MAASAI MARA UNIVERSITY

QUALITY MANAGEMENT SYSTEM BASED ON ISO 9001:2008

MANDATORY PROCEDURE MANUAL

MMU/MPM/MR/2013

VERSION: A

REVISION: 0

Authorized by:	Prof. David K. Serem V.C.	**Sign:** 	**Date:** 4th June 3, 2013
Issued by:	Prof. Gerald N. Kimani MR	**Sign:** 	**Date:** 4th June 3, 2013

TABLE OF CONTENTS

PROCEDURE NUMBER 1: CONTROL OF DOCUMENTS

1.0 GENERAL

1.1 PURPOSE

The purpose of this procedure is to ensure effectiveness and consistency in the control of Quality Management System documents.

1.2 SCOPE

This procedure applies to the control of all QMS documents in the Maasai Mara University.

1.3 REFERENCES

a) Quality Manual – MMU/QM/MR/2013.

b) ISO 9001:2008 clause 4.2.3.

1.4 TERMS AND DEFINITIONS

a) HOD – Head of Department

b) MR – Management Representative

1.5 PRINCIPAL RESPONSIBILITY

The MR shall ensure adherence to this procedure.

2.0 METHOD

2.1 Generation and approval of documents

2.1.1 This shall start with a need to generate a quality management system document from any user i.e. top management, a department/section or a committee. The need may be as a result of:-

a) Customer needs,

b) Emerging technologies, or

c) Legal requirements.

2.1.2 In the event that the need arises from a department or a committee, approval to generate the document shall be sought from the University Management Board by the respective HOD/Committee chairperson.

2.1.3 In approving the need to have the document, the University Management Board shall consider:-

a) Cost of generating the document,

b) The relevance of the document to the University, and

c) Other documents available within the University that may address the need.

2.1.4 In the event of disapproval, the University Management Board shall advise the originator as appropriate.

2.1.5 Upon approval, the University Management Board shall in liaison with the user and the MR appoint a committee to generate the document.

2.1.6 On generating the document by the committee, the committee chairperson shall submit it to the MR for review and input.

2.1.7 In reviewing the document, the MR shall ascertain that the document is in line with the Quality Management System requirements.

2.1.8 Once the document is satisfactory, the MR shall forward it to the University Management Board for input.

2.1.9 Upon the inclusion of the University Management Board's input, the VC shall table the document in the Council meeting for adoption.

2.1.10 In adopting the documents the Council shall consider the following:-

a) Relevance of the document to the University ,
b) Adherence to the University policies, and
c) Effects of the document to the existing system.

2.1.11 In the event that the document requires review before adoption, the Vice Chancellor shall revert it to the committee that developed it for amendment and resubmission.

2.1.12 Once adopted by the Council, the VC shall authorize the use of the document by appending his/her signature on the space provided on the first page of the document.

2.2 Issuance of documents

2.2.1 Before issuing the documents for use, the MR shall ensure that they are identified through indexing as follows:-

a) The first part shall be assigned the initials MMU to denote Maasai Mara University followed by a slash (/).
b) The second part shall be assigned the initials of the document e.g. QP to denote the Quality Policy Statement followed by a slash(/)
c) The third part shall be assigned the initials of the user department/office followed by a slash (/).
d) The fourth part shall be assigned the year of publication.

For example MMU/QP/MR/2013 – This means that the document is the Quality Policy Statement of the Maasai Mara University controlled by the Management Representative and was published in the year 2013.

2.2.2 Upon identification, the MR shall ensure production of enough copies of the authorized document and issue copies to the users of the document.

2.2.3 To ensure legibility the MR shall ensure that the document is produced using quality materials and properly packaged to prevent it from the agents of deterioration.

2.2.4 The MR shall maintain a document issuance register and ensure that the user acknowledges receipt by signing in the register.

2.2.5 The MR shall also issue documents in Portable Document Format through the intranet.

2.3 Document amendment and re-approval

2.3.1 Any user who identifies a need to amend a QMS document shall discuss the change with the respective HOD before filling the document amendment form.

2.3.2 Upon filling the form, the HOD shall forward it to the MR for information of the proposed changes.

2.3.3 Upon receipt of the filled in form, the MR in consultation with the University Management Board shall approve the change(s) guided by the effects of the change(s) to the document and the Quality Management System.

2.3.4 In the event that there is no need to effect the change(s), the MR shall as per the communication procedure number 1 in the Administration Procedure Manual advise the HOD and the originator appropriately.

2.3.5 If the changes are approved, the committee that developed the document shall amend the document and have it approved as an original document.

2.3.6 Once the document has been re-approved, the MR shall issue it to the users in the subsequent revision and/or version. A version change shall be as a result of a fundamental change to the document whereas a revision change shall be as result of any other change except for typographical changes.

2.3.7 In issuing the revised documents, the MR shall withdraw the obsolete documents. The MR shall as per the communication procedure number 1 in the Administration Procedures Manual communicate the withdrawal and subsequent replacement of the obsolete document.

2.3.8 In the event that a user retains a document for any reason, the MR shall stamp it "OBSOLETE" to prevent its unintended use.

2.4 Control of documents of external origin

2.4.1 All documents of external origin shall be received and controlled by the Vice Chancellor's office.

2.4.2 Upon receiving a document, the Vice Chancellor's Secretary shall forward the document to the Vice Chancellor for marking to the relevant user(s).

2.4.3 The VC's Secretary shall then affix the University's stamp on the document and index it as follows:-

a) The first part shall be assigned the initials MMU to denote Maasai Mara University followed by a slash (/).

b) The second part shall be assigned the initials EXT to denote that the document is of external origin followed by a slash (/).

c) The third part shall be assigned the initials of the user department followed by a slash (/).

d) The fourth part shall be assigned a sequential document number starting with 001.

Example: MMU/EXT/PROC/001 – This is the index assigned to the Public Procurement Act (2005) maintained by the Procurement department.

2.4.4 The Secretary shall maintain a list of all documents of external origin and the user(s) issued with copies.

3.0 LIST OF APPLICABLE RECORDS

3.1 Document issuance register.

3.2 Document amendment form.

3.3 Evidence of meetings.

3.4 List of documents of external origin.

PROCEDURE NUMBER 2: CONTROL OF RECORDS

1.0 GENERAL

1.1 PURPOSE

The purpose of this procedure is to ensure effectiveness and consistency in the control of records in the University.

1.2 SCOPE

This procedure applies to the control of all records generated to provide evidence of conformity to requirements and the effective operation of the Quality Management System in the Maasai Mara University.

1.3 REFERENCES

a) Quality Manual – MMU/QM/MR/2013.
b) ISO 9001:2008 Clause 4.2.4.
c) Kenya National Archives and Documentation Act (Cap 19).

1.4 TERMS AND DEFINITIONS

a) PO – Procurement Officer.
b) HOD – Head of Department.
c) MR – Management Representative.

1.5 PRINCIPAL RESPONSIBILITY

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

2.0 METHOD

2.1 Identification of forms and registers

2.1.1 All forms shall be identified using the University's name and logo, the name of the form and indexed as follows:-

a) The first part shall be assigned the initials MMU to denote the Maasai Mara University followed by a slash (/),
b) The second part shall be assigned the initials of the department of origin followed by a slash (/).
c) The third part shall be assigned the form number to denote the subject.

For example: MMU/FIN/F 01– This is the indexing given to the Imprest form that originates from the Finance Department.

2.1.2 All registers used in the University shall be identified through indexed as follows:-

a) The first part shall be assigned the initials MMU to denote the Maasai Mara University followed by a slash (/),

b) The second part shall be assigned the initials of the Department/Office of origin followed by a slash (/).

c) The third part shall be assigned the number of the register in that department starting with R 01, where R denotes Register. The number shall denote the subject of the register.

d) The fourth part shall be assigned the volume of the register starting with VOL 1.

For example: MMU/FIN/R 01/VOL. 1– To denote the first volume of the Cheque Issuance Register maintained by the Town Treasurer's department.

2.1.3 The HOD of the department where the form/register originates shall be the custodian of the forms and registers.

2.2 Storage and protection

2.2.1 Upon generating a record, the officer generating shall forward it to the custodian of the records who shall be the process owner (officer in charge of a process).

2.2.2 On receiving the record, the custodian shall ensure that submitting officer signs the record submission register.

2.2.3 In case the record is generated from a form, the custodian shall as per records management procedure number 5 in the Administration Procedures Manual file it in the respective file.

2.2.4 To prevent the records from unauthorized access and damage, the custodian shall ensure that they remain in cabinets under key and lock.

2.2.5 Any officer generating a record in "soft" shall protect it through use of a password and ensure that the record is backed up as per the backup and restoration procedure number 4 in the ICT Procedures Manual.

2.3 Retrieval of records

2.3.1 This shall start with the custodian of the record receiving a request from an officer to access a record.

2.3.2 The custodian shall determine whether the requesting officer is authorized to access the record.

2.3.3 In the event that the officer is not authorized to access the record, the custodian shall advise him/her to seek authority from the relevant office.

2.3.4 If the officer has authority to access the record, the custodian shall issue the requesting officer with the record and have him/her sign the record movement register.

2.3.5 Upon return of the record after use, the custodian of the records shall ensure that the officer signs the record movement register.

2.3.6 In the event that record is not returned within the agreed upon time, the custodian shall make a follow up and have the record returned.

2.4 Retention and disposition of records

2.4.1 Upon expiry of the retention period of a record as stipulated in the University College's record retention schedule, the custodian of the records shall in consultation with the Registry Clerk archive them.

2.4.2 Guided by the University's record retention schedule and the Public Procurement and Disposal Act of 2005 and its guidelines of 2006, the Registry Clerk shall in liaison with the PO dispose the archived records as per the disposal of assets number 5 in the Procurement Procedures Manual.

3.0 LIST OF APPLICABLE RECORDS

3.1 Record submission register.

3.2 Record movement register.

PROCEDURE NUMBER 3: INTERNAL QUALITY AUDIT

1.0 GENERAL

1.1 PURPOSE

The purpose of this procedure is to ensure effectiveness and consistency in internal quality auditing.

1.2 SCOPE

This procedure applies to the planning and conducting of all internal quality audits in the Maasai Mara University.

1.3 REFERENCES

a) Quality Manual – MMU/QM/MR/2013.
b) ISO 9001:2008 Clause 8.2.2.
c) ISO 19011:2002.

1.4 TERMS AND DEFINITIONS

a) MR – Management Representative.

1.5 PRINCIPAL RESPONSIBILITY

The MR shall ensure that this procedure is adhered to.

2.0 METHOD

2.1 General

The University shall conduct two (2) internal quality audits in a financial year.

2.2 Planning for Internal audits

2.2.1 This shall start with the MR preparing an audit programme at the beginning of each financial year.

2.2.2 In coming up with the audit programme, the MR shall consider the following:-

a) Status and importance of the processes and areas to be audited.
b) Results of the previous audits (as applicable)
c) University's calendar of events.
d) Budgetary allocation.

2.2.3 Upon preparing the audit programme, the MR shall forward it to the VC for input and approval.

2.2.4 In approving the audit programme, the VC shall be guided by the criteria in 2.2.2 above.

2.2.5 In the event the audit programme is not satisfactory, the VC shall give recommendations and return it to the MR for correction and resubmission.

2.2.6 On approval, the VC shall return the programme to the MR for implementation.

2.2.7 At least a month to the audit date, the MR shall in consultation with the VC appoint an audit team leader and a team of auditors from the pool of trained auditors and as per the communication procedure number 1 in the Administration Procedures Manual inform them of the appointment.

2.2.8 At the time of appointing the audit team, the MR shall also as per the communication procedure number 1 in the Administration Procedures Manual issue a general notification to the process owners on the upcoming audit.

2.3 Auditors' preparation

2.3.1 On appointment, the MR in liaison with the audit team leader shall as per the meetings procedure number 4 in the Administration Procedures Manual convene a meeting with the audit team members to plan for the audit.

2.3.2 During the meeting the MR shall issue the audit team with the audit criteria.

2.3.3 In planning for the audit, the meeting shall:-

a) Share out responsibilities during the audit,
b) Prepare an audit plan, and
c) Prepare and agree on the audit checklists.

2.3.4 The audit team leader shall ensure that the auditees are issued with an audit plan at least seven days to the audit.

2.3.5 Prior to the audit, the MR shall prepare audit forms and avail them to the audit team. The forms shall include:-

a) Opening/Closing meeting attendance form,
b) Audit findings form, and
c) Corrective action request forms.

2.4 Conducting the audit and reporting results

2.4.1 On the audit date, the audit team leader shall ensure that the audit is conducted as per the timetable and in liaison with the MR address any issues arising.

2.4.2 The audit team leader shall ensure that an audit report is prepared and submitted to the MR and the auditees within a week after the audit.

2.4.3 On receipt of the audit report, the MR shall analyze it highlighting the areas of common deficiency and forward a copy to the VC for information.

2.5 Undertaking corrective actions and audit follow up

2.5.1 The management of the area audited shall ensure that corrections and corrective actions for the nonconformities identified during the audit are undertaken within two weeks after the audit.

2.5.2 After the elapse of the timeframe for undertaking the corrective actions, the audit team leader shall ensure the audit team undertakes an audit follow up to determine whether actions were taken on the nonconformities identified.

2.5.3 The audit team leader shall ensure that the audit team prepares and submits an audit follow up report to the MR on the status of the corrective actions within three working days of the audit follow up.

2.5.4 The MR shall ensure that the audit records are maintained as per the records control procedure number 2 in this manual.

2.5.5 During the subsequent management review the MR shall present the audit summary report and the status of the corrective action(s) taken.

2.6 Audit close out

2.6.1 The MR shall ensure that auditors close out the audit during the subsequent internal quality audit by determining the effectiveness of the corrective actions taken.

2.6.2 In the event that the action(s) taken were not effective, the auditors shall raise another Corrective Action Request Form and the procedure shall continue as from 2.5 above.

3.0 APPLICABLE RECORDS

3.1 Audit findings form.

3.2 Corrective Action Request Form.

3.3 Records of attendance of opening and closing meetings.

3.4 Audit checklists.

PROCEDURE NUMBER 4: CONTROL OF NONCONFORMING PRODUCTS

1.0 GENERAL

1.1 PURPOSE

The purpose of this procedure is to ensure effectiveness, timeliness and consistency in controlling nonconforming products.

1.2 SCOPE

This procedure applies to the control of all nonconforming products identified in Narok University College to prevent their unintended use or delivery.

1.3 REFERENCES

a) Quality Manual – MMU/QM/MR/2013.

b) ISO 9001:2008 Clause 8.3.

1.4 TERMS AND DEFINITIONS

a) MR – Management Representative.

b) HOD – Head of Department.

1.5 PRINCIPAL RESPONSIBILITY

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

2.0 METHOD

2.1 This procedure shall start with any member of staff either:-

a) Identifying a nonconforming product in the course of service provision, or

b) Receiving information on a nonconforming product from the customer.

2.2 Upon 2.1(a) above, the member of staff shall inform the concerned HOD who shall in turn carry out investigation to determine the extent of the nonconformity.

2.3 After the investigation, the concerned HOD shall determine the action to be taken to deal with nonconforming product and where need be consult the VC.

2.4 In the event that the action determined is to correct the nonconforming product, the HOD shall ensure that the product is re-verified before it is delivered to the customer(s).

2.5 In the event the nonconforming product is identified after delivery or in the course of delivery, HOD shall as per the communication procedure number 1 in the Administration Procedures Manual inform the VC the nature of the nonconforming product.

2.6 Upon receipt of the information, the VC in consultation with the HOD shall determine the action to be taken.

2.7 The VC shall as per the communication procedure number 1 in the Administration Procedures Manual inform the customer(s) of the action the University has taken to address the effects of the nonconforming product.

2.8 The VC shall ensure that the identified action is taken to address the nonconforming product.

2.9 The HOD shall ensure that a corrective action is taken as per the procedure on corrective action number 5 in this manual to ensure the nonconformity does not recur.

2.10 The respective HOD shall maintain records of the nature of nonconforming products and the action(s) taken to address them in the nonconforming products register.

3.0 LIST OF APPLICABLE RECORDS

3.1 Nonconforming products register.

3.2 Evidence of communication.

PROCEDURE NUMBER 5: CORRECTIVE ACTION

1.0 GENERAL

1.1 PURPOSE

The purpose of this procedure is to have a defined method in applying corrective actions to eliminate the causes of non-conformities on the established Quality Management System.

1.2 SCOPE

This procedure covers the collection of data on non-conformities, analysis of the root cause of nonconformities and action planning to prevent recurrence of the nonconformities in University.

1.3 REFERENCES

a) Quality Manual – MMU/QM/MR/2013.

b) ISO 9001:2008 Clause 8.5.2

1.4 TERMS AND DEFINITIONS

a) CAN – Corrective Action Notice.

b) CARF – Corrective Action Request Form.

1.5 PRINCIPAL RESPONSIBILITY

The MR shall ensure that this procedure is adhered to.

2.0 METHOD

2.1 This procedure shall start with a HOD either:-

a) Identifying a nonconformity in the course of duty, or

b) Receiving information on a valid customer complaint from the integrity committee, or

c) Receiving information from any member of staff on a nonconformity.

2.2 The HOD shall in liaison with the MR and where need be the originator and the affected member of staff review the nonconformity to establish its magnitude and the root cause(s).

2.3 Upon identifying the root cause(s) the MR in consultation with the affected HOD and where need be the VC shall evaluate the need for corrective action considering the following:-

a) Effects of the nonconformity,
b) Cost implications in undertaking corrective actions, and
c) Frequency of the nonconformity.

2.4 In the event there is no need for action(s), the HOD shall ensure that a correction is undertaken and matter closed.

2.5 In case there is need to undertake a corrective action, the MR shall raise CAN and through the HOD forward it to the concerned member of staff.

2.6 Upon receipt of the CAN, the affected member of staff shall in liaison with the HOD/Supervisor determine the action(s) to take to prevent recurrence of the nonconformity and the time frame for undertaking the action.

2.7 The HOD shall ensure that the corrective action is implemented within the agreed upon time and records of the results maintained.

2.8 Upon expiry of the timeframe for undertaking the corrective action, the MR shall confirm whether the action(s) was taken.

2.9 In the event that action was not taken, the MR shall raise another CAN and the procedure shall continue as from 2.6 above.

2.10 If action was taken, the MR shall note in the CAN that the action was taken.

2.11 During internal audits, the MR shall ensure that auditors review the nonconformities identified within the period under review to determine whether the action(s) was effective.

2.12 In the event that the action(s) taken was not effective, the auditors shall raise CARFs and the procedure shall continue as per the internal audit procedure number 3 in this manual.

2.13 If the corrective action was effective, the auditors shall complete the CAN, return it to the MR for safe custody.

2.14 During every management review meeting, each HOD shall table a report the status of corrective actions for the period under review.

3.0 LIST OF APPLICABLE RECORDS

3.1 Corrective Action Notices.

3.2 Evidence of communication.

PROCEDURE NUMBER 6: PREVENTIVE ACTION

1.0 GENERAL

1.1 PURPOSE

The purpose of this procedure is to have a defined method in applying preventive actions to eliminate the cause of potential non-conformities on the established Quality Management System.

1.2 SCOPE

This procedure covers the collection of data on potential non-conformities, analysis of the potential root causes of nonconformities and action planning to prevent occurrence of non-conformities in the University.

1.3 REFERENCES

a) Quality Manual – MMU/QM/MR/2013.

b) ISO 9001:2008 Clause 8.5.3.

1.4 TERMS AND DEFINITIONS

a) MR – Management Representative

b) PAN – Preventive Action Notice

1.5 PRINCIPAL RESPONSIBILITY

The MR shall ensure that this procedure is adhered to.

2.0 METHOD

2.1 This procedure shall start with a HOD either:-

a) Identifying a potential nonconformity in the course of duty, or

b) Receiving information from any member of staff on a potential nonconformity.

2.2 Upon 2.1 above, the HOD concerned shall investigate and determine the causes of the potential nonconformities in consultation with the departmental staff.

2.3 Upon determination of the causes, the HOD shall in consultation with MR and where need be the VC evaluate the need for action to prevent occurrence of the potential nonconformity considering:-

a) Potential effects of the nonconformity,

b) Probability of occurrence, and

c) Cost of undertaking preventing action(s).

2.4 In the event that there is no need for action, the MR shall drop the matter and communicate to the originator where applicable.

2.5 In case there is need to undertake a preventive action, the MR shall raise PAN and through the HOD forward it to the concerned member of staff.

2.6 Upon receipt of the PAN, the concerned member of staff shall in liaison with the HOD/Supervisor determine the action(s) to take to prevent occurrence of the potential nonconformity and the time frame for undertaking the action(s).

2.7 The HOD shall ensure that the preventive action is implemented within the agreed upon time and records of the results maintained.

2.8 Upon expiry of the timeframe of undertaking the preventive action, the MR shall confirm whether the action(s) was taken.

2.9 In the event that action was not taken, the MR shall raise another PAN and the procedure shall continue as from 2.6 above.

2.10 If action was taken, the MR shall ascertain that in the PAN.

2.11 During internal audits, the MR shall ensure that auditors review the potential nonconformities identified within the period under review to determine whether the action(s) was effective.

2.12 In the event that the action(s) was not effective, the auditors shall inform the MR who shall in turn raise another PAN and the procedure shall continue as from 2.6 above.

2.13 If the preventive action was effective, auditors shall complete the PAN, return it to the MR for safe custody.

2.14 During every management review meeting, each HOD shall table a report the status of preventive actions for the period under review.

Note: On a quarterly basis, the MR shall ensure that each department conducts a risk assessment to determine potential nonconformities and address them as per the above procedure.

3.0 LIST OF APPLICABLE RECORDS

3.1 Preventive Action Notice.

3.2 Evidence of communication.