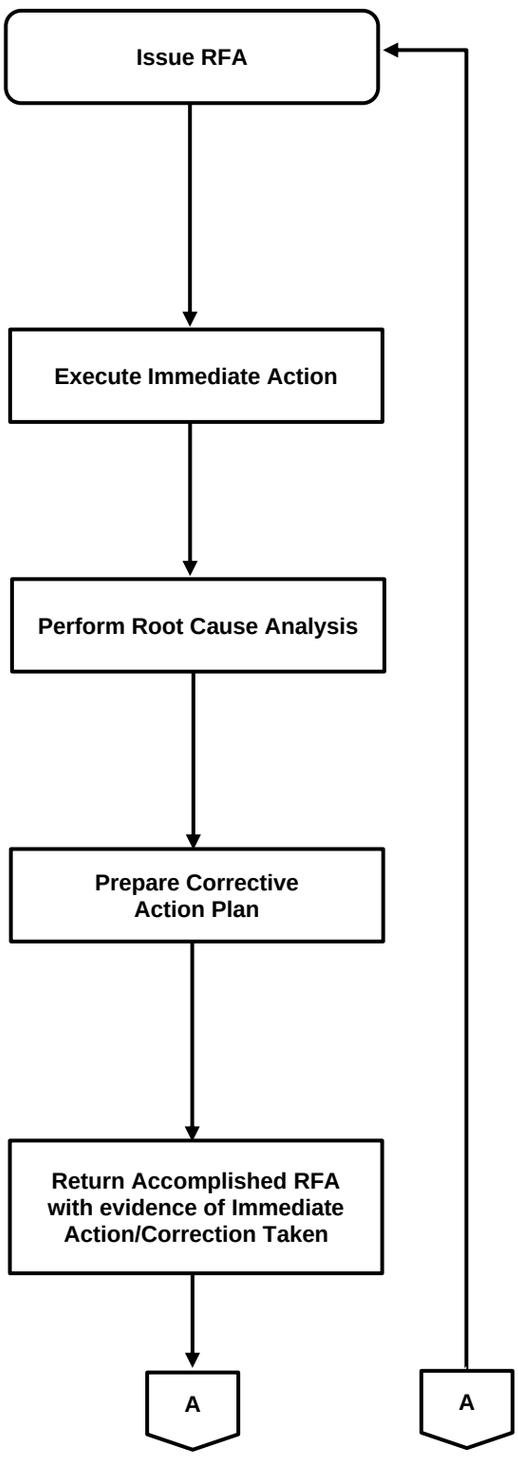
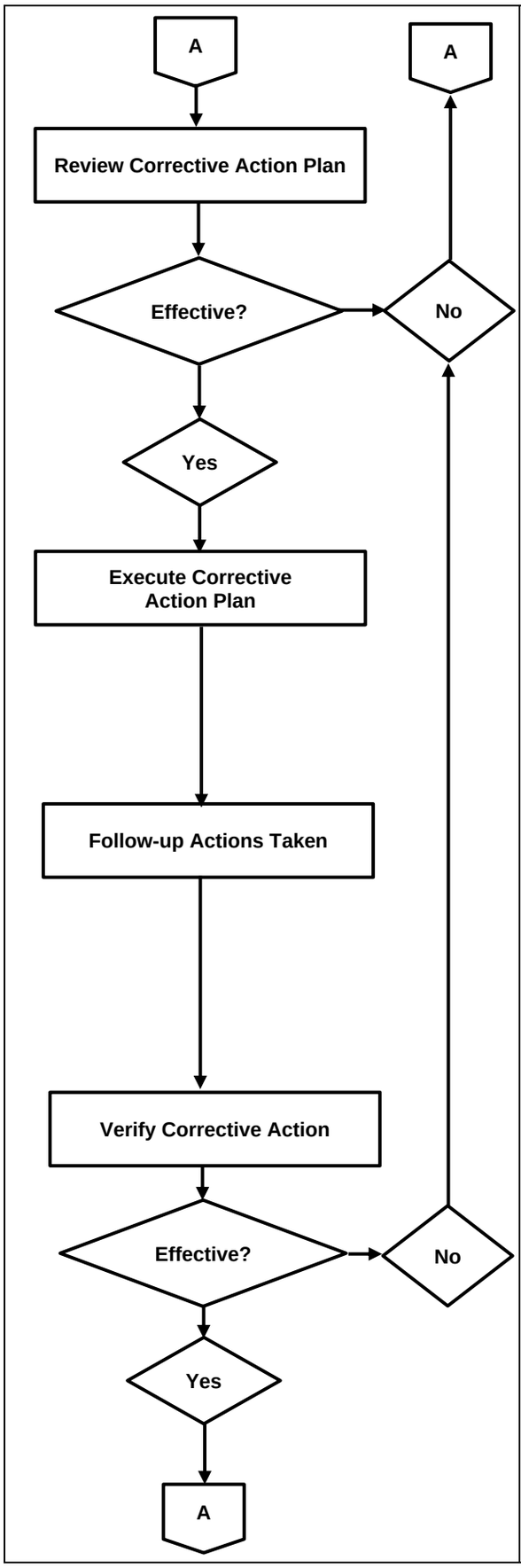
STANDARD OPERATING PROCEDURE

TITLE	**PROCESSING OF REQUEST FOR ACTION**
SCOPE	This covers the procedure for processing of Request for Action, commencing at the issuance of RFA form to the process owners and culminating at the closure of the audit findings.
OBJECTIVES	To ensure timely and effective processing of request for action as a significant part of the continual improvement of the management system

Activity	**Persons Responsible/ Activity Details/Interface**
	The internal auditors and/or lead auditor issue the Request for Action to the concerned process owner within one (1) day after the finalization of the audit report. Refer to: • FM-IQA-004 (Audit Report) • FM-IQA-005 (Audit Report Summary) • FM-QMS-010 (Request for Action Form) • FM-IQA-006 (Request for Action Monitoring Log) The process owner executes immediate action/correction to address the audit observation, and ensures the preparation and retention of the documented information as evidence of the immediate action/correction. Refer to: • FM-QMS-010 (Request for Action Form) The process owner performs root cause analysis through the Fish Bone Diagram and/or the 5Why Methods, to determine the root cause of the audit finding and the officer responsible for crafting the corrective action plan. Refer to: • FM-QMS-010 (Request for Action Form) • FM-IQA-014 (Root Cause Analysis Form) The responsible officer prepares the corrective action plan to address the root cause of the audit finding, and avoid the recurrence of such finding. The corrective action plan should clearly identify the step-by-step activities, person/s responsible, timeframe, and resources needed. Refer to: • FM-QMS-010 (Request for Action Form) The process owner returns the accomplished RFA form with the evidence of immediate action taken to address the audit finding, together with the accomplished Root Cause Analysis Form, within ten (10) days after the issuance of the RFA form. Refer to: • FM-QMS-010 (Request for Action Form) • FM-IQA-014 (Root Cause Analysis Form)



The lead auditor reviews the corrective action plan and evaluates its effectiveness to address the root cause of the audit finding and to avoid the recurrence of the said finding, within five (5) days upon return. If not effective, the lead auditor provides reason for the decision on the Review Section of the RFA Form, and issues a new RFA Form to the process owner/responsible officer for the preparation of a new corrective action plan. The process then restarts at the issuance of the RFA. Refer to:

- FM-QMS-010 (Request for Action Form)
- FM-IQA-014 (Root Cause Analysis Form)
- FM-IQA-006 (Request for Action Monitoring Log)

If effective, the execution of the corrective action plan follows based on the timeframe identified. The responsible officer ensures the preparation and retention of all documented information as evidence of the execution of the corrective action plan. Refer to:

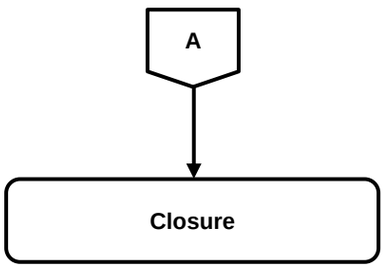
- FM-QMS-010 (Request for Action Form)

The lead auditor conducts follow-up to determine the status of the step-by-step activities in the corrective action plan. This shall be done quarterly in conjunction with the internal audit schedule. The lead auditor records follow-up status/remarks in the Follow-up Section on the second page of the RFA form, and collects the evidence for the actions taken. Refer to:

- FM-QMS-010 (Request for Action Form)
- FM-IQA-006 (Request for Action Monitoring Log)

Based on the timeframe of the last activity identified in the corrective action plan, the lead auditor conducts verification of the corrective action plan, reviews the evidence for the action taken, and evaluates whether the root cause has been addressed. If not, the lead auditor provides reason for the decision, and issues a new RFA Form to the process owner/responsible officer for the preparation of a new corrective action plan. The process then restarts at the issuance of the RFA. Refer to:

- FM-QMS-010 (Request for Action Form)
- FM-IQA-006 (Request for Action Monitoring Log)

	If the lead auditor finds the corrective actions taken effective in addressing the root cause, and avoiding the recurrence of the audit finding, the request for action is closed out. Refer to: • FM-QMS-010 (Request for Action Form) • FM-IQA-006 (Request for Action Monitoring Log)

DEFINITION OF TERMS

IQA – Internal Quality Audit
RFA – Request for Action

LIST OF DOCUMENTS USED

FM-IQA-004 (Audit Report)
FM-IQA-005 (Audit Report Summary)
FM-QMS-010 (Request for Action Form)
FM-IQA-006 (Request for Action Monitoring Log)

LIST OF RECORDS GENERATED

QR-IQA-003 (Requests for Action)

Prepared by:	**Reviewed and Approved by:**
JOPET VINCENT B. MEDALLA	**SHIRLEY G. DICEN**
Lead Auditor	ISO Head
Date Signed:	**Date Signed:**

AUDIT REPORT

I. Date and Place of the Internal Audit

II. Objectives

1. To determine the adequacy of the documented quality management system;
2. To verify compliance and adherence to quality policy;
3. To verify achievement of objectives and targets;
4. To determine conformance to the requirements of ISO 900l:2015 standard, and other existing statutes, rules & regulations; and
5. To determine areas for improvement on all processes

III. Internal Audit Criteria

Audit Criteria are as follows:

1. ISO 9001:2015
2. Quality Manual
3. Quality Objectives
4. Operations (Procedures) Manual
5. Statutory and Regulatory Laws Affecting the Organization

IV. The Audit Scope

Area/Department Audited	Auditor	Auditee

V. Good Observations/Conformities:

Good Observations/Conformities	Area/Department
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

AUDIT REPORT

VI. Summary of Non-Conformities

Ref. No.	Clause No.	Non-Conformities	Major/Minor	Area/Dep't
1				
2				
3				
4				
5				
6				
7				

VII. Potential Non-Conformities/Opportunities for Improvements

Ref. No.	Clause No.	Particulars	Area/Dep't
1			
2			
3			
4			
5			
6			
7			

Prepared by:

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Internal Auditor

	Republic of the Philippines **SORSOGON STATE UNIVERSITY** **Quality Assurance Office** **ISO – Internal Quality Audit Unit** *Magsaysay Street, Salog (Pob), Sorsogon City, Sorsogon* Tel. No.: 056 211-0103; Email Add: qa.iso@sorsu.edu.ph	Doc. Code: **FM-IQA-010**
		Effectivity Date: **November 3, 2023**
		Revision No: **00**
	AUDIT REPORT SUBMISSION LOG	Page No.: **1 of 1**

Place of Audit:	
Date of Audit:	
Name of Team Leader:	

No.	Name of Internal Auditor	Assignment	Date of Submission
1	Dr. Leny D. Berdin		
2	Ms. Sherlyn B. Cendaña		
3	Prof. Sherly G. Dicen		
4	Prof. Maricel A. Dichoso		
5	Ms. Maria Cristina B. Ditan		
6	Ms. Erlinda P. Enguerra		
7	Prof. Aldrin John J. Estonanto		
8	Dr. Ma. Sylisa J. Estur		
9	Mr. Johnnel D. Francisco		
10	Ms. Mary Joy P. Garbo		
11	Dr. Sherill A. Gilbas		
12	Prof. Sheryl A. Gregory		
13	Ms. Beatrice S. Hizola		
14	Prof. Roman Julio B. Infante		
15	Mr. Nestor L. Lasala Jr.		
16	Engr. Ronalyn T. Marbella		
17	Dr. Sharon D. Mariano		
18	Mr. Jopet Vincent B. Medalla		
19	Prof. Maria Flora J. Renovalles		
20	Dr. Mae H. San Pablo		
21	Dr. Diana V. Sales		
22	Engr. Rap Anthony D. Tatad		
23			
24			
25			

Prepared by:

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Team Leader

I. Date and Place of Internal Audit:

January 15 – 18, 2024 | Sorsogon State University

II. Good Points:

- **Bulan Campus**
  1. The commitment of the auditees in implementing the QMS is commendable.
  2. The Campus Director is well-aware of the operational processes of the office and campus.
  3. Most offices are clean, organized, and conducive for productive office works.
  4. Generally, the auditees have updated trainings relevant to their designation showcasing commitment to continual improvement.
  5. The BME program initiatives to comply with CMO guidelines and standards is commendable: all BME programs have COPC.
  6. The faculty members of BS ENTREP program are all permanent and full pledged masteral degree holder.
  7. The BSAIS passing percentage for Certified Tax Technician is above 90% which is commendable.
  8. Research targets for 2023 were met exceedingly (185%).
  9. The faculty members and students are involved in extension projects.
  10. The from-birth-to-grave documentation of student activities is impressive.
  11. Student organizations promptly submit accomplishment reports and terminal report of activities.
  12. Medical and dental records of faculty and students are properly documented and properly kept in an organized manner.
  13. Ongoing construction of infrastructure projects such as admin bldg. (where Sports Unit office will be placed) to perform its functions and achieve its objectives is noteworthy.
  14. The GAD Office of Bulan Campus has established a Gender Focal Point System effective December 28, 2023, indicating a structured approach to gender-sensitive practices and in compliance with RA 9710 or the Magna Carta for Women.
  15. Gender-disaggregated data is being collected.
  16. The office conducts DRR related training to students and faculty every semester.

- **Castilla Campus**
  1. The auditees/process owners are well-oriented and knowledgeable of their work and field of assignments.
  2. The auditees/process owners are open to continued improvement.
  3. Documents are well-filed and can be conveniently and quickly located.
  4. Offices are clean and refreshing.
  5. The Campus has strategically mounted preventive maintenance checklist beside each equipment.
  6. The SSU Castilla Campus, administrator, faculty members and staff are very accommodating.
  7. The stakeholders are actively involved in the operational planning of the campus.

- **Magallanes Campus**
  1. Young, and highly trainable faculty members in BSF program where 58% of faculty members are about to finish their master's degree to comply with the CMO for qualification of faculty members.
  2. GAD bulletin board and advocacy pamphlets are available in the office.

3. The GAD office is spacious and well-maintained.
4. Office orders are readily available.
5. Medical records of faculty and students are well organized.
6. The librarian is knowledgeable of her functions.
7. The library is well-organized.
8. Auditees were very accommodating in providing documents requested.
9. The coordinators commitment in implementing and maintaining the QMS is commendable.
10. The offices observe cleanliness and orderliness.
11. Documents are in place.
12. There are vibrant student activities, programs and projects.

- **Sorsogon City Campus**
  1. SGS- The Office Dean commits to further improve their unit's processes, The portfolio documents are organized and are readily available for inspection. Part-time faculty members also submit portfolio documents.
  2. Education & Midwifery- Portfolio documents are packaged neatly available. 100% of faculty members have updated licenses and 90% are with permanent appointment. Licensure performance of BEED and BSED is commendable. (98.14% and 86.20% for CY 2023)
  3. Engineering and Architecture- Clean, Offices, Comfort rooms and other facilities. Monitoring report of attendance of faculty holding their classes is a good practice.
  4. Business Management- The Dean and Program Chair have positive perception of ISO standards and are generally accommodating during the internal audit of the College.
  5. Reports/records are stored in cloud; maintenance of monitoring log for research submitted, approved, and published. The personnel showed positive attitude towards ISO standards.
  6. The university was able to meet its targets for research and extension for FY 2023
  7. Supply - Supply & BAC (Mr. Acosta) no irregularities on the preparation of documents, no missing supporting documents and date and signatures considered)- all in order
  8. HRMDO- Faculty members are sent to various national and international learning and development activities. The Learning and Development Plan is a consolidation of L & D of campuses.

III. Audit Findings:

Ref No.	Clause No.	Details of any finding(s) raised.	Type (Major NC, Minor NC, OFI or AoC)
1	4.1	The documents pertaining to the context of the organization are not updated (Planning).	Minor
2	6.1	No risk register (NSTP-Bulan, GAD-Magallanes, DRR-Bulan, ILDO-Magallanes)	Minor
3	6.2	a. The quality objectives are not consistent with the functions identified in the Terms of Reference (OVPAA, OVPA) b. Need to include annual and operational as part of the quality management system. (OVPRET) c. The quality objectives and planning are not completely effective (the QOP did not include item	Minor

AUDIT REPORT SUMMARY

		9,12,19 of the terms & reference of the Dean). (COT – Dean's Ofice) d. The process flow stated in the SOP is not consistent with the QOP, office order and actual processes. (General Services & Maintenance) e. The quality objectives and planning of the library services are not completely effective (Inventory was not included in the QOP). (Library Services) f. Need to update the QOP consistent with the Terms of Reference. (ILDO Unit) g. The ORD's QOP does not include items 7 and 9 of the terms and reference (office order). (Office of Research and Development) h. The functions, roles and processes of the local BAC office are not clearly defined and not standardized/common to all campuses. (BAC)	
4	7.2	The control of competency was not effective. 1. Three faculty members have expired licenses (College of Technology): a. Julie Ann M. Betes b. Jona L. Jaso c. Caroline Hamor 2. There is a need to hire masteral degree graduate in BSA and BSAIS since only 2 of the required faculty are holder of advanced degree. The 3 faculty members are temporary. (BME) 3. As the new program being offered, a full time/full pledge/permanent faculty members are needed to complete the faculty requirements based from the PSG. (Program Chair Office – BSAgribusiness) 4. There is only 65% of full pledge/full time faculty with master's degree. This is inconsistent with the PSG of BSA faculty requirements of 75%. (Program Chair) 5. To provide for an additional licensed guidance counselor to cater to the needs of the students. (GUC) 6. The master's degree of 415 faculty is MBA; only Ms. Jacob is enrolled in MA in International Tourism; 2 out of 5 have NCII Tourism Promotion/Travel Service and only 2 out of 5 have NCII Events Management. (CBM - Tourism)	Minor
5	8.5.1 7.5.3	The control of operations on teaching and learning was not effective: 1. Timely submission of complete and accurate teaching and learning documents is not observed: a. In the sampled portfolio of Dr. Led Despuig, no rubrics and IMs were included. (CBME) b. The 2nd sem 2022-2023 2nd 1st sem 2023-24 portfolio of faculty are not yet available. (CBME) c. Class observations documents are not yet submitted/available. (CBME)	Minor

		d. Student grading system was inconsistent with what is in the Student handbook: e.g. grading system in syllabi of Ms. Gloriane Delmonte in the subject Resource Mgt; Ms. Abegail Fulgar in the subject Entrep Behavior – participation is 10% which should include attendance. (CBME) e. The references used by the following faculty members needs to be revisited: Ms. Gloriane Delmonte in the subject Resource Mgt- outdated references in the year 2006, 2009 by Cook Mendoza and Abramson; There is a need to update 2018 references of Mr. Ambrose, Ms. Bongalonta, Mrs. Militante; Mr. Allyboy Militante references in Project Management is only 4, Need to add a reference to comply with 5 as required; Mr. Deo Geocada references in Kontekstwalisadong Komunikasyon are outdated- 2014, 2018; The references of Dr. Led Despuig in the subject Social Entrep is only 2, Need to add 3 more; Need to check signatories of syllabi: Mr. Ambrose, Mr. Militante (CBME) f. Hard copies of faculty portfolio of College of Education and Midwifery and College of Engineering and Architecture for 1 st Sem 2023-2024 are not yet submitted (CoTEdM) g. Most of the faculty members do not have grading sheets, TOS, copy of midterm and final exam (Educ-Magallanes) h. PDS, PRC licenses, and TORs of faculty members are not available (Educ-Magallanes). i. Class program for 2nd Sem 2022-2023 and the rest of portfolio of the following are not available: Mr. Malto, Ms. Belgica, Ms. Legarde, Ms. Bailon, and Mr. Calaminos (Fisheries-Magallanes) j. No portfolio submitted for 1st Sem 2023-2024 for Mr. Malto, Ms. Belgica, Mr. Cayetano (Fisheries) k. No syllabus presented for 2nd sem 2023-2024 yet (Fisheries-Magallanes) l. The coverage of exam for Midterm was not completed/met evidence vis-a-vis the coverage planned in the course outline: Syllabus of Mr. Galapon on Environmental Science (1st Sem 2023-2024), No signature in class record and no grading sheets submitted (Fisheries-Magallanes).	

		m. Document to show that the incomplete requirements of the class for BSF 4 need to be compiled. The whole class was incomplete (Fisheries-Magallanes). n. Some references in the syllabus of Jose Pamparo are outdated Principle of Crop Production 2017 and Crop 4 (2017), Faculty workload for 2nd Semester 2023-2024 not yet available. (Program Chair-BSA). o. There is no turnover of documents from the previous Program Chair to the new Program Chair of the Program being audited. (QMS forms, faculty portfolio, Syllabi, FWL, Teachers and class Program. (Program Chair Office - BSAgribusiness) p. Hard copies of faculty portfolio of College of Education and Midwifery and College of Engineering and Architecture for 1 st Sem 2023-2024 are not yet submitted (CoTEdM) q. Most of the faculty members do not have grading sheets, TOS, copy of midterm and final exam (Educ-Magallanes) r. PDS, PRC licenses, and TORs of faculty members are not available (Educ-Magallanes). s. Class program for 2nd Sem 2022-2023 and the rest of portfolio of the following are not available: Mr. Malto, Ms. Belgica, Ms. Legarde, Ms. Bailon, and Mr. Calaminos (Fisheries-Magallanes) t. No portfolio submitted for 1st Sem 2023-2024 for Mr. Malto, Ms. Belgica, Mr. Cayetano (Fisheries) u. No syllabus presented for 2nd sem 2023-2024 yet (Fisheries-Magallanes) v. The coverage of exam for Midterm was not completed/met evidence vis-a-vis the coverage planned in the course outline: Syllabus of Mr. Galapon on Environmental Science (1st Sem 2023-2024), No signature in class record and no grading sheets submitted (Fisheries-Magallanes). w. Document to show that the incomplete requirements of the class for BSF 4 need to be compiled. The whole class was incomplete (Fisheries-Magallanes). x. There are no available textbooks / IMs for laboratory/shop subjects for Mechanical	

		Technology published for the last 5 years in the library. (COT (WAF) y. The curriculum plotting of Mr. Del Ayre in the syllabus was not appropriately executed vis-à-vis program outcomes/objectives, teaching strategies and materials are repetitive for all topics all throughout the semester, and topics are listed in the midterm TOS do not directly reflect the topics stated for syllabus. (COT-WAF) z. All three (3) area chairs of the college are given subjects/load exceeding the maximum required load as per faculty manual. (COT – Dean / Area Chairs) aa. One (1) Faculty member is handing subject that is not vertically aligned to his specialization (Elmer Esplana). (COT – Area Chairs / Faculty / Dean) bb. Five (5) permanent faculty members did not submit the required portfolio (2nd Semester 2023) (Araya, Balgemino, Esplana, Garcia, Decano). (COT – Dean / Area Chairs / Faculty) cc. Prof. Lacson, Dulce has no submitted portfolio for the 2nd Semester 2022-2023. (CMB - Entrep) dd. Mr. Guidez, Roberto has no class record submitted, only class attendance (for 2nd Semester A.Y 2022-2023). (CMB - Entrep) ee. Ms. Estajera has class record but the raw scores/itemized scores per quiz / other indicators are not reflected in the record; no preserved class record for 1st Semester A.Y 2022-2023 with raw scores. (CMB - Tourism) 2. There were unmet targets for licensure examination performance (2023 target: 57%) – (Planning) a. BS Architecture - 29.73% b. BS Civil Engineering - 56% c. Master Plumber - 47.76% d. BS Accountancy (Sor) – 29.41% e. BS Accountancy (Bulan) – 40% f. BS Fisheries (Mag) – 41.67% g. BS Agriculture (Cas) – 17.11%	
6	8.5.2	The tracing of graduate employability per delivery unit was not effective. The graduate employability target for the years identified were not met: a. Sorsogon City (SY 2021-2022)	Minor

AUDIT REPORT SUMMARY

		b. Bulan (SY 2019-2022) c. Castilla (SY 2019-2022) d. Magallanes (SY 2019-2022)	
Bulan Campus			
1	7.5	a. There is a need to review and revise to ensure the completeness of the details of the QMS forms (PLM, QAO). b. The documents aligned with the QMS are filed and coded. (Planning) c. There is a need to review and revise to ensure the completeness of the details of the QMS forms. (Planning) d. The QMS documents presented were not reviewed and approved. (Planning) e. The Dean can improve how he organizes its units QMS documents (i.e. Coding, sequence of masterlist). (CICT - Dean) f. The documents aligned with the QMS are filed and coded. (Planning) g. Ensure that the university Annual GAD Plan for FY 2023 is signed. (GAD) h. No Operational Plan for 2024. (DRR) i. The storage is not very organized, materials & goods are sorted but not properly labelled according to types of substance, expiration date, functioning/not functioning materials/equipment. (Supply) j. The QOP form is unsigned and the auditee can't provide the office order/TOR. (Registrar) k. Need to ensure that forms used by the unit is coded and updated. Include the existing forms in the master list of forms. Need to ensure that effectivity of the SOP and procedures in the master lists are the same. Ensure that coding of forms is correct and updated. Include the accomplished recruitment form in the master list of Quality Records. (Sports, Culture and Arts Unit) l. No updated inventory of Sports Equipment. (Sports, Culture and Arts Unit) m. Consider revising the Quality Objectives Plan based on the Standard Operating Procedures. (Sports, Culture and Arts Unit) n. Log Sheet entries are incomplete/inconsistent. (Office of Admission Services) o. Absence of signature in the QMS and SOP. (Cashier Department) p. Need to follow the DCC Guidelines and the proper coding, labelling of the documents as well as the dissemination/distribution of documents. (Records Office) q. Absence of signature in the QMS and SOP. (Accounting Department)	OFI

AUDIT REPORT SUMMARY

		r. There is a need to review and revise to ensure the completeness of the details of the QMS forms. (Planning) s. There is a need to provide a logbook of transactions. t. There is no record of incoming and outgoing documents. (QAO) u. The documents aligned with the QMS are not filed and coded. (QAO) v. There is a need to review and ensure the completeness of the details of the QMS forms. (QAO) w. The QMS documents presented were not reviewed and approved. (QAO) x. The QMS documents presented were not reviewed and approved. (Planning) y. The Dean can improve how he organizes its units QMS documents (i.e. Coding, sequence of masterlist). (CICT - Dean) z. Need to ensure to attach the signature in all QMS forms (EXT) aa. Need to ensure that quality records are properly filed and coded (EXT). bb. Need to assure that forms are properly coded, dated and signed by both the process owner and campus director. (SFA) cc. To provide an SOP for the Student Assistantship (SFA) dd. Need to assure that forms are properly coded, dated and signed by both the process owner and campus director. Forms that are not used by the office should be removed from the masterlist. (GUC) ee. Ensure that the risk register has indicated ratings and signed by both the process owner and campus administrator. (GUC) ff. Need to assure signature of the process owner and Campus Director in Operational plan. QOP and QOM. (DRR)	
2	7.1.2	Need to designate a Human Resource Management Officer.	OFI
3	7.3	Need to ensure that the person-in-charge is fully aware of the processes (HRM).	OFI
4	7.1.3 7.1.4	a. There is a need to provide appropriate office supplies and a separate office for Planning and Quality Assurance for a more conducive work environment. (PLM, QAO) b. Need to improve the organization of the workplace (NSTP) c. Permanent office be established. (RDS)	OFI
5	6.1	a. Consider identifying clearly the risk/opportunity event on the objective number 1. (SCA)	OFI

AUDIT REPORT SUMMARY

		b. Need to ensure that the action taken to address the identified risk are monitored to evaluate its effectiveness (PLM)	
6	9.1.2	a. Need to conduct client satisfaction survey (EXT) b. Ensure that there is a separate intended box for the customer feedback form, since the registrar and scholarship services have the same office. (SFA) c. There was no available secured suggestion box for customer's feedback/evaluation (PLM, QAO, Admission, NSTP)	OFI
Magallanes Campus			
1	7.5	a. There are no available QMS documents that clearly define the standard procedures and operating of the local BAC office. b. Need to ensure signed proposals of conducted activities in the campus related to GAD. c. Need to provide accomplishment reports and narrative reports of GAD initiatives in the campus. d. QOP and QOM forms should have indicated date signed (Health). e. Citizen's charter should be visible to the clients (Health). f. The action taken stipulated in the Risk Register is not properly documented (Planning). g. There are inconsistencies in the attendance and minutes of the Preparation for Annual Operation Plan for 2023 (Planning). h. There was no evidence presented that a monitoring was conducted for 2023 AOP; 2023 AOP presented is not approved (Planning). i. The documents aligned with the QMS are not coded (Planning). j. The documents aligned with the QMS are not filed and coded (QA Office). k. There is a need to review and revise the details of the QMS forms (Planning, QA). l. There is a need to provide a logbook of transactions. There is no record of incoming and outgoing documents (Planning, QA). m. There is a need to improve the filing of student organization documents to separate filing per organization (SDS). n. Need to ensure to update the master list of quality records and SOPs (Extension). o. Need to ensure that quality records are properly filed and coded. p. Library cards are printed in ordinary paper. (Library) q. The storage of the documents are not organized. (Library) r. There are no recognized logbooks for incoming & outgoing communication and visitor's and/or clientele. (HRMO) s. There is no archiving system for the old documents.	OFI

AUDIT REPORT SUMMARY

		(Registrar's Office) t. Book of abstracts and research manual are kept in the filing cabinet hence not visible and accessible by possible users. (Research and Development) u. No display of journals where faculty researchers published their research. (Research and Development) v. The research manual is not included in the masterlist of quality records. (Research and Development) w. There is no office order given to the auditee as Supply Officer. (Supply & Property Office) x. Need to ensure to update the SOP. (Extension) y. Need to ensure the proper data input on the QMS forms, complete data, and update code. (Records Office) z. Codes and effectivity date of the existing forms are not updated. Obsolete forms need to be excluded in the masterlist of forms. Need to ensure that all QMS documents are signed. Need to update quality objectives consistent with the processes of the unit. (ILDO Unit) aa. Need to ensure proper filing of logsheets. (Office of Admission) bb. The QMS Forms have no signatories. (NSTP) cc. There are forms but no codes. (NSTP) dd. The storage of the documents are not organize/available. (NSTP) ee. There are no logbooks for incoming and outgoing/visitors and clientele. (NSTP) ff. There are no customer satisfaction monitoring. (NSTP) gg. Office Order is not available. Need to ensure that the office order is issued to the employee concern. (General Services and Maintenance) hh. Continual improvement of QMS. Need to ensure to update QMS related documents. (General Services and Maintenance) ii. Some forms are noted coded. (GAD) jj. No copy of approved GFPS. (GAD) kk. No sex disaggregated data of the campus. (GAD) ll. Secured a copy of signed and approved annual GAD Plan for FY 2023. (GAD) mm. No SOP or Process Flow. (GAD)	
2	7.2	There is no relevant training/seminar attended/conducted for BAC personnel since 2019. (BAC)	OFI
3	7.1.3 7.1.4	a. There should be separate ward beds for male and female patients (Health). b. Computer seats for students need to be replaced with more comfortable seats (Library). c. Need to provide and maintain a suitable office for the operation of its process. (Sports, Culture and Arts Unit) d. Conduct of periodic inventory is not performed. (Library) e. Only one CR for use of the library. (Library)	OFI

AUDIT REPORT SUMMARY

		f. No CCTV inside is installed. (Library) g. The workplace shall maintain good office environment. (Library) h. Supply materials are sorted but not systematically; there should be systematic sorting and labeling according to types of substance, flammable/hazardous, serviceable/non-serviceable equipment. (Supply & Property Office) i. Need to ensure the purchase of additional steel cabinet for filing of records. (Records Office) j. Need to ensure a separate office for BAC which is currently located at Records Office. (Records Office) a. No schedule of preventive maintenance of equipment and furniture. (General Services and Maintenance)	
4	9.1.2	There was no available secured suggestion box for customer's feedback/evaluation (Planning, QA)	OFI
5	7.1.2	The auditee is absent during the scheduled audit. (SCHOLARSHIP Unit)	OFI
		The Registrar has no other personnel who can work with her. (Registrar's Office)	
Castilla Campus			
1	7.5	a. There should be a systematic and organized filing, sorting and labeling of documents. (GUC) b. Ensure to update the QMS related documents. (Campus Director) c. There is a need to improve the packaging of the documents in its declared location. (STC) d. There is no evidence provided on the action taken in the risk register. (STC) e. Emergency procedures like evacuation plan should be mounted at strategic places for awareness (DRR). f. QOP and QOM forms should have indicated date signed (Health). g. Ensure to update document codes of QMS forms (Maintenance). h. Masterlist of procedures should be dated and signed (Scholarship). i. Need to ensure a systematic and organized filing, sorting and labeling of documents (Scholarship, Guidance). j. Need to ensure that the SOP be updated and made readily available; All QMS forms be updated (Guidance). k. There is a need to update/ revise the QMS documents to align with the latest DCC guidelines (Biosecurity). l. There is a need to separate the procedures for assessment and monitoring of biosecurity protocols, and monitoring of bio-assets of the campus (Biosecurity). m. Need to include all filed documents of sports and culture-related activities in the masterlist of quality records. Need to update monitoring and evaluation form (Sports).	OFI

		n. No accomplished monitoring for the 2023 culture-related activities (Buwan ng Wika). Need to ensure that timely monitoring and evaluation of activities are conducted and documents are retained. (Sports) o. The unit may improve its Quality Management System documents organization and update them accordingly, i.e., coding, refined targets etc. (Program Chair-BAT) p. Need to ensure that quality records are properly filed and coded (Extension). q. Need to ensure proper coding, filing of records and logbooks. (Records Officer) r. There is a need to provide evidence that the recommendation made based on the findings of the evaluation was received by the SDS Units. (STC) s. There should be a regular schedule of monitoring of internet connectivity among offices with monitoring forms to be filled out/system. (Management Information System) t. There are QMS documents but need revision/updating vis-à-vis actual operating processes; flow of procedures & forms should be revised. (Management Information System) u. Need to identify clearly the risk/opportunity event, risk impact, and risk trigger in the risk register. v. Need to prepare risk monitoring and analysis (Sports, Culture and Arts Unit) w. Need to update SAS monitoring and evaluation form and prepared monitoring for 2023 culture – related activities. (Sports, Culture and Arts Unit) x. Need to include inventory form in the master list of forms. (Sports, Culture and Arts Unit) y. To Assure that all QMS Forms are dated and signed by both the process owner and Campus Director. (Scholarship) z. There was a campus level audit and the office had conducted meetings prior to the activity, but the result of the audit and minutes of the meetings are missing. (Office of Quality Assurance) aa. There are QMS documents but used revision/updating vis-à-vis actual operating procedures and office order, flow of procedures and forms should be revised. (Public Information Office) bb. Update the organizational chart. (NSTP) cc. Minutes of the meeting should put in minutes form and update logbook for communications. (NSTP) dd. The risk register should be updated for actions taken. (Internal Relations Office) ee. Need to establish coding system for operational plan 2024. (Health)	

AUDIT REPORT SUMMARY

2	7.1.3 7.1.4	a. Need to ensure a larger space for records keeping and the availability of Archive Room. (Records Officer, Campus Director) b. No Material Recovery Facility (MRF). (Campus Director) c. Ensure to prepare schedule of preventive maintenance monitoring of resources. (Maintenance)	OFI
3	9.1.2	There was no available secured suggestion box for customer's feedback/evaluation (SDS, STC, QAO, NSTP, Extension)	OFI
4	8.2.1	a. The Citizen's Charter was not posted in a conspicuous place (STC, NSTP)	OFI
Sorsogon City Campus			
1	7.5	a. The unit may improve its Quality Management System documents organization and update them accordingly, i.e., coding, refined targets etc. (SGS Dean) b. Need to formulate a Standard Operating Procedure for the Formulation/Review/Enhancement of RET guidelines/manual. (OVPRET) c. Need to update the QMS & SOP. (Accounting Dept.) d. Needs to ensure systematic and organized filing, coding and labelling of all the documents. Consider the request filing cabinets and file boxes. Consider separate the ILDO documents from placement unit documents. (ILDO (Coordinator) e. The documents & records are sorted & labeled but not all; folders, records and cabinets should be properly labeled and coded per ISO standards. (Admission Office) f. Revise/update the QMS documents to align with the latest DCC Guidelines. (OVPRET) g. There are QMS documents but they should be revised/updated; all documents/records should be coded, standardized/ uniform in format. (COT - Professional Subjects) h. To ensure that all documents/communications for speaking engagements, whether internal or external be filed and kept in an orderly manner. (GUC) i. Failure to gather complete student data for proper classification, assessment, and comprehensive students. (GUC) j. There is no standard operating procedure for the formulation/review/enhancement of RET manual/guidelines (OVPRET). k. The ORDES Risk Register Monitoring was not accomplished, the SOPs are not with updated QMS forms (RDS). l. There is a need to improve Process No. 1 (purchasing and distribution). To include in the process: Inventory tagging and Supplier evaluation (Supply)	OFI

AUDIT REPORT SUMMARY

		m. Need to prepare/finalize the summary of accomplishment of the entire university for FY 2023 (Planning). n. The QMS documents presented were not reviewed and approved (SDS). o. There is a need to review and improve and provide a more comprehensive SOP for Student Discipline (SDS). p. Coded documents need to be properly filed in its location (SDS). q. Need to update all the QMS documents as well as the existing forms used by the unit. Need to ensure that QMS documents are duly signed to make it official. (ILDO/Placement).	
2	7.1.2	a. The auditee is not present during the conduct of the internal audit (ILDO/Placement). b. To provide a coordinator for the different programs (IRO).	OFI
3	6.1	a. Need to include in the risk register of the Planning Office the risk assessment regarding the university's operations, target meeting and external party requirements (Planning). b. There is a need to review the content of the risk register and ensure that the action taken to address the identified risks are monitored and evaluated (SDS).	OFI
4	7.2	Need to ensure that all permanent faculty members have relevant master's degrees (6 permanent faculty without master's degrees) (HRMO).	OFI
5	7.3	The office aide who was around during the audit do not have the access on the filed documents unaware of the same and QMS (not updated). (ILDO/Placement (Director's Office) The auditee is not fully aware of the CHED guidelines on student internship (ILDO/Placement).	OFI
6	4.2	There is a need to review organizational structure of the Student Development and Services as it is not consistent with CMO No. 9, s. 2013 (SDS).	OFI
7	8.2.1	a. Need to update the citizen's charter (HRMO). b. CHED CMO no. 104, s. 2017 is not visible in the office for students' guidance and reference (ILDO/Placement).	OFI
8	7.1.3 7.1.4	a. Need to provide a filing cabinet for the safekeeping of documents (IRO). b. There is a need to provide a separate office/center for the SDS university director and heads to clearly separate university from campus level offices and services (SDS). c. There should be a systematic quiring for clienteles with special fast lane for PWDs, senior citizens, pregnant women, Ips; transaction should be classified into new transactions/follow-up/multiple/simple, etc. (Admission Office)	OFI

AUDIT REPORT SUMMARY

		d. The auditee does not conduct inventory of books. (Library) e. The number of equipment/machines/tools in laboratory/shop subjects is insufficient per student ratio. (COT)	

IV. Audit Conclusion

The audit proved that the implementation and maintenance of the quality management system was in accordance to the requirements of the standard, ISO 9001:2015; therefore, continued quality improvement should be undertaken for recommendation for re-certification.

JOPET VINCENT B. MEDALLA
Lead Auditor

Republic of the Philippines
SORSOGON STATE UNIVERSITY
Magsaysay Street, Salog (Pob.), Sorsogon City, Sorsogon
Tel No.: 056 211-0103; Email Add.: qa.iso@sorsu.edu.ph

REQUEST FOR ACTION

RFA Ref. No. (Auditor)

Date Issued

PART 1: What is wrong? — NON-CONFORMITY (NC) DATA

Originator's Name/ID No.	Unit/Department	Phone	E-mail

This RFA is intended to:
☐ correct a NC / eliminate source of non-conformance
☐ prevent a potential NC / mitigate risk ☐ For Improvement

Department (where NC exists)

Description of the Non-Conformance

☐ IQA-Related ☐ Supplier-Related ☐ 3rd Party Audit Related ☐ Process/Procedural-related
☐ Customer Satisfaction Related ☐ Relates to KPI/Quality Objective Review ☐ HRD-Related
☐ Others (Please Specify):

DESCRIPTION OF NON-CONFORMANCE (Existing or potential; specify the objective evidence).

The number of serial numbers issued are less than the number of completers (650/678=95%).

ISO Clause / Reference:

Category (Major/Minor):

Immediate Action/Correction:

Prepare letter of request for additional serial numbers to CHED, duly attested by the CD and NSTP Director

Acknowledged by:
RICHARD G. RABULAN

Date

PART 2: What is the root cause? — CAUSE ANALYSIS DATA

CAUSE OF NON-CONFORMANCE Note: Attach copy (if necessary) of root cause analysis.

Date:

Responsible Officer:

Estimated Close Out Date:

PART 3 : What solutions can we formulate? — SOLUTION DATA

ACTION PLANS

Note: Please use continuation sheet if necessary

Step-by-Step Activities	Responsible Person/Unit	Time Frame	Resources Needed	CONFIRMATION OF EFFECTS OF COUNTERMEASURES Result:

"I certify that the aforesaid action plans have been reviewed and authorized for implementation. I, therefore, support the implementation of said action plans".

Signature

REVIEW OF ACTION PLAN

☐ Accepted **(Effective)** ☐ Not Accepted **(Not Effective)** *If not accepted, state reasons:

Reviewed by:

Date:

PART 5: Have you followed up your solution implementation?

FOLLOW UP

Status	Initials / Responsibility	Date

PART 6: Were you able to establish the effectiveness of the implemented actions?

VERIFICATION

Verification of Effectiveness of Implemented Actions

No. of Visits	Date	Follow-up Audit Result (Objective Evidences)	New Target Date	Status
				Was Action Taken Effective? ☐ Close (Effective) ☐ Close (Not Effective) New RFA #: _____

PART 7: What is the current status of this corrective/preventive action?

CLOSE OUT

☐ Auditor	**Name**	**Date**
☐ Process Owner	**Name**	**Date**

Republic of the Philippines
SORSOGON STATE UNIVERSITY
Magsaysay Street, Salog (Pob.), Sorsogon City, Sorsogon
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REQUEST FOR ACTION

RFA Ref. No. (Auditor): NQA-NC-01
Date Issued: 02-15-2024

PART 1: What is wrong? — NON-CONFORMITY (NC) DATA

Originator's Name/ID No.	Unit/Department	Phone	E-mail
RANNIE L. BERNARDINO	NQA		

This RFA is intended to:
- [x] correct a NC / eliminate source of non-conformance
- [ ] prevent a potential NC / mitigate risk
- [ ] For Improvement

Department (where NC exists): College of Teacher Education & Midwifery (BS Midwifery Program)

Description of the Non-Conformance:
- [ ] IQA-Related
- [ ] Supplier-Related
- [ ] 3rd Party Audit Related
- [ ] Process/Procedural-related
- [ ] Customer Satisfaction Related
- [ ] Relates to KPI/Quality Objective Review
- [x] HRD-Related
- [ ] Others (Please Specify):

DESCRIPTION OF NON-CONFORMANCE (Existing or potential; specify the objective evidence).

The control of operations related to faculty competency was not effective.
Evidence: The following personnel competency were noted not registered midwife as per the requirement of CHED CMO No. 3 and No. 33:
1. Aaron Funa, RN (Teaching M100, Mid. Research 2, CP PHC2, MEPM)
2. Robert Jamisola, RN (Teaching M100, Anatomy)

ISO Clause / Reference: 7.2, 8.5.1

Category (Major/Minor): Minor

Immediate Action/Correction:

Encourage the faculty members concerned to take the Midwifery Licensure Examinations since they are both qualified to take the exam.
Prioritize the hiring of new faculty members in the 2024 Annual Operational Plan.

Acknowledged by: ALFONSO L. GARCIA JR.
Date: FEB. 15, 2024

PART 2: What is the root cause? — CAUSE ANALYSIS DATA

CAUSE OF NON-CONFORMANCE Note: Attach copy (if necessary) of root cause analysis.

There is limited number of qualified core faculty members of the BS Midwifery program; hence, the two faculty members identified were given teaching load, considering that BS Nursing is an allied field of the midwifery program. The two faculty members were originally hired in preparation for the offering of the BS Nursing program.

Date: FEB. 19, 2024
Responsible Officer: ABNER L. DELLOSA
Estimated Close Out Date:

PART 3 : What solutions can we formulate? — SOLUTION DATA

Note: Please use continuation sheet if necessary

ACTION PLANS

Step-by-Step Activities	Responsible Person/Unit	Time Frame	Resources Needed	CONFIRMATION OF EFFECTS OF COUNTERMEASURES — Result:
Review the Program Standards and Guidelines of BS Midwifery to identify the qualifications of the faculty members	COTEdM Dean VPAA HRMO	April 2024	Paper, laptop, internet	
Improve the hiring and selection strategies for the needed faculty members in the BS Midwifery program	HRMO	2nd – 3rd Quarter 2024	Paper, laptop, internet	
Hire qualified core faculty members of the BS Midwifery Program	HRMO COTEdM Dean	3rd Quarter 2024	Paper, laptop, internet	
Assign the major/specialization courses to the qualified faculty members	COTEdM Dean	1st Semester 2024-2025	Paper, laptop, internet	

"I certify that the aforesaid action plans have been reviewed and authorized for implementation. I, therefore, support the implementation of said action plans".

Signature

JHONNER D. RICAFORT, PhD
Vice-President for Academic Affairs

REVIEW OF ACTION PLAN

☐ Accepted **(Effective)** ☐ Not Accepted **(Not Effective)** *If not accepted, state reasons:

Reviewed by:

Date:

PART 5: Have you followed up your solution implementation?

FOLLOW UP

Status	Initials / Responsibility	Date

PART 6: Were you able to establish the effectiveness of the implemented actions?

VERIFICATION

Verification of Effectiveness of Implemented Actions

No. of Visits	Date	Follow-up Audit Result (Objective Evidences)	New Target Date	Status
				Was Action Taken Effective? ☐ Close (Effective) ☐ Close (Not Effective) New RFA #: _____

PART 7: What is the current status of this corrective/preventive action?

CLOSE OUT

☐ Auditor	**Name** **RANNIE L. BERNARDINO JR.**	**Date**
☐ Process Owner	**Name** **ALFONSO L. GARCIA JR.**	**Date**

Republic of the Philippines
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ISO – Internal Quality Audit Unit
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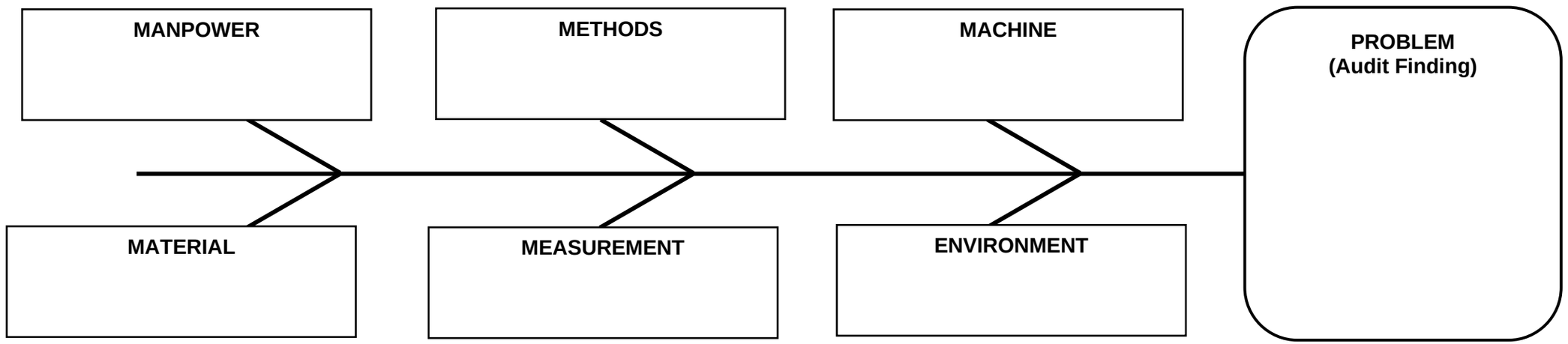
ROOT CAUSE ANALYSIS FORM

Date of Issuance of RFA		**Name of Office / Process**	
Name of Process Owner		**Position/Designation**	

FISH BONE DIAGRAM



Why 1		**ROOT CAUSE**
Why 2		
Why 3		
Why 4		
Why 5		

Signature of Process Owner		**Responsible Officer**	Name		***I hereby affix my signature to acknowledge that my office is responsible for the root cause of the audit finding; thus, I am tasked to prepare the corrective action plan to address it:***
			Position		

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REQUEST FOR ACTION MONITORING LOG

Type of Audit: **Surveillance Audit**

Date of Audit: **August 25, 2023**

Non-Conformances:

REF. NO.	PROCESS UNIT	DESCRIPTION OF NON-CONFORMANCE	Immediate Action Taken with evidence? (YES or NO)	Review of Corrective Action Plan (Effective? YES or NO)	If Corrective Action not effective, identify new RFA No.	FOLLOW-UP VISITS (Indicate date and status)					Status (CLOSED OPEN)
1											

Opportunities for Improvement (OFI)

REF. NO.	PROCESS UNIT	DESCRIPTION OF NON-CONFORMANCE	Immediate Action Taken with evidence? (YES or NO)	Review of Corrective Action Plan (Effective? YES or NO)	If Corrective Action not effective, identify new RFA No.	FOLLOW-UP VISITS (Indicate date and status)					Status (CLOSED OPEN)
1											
2											
3											
4											
5											
6											

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REQUEST FOR ACTION MONITORING LOG

Type of Audit: **Surveillance Audit**

Date of Audit: **August 24-25, 2023**

REF. NO.	PROCESS UNIT	DESCRIPTION OF NON-CONFORMANCE	Immediate Action Taken with evidence? (YES or NO)	Review of Corrective Action Plan (Effective? YES or NO)	If Corrective Action not effective, identify new RFA No.	FOLLOW-UP VISITS (Indicate date and status)					Status (CLOSED OPEN)
7											
8											
9											
10											

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Doc. Code: **FM-IQA-008**
Effectivity Date: **November 3, 2023**
Revision No: **02**
Page No.: **1 of 1**

EVALUATION OF INTERNAL AUDITOR

Name of Evaluator: _____

Position of Evaluator:

- Process Owner/ Auditee
- Co-Auditor
- Lead Auditor
- ISO Head

Name of Internal Auditor: _____

Date of Audit: _____ Place of Audit: _____

Instruction: Assess the performance of the internal auditor, taking into account the specified areas identified by the indicators provided for each category. Use the scale provided below for your evaluation. We also encourage you to provide comments in each area as additional inputs for improvement.

5 – Excellent: Outstanding performance; Consistently surpasses expectations, demonstrating exceptional competence

4 – Above Average: Exceeds expectations; Demonstrates strong proficiency and contributes positively

3 – Average: Meets expectations; Competent performance with room for improvement

2 – Below Average: Below expectations; Some improvement needed in this area

1 – Poor: Significantly below expectations; Requires substantial improvement and additional training

Indicators	**Rating**					**Comments/Feedback**
A. Knowledge of ISO 9001:2015 Standards	**5**	**4**	**3**	**2**	**1**	
1. The internal auditor demonstrates understanding of ISO 9001:2015 requirements.						
2. The internal auditor applies knowledge effectively during audits.						
3. The internal auditor stays updated on changes to the standard.						
4. The internal auditor can articulate how ISO 9001 principles apply to specific processes.						
5. The internal auditor is able to interpret and apply audit criteria to diverse situations.						
B. Communication Skills	**5**	**4**	**3**	**2**	**1**	
1. The internal auditor communicates effectively with auditees.						
2. The internal auditor listens actively and asks relevant questions.						
3. The internal auditor provides clear and constructive feedback.						
4. The internal auditor demonstrates proficiency in written and verbal communication.						
5. The internal auditor conveys complex audit findings in an understandable manner.						
C. Audit Execution	**5**	**4**	**3**	**2**	**1**	
1. The internal auditor follows the established audit process.						
2. The internal auditor demonstrates professionalism and objectivity.						

EVALUATION OF INTERNAL AUDITOR

3. The internal auditor adapts to unexpected situations during audits.						
4. The internal auditor uses effective questioning techniques to gather information.						
5. The internal auditor demonstrates a keen attention to detail during the audit process.						
D. Reporting and Documentation	**5**	**4**	**3**	**2**	**1**	
1. The internal auditor generates accurate and comprehensive audit reports.						
2. The internal auditor documents non-conformities and opportunities for improvement clearly.						
3. The internal auditor submits reports within the specified timeframe.						
4. The internal auditor uses a standardized format for reporting findings.						
5. The internal auditor includes relevant evidence and references in audit documentation.						
E. Continual Improvement	**5**	**4**	**3**	**2**	**1**	
1. The internal auditor actively seeks feedback and identifies areas for personal improvement.						
2. The internal auditor contributes to the improvement of the university's quality management system.						
3. The internal auditor encourages a culture of continuous improvement within the team.						
4. The internal auditor demonstrates a proactive approach to professional development.						
5. The internal auditor integrates lessons learned from previous audits into current practices.						

General Comments/Feedback:

_____
_____
_____
_____

_____
Evaluator's Signature

bit.ly/SorSUIQAEvaluation