reports and programme	Audit programme audit reports and audit notice	DQA
<b>6</b>	Consultants	External	Strict adherence to training and audit programme.	Training calendar, audit calendar, training manuals	DQA
<b>7</b>	IQA (auditors)	Internal	Timely and accurate audit programme, notice and appointment letters	Iso 9001:2015, QMS document, audit programme	DQA

<b>Internal Issues</b>			
<b>#</b>	<b>Issue</b>	<b>Category</b>	<b>Summary description</b>
<b>1</b>	Changes in management structure	Structure	Making key personnel changes in management could derail implementation of the QMS
<b>2</b>	Attitude	Shared values	Negative attitudes towards QMS could derail implementation of the QMS
<b>3</b>	Culture/Attitude	Shared values	Resistance to change could derail implementation of the QMS
<b>4</b>	Lack of competence among auditors	Skill	Lack of refresher courses leads to stale knowledge among auditors which leads to poor quality audits and reports and derail implementation of the QMS
<b>5</b>	Recurrent NCs	systems	Recurrent systematic weaknesses could cause apathy and derail QMS implementation
<b>6</b>	Inadequate staff	Staff	Lack of enough man power in the Quality Assurance Directorate can lead to inefficiencies in service delivery
<b>7</b>	Inadquate internal auditors	Staff	Transfers of trained auditors will cause fatigue and burn out in the remaining few and derail QMS implementation.

<b>External Issues</b>			
<b>#</b>	<b>Issue</b>	<b>Category</b>	<b>Summary description</b>
<b>1</b>	Lack of funds	Economic	Insufficient funds affect audit programme implementation negatively.
<b>2</b>	Government policies/directives	Legal	Ministry directives on university activities derail implementation of programme
<b>3</b>	Inconsistent internet and power flow	Technological	Lack of internet infrasture has affected installation of audit software/ loss of data
<b>4</b>	Negative publicity of the University	Political	Negative publicity about the University damages the reputation and immagine of the University

<b>Products and Services</b>			
<b>#</b>	<b>Product or service title</b>	<b>Brief description</b>	<b>Summarize usage and importance</b>
<b>1</b>	Control of documented information	Ensuring documented information is developed, identified, and maintained.	For safe custody of information
<b>2</b>	Managing audits	Ensuring the timely development and execution of the audit program.	To monitor the implementation of the QMS
<b>3</b>	Managing NCs	Ensuring timely and satisfactory action is taken on all NCs raised.	To improve performance of the QMS
<b>4</b>	Advisory on QMS matters	This includes timely analysis of audit reports, Management review inputs, communicating resolutions of MR meetings etc. to relevant personnel.	To monitor the performance of the QMS
<b>5</b>	Linking university with external bodies (Consultant and BV)	Timely correspondences to external partners.	For the University to stay up dated about the emerging issues, trends and new products on matters of QMS

<b>Laws and Regulations</b>			
<b>#</b>	<b>Law / regulation title or reference</b>	<b>Brief description of Quality requirement</b>	<b>Who is responsible for compliance?</b>
<b>1</b>	QMS	This is the current version of documents relevant to the Quality Management System, including: Work Procedures, Quality Policy, Context of the organization, Quality Objectives etc.	VC/QAD/HoCCs
<b>2</b>	Relevant ISO standard (9001:2015)	The current ISO 9001:2015 standard which contains QMS requirements. The standard is maintained in soft and hard copies.	DQA

<b>Communication</b>					
<b>Sno</b>	<b>What will be communicated</b>	<b>When to communicate</b>	<b>With whom to communicate</b>	<b>How to communicate</b>	<b>Who communicates</b>
<b>1</b>	Audit programme	2nd Week at the beginning of the year	Top Management, Senate, Deans, Directors, CoDs, and all functional heads.	Memo, e-mail	DQA
<b>2</b>	Audit plan	Seven days to the audit	Top Management, Senate, Deans, Directors, CoDs, and all functional heads.	Memo, email	DQA
<b>3</b>	Appointment of auditors	Two weeks to the audit	Internal Quality Auditors	Appointment letters to the auditors.	DQA
<b>4</b>	Audit report	Within three weeks after discussion by University Management Board	Top Management, Senate, Deans, Directors, CoDs, and all functional heads.	Audit report	DQA
<b>5</b>	Management Review Meeting minutes (MRM)	After every Internal/External quality audit	Top Management, Deans, Senate Directors, CoDs, and all functional heads.	Memo, email	DQA
<b>6</b>	Request for audit from the external body (BV)	1 month to the audit	BV/UMB Chair person	E-mail, Memo	DQA
<b>7</b>	Trainings	When need arises	Top Management, Senate, Deans, Directors, CoDs, and all functional heads.	E-mail, Memo	DQA

<b>Monitoring, Measurement, Analysis and Evaluation</b>				
<b>#</b>	<b>What needs to be Monitored and Measured</b>	<b>Methods of MMAE</b>	<b>When to Monitor and Measure</b>	<b>When the results of Monitoring and Measurement shall be Analysed and Evaluated</b>
<b>1</b>	Implementation of Quality Management System	internal and external quality audits	Twice a year	3 weeks after each audit.
<b>2</b>	Actions on Non Conformities raised	Follow ups	2 weeks after audit	In the subsequent Management Review Meeting.
<b>3</b>	Implementation of the Audit Program	Audits/ MRM minutes	Twice a year	At the end of each calendar year
<b>4</b>	Implementation of quality objectives	Departmental meetings	Quarterly	At the end of each calendar year
<b>5</b>	Internal and external issues affecting QMS	Departmental meetings	Quarterly	Annually
<b>6</b>	Risks	Departmental meetings	Quarterly	At the end of each calendar year



	<b>ORGANIZATIONAL KNOWLEDGE</b>	<b>DESCRIPTION</b>
1	QMS documents,audit reports.	These are documents relevant to the QMS, including: Work Procedures, Context of the organization, Quality Objectives, QP, and Risk Registers etc. They are maintained in hard copy and soft copy, In relevant QMS files. ( Internal Quality Audits and DQA) Soft copy documents are stored on flash disks, hard disks and desk tops. They are made available as required.
2	The ISO 9001:2015 standard	The ISO 9001:2015 standard which contains QMS requirements. The standard is maintained in hard copy. They are made accessible as required by relevant personnel.
3	Trainings	These are trainings on relevant QMS matters. They are maintained in hard copy notes and reports and made available whenever needed.



MASINDE MULIRO UNIVERSITY OF SCIENCE AND TECHNOLOGY  
QUALITY MANAGEMENT SYSTEM BASED ON ISO 9001:2015 STANDARD

QAD - MANDATORY WORK PROCEDURES PROCEDURE MANUAL

Doc Ref No. MMU/MAN: 201003

VERSION 1


REVISION 2

Authorized for use by: <u>Prof. Maurice V. Omolo</u> (Director Quality Assurance) Signed: <u>[Signature]</u> Date: <u>24/02/2020</u>
Approved for use by: <u>Prof. Azenath Sigot</u> (Vice Chancellor) Signed: <u>[Signature]</u> Date: <u>24/02/2020</u>
Issued for use by: _____ (DQA) Signed: <u>[Signature]</u> Date: <u>24/2/2020</u>

MASINDE MULIRO UNIVERSITY  
OF SCIENCE & TECHNOLOGY  
MR office  
17 FEB 2020  
Approved & issued

Version 1

Revision 2

	<b>MASINDE MULIRO UNIVERSITY OF SCIENCE AND TECHNOLOGY</b> ISO 9001:2015	<b>REF: MMU/MAN:500001</b>	
		<b>DEPT</b>	<b>DVC ACADEMIC &amp;STUDENT AFFAIRS (DIVISION)</b>
		<b>ISSUE DATE</b>	<b>17<sup>th</sup> FEBRUARY 2020</b>
		<b>VERSION</b>	<b>1</b>
		<b>REVISION</b>	<b>2</b>
<b>TITLE: TEACHING &amp; LEARNING PROCEDURE MANUAL</b>			

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MASINDE MULIRO UNIVERSITY  
OF SCIENCE AND TECHNOLOGY  
ISO 9001:2015

TITLE: TEACHING & LEARNING  
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17<sup>th</sup> FEBRUARY 2020

VERSION

1

REVISION

2


## DISTRIBUTION LIST

### MASINDE MULIRO UNIVERSITY OF SCIENCE AND TECHNOLOGY

### DISTRIBUTION LIST

MMU/LIS: 201004

NO	NAME OF COST CENTRE	CENTRE CODE	DATE RECEIVED	NAME OF RECEIVER	SIGN
1.					
2.					
3.					
4.					
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## **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 MMUST.

#### **1.3 REFERENCES**

ISO 9001:2015 Clauses 6.3 and 7.5

#### **1.4 TERMS AND DEFINITIONS**

- a) MMUST – Masinde Muliro University of Science and Technology
- b) DQA- Director, Quality Assurance
- c) QAD Quality Assurance Directorate
- d) QMS- Quality Management System
- e) HOCC- Head of Department

#### **1.5 PRINCIPAL RESPONSIBILITY**

The DQA shall ensure adherence and maintenance of this procedure.


#### **1.6 INTERFACES**

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

- a) The Vice Chancellors office for approvals and guidance
- b) All Departments in the University for implementation, guidance, consultation and compliance

#### **1.7 PERFORMANCE TARGET**

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

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<b>PERFORMANCE TARGET</b>	<b>MONITORING AND MEASUREMENT</b>
Complete Quality Management System as per ISO 9001:2015	a) QMS Forms b) ISO 9001:2015
Complete Document Identification	a) Indexed/folioed filling b) Master list of document s
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

<b>INPUTS</b>	<b>OUTPUTS</b>
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 University shall be established by the respective process owners in consultation with the respective users in reference to the operations of the university.
- 2.1.2 After establishment of any QMS document, the process owner shall forward it to the DQA for consideration.
- 2.1.3 After finalization, the QMS document shall be authorized for use as follows through signing on the space provided:-
  - a) The Quality Policy, Mandatory Procedures, Departmental Work Procedures, quality objectives, risk registers, opportunities and context documents shall be approved and

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authorized for use by the Vice Chancellor, DVC's, Deans, CoDs, Directors and issued by DQA

- b) The DQA retains copies of all QMS documents including 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 MMU denoting Masinde Muliro of Science and Technology followed by a forward slash (/)*
- b) *The second part shall be assigned the initials of the document/manual document followed by a full colon (:).*
- c) *The third part shall be assigned a three digit number denoting the document origin (Department/Office/Section/ Cost centre) of the document.*
- d) *The fourth part shall be a number to denote the number of documents in the Department/Office/Section/ Cost centre of origin.*

### Notes

- a) *The documents shall also bear the version and the logo of the University.*
- 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: MMU/POL: 201001 denoting that the document is the Quality Policy and it is controlled from the Quality Assurance Office and it is the first document in the DQA's office.*


## 2.3 Document Packaging

2.3.1 QMS documents shall be packaged into procedures, manuals, registers as applicable.

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

2.3.3 Soft copy QMS documents shall be packaged and maintained in protected Portable Document Format (PDF), where possible.




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## 2.4 Document Issuance and Circulation

- 2.4.1 After approval of the QMS documents, the DQA 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 DQA 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 distribution list to 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 DQA with a copy of the filled-in distribution 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:
- Staff identifying un-practicability of a procedure*
  - Customer complaint on service delivery traceable to a procedure*
  - Recommendations from a Quality Audit*
  - Change of policies affecting the operation of the University*
  - The Management Review meeting every two years for scheduled review.*
- 2.5.2 Any recommendation for change shall be forwarded to the DQA through respective Division/Deans/Directors/CoDs/HOCC/Section heads by filling a Quality Management System document review form.
- 2.5.3 The DQA 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 DQA shall withdraw the previously issued documents and re-issue the revised documents using the document issuance form.

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2.5.7 The DQA 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 DQA shall ensure that such documents are stamped “Obsolete”

## 2.6 Identification and control of documents of external origin

Any external documents deemed necessary for effective implementation of the QMS shall be controlled from the Vice Chancellors office where a register for such shall be maintained and indexed as follows:-

- a) *First part shall be MMU denoting Masinde Muliro University of Science and Technology followed by a slash (/)*
- b) *The second part shall be EXD denoting external document followed by a full colon (:)*
- c) *The third part shall be assigned the centre code of the Department/Cost Centre/Section.*
- d) *The last part shall be a number allocated to indicate number of documents of external origin in that particular cost centre.*

**Example:** *Indexing the CUE Guidelines: MMU/EXD: 501001 denoting that the document belongs to the university, its external, it is controlled from the REGISTRAR ACADEMICS 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 Quality Assurance Directorate shall establish and maintain a master list of documents for all internally developed QMS documents.

## 2.8 Revision and Version Status of QMS Documents

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2.8.1 After every major amendment affecting most of the QMS documents, the document shall be issued under a new version starting with version 1. While a Revision level change shall be made when the effected changes don't constitute a fundamental shift on the content. In such cases, the documents shall be issued as the succeeding Revision starting from Revision 0. This shall be indicated in the Header section of every QMS document.

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

## 2.9 Management of Records

2.9.1 The University 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 University.

2.9.3 The records to be maintained shall 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 University 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 MMU to denote *Masinde Muliro University* followed by a slash (/)
- b) The second part shall be given the initials of the Document followed by a full colon
- c) The third part shall be assigned a serial number to denote the cost centre code

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- d) The fourth part shall be assigned a serial number starting with 01 to denote the sequence of generation and this comes immediately after the cost centre code and followed by a forward slash (/) in case of existence of more than one file volumes.
- e) The fifth part shall be a file Volume number abbreviated VOL followed by a dot and then the number
- f) The sixth part shall be a serial number in brackets denoting folio number of the record

*For example MMU/COR:201007/VOL.II (08) to denoting a correspondence No 7 internally generated by the University from the Cost Centre 201 and is in Volume II file where the correspondence is folioed 08*

## **2.11 Storage and Filing of Records**

- 2.11.1 The respective officers where documents and records are established shall ensure their storage 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 documentation procedure 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 documentation procedure guidelines.

## **2.13 Retention and Disposal of Records**

- 2.13.1 Records maintained in the University shall be retained for such periods as prescribed in University documentation procedure guidelines and other applicable laws.
- 2.13.2 Records disposition shall be as per University documentation procedure guidelines 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.

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3.4 Master list of documents and records

3.5 Document Withdrawal form.

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## **PROCEDURE NUMBER 2: INTERNAL QUALITY AUDITING AND MANAGEMENT REVIEW**

### **1.0 GENERAL**

#### **1.1 PURPOSE**

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

#### **1.2 SCOPE**

This procedure applies to all internal Quality Audits and management review meetings conducted in the University.

#### **1.3 TERMS AND DEFINITIONS**

- a) University Management Board (UMB)
- b) Vice Chancellor (VC)

#### **1.4 REFERENCES**

- a) ISO 9001: 2015 Clause 9.2
- b) ISO 19011: 2011 – Guidelines for auditing Management Systems.

#### **1.5 RESPONSIBILITY**

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

#### **1.6 INTERFACES**


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

- a) UMB for policy Direction
- b) The Vice Chancellor for approvals, guidance, consultation and ensuring adherence
- c) All Cost Centres in the University for compliance, support and implementation

#### **1.7 PERFORMANCE TARGET**

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

<b>PERFORMANCE TARGET</b>	<b>MONITORING AND MEASUREMENT</b>
Conducting an internal quality audit at least twice each year	<ol style="list-style-type: none"> <li>a) Audit notification</li> <li>b) Audit programme</li> <li>c) Appointment of auditors and Team leader</li> <li>d) Audit checklist</li> <li>e) Audit report</li> <li>f) Management review meeting minutes</li> </ol>

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## 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 University shall undertake at least 2 internal Quality Audits every academic year

2.1.2 The DQA shall prepare an internal audit programme for the whole succeeding year at the end of the first quarter each year.

2.1.3 In preparing the programme, the DQA shall consider:

- a) Status and importance of the processes
- b) Areas to be audited
- c) Results of the previous audits.
- d) University calendar of events.


2.1.4 The DQA shall forward the programme to the Vice Chancellor for approval.

2.1.5 At the onset of any year, the DQA shall circulate the programme to all the process owners and Internal Quality Auditors for information. The DQA shall monitor the implementation of the audit programme, review and improve as applicable.

### 2.2 Selection of auditors and preparation for audits

2.2.1 The DQA shall;

- a) Issue a general audit notification to the auditees two weeks to an audit

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b) Appoint an audit team and a team leader/Lead auditor from the University pool of trained auditors detailing their responsibilities

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

- a) Areas to be audited and complexity of the processes, scope, criteria,
- b) Number of audit days.
- c) Competence and independence of auditors

2.2.3 The audit team leader shall in consultation with the auditors, prepare for the audit by preparing an audit plan and distributing it to the auditees at least seven days to the audit.

2.2.4 Team leader, while preparing the audit plan shall consider 2.2.2 above

2.2.5 The audit plan shall detail areas to be audited ,date and time of the audit ,scope, audit objective, auditors, auditees, criteria and resources required

2.2.6 The internal quality auditors will prepare the checklist of the areas to be audited and other forms required in liaison with the team leader.

### **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 phases of the audit are undertaken,
- b) All audit findings are recorded in the audit findings report forms.
- c) 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 corrective action request form(s) and acknowledged by the auditee in the closing meeting.


2.3.3 The DQA 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 DQA, the auditees and the Vice Chancellor within five working days of the audit. The Report shall contain:

- i. Audit objectives
- ii. Audit scope



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- iii. Identification of auditor(s)
- iv. Dates and places where audit was conducted
- v. Audit criteria
- vi. Audit findings
- vii. Audit conclusions
- viii. Any areas covered although not within the audit scope
- ix. Any unresolved diverging opinions between the auditor and auditee
- x. Recommendation for improvement, if specified in the audit objectives
- xi. A statement of the confidential nature of the contents
- xii. The distribution list for the audit report

2.4.2 After receipt of the Audit Report, the DQA shall analyse the audit findings and prepare an audit analysis report establishing trends in the Quality Management System compliance within five days of receipt

2.4.3 The DQA shall discuss the audit analysis report with the Vice Chancellor before tabling it in the subsequent Management Review forum for deliberations.


## **2.5 Corrective action follow-up**

2.5.1 Corrective action determined in the University 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 DQA 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 DQA 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 DQA for information and action.

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2.5.5 During the subsequent audit, the DQA 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 DQA in liaison with the Vice Chancellor shall as per the meetings procedure, convene the Management Review meeting. The agenda of the meeting shall be as outlined in Clause 9.3.2 of ISO 9001:2015.

2.6.2 The DQA shall table the audit analysis report as the agenda of the review meeting 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 DQA 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 Appointment letters

3.2 Audit checklists.


3.3 Nonconformity report forms.

3.4 Audit findings forms.

3.5 Audit report.

3.6 Audit follow up report.

3.7 Management review invitation ,agenda and minutes

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### **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 University.

#### **1.3 REFERENCES**

ISO 9001:2015 Clause 8.7.

#### **1.4 TERMS AND DEFINITIONS**

HOCC- head of Cost Centre

#### **1.5 RESPONSIBILITY AND AUTHORITY**

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

#### **1.6 INTERFACES**

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

- a) Vice Chancellor's Office for approvals ,guidance and consultations
- b) All Cost Centres in the University to ensure adherence, guidance and consultation

#### **1.7 PERFORMANCE TARGET**


The performance shall be measured through the overall performance of a Cost Centre based on;

<b>PERFORMANCE TARGET</b>	<b>MONITORING AND MEASUREMENT</b>
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

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## 1.9. INPUTS AND OUTPUTS

<b>INPUTS</b>	<b>OUTPUTS</b>
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 output(s) 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 HOCC 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 HOCC shall dismiss it and communicate to the originator with reasons for the dismissal.

2.5 If the alleged nonconforming output is valid, the HOCC 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 Vice Chancellor 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 DQA shall ensure that the nonconformity is dealt with as per the nonconformity and corrective action procedure number 4 in this manual.

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

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### **3.0 REPORTS AND RECORDS**

#### **3.1 Nonconforming outputs register.**

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## **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 University.

#### **1.2 SCOPE**

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

#### **1.3 REFERENCES**

ISO 9001: 2015 Clause 10.2

#### **1.4 TERMS AND DEFINITIONS**

QMS- Quality management system

HOCCs-Head of Cost Centre(s)

CAN – Corrective Action on Nonconformities

#### **1.5 RESPONSIBILITY AND AUTHORITY**

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

#### **1.6 INTERFACES**

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

- a) Vice Chancellor`s Office for guidance and consultations
- b) All HOCCs in the University for actions and implementation

#### **1.7 PERFORMANCE TARGET**


The performance shall be measured through the overall performance of a Cost Centre based on;

<b>PERFORMANCE TARGET</b>	<b>MONITORING AND MEASUREMENT</b>
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

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c) Time

## 1.9 INPUTS AND OUPUTS

<b>INPUTS</b>	<b>OUTPUTS</b>
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 nonconformity by any officer in the course of service delivery.

### 2.2 Reviewing and analysing 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 HOCC who in liaison with DQA shall review the nonconformity to determine its validity.

2.2.2 In reviewing and analysing the nonconformity to establish its validity, the DQA and the HOCC/ 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 DQA 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 DQA who shall undertake any analysis to determine if similar nonconformities exist or could potentially occur

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and update the CAN accordingly in consultation with the HOCC 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 DQA 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 Vice Chancellor for further action.


## **2.6 Reviewing the effectiveness of the corrective action taken**

- 2.6.1 The DQA 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 HOCC.
- 2.6.3 If the action taken is effective, the auditor shall close out the nonconformity and forward the completed CAN to the DQA 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 DQA shall in liaison with the respective HOCC 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 DQA in liaison with the respective HOCC shall ensure implementation of the corrections and corrective actions.



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2.7.3 The DQA 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

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Version: 1

Revision: 2

Prepared/Reviewed by: Quality Assurance Directorate Sign: 

Approved by: Vice Chancellor Sign: 

Issued by: Director Quality Assurance Sign: 

Issue Date: 17th February 2020



S N	PROCE SS	INTERESTED PARTIES & THEIR REQUIREME NTS	RISK DESCRIPTION	CAUSES	AREA OF IMPACT	RISK OWNE R	I M P A C T	L I M I T E D	R I S K L E V E L	STRA TEGY	EXISTING CONTROL S	ADDITIO NAL CONTROL S	RESOU RCES	TARGE T DATE	RESIDU AL RISK			RESP ONSIB ILITY
															I M P A C T	L I M I T E D	R I S K L E V E L	
1	IQA	Top management/D eans/CoDs HoDs/students	Recurrence of Non-Conformities	Non enforcement by process owners	Legal/ regulatory	DQA	2	3	6	Reduc e risk	QMS developed	Enforcemen t by DQA especially during managem ent reviews.	Finance / Staff	June 2021,				
2	QMS processe s	Top mgt/ HoDs/students	Negative attitudes	Culture	Legal/ regulatory	DQA	2	5	1 0	Reduc e risk	Trainings	Motivation by positive appraisal and honoraria	Finance / Staff	June 2021,				
3	IQA	Top mgt/ HoDs/students	Incompetent auditors	Lack of training	Operational	DQA	2	4	8	Reduc e risk	Trainings of existing internal quality auditors and attaching of auditors to client firms.	Motivation by positive appraisal and honoraria	Finance / Staff	June 2020,				

**OPPORTUNITIES ASSESSMENT**

#	ISSUES	OPPORTUNITIES	ACTION
1	Incompetent auditors	Trainings	Perform refresher courses.
2	Social Media	Improve communication	Form social network groups, communicate through the social media groups
3	Inadequate number of auditors	Train more auditors	Engage top management to provide resources for training



# MASINDE MULIRO UNIVERSITY OF SCIENCE AND TECHNOLOGY

QUALITY MANAGEMENT SYSTEM BASED ON ISO 9001:2015 STANDARD

QUALITY ASSURANCE QUALITY OBJECTIVES

DOC REF.NO MMU/QOB: 201002

Authorized for use by:

Prof. Maurice Vincent Omulo Director Quality Assurance

Signed:

Date: 29/02/2020

Approved for use by:

Prof. Asenath Sigot (Vice Chancellor)

Signed:

Date: 24/02/2020

Issued for use by:

(DQA)

Signed:

Date: 29/2/2020



VERSION: 1

<b>Objective</b>	<b>Who will be responsible?</b>	<b>What will be done?</b>	<b>What resources will be required?</b>	<b>When will it be completed?</b>	<b>How will the results be monitored and evaluated?</b>
To increase the number of Internal Quality Audits held in MMUST from the current twice to thrice a year 2020/2021 financial year.	Director Quality Assurance	Revise the QAD work plan to include the three internal quality audits.	Qualified personnel Funds	June 2021	Check for inclusion of activity in the Directorates work plan.  Audit reports.
To maintain the number of Quality Assurance awareness trainings at twice yearly in the 2020/2021 financial year.	Director Quality Assurance	Present proposal to management for approval	Funds Consultant	June 2021	Training schedule and reports
To have one refresher training course for Internal quality auditors in order to improve their auditing skills before the end of the 2020/2021 financial year.	Director Quality Assurance	Present proposal to management  Source for consultant	Funds Consultant	June 2021	Clients to evaluate individual auditor using prescribed tool
To increase the number of processes covered during monitoring and evaluation from the current one (academic functions) to two (administrative functions) by June 2021.	Director Quality Assurance	M&E aspects of finance and administration.	Funds  Qualified personnel	June 2021	Reports from M&E exercise

PREPARED BY: Directorate of Quality Assurance

18/01/2021