



## KITALE NATIONAL POLYTECHNIC



QUALITY MANAGEMENT SYSTEM BASED ON ISO 9001:2015 STANDARD

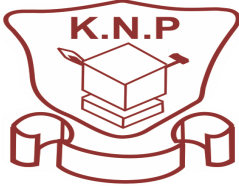
### MANDATORY PROCEDURE MANUAL

KNP/PM/MR/ 04

VERSION: C

REVISION: 1

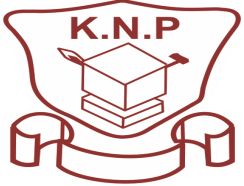
Authorized by: _____ Principal	Sign: 	Date: <u>25<sup>TH</sup> OCT 2021</u>
Issued by: _____ Management Representative	Sign: 	Date: <u>25<sup>TH</sup> OCT 2021</u>

	<b>KITALE NATIONAL POLYTECHNIC</b> <b>ISO 9001:2015</b>	<b>Ref: KNP/PM/MR/04</b>	
		<b>Dept</b>	<b>MR</b>
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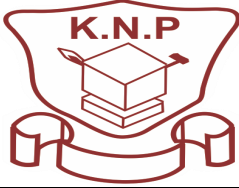
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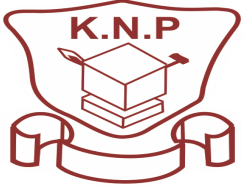
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### RECORD OF CIRCULATION

NAME	COPY NO.
Principal	1.
Deputy Principal Administration	2.
Deputy Principal Academics	3.
Registrar Admissions	4.
Registrar Administration	5.
Dean of students	6.
Management representative	7.
HOD Agriculture	8.
HOD Building and civil engineering	9.
HOD Business	10.
HOD Electrical /electronic	11.
HOD Institutional Management and Hospitality	12.
HOD ICT Academic	13.
HOD Liberal studies	14.
HOD Applied Sciences	15.
HOD Mechanical Engineering	16.
Examinations Officer	17.
Finance Officer	18.
Procurement Officer	19.
HOD Guidance and Counseling	20.
HOD Library	21.
Industrial Liaison Officer	22.
PC Coordinator	23.
Sports Officer	24.
Maintenance Officer	25.
Career Services	26.
External partnerships	27.

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Curriculum Development	28.
Security	29.
ODEL	30.
Internal Audit	31.
Driving School	32.
Career Services	33.

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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 Kitale National Polytechnic.

#### **1.3 REFERENCES**

ISO 9001:2015 standard Clause 7.5

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

- a) MR- Management Representative
- b) QMS Quality Management System
- c) HOD- Head of Department
- d) PPRA- Public Procurement Regulatory Authority

#### **1.5 RESPONSIBILITY**

The MR shall ensure adherence and maintenance of this procedure.

#### **1.6 INTERFACES**

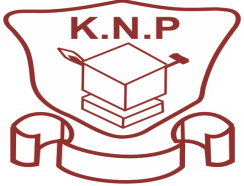
During the implementation of the process the MR shall work hand in hand with

- 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;

<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 filing b) Master document list
100% Document review process adherence	Approved Review forms
Accurate Record Maintenance	Completed forms and registers

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## 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
Analysed data	Improvement in decision making

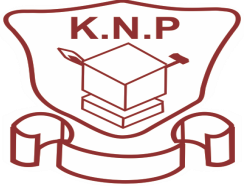
## 2.0 METHOD

### 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, Departmental Procedure Manuals, Quality Objectives, Risk Registers, Opportunities and Context Documents shall be approved and authorized for use by the PRINCIPAL.
  - b) The MR 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 KNP denoting Kitale National Polytechnic followed by a slash (/)

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- b) The Second part shall be assigned initials of the document subject followed by a slash (/) e.g. P to mean Procedures, PM to mean Procedures 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: **KNP/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.

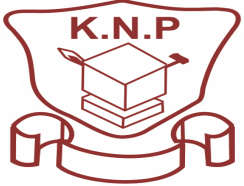
**2.3 Document Packaging**

- 2.3.1 QMS documents shall be packaged into procedures manuals, forms, registers as applicable.
- 2.3.2 Hard copies of 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 copies of QMS documents shall be packaged and maintained 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.



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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 impracticable procedure(s)
- 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 HODs/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.

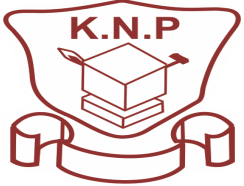
2.5.6 After any review or update, the MR shall withdraw the previously issued documents and re-issue the revised documents using the document issuance form.

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 Principal's office where a register shall be maintained and indexed as follows:-

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- a) First part shall be KNP denoting Kitale 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 name or subject of the document followed by a slash (/).
- d) The fourth part shall be the source of the document followed by a slash (/).
- e) The last part shall be a number allocated to indicate number of documents received

**Example:** An act from PSC shall be indexed: **KNP/EXT/ACT/PSC/01** denoting that the document belongs to the Polytechnic, its external, it is an Act originating from PSC and it is the first external document.

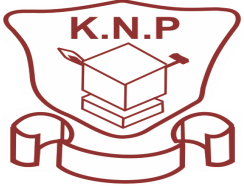
**NB:** For the external documents, serializing shall be done before issuance

## **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 major amendment affecting most of the QMS documents, the document shall be issued under a new version starting with version A 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 o. 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.

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## **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

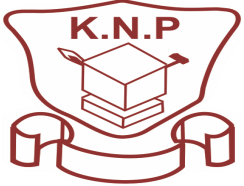
## **2.10 Records identification**

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 KNP to denote Kitale National Polytechnic followed by a slash (/)
  - b) The second part shall be given the initials of the Office of origin followed by a slash (/)

NB. The institution has determined the following control points:

- I. Administration-ADM
- II. Academics- ACAD
- III. MR-MR
- IV. Finance-FO
- V. Internal Audit-IA
- VI. Registrar-REG
- VII. Procurement-PO

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- c) The third part shall be assigned a serial number starting with 01 to denote the sequence of generation.

*For example KNP/ADM/01 denoting form No 1 internally generated by the Polytechnic Administration.*

Registers shall be labelled and indexed as follows:-

- a) The first part shall be given the initials KNP to denote Kitale 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 REG to denote that it is a register followed by a slash
- d) The fourth part shall be a number assigned to registers chronologically based on the subject
- e) The 5th 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: -**KNP/MR/REG/01/ VOL 1.***

- f) All registers shall be clearly titled as per the subject matter

## **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.

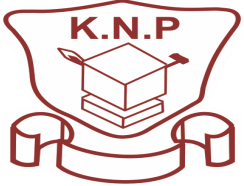
2.11.3 Records maintained in soft copy shall be protected by use of passwords and backed up as per the backup procedure.

## **2.12 Retrieval of Records**

Retrieval of records shall be as per the registry guidelines.

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

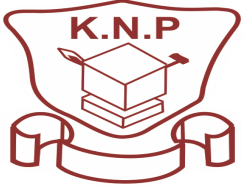
2.13.1 Records maintained in the Polytechnic shall be retained for such periods as prescribed in the Polytechnic records' retention and disposition schedule and other applicable laws.

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

### **3.0 LIST OF APPLICABLE RECORDS AND REPORTS**

- a) Document issuance form.
- b) Departmental circulation list.
- c) Quality Document Review form.
- d) Master document list.
- e) 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 consistency and effectiveness in undertaking Internal Quality Audits and Management Reviews.

#### **1.2 SCOPE**

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

#### **1.3 REFERENCES**

- a) ISO 9001:2015 Clause 9.2 and 9.3
- b) ISO 19011:2011-Guidelines for auditing QMS

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

- a) MR- Management Representative
- b) QMS- Quality Management System

#### **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) The Principal for approvals, guidance, consultation and ensuring adherence
- b) 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;

<b>PERFORMANCE TARGET</b>	<b>MONITORING AND MEASUREMENT</b>
Conducting internal quality audit and management review 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> </ol>

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	f) Management review meeting minutes
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## 1.8 RESOURCES

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

- a) Personnel
- b) Finance
- c) Time

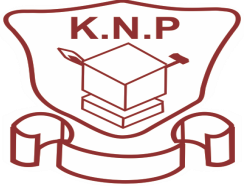
## 1.9 INPUTS AND OUTPUTS

<b>INPUTS</b>	<b>OUTPUTS</b>
<b>FOR AUDITS</b> Audit programme Audit criteria Auditors Audit forms and checklists <b>FOR MANAGEMENT REVIEW</b> Notice Agenda Minutes of previous meeting Audit report	<b>FOR AUDITS</b> Approved programme Audit report Completed forms Correction and corrective actions Improvement in decision making <b>FOR MANAGEMENT REVIEW</b> Minutes

## 2.0 METHOD

### 2.1 Planning for quality audits

- 2.1.1 The Polytechnic shall undertake at least 2 Internal Quality Audits every academic year
- 2.1.2 The MR shall prepare an internal audit programme for the whole succeeding year at the beginning of each 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. The MR shall monitor the implementation of the audit programme, review and improve as applicable.

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## **2.2 Selection of auditors and preparation for audits**

2.2.1 The MR shall;

- a) Issue a general audit notification to the auditees two weeks to an audit
- b) Appoint an audit team and a team leader/Lead auditor from the Polytechnic pool of trained auditors detailing their responsibilities

2.2.2 In appointing the team, the MR 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**

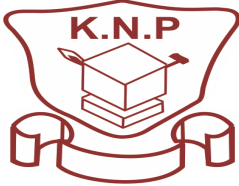
2.3.1 During the audit period, the team leader shall ensure that the audit timetable is adhered to and ensure that:-

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



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## **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. The Report shall contain:

- i. Audit objectives
- ii. Audit scope
- 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 MR shall analyse the audit findings and prepare an audit analysis report establishing trends in the Quality Management System compliance within five days of receipt

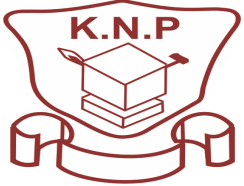
2.4.3 The MR shall discuss the audit analysis report with the Principal before tabling it in the subsequent Management Review forum for deliberations.

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

2.5.1 Corrective action determined in the 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

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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 meeting. The agenda of the meeting 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 review meeting for deliberation.

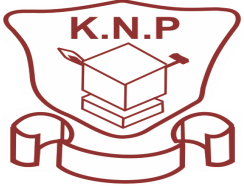
2.6.3 The respective process owner shall report on their processes performance and conformity of products and services including, effectiveness of actions to address risks and opportunities and corrective actions raised.

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

## **3.0 LIST OF APPLICABLE RECORDS AND REPORTS**

- a) Internal Auditors Appointment letters
- b) Audit checklists.
- c) Nonconformity report forms.
- d) Audit findings forms.
- e) Audit report.
- f) Audit follow up report.
- g) Management review invitation
- h) Agenda
- i) 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 Polytechnic.

#### **1.3 REFERENCES**

ISO 9001:2015 Clause 8.7.

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

HOD- Head of Department

D/P ADM- Deputy Principal Administration

D/P ACAD- Deputy Principal Academics

#### **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**

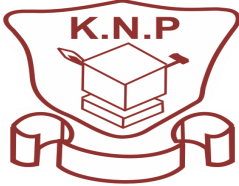
The performance shall be measured through the overall performance of the department based on;

<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

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c) Time

### 1.9. INPUTS AND OUTPUTS

INPUTS	OUTPUTS
Non conforming outputs' reports	Concessions/approvals Non conforming 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 Principal or respective Deputy 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.


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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.

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## **PROCEDURE NUMBER 4: NON-CONFORMITY 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**

QMS- Quality management system

#### **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 guidance and consultations
- b) All Departments in the Polytechnic for actions and implementation

#### **1.7 PERFORMANCE TARGET**


The performance shall be measured through the overall performance of the department 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
- c) Time

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## 1.9 INPUTS AND OUPUTS

INPUTS	OUTPUTS
Nonconformities	Corrections and corrective actions
	Improvement in decisions

## 2.0 METHOD

2.1 This procedure shall 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 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

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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 Deputy Principal (Admin) 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.



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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 LIST OF APPLICABLE RECORDS AND REPORTS**

- a) Corrective Action Notices.
- b) Report on status of corrective actions.