Republic of the Philippines
Department of the Interior and Local Government
Regional Office 1

SYSTEM PROCEDURE MANUAL

9001:2015

"Matino, Mahusay at Maaasahan"

DILG REGIONAL OFFICE 1

MASTERLIST OF MAINTAINED INTERNAL DOCUMENTED INFORMATION

Document Code		
FM-SP-R01-01A-02		
Rev. No.	Eff. Date	Page
00	10.01.17	1 of 3

DIVISION/OPERATING UNIT	**DILG R1**
QUALITY PROCEDURE TITLE	System Procedures

DOCUMENT CODE	DOCUMENT TITLE	REVISION					
		00	01	02	03	04	05
SP-RO1-01A	Control of Maintained Documented Information (Internal)	10.01.17					
FM-SP-RO1-01A-01	Document Control Request Form (DCR) (Internal Document)	10.01.17					
FM-SP-RO1-01A-02	Masterlist of Maintained Documented Information (Internal)	10.01.17					
FM-SP-RO1-01A-03	Distribution List Form	10.01.17					
FM-SP-RO1-01A-04	DCR Logsheet	10.01.17					
SP-RO1-01B	Control of Maintained Documented Information (External)	10.01.17					
FM-SP-RO1-01B-01	Masterlist of Maintained Documented Information (External)	10.01.17					
SP-RO1-02	Control of Retained Documented Information	10.01.17					
FM-SP-RO1-02-01	Masterlist of Retained Documented Information	10.01.17					
SP-RO1-03	Corrective Action	10.01.17					
FM-SP-RO1-03-01	Corrective Action Report Form	10.01.17	07.15.18				
SP-RO1-04	Regional Internal Quality Audit	10.01.17	07.15.18				
FM-SP-RO1-04-01	Regional Internal Quality Audit Program	10.01.17					
FM-SP-RO1-04-02	Regional Internal Quality Audit Plan	10.01.17					

FM-SP-RO1-04-03	Regional Internal Quality Audit Checklist						
FM-SP-RO1-04-04	Regional Initial Audit Report						
FM-SP-RO1-04-05	Opportunities for Improvement Report						
FM-SP-RO1-04-06	CAR Monitoring Matrix						
FM-SP-RO1-04-07	OFIR Monitoring Matrix						
FM-SP-RO1-04-08	Regional Internal Quality Audit Report						
FM-SP-RO1-04-09	Attendance Sheet						
SP-RO1-05	Management Review	10.01.17					
FM-SP-RO1-05-01	Management Review Minutes	10.01.17					
SP-RO1-06	Control of Nonconforming Service or Output	10.01.17					
FM-SP-RO1-06-01	Nonconforming Services Form	10.01.17					
FM-SP-RO1-06-02	Nonconforming Output Logsheet						
SP-RO1-07	Risk Identification, Evaluation, and Control	10.01.17					
RRO-QP Codes	Risk Register (Objective)	10.01.17					
RRP-QP Codes	Risk Register (Process)						
FM-SP-RO1-07-01	Risk Criteria Matrix						
FM-SP-RO1-07-02	Risk Control/Opportunity Plan Status Monitoring						
FM-SP-RO1-07-03	Opportunity Management Plan						
SP-RO1-08	QMS Planning	10.01.17					
QO-QP Code	Quality Objective	10.01.17					
QAP-QP Code	Quality Action Plan	10.01.17					
QP Code	Quality Procedure						
SP-RO1-09	External Customer Satisfaction Survey	10.01.17					

MASTERLIST OF MAINTAINED INTERNAL DOCUMENTED INFORMATION

FM-SP-RO1-09-01	Customer Satisfaction Survey Summary Logsheet	10.01.17					
FM-SP-RO1-09-02	Customer Satisfaction Survey Form	10.01.17					
SP-RO1-10	Process Performance Monitoring and Measurement	10.01.17					
QME-QP Code	Process Quality Monitoring and Evaluation	10.01.17					
FM-SP-RO1-10-01	QMS Process Summary Logsheet	10.01.17					
FM-SP-RO1-10-02	QMS Performance Analysis Report	10.01.17					

Prepared By	Noted By
PRAYANDLEO E. CAHIGA ITO I	**VICTORIA H. RAMOS, CESO V** Assistant Regional Director
Regional Document Controller	QMR

PROCEDURE TITLE	**CONTROL OF MAINTAINED INTERNAL DOCUMENTED INFORMATION**
SCOPE	This process starts from the identification of the need for creation/revision of document, control and issuance at points of use, up to recall of obsolete or deletion of internal documents.
PURPOSE/S	To manage and control the creation, revision, distribution and deletion of internal documents and recall of obsolete copies.

PROCESS DESCRIPTION

INPUT	PROCESS	OUTPUT
Process Owner — Document Control Request (DCR) →	Control of Maintained Internal Documented Information →	Controlled Documented Information → Copy Holders

DESCRIPTIVE STATEMENT:
The process owner submits a duly accomplished Document Control Request Form together with the draft of the document to be changed to the Regional Document Controller who reviews the request and the draft of the document, layouts accordingly and return to process owner for review and approval by the designated signatories. Upon approval, document controller subjects the document to control, securing of e-copy against unauthorized access it also includes updating the Master List, stamping of control status, recalling obsolete copies and distributing control copies.

Step No.	Responsible Personnel	Process/Activity	Details	References
1	**Process Owner**	Identify the need for document creation/ revision/ deletion	• Accomplish the Document Control Request (DCR) Form (Internal Document) and have it signed by authorized signatories. • For approved deletion of document, forward the DCR to the Regional Document Controller, and proceed to Step 3.	• Document Control Request (DCR) Form
2	**Process Owner**	Draft the new Document or proposed revision	• Draft the Document following the prescribed format and forward to Regional Document Controller (RDC) together with the approved DCR and the e-copy of the Document.	• DCR Form • New/Revised Document
3	**Regional Document Controller (RDC)**	Record the DCR Control Number and layout the Document	• Review the DCR and if found okay, assign DCR Control No. and record in the DCR Log Sheet.	• DCR Form • DCR Log Sheet • Soft copy of the Document • Document

			Note: For reference document (e.g. Policies, Memorandum, manual, brochure), proceed to Step 5. • For deletion, proceed to Step 5. • For creation or change/revision, review the document and layout in appropriate form indicating the document controls such as: Document Code;Revision Number; Effectivity Date; Authorized Signatories; and other Document Control indicators (Header/Footer). • Print the Document and forward to the designated signatories.	
4	**Designated Signatories**	Approve the document	• Review the document and if found okay, sign the document, otherwise, return to RDC for appropriate action. • Return signed document to RDC.	• Document
5	**Regional Document Controller (RDC)**	Update the Master List of Internal Documents	• Update the corresponding Master List of Internal Document Information to include the approved changed/created document. • Sign the updated Master List and secure signature of concerned Deputy QMR or QMR.	• Master List of Internal Documents
6	**Regional Document Controller (RDC)**	Control the master copy of the updated documents	• Store/save the e-copy of the master copy in a secured online drive with access only to authorized person to prevent unauthorized access to softcopies • Stamp "MASTER COPY" at the back of the updated documents and affix initial. • Delete previous obsolete master copy to the secured online storage (if any) and	• Master copy • E-copy of the Master copy

			store the revised master copy • Scan the master copies of the updated documents. • Tag the scanned obsolete master copy by renaming the file, OBSxxfilename. Where xx stands for the revision no. and filename is the default filename as distributed by the RDC. • Reproduce the document based on the distribution list. • Stamp the reproduced copies "CONTROLLED COPY" and affix initial on the lower left corner • Distribute the controlled copies to the concerned offices/process owners	
7	**Regional Document Controller (RDC)**	Retain the Obsolete Master Copy	• Retrieve the previous (obsolete) master copy of the updated document and stamp "OBSOLETE COPY" on the lower left corner and affix initial. • Record the obsolete document in the Registry of Obsolete Documents	• Obsolete master copy • Registry of Obsolete Documents
8	**Provincial QMS Focal Person**	Recall the obsolete controlled copies of the document, if any	• Upon receipt of the controlled copies of the updated documents, retrieve the obsolete controlled copies • Recall the previously distributed obsolete controlled copies, if any, and record the document retrieval with indicated date of recalling to the DCR logsheet Document Recalled/Withdrawn field • Mark the retrieved obsolete controlled copies with page-wide "X" and re-use.	• DCR logsheet • Obsolete copies

9	**Provincial QMS Focal Person**	Distribute the Document	• Distribute the document to the concerned copy holders let them sign the Revision Distributed field in the DCR logsheet	• Document • DCR logsheet
10	**Regional Document Controller (RDC)**	Retain Records	• Retain records in accordance with the Control of Retained Documented Information procedure and the Master List of Records.	• Control of Retained Documented Information Procedure • Master List of Records

Prepared By	Reviewed By	Approved By
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Head, QMS Secretariat	QMR	Top Management

DILG REGIONAL OFFICE 1

MASTERLIST OF MAINTAINED INTERNAL DOCUMENTED INFORMATION

Document Code		
FM-SP-R01-01A-02		
Rev. No.	Eff. Date	Page
00	10.01.17	1 of 1

DIVISION/OPERATING UNIT	
QUALITY PROCEDURE TITLE	

DOCUMENT CODE	DOCUMENT TITLE	REVISION					
		00	01	02	03	04	05

Prepared By	Noted By
Regional Document Controller	QMR

Prepared By	Reviewed By	Approved By
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Supervising Administrative Officer	Assistant Regional Director	Regional Director
QMS Secretariat Head	QMR	Top Management

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DOCUMENT CONTROL REQUEST (DCR) FORM (Internal Document)

Document Code		
FM-SP-RO1-01A-01		
Rev. No.	Eff. Date	Page
00	10.01.17	1 of 1

DATE OF REQUEST						
REQUEST FOR Please tick(✔) appropriate checkbox		Creation		Change		Deletion

TITLE OF DOCUMENT				
DOCUMENT CODE				
PROPOSED CHANGE				
REVISION NO.	**FROM/CURRENT:**		**TO:**	
EFFECTIVITY DATE				

REASON FOR THE REQUEST (State Purpose of the New Document or Reason for Change or Deletion

Note: For creation (new document), signatories are as identified in the Document Responsibility Matrix. For change and creation, signatories are the same with the signatories in the original document being requested for revision/deletion.

Prepared by:	Reviewed by:	Approved by:
Name:	Name:	Name:
Date:	Date:	Date:
Position Title:	Position Title:	Position Title:
Date received by the QMS Secretariat		DCR Control No.

Prepared By	Reviewed By	Approved By
CORAZON C. SIBAYAN	**VICTORIA H. RAMOS, CESO V**	**JAMES F. FADRILAN, CESO IV**
Supervising Administrative Officer	Assistant Regional Director	Regional Director
QMS Secretariat Head	QMR	Top Management

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DISTRIBUTION LIST FORM

Document Code		
FM-SP-ROI-01A-03		
Rev. No.	**Eff. Date**	**Page**
00	10.01.17	1 of 1

Document Title:
Document Code:
Revision No.:
Effectivity Date:

No.	Copy Holders	Received By:		Date
		Name	Signature	

Prepared By:	Noted By:
Regional Document Controller	QMR

Prepared By:	Reviewed By:	Approved By:
CORAZON C. SIBAYAN SAO	VICTORIA H. RAMOS Assistant Regional Director	JAMES F. FADRILAN, CESO IV Regional Director
QMS Secretariat Head	QMR	Top Management

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DCR LOG SHEET

Document Code		
FM-SP-RO1-01A-04		
Rev No.	Eff. Date	Page
00	**10.01.17**	**1 of 1**

No	DCR Control No. (yyyymm-XXX-I/E)	Date of Request	Type of Request (Creation/ Change/ Deletion)	Document Code	Title of Document	Revision No.		Document RECALLED / WITHDRAWN [Indicate Office/Process Owner (PO)] (Document Controller to sign upon receipt of document from copy holder)				REVISION DISTRIBUTED TO COPY HOLDERS [Indicate Office/Process Owner (PO)]			
						From	To	Office/PO	Date	Office/PO	Date	Office/PO	Signature	Office/PO	Signature

Prepared by	Noted by
Regional Document Controller	QMR

Prepare by	Reviewed by	Approved By:
CORAZON C. SIBAYAN Supervising Administrative Officer	**VICTORIA H. RAMOS, CESO V** Assistant Regional Director	**JAMES F. FADRILAN, CESO IV** Regional Director
QMS Secretariat Head	QMR	Top Management

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PROCEDURE TITLE	**CONTROL OF MAINTAINED EXTERNAL DOCUMENTED INFORMATION**
SCOPE	This process starts from identification of the need for acquisition up to registration of the external document in the QMS through the Master List of External Document and subjecting the Master List to document control.
PURPOSE	To define the controls for managing and controlling the acquisition and registration of external document to the QMS through the Master List and accordingly subjecting the Master List to document control.

PROCESS DECSRIPTION:

INPUT	PROCESS	OUTPUT
Process Owner → External Document	Control of Maintained External Documented Information	Master List of External Document → Document Control Team

DESCRIPTIVE STATEMENT:

The process owner identifies and acquires the relevant external document, submits a duly accomplished and signed DCR to the Regional Document Controller who registers the external document in the QMS through the Master List of External Document then subjects the Master List to control including stamping, recall (if, any) and distribution in accordance with the Control of Maintained Documented Information Procedure.

Step No.	Responsible Personnel	Process/Activity	Details	References
1	**Process Owner**	Identify the need for acquisition of external document	• Identify the relevant external documents needed for the planning and operation of the QMS processes.	
2	**Process Owner**	Acquire the external document	• Acquire copy of the needed external document thru purchasing, downloading or by other means (e.g. supplied manuals or references) and save e-copy to secured online storage area accessible only by authorized person • Delete previous obsolete version to the secured online storage (if any) and store the revised document **Note:** *Use of external documents is generally under the control of each concerned Office/Process Owners only.*	• External Document

			Thus, distribution and identification of control status is not practiced except for ISO standards for internal audit purposes.	
3	**Regional Document Controller (RDC)**	Update the Master List of External Documents	• Update the Master List of External Documents indicating the version/edition, if any, of the acquired document.	• Master List of External Documents
4	**Regional Document Controller (RDC); Deputy Document Controller (DDC)**	Control the master copy of the updated Master List	• Control the master copy of the updated Master List, including, stamping, recall (if any), and distribution in accordance with the Control of Maintained Internal Documented Information Procedure.	• Master copy • Control of Maintained Internal Documented Information • DCR logsheet
5	**Regional Document Controller (RDC); Deputy Document Controller (DDC)**	Retain Records	• Retain records in accordance with the Control of Retained Documented Information Procedure and Master List of Records	• Master List of External Document • Control of Retained Documented Information • Master List of Records

Prepared By	Reviewed By	Approved By
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DILG REGIONAL OFFICE 1

MASTERLIST OF MAINTAINED EXTERNAL DOCUMENTED INFORMATION

Document Code		
FM-SP-R01-01B-01		
Rev. No.	Eff. Date	Page
00	10.01.17	1 of 1

DIVISION/OPERATING UNIT	
QUALITY PROCEDURE TITLE	

DOCUMENT CODE	DOCUMENT TITLE	REVISION/EDITION					
		00	01	02	03	04	05

Prepared By	Noted By
Regional Document Controller	QMR

Prepared By	Reviewed By	Approved By
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Head, QMS Secretariat	QMR	Top Management

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PROCEDURE TITLE	**CONTROL OF RETAINED DOCUMENTED INFORMATION**
SCOPE	This process starts from the identifying records up to disposition when retention period is reached.
PURPOSE	To ensure that quality records are appropriately identified, managed, controlled and maintained.

PROCESS DESCRIPTION

INPUT	PROCESS	OUTPUT
Operating Unit → Identify Records	Control of Retained Documented Information	Store and archive records → Doc. Controller/ Operating Unit

DESCRIPTIVE STATEMENT:

This procedure starts with the identification of the documented information to be retained by the process owners. Upon validation and finalization of the filing procedures, the identified documented information to be retained will be stored and archived by the document controller and the process owner.

Step No.	Responsible Personnel	Process/Activity	Details	References
1	**Process Owner**	Identify records	• Identify the records generated from the implementation of QMS processes and record them in the Masterlist of Retained Documented Information	• Masterlist of Retained Documented Information
2	**Process Owner**	Define Retention Period and retrieval mechanism	• Define the retention Period in accordance with RA 9470, the National Archive of the Philippines (NAP) Act of 2007. • Coordinate with Regional Records Officer. • Filing Mechanism could either be chronological, alphabetical, and sequential.	• Masterlist of Retained Documented Information • RA 9470 – National Archiving of the Philippines Act of 2007
3	**Process Owner**	Define storage location	• Define storage location (hardcopy/softcopy) in the Masterlist of Retained Documented Information. • Storage location should be appropriate to prevent damage and	• Masterlist of Retained Documented Information

Step No.	Responsible Personnel	Process/Activity	Details	References
			unauthorized access to softcopies by properly securing the online storage giving access only to authorized person	
4	**Process Owner**	Store records	• Store records according to the defined filing system and retention period. Upon reaching the retention period, turn-over all records to the Regional Document Controller.	• Masterlist of Records Memo transmittal with the list of records for turn-over

NOTES:
The following records will be treated to special handling prior to filing:

- Records in thermal paper such as fax papers – File the photocopy.
- Records with pencil entries – Provide equivalent record in Ink.
- Rectification of records with erroneous entry – Provide horizontal line across the wrong entry and indicate the correct entry/data; Affix initial.

DEFINTION OF TERMS:

- Process Owner – The personnel who has the highest number of and/or immense activities/steps in the process, thereby having the ultimate responsibility for the process performance and has the authority and ability to initiate necessary changes in the process.
- Regional Records Officer – The Chief of the Records Unit, Finance and Administrative Division who is responsible for ensuring the DILG-RO1 compliance with the National Archives of the Philippines Act of 2007 and who plays a lead role in the management, generation, collection, filing/storage, protection, retrieval, retention, and disposition of QMS records.

Prepared By	Reviewed By	Approved By
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Head, QMS Secretariat	QMR	Top Management

DILG REGIONAL OFFICE 1

MASTERLIST OF RETAINED DOCUMENTED INFORMATION

Document Code		
FM-SP-RO1-02-01		
Rev. No.	Eff. Date	Page
00	10.01.17	1 of 1

DIVISION/OPERATING UNIT	
QUALITY PROCEDURE TITLE	

DOCUMENT CODE	DOCUMENT TITLE	CUSTODIAN	LOCATION	FILING SYSTEM		RETENTION PERIOD			DISPOSAL
				FOLDER	SCHEME	ACTIVE	STORAGE	TOTAL	

Prepared By	Noted By
Process Owner	Immediate Supervisor

Prepared By	Reviewed By	Approved By
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Supervising Administrative Officer	Assistant Regional Director	Regional Director
Head, QMS Secretariat	QMR	Top Management

PROCEDURE TITLE	**NON-CONFORMITY AND CORRECTIVE ACTION**
SCOPE	This procedure starts from the identification of nonconformity up to the closeout after verification of corrective action effectiveness.
PURPOSE	To define the process that ensure that nonconformities are properly and effectively addressed with appropriate corrective action to prevent the occurrence or recurrence of the NC and their root causes.

PROCESS DECSRIPTION:

INPUT	PROCESS	OUTPUT
Internal Quality Audit QMS Secretariat Corrective Action Report (CAR) – Audit Related Corrective Action Report (CAR) – Non-Audit Related	Non-Conformity and Corrective Action	Non Recurrence or Occurrence of detected Nonconformity Affected QMS Process All Operating Units

DESCRIPTIVE STATEMENT:

The process is triggered by the identified non-conformity by the Internal Quality Auditors as a result of their audit or by the QMS Secretariat when there is a reported unmet target, feedback from clients, output from Management Review, and other lapses or deviation identified. Process Owners plan and implement corrections by identifying the root cause of the non-conformity, establish corrective action plan and implement the corrective action plan. Internal Quality Auditors and QMS Secretariat will verify the effectiveness of the corrective actions. Results of the action taken may result to updating of the risk register when there are changes, together with other affected process documented information.

Step No.	Responsible Personnel	Process/Activity	Details	References
1	Internal Quality Auditor/ QMS Secretariat	Identify nonconformity	• Identify nonconformity using CAR Form. Possible sources of nonconformities may be: <u>QMS Secretariat:</u> a. Unmet objectives and targets b. Client Feedback c. Management Review Output d. Other lapses or deviations identified <u>Internal Quality Auditor:</u> a. Internal audit findings b. External audit findings • Issue Corrective Action Report (CAR) to concerned Process Owner duly signed by the IQA Head/QMS Secretariat.	• CAR
3	Process Owner	Plan and implement corrections	• Plan and implement corrections/immediate actions to stop the nonconforming situation from continuing duly confirmed by the Head of Office for non-audit related CAR. Include actions to deal with the consequences of the NC.	• CAR

			Note: For audit-related CAR, confirmation by the IQ Auditor shall be made during the verification of corrective action.	
4	Process Owner	Identify the root cause of the nonconformity	• Identify the root cause/s of the nonconformity; may use the "5-WHY" or fish bone analysis technique. • Record in the CAR.	• CAR
5	Process Owner/ Deputy QMR/ Regional QMR	Formulate/ Review and approve Corrective Action Plan (CAP)	• Formulate Corrective Action Plan (CAP) duly reviewed by the Division Chief/Head of Office approved by the QMR with identified person responsible and specified timelines. • Determine existing NC or potential occurrence elsewhere in the QMS and consider in the corrective action. • Furnish accomplished CAP to QMS Secretariat/Internal Quality Auditor within 10 working days upon receipt.	• CAR
6	Process Owner	Implement the CA plan	• As specified, implement the corrective actions at indicated timelines. • Monitor progress against corrective action plans. If any proposed corrective action cannot be/ is not implemented, discuss with the head of office for possible additional intervention.	• CAR
7	IQA/QMS Secretariat	Verify effectiveness of CA	• After at least 2 months of corrective action implementation, verify and confirm the effectiveness of corrective action taken. Verification can be in the form of process verification or internal quality audit. Verification can happen more than once, if the initial (first) verification does not provide evidence of recurrence of root cause identified. • If non-recurrence of the root cause is verified, closeout the CAR, duly approved by the QMS Secretariat/IQA Head; else, coordinate with concerned Office for continuous CAP implementation and/or take any further appropriate action; else, let the CAR remain open and schedule the subsequent (2nd or 3rd) verification. • Communicate the results of	• CAR

			verification to concerned Office.	
8	Process Owner/QMS Secretariat/ IQ Auditor	Review risk register and update other affected QMS documented information	• Review and update the risk register accordingly. • Ensure that relevant documentation are appropriately revised, if applicable, in accordance with Control of Maintained Documented Information Procedure.	• Risk Register • Control of Maintained Documented Information Procedure
9	Designated Custodian	Retain records	• Retain records in accordance with Control of Retained Documented Information Procedure and Master List of Records	• Control of Retained Documented Information Procedure • Master List of Records

Definition of Terms:

- Correction – action taken to eliminate (or address) a detected non-conformity (i.e. stop gap measure, quick fix, mitigation, band-aid solution
- Corrective Action – an action taken to address the root cause of the identified nonconformity in order to prevent its recurrence.
- Corrective Action Report (CAR) – the specified form to record a detected noncomformity, the identified root cause and the actions taken to prevent its recurrence.

Prepared By	Reviewed By	Approved By
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Head, QMS Secretariat	QMR	Top Management

DILG REGIONAL OFFICE 1

CORRECTIVE ACTION REPORT

Document Code		
FM-SP-RO1-03-01		
Rev. No.	Eff. Date	Page
01	07.15.18	1 of 3

CAR No.:	Date of Issue:
Office / Division:	Process:

Source of Nonconformity:

☐ Unmet Quality Objective ☐ Client Complaint ☐ Audit ☐ Other :

A. DESCRIPTION OF NONCONFORMITY:

ISSUED BY:	ACCEPTED BY:
Signature over Printed Name of QMS Secretariat Head for Non-audit Related or RIQA Leader for Audit Related	Signature over Printed Name of concerned Process Owner/ Division/Field Office Head/QMR

B. CORRECTION/IMMEDIATE ACTION:

ACTIVITY	RESPONSIBLE	TIMELINE

C. CONSEQUENCES, if any, and PLANNED ACTIONS:

Potential Consequence	Planned Action

CORRECTIVE ACTION REPORT

Document Code		
FM-SP-RO1-03-01		
Rev. No.	Eff. Date	Page
01	07.15.18	2 of 3

D. ROOT-CAUSE ANALYSIS: (Use 5-Why Analysis or Fishbone Diagram)

WHY	RESPONSE	BASIS
1		
2		
3		
4		
5		

E. PLANNED CORRECTIVE ACTION: (submit to QMS Secretariat/IQA within 10 days upon receipt of CAR)

ACTIVITY	RESPONSIBLE	TIMELINE		STATUS MONITORING			VERIFICATION	
		START	END	Remarks	By	Date	By	Date

Prepared by:	Reviewed By:	Approved by:	Received by:
Signature over Printed Name of Process Owner/ Date	Signature over Printed Name of **Division Chief/** Head of Office/ Date	Signature over Printed Name of Regional QMR / Date	Signature over Printed Name of RIQA Leader / QMS Secretariat/ Date

CORRECTIVE ACTION REPORT

Document Code		
FM-SP-RO1-03-01		
Rev. No.	Eff. Date	Page
01	07.15.18	3 of 3

F. VERIFICATION OF CA EFFECTIVENESS: (For non-audit related, at least 2 months after full implementation of the planned CA and non-recurrence of the identified root-cause/s. For audit related, the effectiveness of the CA will be verified in the next audit).

Date of Verification:	Results of CA verification/ REMARKS *(Effective / Not Effective)*	NC Status (Open / Closed)	Verified By
(1)			
(2)			
(3)			

Note: (2) and (3) verification is necessary if the CAR cannot be closed after the (1st) first verification.

Verified by:	Approved by:
/	/
Signature over Printed Name of QMS Secretariat Member for Non-Audit or RIQA Auditor for Audit Related/ Date	Signature over Printed Name of QMS Secretariat Head for Non-Audit or RIQA Leader for Audit Related/ Date

G. Risk Register review and update:

Document Code	Effectivity Date	Revision Number

H. Document review and revision:

Document Code	Effectivity Date	Revision Number

Prepared By	Reviewed By	Approved By
LILY ANN Z. VICTORIO	**VICTORIA H. RAMOS, CESO V**	**JAMES F. FADRILAN, CESO IV**
LGOO VI/ ADC, LGCDD	Assistant Regional Director	Regional Director
Head, QMS Secretariat	QMR	Top Management

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PROCEDURE TITLE	**REGIONAL INTERNAL QUALITY AUDIT**
SCOPE	This procedures starts with the audit program preparation, communication of audit plan to concerned auditees, conduct of audit proper, preparation of audit report and ends with the review of audit program.
PURPOSE/S	To define the process of regional internal quality auditing to determine Regional compliance to its established QMS standards, department's policies and the applicable legal requirements.

PROCESS DESCRIPTION

INPUT	PROCESS	OUTPUT
Regional Office → Regional QMS Scope	Regional Internal Quality Audit	IQA Report → Deputy QMR CO, QMR RO

DESCRIPTIVE STATEMENT:

The Regional Internal Quality Audit (RIQA) Team Leader prepares the Annual Regional Audit Program reviewed by the Regional Quality Management Representative (QMR), and approved by the Regional Director. Once approved, the Regional Internal Quality Audit (RIQA) Leader prepares the Regional Audit Plan to be reviewed and approved by the Regional QMR and communicates to all concerned Auditees. All assigned Auditors prepare the audit checklist, conduct the audit, generate the findings and issue CAR and OFIR (if any), and prepare the IQA report. The verification of implementation of CA Plans/ Action Plans are then monitored in accordance with the Nonconformity and Corrective Action Procedure. The process ends with the review of the Audit Program by the RIQA Team Leader to be reviewed by the QMR and approved by the Regional Director.

Step No.	Responsible Personnel	Process/Activity	Details	References
1	Regional Internal Quality Audit (RIQA) Team Leader	Prepare the Annual Regional Audit Program	• Prepare the Annual Regional Audit Program for the current year and submit to Regional QMR for review Notes: 1. Audit Program is prepared during the Regional OPB Preparation 2. Include the verification of Corrective Action effectiveness of the open CARs in the Annual Regional Internal Quality Audit Program. 3. The planned interval of the conduct of internal quality audit is every six (6) months.	• Annual Regional Audit Program

2	Regional QMR	Review the Annual Regional Internal Audit Program	• Review the Annual Regional Internal Audit Program for suitability and adequacy. • Make necessary comments/instructions if any, for appropriate action of the Regional Internal Quality Audit (RIQA) Leader; else, indorse for approval by the Regional Director.	• Annual Regional Internal Audit Program
3	Regional Director	Approve the Annual Regional Internal Audit Program	• Sign the Annual Regional Internal Audit Program.	• Annual Regional Internal Audit Program
4	RIQA Team	Prepare the Regional Audit Plan	• RIQA: Prepare the Regional Audit Plan covering the audit period based on the Annual Regional Internal Qality Audit Program indicating the auditees, audit timelines and audit scope . • RIQA Leader: Review the Audit Plan as to consistency with the Audit Program, and completeness and appropriateness of relevant requirements. Note: Include follow-up/ verification of effectiveness of Corrective Action (CA) Plan of open Corrective Action Report/s (CAR/s), if any.	• Annual Regional Internal Audit Program • Regional Audit Plan
5	Regional QMR	Review and approve the Regional Audit Plan.	• Review the Regional Audit Plan for suitability and adequacy. • Make necessary comments/instructions if any, for appropriate action of the Regional Internal Quality Audit (RIQA) Leader. • Approve the Regional Audit Plan.	• Regional Audit Plan
6	RIQA Team Leader	Communicate IQ Audit Plan to all concerned	• Prepare the Memorandum communicating the audit schedule, scope and assigned auditors based on the approved IQ Audit Plan to concerned auditees, for review of the Regional QMR and signature of the Regional Director.	• Memoran dum • Regional IQ Audit Plan

7	Regional IQ Auditor	Prepare Regional IQ Audit Checklists	• Prepare the checklists relevant to the assigned audit area based on the Regional IQA Plan. • Ensure all applicable clauses to the area of audit are considered in the checklist.	• Regional IQ Audit Checklists
8	RIQA Team Leader	Review and approve the Regional IQ Audit Checklist	• Review the Regional IQ Audit Checklist for adequacy and suitability of the audit points. • Make necessary comments/instructions if any, for appropriate action of the Internal Quality Auditor. • Approve the Regional IQ Audit Checklist.	• Regional IQ Audit Checklists
9	RIQA Team	Conduct Opening Meeting	• Conduct the opening meeting to the auditees of the concerned office to discuss the following: (a) Objectives, scope and coverage of the Audit; (b) Agreement of the Audit schedule; and (c) Reporting of Audit findings.	• Attendance sheet • IQ Audit Plan
10	RIQA Team	Conduct Audit	• Conduct audit in accordance with the Regional IQ Audit Plan and Regional IQ Audit Checklists. • Confirm the implementation of the specified processes. • Accomplish the Regional IQ Audit Checklist to be approved by the RIQA Leader. • Record conformities, non-conformities, opportunities for improvements and items for follow-up. • If audit includes verification, verify effectiveness of Corrective Action. If found fully implemented and root cause did not recur, recommend close out of the Corrective Action Report (CAR) by signing the "Verified" field by the IQ Auditor and the "Approved" field by the RIQA Leader; else, continue verification until full implementation and verified effectiveness of the CA. • For Field Audits, conduct	• Regional IQ Audit Checklists • Regional IQ Audit plan

			Provincial Level Closing Meeting. Present the findings (conformity/nonconformity/opportunity for improvement) verbally based from the audit notes in the Audit Checklist.	

11	RIQA Team	Conduct Audit Team Meeting	• Conduct an audit meeting atleast an hour before the closing meeting chaired by the RIQA Leader to discuss the following:
			  • To review the recorded nonconformities with supporting audit evidence, oportunities for improvements and other audit observations, against the audit objectives;
			  • To agree on the audit conclusions;
			  • To prepare the audit findings presentation for the closing meeting;
			  • To discuss the flow of the closing meeting
				• Audit Checklist
				• Audit Plan
				• Regional Intitial Audit Report

12	RIQA Team	Conduct Regional closing meeting	• Present audit findings and conclusions to the auditees of the concerned office.	• Regional Initial Audit Report
13	RIQA Team	Formalize the Audit Findings and Issue CAR/OFIR	• RIQ Auditor: Formalize the audit findings. State the nonconformity in the Corrective Action Report and the opportunity for improvement for raising the bar of quality in the OFIR. • RIQA Leader: Review the nonconformity statement as to clarity, reliability and accuracy and/or the Opportunity for Improvement statement as to appropriateness and sign. Else, make necessary comments and instructions for appropriate action of the RIQA Auditor. • RIQ Auditor: Secure acceptance by the concerned	• Regional IQ Audit Checklist • CAR • OFIR • CAR Monitoring Matrix • OFIR Monitoring Matrix

			Division/Field Office Head/QMR. • RIQ Auditor: Release CAR/OFIR to concerned Process Owner and log accordingly. NOTE: Concerned Process Owners shall submit Corrective Action/s/Action Plan/s within 10 woking days upon receipt of CAR/OFIR in accordance with the Nonconformity and Corrective Planning Procedure Upon receipt of the submitted Action Plan from the process owner: • Regional IQ Auditor: Evaluate the proposed CA Plan/Action Plan in the CAR/OFIR. If found appropriate, forward to RIQA Leader for acceptance; else, return CAR/OFIR to Process Owner for revision with timeframe for the auditee to re-submit CA Plans/Action Plans. • Provide copy of the accepted CAR/OFIR to the concerned Process Owner.	
14	RIQA Team, Regional QMR	Prepare the Regional Internal Quality Audit Report	• IQ Audit Team: Prepare the Regional Internal Quality Audit Report and Transmittal to Regional Director thru Regional QMR and attach the issued CARs, OFIRs, and CAR/OFIR Monitoring Matrix to form the Regional IQ Audit Report. • Regional QMR: Review the Audit Report. If found acceptable, approve the Audit Report and sign the Transmittal and submit to Regional Director; else, return to RIQ Audit Team for appropriate action. • Furnish copy of the Regional IQA Report to Central Office Deputy QMR and Internal Audit Service (IAS).	• Regional Internal Quality Audit Report • Transmittal

Verification of implementation of CA Plans/ Action Plans				
15	Regional IQ Auditor	Verify implementation of Corrective Action (CA) plans/action plans	• Verify the implementation of the proposed CA Plan/Action Plan in the CAR/OFIR, refer to Corrective Action Process. • Record result of verification in the CAR and update the CAR monitoring Matrix.	• CA Plans • CAR • OFIR • CAR Monitoring Matrix • OFIR Monitoring Matrix
16	Regional IQ Auditor	Review IQ Audit Program and revise as necessary	• Based on the results of the audit, review the IQ audit program and revise as necessary duly approved by the Regional Director.	• IQ Audit Program • CAR Monitoring Matrix
17	Records Custodian	Retain Records	• Retain records in accordance with Control of Retained Documented Procedure and the Masterlist of Records.	• Control of Retained Documented Procedure • Masterlist of Records

Prepared By	Reviewed By	Approved By
MARIFE M. DOCULAN Planning Officer III	**VICTORIA H. RAMOS, CESO V** Assistant Regional Director	**JAMES F. FADRILAN, CESO IV** Regional Director
Team Leader, RIQA	QMR	Top Management

DILG REGIONAL OFFICE 1

ANNUAL REGIONAL INTERNAL QUALITY AUDIT PROGRAM

Document Code		
FM-SP-RO1-04-01		
Rev. No.	Eff. Date	Page
00	10.01.17	1 of 3

(YYYY) REGIONAL INTERNAL QUALITY AUDIT PROGRAM	
I. OBJECTIVE/S:	
II. SCOPE:	
III. REFERENCE STANDARD:	

IV. AUDIT SCHEDULE:

Procedure Title	Process Owner (Office/Division)	J	F	M	A	M	J	J	A	S	O	N	D	Relevant ISO 9001:2015 Clauses/ Legal Requirements

V. BUDGETARY REQUIREMENTS

ACTIVITY	PARTICULARS	AMOUNT
	Total	

V. SELECTION CRITERIA FOR INTERNAL AUDITORS:

Education: Graduate of any 4 year course.

Training: Has attended the following trainings:

1. Understanding ISO 9001:2015
2. Effective Internal Auditing (ISO 9001:2015)

Skills: Communication Skills both oral and written
Analytical Skills
Computer Skills on MS Office (Word, Excel, Powerpoint)

Experience: at least 6 months in service at DILG

VI. AUDITORS:

VII. AUDIT METHODOLOGY:

VIII. VERIFICATION OF CORRECTIVE ACTION (CA) PLAN/ACTION PLAN

Verification of CA Plan/Action Plan Implementation:

Verification of CA Plan Effectiveness:

IX. INTERNAL AUDIT RECORDS:

Prepared By	Reviewed By	Approved By
CORAZON C. SIBAYAN Supervising Administrative Officer	**VICTORIA H. RAMOS, CESO V** Assistant Regional Director	**JAMES F. FADRILAN, CESO IV** Regional Director
Team Leader, RIQA	QMR	Top Management

DILG REGIONAL OFFICE 1

REGIONAL INTERNAL QUALITY AUDIT PLAN

Document Code		
FM-SP-RO1-04-02		
Rev. No.	Eff. Date	Page
00	10.01.17	1 of 1

I. SCOPE:	
II. OBJECTIVES:	
III. AUDIT SCHEDULE:	
IV. REFERENCE STANDARD:	

V. AUDIT PROCESS/ACTIVITY, AUDITOR, AUDITEE AND ISO CLAUSES/LEGAL REQUIREMENTS:

Composition of Audit Teams:

Team Leader:
Team Members:

Audit Schedules:

Date /Time	Activity/Procedure/Area	AUDITOR	AUDITEE	ISO Clauses/ Legal Requirements
Day 1				
Time				
Day nth				
Time				
End of Audit				
	Internal Quality Audit Report Writing			

Note: Include follow-up/verification of effectiveness of Corrective Action (CA) Plan of open Corrective Action Report/s (CAR/s), if any.

Prepared By	Reviewed By	Approved By
CORAZON C. SIBAYAN Supervising Administrative Officer	**VICTORIA H. RAMOS, CESO V** Assistant Regional Director	**JAMES F. FADRILAN, CESO IV** Regional Director
Team Leader, RIQA	QMR	Top Management

DILG REGIONAL OFFICE 1

REGIONAL INTERNAL QUALITY AUDIT CHECKLIST

Document Code		
FM-SP-RO1-04-03		
Rev. No.	**Eff. Date**	**Page**
00	10.01.17	1 of 1

Office:			**Auditor:**	
Process Name:			**Date of Audit:**	
ISO 9001:2015 Clause	**Audit Particulars**	**Evidence of Compliance**		**AUDIT NOTES/REMARKS**
		Documentation	**Implementation**	

Prepared By	Approved By
RIQ Auditor	RIQ Audit Team Leader

Prepared By:	Reviewed By:	Approved By:
CORAZON C. SIBAYAN Supervising Administrative Officer	**VICTORIA H. RAMOS, CESO V** Assistant Regional Director	**JAMES F. FADRILAN, CESO IV** Regional Director
Team Leader, RIQA	QMR	Top Management

DILG REGIONAL OFFICE 1

REGIONAL INITIAL AUDIT REPORT

Document Code		
FM-SP-RO1-04-04		
Rev. No.	Eff. Date	Page
00	10.01.17	1 of 1

Office:	**Date of Audit:**
Audit Summary	
CONFORMITIES: *(Describe briefly the general positive impressions about the processes audited)* • •	
NONCONFORMITIES: *(Describe briefly the observed lapses/deviation or nonconformity, if any)* • •	
OPPORTUNITIES FOR IMPROVEMENT: • •	
VERIFICATION AND STATUS OF PREVIOUS NONCONFORMITIES OR OFIR: • •	
Note: Please refer to the CARs or OFIRs for the specific finding	

AUDIT TEAM	SIGNATURE
Audit Team Leader:	
Audit Team Member/s:	

Prepared By	Reviewed By	Approved By
CORAZON C. SIBAYAN Supervising Administrative Officer	**VICTORIA H. RAMOS, CESO V** Assistant Regional Director	**JAMES F. FADRILAN, CESO IV** Regional Director
Team Leader, RIQA	QMR	Top Management

DILG REGIONAL OFFICE 1

OPPORTUNITIES FOR IMPROVEMENT REPORT

Document Code		
FM-SP-RO1-04-05		
Rev. No.	Eff. Date	Page
00	10.01.17	1 of 3

OFIR NO:	DATE OF ISSUANCE:
OFFICE/DIVISION/SECTION:	PROCEDURE TITLE:

A. STATEMENT OF RAISING THE BAR OF QUALITY:

ISSUED BY:	REVIEWED BY:	ACCEPTED BY:
Signature over Printed Name of RIQ Auditor	Signature over Printed Name of RIQA Leader	Signature over Printed Name of concerned Division/Field Office Head/QMR

OPPORTUNITIES FOR IMPROVEMENT REPORT

B. ACTION PLAN:

ACTIVITY	RESPONSIBLE PERSON	TIMELINE	
		START	END

Prepared by:	Noted by:	Accepted by:
/	/	/
Signature over Printed Name of concerned Division/Field Office Head/QMR / Date	Signature over Printed Name of Regional QMR / Date	Signature over Printed Name of RIQA Leader / Date

C. VERIFICATION OF ACTION PLAN IMPLEMENTATION: *(at least 2 months after full implementation).*

ACTIVITY	STATUS AND REMARKS / Verified by / Date

OPPORTUNITIES FOR IMPROVEMENT REPORT

Verified by:	Approved by:
/	/
Signature over Printed Name of Internal Quality Auditor /Date	Signature over Printed Name of RIQA Leader / Date

Prepared By	Reviewed By	Approved By
CORAZON C. SIBAYAN Supervising Administrative Officer	**VICTORIA H. RAMOS, CESO V** Assistant Regional Director	**JAMES F. FADRILAN, CESO IV** Regional Director
Team Leader, RIQA	QMR	Top Management

DILG REGIONAL OFFICE 1

ATTENDANCE SHEET

Document Code		
FM-SP-RO1-04-09		
Rev. No.	Eff. Date	Page
00	10.01.17	1 of 1

TITLE OF ACTIVITY			
DATE OF ACTIVITY			
NAME	**OFFICE**	**POSITION**	**SIGNATURE**

Prepared By	Reviewed By	Approved By
CORAZON C. SIBAYAN Supervising Administrative Officer	**VICTORIA H. RAMOS, CESO V** Assistant Regional Director	**JAMES F. FADRILAN, CESO IV** Regional Director
Team Leader, RIQA	QMR	Top Management

DILG REGIONAL OFFICE 1

CORRECTIVE ACTION REPORT MONITORING MATRIX

Document Code		
FM-SP-RO1-04-06		
Rev. No.	Eff. Date	Page
00	10.01.17	1 of 1

CAR Control Number	Date Issued	Process Owners	DATE				Status of Implementation	CA Plan Effectiveness Closed (C)/Open (O)			Remarks
			CA Plan Received	CA Plan Accepted	Committed Completion	CA Plan Implementation Verified		1	2	3	

Prepared By:	Reviewed By:	Approved By:
CORAZON C. SIBAYAN Supervising Administrative Officer	**VICTORIA H. RAMOS, CESO V** Assistant Regional Director	**JAMES F. FADRILAN, CESO IV** Regional Director
Team Leader, RIQA	QMR	Top Management

DILG REGIONAL OFFICE 1

OPPORTUNITIES FOR IMPROVEMENT REPORT (OFIR) MONITORING MATRIX

Document Code		
FM-SP-RO1-04-07		
Rev. No.	Eff. Date	Page
00	10.01.17	1 of 1

OFIR Control Number	Date Issued	Process Owner	DATE				Status of Implementation	Remarks
			Action Plan Received	Action Plan Accepted	Committed Completion	Action Plan Implementation Verified		

Prepared By:	Reviewed By:	Approved By:
CORAZON C. SIBAYAN Supervising Administrative Officer	**VICTORIA H. RAMOS, CESO V** Assistant Regional Director	**JAMES F. FADRILAN, CESO IV** Regional Director
Team Leader, RIQA	QMR	Top Management

DILG REGIONAL OFFICE 1

REGIONAL INTERNAL QUALITY AUDIT REPORT

Document Code		
FM-SP-RO1-04-08		
Rev. No.	Eff. Date	Page
00	10.01.17	1 of 1

Regional Office:	**Date of Audit:**

EXECUTIVE SUMMARY

KEY FINDINGS

CONFORMITIES: *(Describe briefly the general positive impressions about the processes audited)*

-
-

NONCONFORMITIES: *(Describe briefly the observed lapses/deviation or nonconformity, if any)*

-
-

OPPORTUNITIES FOR IMPROVEMENT:

-
-

VERIFICATION AND STATUS OF PREVIOUS NONCONFORMITIES OR OFIR:

-
-

Note: Please refer to the CARs or OFIRs for the specific finding

ANNEXES:

- CORRECTIVE ACTION REPORT (CAR)
- OPPORTUNITIE FOR IMPROVEMENT REPORT (OFIR)
- CAR/OFIR MONITORING MATRIX

AUDIT TEAM	SIGNATURE
Audit Team Leader:	
Audit Team Member/s:	

Approved by:

_____

(Regional Quality Management Representative)

Prepared By:	Reviewed By:	Approved By:
CORAZON C. SIBAYAN	**VICTORIA H. RAMOS, CESO V**	**JAMES F. FADRILAN, CESO IV**
Supervising Administrative Officer	Assistant Regional Director	Regional Director
Team Leader, RIQA	QMR	Top Management

PROCEDURE TITLE	**MANAGEMENT REVIEW**
SCOPE	This process starts from scheduling the management review up to recording of management review minutes.
PURPOSE	To define the process of conducting Management Review as per requirements of the ISO 9001:2015 standard and the Region's requirements to ensure the continuing suitability adequacy, effectiveness and alignment to DILG's strategic direction.

PROCESS DESCRIPTION:

INPUT	PROCESS	OUTPUT
Internal Quality Audit QMS Secretariat Corrective Action Report (CAR) – Audit Related Corrective Action Report (CAR) – Non-Audit Related	**MANAGEMENT REVIEW**	Non Recurrence or Occurrence of detected Nonconformity Affected QMS Process All Operating Units

DESCRIPTIVE STATEMENT:

The Management Review Committee (MRC) will agree on the schedule of Management Review (MR) after the conduct of Internal Quality Audit and a Regional Order will be prepared and approved. The QMS Secretariat will prepare the necessary documents for the conduct of MR. MRC members will submit necessary inputs for the said meeting. After each meeting, QMS Secretariat will prepare the Minutes of the Meeting to be reviewed by the Regional Deputy QMR and approved by RQMR. Upon approval of RQMR, QMR Secretariat will prepare a memorandum to communicate to all MRC members the approved MR Minutes.

QMS Secretariat will monitor the implementation of the decisions and agreement during the MR and submit status report and approved MR minutes to the Regional Director and RQMR.

QMS Secretariat will retain documented information of the MR in accordance with the Control of Retained Documented Information procedure and Masterlist of Retained Document Information.

Step No.	Responsible Personnel	PROCESS/ACTIVITY	Details	References
1	QMS Secretariat; Members of the Management Review Committee	• Prepare for the conduct of Management Review	**QMS Secretariat:** • Prepare the necessary documents for the conduct of the Management Review inclusive of budgetary requirements, dates, venue participants, and agenda. • Secure approval of concerned signatories. • Upon approval of the activity, communicate with all concerned including their preparation of inputs to the Management	• Activity Design, Memo, Department Order, as appropriate

Step No.	Responsible Personnel	PROCESS/ACTIVITY	Details	References

			Review.
			Members of the Management Review Committee:
			• Prepare the following assigned topics:
			  • Regional QMR – Follow-up Items from previous Management Review, Results of External Audit Certification and QMS Performance;
			  • IQA – Results of Internal Quality Audit and status of CAR;
			  • All Divisions - Summary of previous year's performance results / accomplishment vs. quality objectives, Client Feedback/Satisfaction, changes that could affect the QMS and recommendations for QMS Improvement.
			• Submit the above reports to the QMS Secretariat for consolidation and reproduction for reference of the participants.
				• Pertinent Management Review Inputs

2	Management Review Committee (MRC)	• Conduct the Management Review with the QMR as the presiding officer	• Discuss the following Management Review Inputs/agenda Items: a) the status of actions from previous management reviews (except for the 1st MR); b) changes in external and	• Pertinent Management Review Inputs

Step No.	Responsible Personnel	PROCESS/ACTIVITY	Details	References
			internal issues that are relevant to the quality management system; c) information on the performance and effectiveness of the quality management system, including trends in: 1) client satisfaction and feedback from relevant interested parties; 2) the extent to which quality objectives have been met; 3) process performance and service conformity; 4) nonconformities and corrective actions; 5) monitoring and measurement results; 6) audit results; and 7) the performance of external providers; d) the adequacy of resources; e) the effectiveness of actions taken to address risks and opportunities; and f) opportunities for improvement	
3	QMS Secretariat	• Prepare the record	• Prepare the minutes of the MR	• MR Minutes

Step No.	Responsible Personnel	PROCESS/ACTIVITY	Details	References
		(Minutes) of the MR	• Indicate actions, decisions, agreements • Submit to QMR	
4	QMR	• Review the minutes	• Review the MR Minutes as to accuracy and completeness of inputs and outputs, if not in order, return to QMS Secretariat for appropriate action; • Forward to Regional Director for approval.	• MR Minutes
5	Regional Director	• Approve the minutes	• Approve the MR minutes and return to QMS Secretariat.	• Signed MR Minutes
6	QMS Secretariat	• Communicate the approved MR Minutes	• Furnish all members of the MRC the approved MR Minutes.	• Approved MR Minutes
7	QMS Secretariat	• Retain documented information	• Retain documented information in accordance with the Control of Retained Documented Information and Masterlist of Retained Documented Information	• SP-RO1-02 Control of Retained Documented Information • Masterlist of Retained Documented Information

Definition of Terms:

- **Management Review Committee**–the committee that reviews the performance of the RQMS every six months or as deemed necessary to evaluate the continuing adequacy, suitability, effectiveness, and alignment to DILG RO1's strategic direction.

  Records of Management Reviews are controlled by the QMS Secretariat. The DILG RO1's Management Review Committee is composed of the following:

  - Regional Director
  - Assistant Regional Director – Regional Quality Management Representative (RQMR)
  - Provincial Directors – Deputy Quality Management Representative (DQMR)
  - Division Chief - Deputy Quality Management Representative (DQMR)
  - Program Managers and Cluster Leaders
  - Unit/ Section Chiefs

Prepared By	Reviewed By	Approved By
CORAZON C. SIBAYAN Supervising Administrative Officer	**VICTORIA H. RAMOS, CESO V** Assistant Regional Director	**JAMES F. FADRILAN, CESO IV** Regional Director
Head, QMS Secretariat	QMR	Top Management

DILG REGIONAL OFFICE 1

MANAGEMENT REVIEW MINUTES

Document Code		
FM-SP-RO1-05-01		
Rev. No.	**Eff. Date**	**Page**
00	10.01.17	1 of 1

Date of Management Review: _____ **Venue:** _____

Present: _____ _____ _____

_____ _____ _____

_____ _____ _____

Absent: _____ _____ _____

Item	Agenda Item	Issues / Highlights of Discussion / Management Action and Decisions	Action Plan (What, Who, When to Do)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

Prepared By: Reviewed By Approved By

_____ _____ _____

QMS Secretariat Head **Regional Quality Management Representative** **Regional Director**

Prepared By	Reviewed By	Approved By
CORAZON C. SIBAYAN Supervising Administrative Officer	**VICTORIA H. RAMOS, CESO V** Assistant Regional Director	**JAMES F. FADRILAN, CESO IV** Regional Director
Head, QMS Secretariat	QMR	Top Management

DILG-R1 QMS CONTROLLED COPY

PROCEDURE TITLE	**CONTROL OF NONCONFORMING OUTPUT**
SCOPE	This process describes the procedure in identifying and controlling nonconforming output, including the disposition actions and responsibilities.
PURPOSE	To ensure prevention of unintended delivery of nonconforming output.

PROCESS DESCRIPTION:

INPUT	PROCESS	OUTPUT
Client → Identified Nonconforming Output	Control of Nonconforming Output	Disposition / Nonconforming Output record → Client

DESCRIPTIVE STATEMENT:

The Process Owner identify the nonconforming output, determine the appropriate disposition or action, and submit to DC or Head of Office for review and approval. The disposition is then implemented and verified. Copy of the signed Nonconforming Output record is submitted to QMS Secretariat for logging and consolidation.

Step No.	Responsible Personnel	Process/Activity	Details	References
1	**Process owner**	Identify nonconforming output	• Identify/detect and record nonconforming output such as: - Typographical errors - Other errors resulting from processing lapses • Describe the detected nonconforming service.	• Nonconforming Output Form (NOF)
2	**Process owner**	Decide appropriate disposition	• Determine the appropriate disposition/recommended action to address the nonconforming service such as: - Replacement - Rework/Reprocess - Other appropriate action • Submit to Division Chief/ Head of Office for review and approval.	• Nonconforming Output Form (NOF)
3	**Division Chief/OIC/Head of Office**	Review and approve the recommended disposition	• If recommended disposition is found in order, sign the NOF; else, return to Process Owner for appropriate action.	• Nonconforming Output Form (NOF)

4	**Process Owner, Division Chief/OIC/Head of Office**	Implement disposition	• Process Owner: Record the implementation of the disposition. • Division Chief/ Head of Office: Verify and ensure that the resulting service conforms to specified requirements. • If verification shows that requirements are not met, advise process owner to take appropriate action; else, sign the NOF. • Submit copy of the signed NOF to the QMS Secretariat.	• Nonconforming Output Form (NOF)
5	**QMS Secretariat**	Log the nonconforming output	• Log the nonconforming output in the Nonconforming Output Log Sheet	• Nonconforming Output Log Sheet
6	Designated Custodian	Retain records	• Retain records in accordance with the Control of Retained Documented Information Procedure and Master List of Records	• Control of Retained Documented Information Procedure • Master List of Records

Definition of Terms:

- Nonconforming Output – is a service or product resulting from QMS processes that does not meet specified requirements.
- Nonconforming Service Form (NOF) – the specified form used to record the nonconforming output and the actions taken to rectify it.

Prepared By	Reviewed By	Approved By
CORAZON C. SIBAYAN Supervising Administrative Officer	**VICTORIA H. RAMOS, CESO V** Assistant Regional Director	**JAMES F. FADRILAN, CESO IV** Regional Director
Head, QMS Secretariat	QMR	Top Management

DILG REGIONAL OFFICE 1

NONCONFORMING SERVICE FORM

Document Code		
FM-SP-RO1-06-01		
Rev. No.	Eff. Date	Page
00	10.01.17	1 of 1

Date:_____

Office:_____ **Division/Unit:-**
_____

Process/ Service: _____

1. Type of NC Service

- ☐ **Typographical error**
- ☐ **Process lapses**
- ☐ **Others:** _____

2. Description of detected nonconforming product / service:

_____
_____
_____
_____

3. Disposition / Recommended action to address the nonconforming service:

- ☐ **Replace**
- ☐ **Repair/ Rework/Reprocess**
- ☐ **Other Action** _____

4. Disposition/ Recommended Action Statement

_____
_____
_____

_____
Prepared by:
(Name and Signature of Process owner)

_____
Approved by:
(Name and Signature of Division Chief/ Head Office)

5. Status of implementation of disposition / recommended action:

- ☐ **Implemented** **Date Implemented:** _____
- ☐ **Not Implemented** **Reason:** _____
  _____
  _____

_____
6. Verified by:
(Name and Signature of Division Chief / Head Office)

Date Verified: _____

Prepared By	Reviewed By	Approved By
CORAZON C. SIBAYAN Supervising Administrative Officer	**VICTORIA H. RAMOS, CESO V** Assistant Regional Director	**JAMES F. FADRILAN, CESO IV** Regional Director
Head, QMS Secretariat	QMR	Top Management

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DILG REGIONAL OFFICE 1

NONCONFORMING OUTPUT LOGSHEET

Document Code		
FM-SP-RO1-06-02		
Rev. No.	Eff. Date	Page
00	10.01.17	1 of 1

Office: _____

No.	Process	Type of Nonconforming Output	Description of Nonconforming Output	Disposition / Recommended Action	Date Implemented	Reason for Non-implementation	Remarks, if any

Prepared By:	Noted by:
QMS Secretariat Member	QMS Secretariat Head

Prepared By	Reviewed By	Approved By
CORAZON C. SIBAYAN Supervising Administrative Officer	**VICTORIA H. RAMOS, CESO V** Assistant Regional Director	**JAMES F. FADRILAN, CESO IV** Regional Director
Head, QMS Secretariat	QMR	Top Management

PROCEDURE TITLE	**RISK IDENTIFICATION, EVALUATION AND CONTROL**
SCOPE	This process starts from the identification up to controlling of risks as well as opportunities relative to the DILG Region's organizational context, needs and expectations of its interested parties and its QMS scope.
PURPOSE	To define the process of proper, accurate and effective determination, evaluation and control of risks.

PROCESS DECSRIPTION:

INPUT	PROCESS	OUTPUT
QMS Planning → Internal and External Issues; Requirements, Needs and Expectations of Interested Parties; Objectives; Processes	Risk Identification, Evaluation and Control	Risk Register → Concerned Process Owners

DESCRIPTIVE STATEMENT:

This procedure starts from determining risks and opportunities considering the organization's internal and external issues, requirements of interested parties, scope of QMS and products and services. Then, a defined risk assessment criteria provides a basis for determining significant risks which require further control actions. An oversight review process ensures the reasonable accuracy and reliability of the risk assessment outputs, called Risk Registers. Further, control and opportunity plans are assessed for effectiveness prior to inclusion in existing QMS process and documents.

Step No.	Responsible Personnel	Process/Activity	Details	References
1	**Process Owner**	Determine risks and opportunities	• Determine internal and external issues, both positive and negative, interested parties, objectives, processes and corresponding risks and opportunities as follows: • Objectives • Process	• Context Registry • Interested Parties Matrix • Quality Objectives • QMS Scope • Risk Register • Opportunity Management Plan
2	**Process Owner**	Determine risk trigger, consequence, and existing control measures	• Determine: • Risk trigger • Potential effects/consequences of risk as well as opportunities, where applicable • existing control measures, if any, to prevent the risk from happening, or treat and	• Documented operating procedures Risk Register

			mitigate its effect/consequence.	
3	**Process Owner**	Rate the risk	• Calculate the risk level or risk rating by estimating the severity of consequence and the likelihood of its occurrence based on the following Risk Criteria: • Severity • Likelihood • Detection • Determine significant (high) risk. • Note: If the consequence is 5 and likelihood is high (5), this should be considered as significant risk regardless of the detection rating.	• Risk Criteria Matrix • Risk Register
4	**Process Owner**	Prepare risk control plan and opportunity management plan	• Establish a risk control plan for significant risks and opportunity management management plan for opportunities that require an action plan or project in order to pursue. **Notes:** 1. Some opportunities do not require a specific set of activities in order to realize its benefits; others do require a specific project or action plan before realizing the benefits. In case of risks detected as part of an opportunity pursuit, conduct also a risk assessment before proceeding. 2. Possible management	• Risk Register

			actions to address risks: a) Avoiding risk b) Taking risk to pursue an opportunity c) Eliminating the risk source d) Reducing the risk by changing either or both likelihood and/or consequence e) Sharing the risk (e.g. through insurance) f) Retaining the risk by informed decision 3. Possible management actions to pursue an opportunity a) Adoption of new products b) Launching new products c) Opening new markets d) Addressing new customers e) Building partnerships or joint ventures f) Using new technology g) Other desirable and viable possibilities to address the organization's or customer's needs	
5	**Division Chief/ Head of Office**	Review the risk assessment results	• Review the risk assessment results and the corresponding action plans to ensure appropriateness and accuracy of ratings used and adequacy of planned actions. • For any comments/changes, return to process owner for appropriate action. • Forward to the Regional Risk Review Commitee.	• Risk Register

			Note: All Risk Registers must be submitted to the Regional Risk Review Committee one month before the Regional Planning activity.	

6	**Regional Risk Review Team**	Conduct oversight review to confirm the risk assessment results	• Conduct a risk review meeting to:
			  • Confirm the risk ratings determined by the concerned process owners.
			  • Ensure the adequacy of the risk control plan and opportunity management plans.
			• Return to concerned office for appropriate action.
				• Risk Registers
				• Opportunity Management Plan

7	**Process Owner/Division Chief**	Finalize the Risk Register	• Finalize the risk register and the Opportunity Management Plan (OMP) considering inputs from the Risk Review Team. • Secure signature of the Risk Review Team Leader and the recommendation for approval by the Regional Quality Management Representative.	• Risk Register • Opportunity Management Plan
8	**Regional Director**	Approve the Risk Register	• Approve the Risk Register and/or the Opportunity Management Plan	• Risk Register • Opportunity Management Plan
9	**Concerned Personnel**	Take action	• Implement the risk control plan and the opportunity management plan. • Monitor results of implementation, every end of the quarter and address any issue or problem encountered.	• Risk Registers • Opportunity Management Plan • Risk Control Plan/Opportunity Management Plan Status Monitoring

10	**Process Owner**	Re-assess the risk	• One month after full implementation of the risk control plan, re-assess the risk to confirm effectiveness of the actions taken and verify whether or not risk controls are effective. • If risk remain significant provide additional risk control action plan. Revise the Risk Registers as necessary.	• Risk Register
11	**Concerned personnel**	Integrate effective risk controls to the respective process and documents	• Integrate effective risk controls into the respective QMS processes and documents, such as planning, policies and procedures, forms, and other QMS processes and documents. • Revise/update the affected QMS document, as necessary, in accordance with the Control of Maintained Documented Information Procedure	• Affected QMS Document • Control of Maintained Documented Information Procedure
12	**Designated Custodian**	Retain Records	• Retain records in accordance with the Control of Retained Documented Information Procedure and Master List of Records.	• Control of Retained Documented Information Procedure • Master List of Records

Definition of Terms:

Risk – effect of uncertainty
Effect – deviation from the expected, whether positive or negative
Consequence – outcome of an event affecting objectives or controls

Uncertainty – the state of deficiency of information related to, understanding of, or knowledge of an event, its consequence, or likelihood
Risk Register – a documented information summarizing the results of the risk assessment
Risk trigger – a condition which causes the risk to occur
Risk assessment – process of estimating the magnitude of the effect of risk using a defined risk criteria to determine whether or not the risk is significant
Risk criteria – terms of reference against which risk is assessed by estimating its impact (severity or benefit) and likelihood of occurrence.
Risk rating – the magnitude of risk considering the impact of the effect and its likelihood
Impact – the severity (negative effect) or benefit (positive effect) of risk
Severity - the seriousness of the harm, impact or consequence of the risk
Likelihood – the probability of occurrence of the effect of risk
Detection – the probability that occurrence of risk can be detected early enough to enable proper responses to be initiated
Existing Risk Control Measures - modify the severity of consequence, likelihood or detection of risk
Risk Treatment – any action intended to modify or lower down the risk magnitude
Significant risk – a risk whose rating exceeds the threshold
Opportunity – a positive effect of uncertainty which may or may not require specific actions in order to pursue or realize; also refers to **benefits** or gains realized from the positive effect of ris

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Head, QMS Secretariat	QMR	Top Management

DILG REGIONAL OFFICE 1

RISK REGISTER (Objective)

Document Code		
RRO-QP Code		
Rev No.	Eff. Date	Page
00	**10.01.17**	**1 of 1**

DIVISION/OPERATING UNIT	
QUALITY PROCEDURE TITLE	

OBJECTIVE	RELEVANT ISSUE(S)	RELEVANT INTERESTED PARTIES *(refer to IP Matrix for Requirements)*	POTENTIAL RISK	RISK TRIGGER	CONSEQUENCE *(Positive or Negative)*	EXISTING RISK CONTROL MEASURE	RISK ASSESSMENT								RISK CONTROL PLAN			
							IMPACT	LIKELIHOOD	DETECTION	RATING	RISK LEVEL (L, M, H)	S, NS	RISK CONTROL ACTION	RPN *(Risk Priority No.)*	ACTION PLAN (if risk rating is significant)	RESPONSIBLE	TIMELINE	RESOURCE

RISK ASSESSMENT:	RISK RATING	RISK LEVEL	RISK DESCRIPTION	ACTION REQUIRED	RPN
IMPACT: 1-Insignificant; 2-Minor; 3-Moderate; 4-Major; 5-Extreme	1 - 25	LOW	Not Significant	**No further action required** (Retain risk by informed decision)	**3**
LIKELIHOOD: 1-Rare; 2-Unlikely; 3-Moderate; 4-Likely; 5-Almost Certain	26-40	MODERATE	Not Significant	**Alert** level but no further action required for now	**2**
DETECTION: 1 - Very likely, 2 - Likely; 3 - Low, 4 - Remote 5 - Very remote	>40	HIGH	Significant	**Control** (e.g.. Treat/Mitigate Transfer, Terminate)	**1**
Risk Rating = Impact X Likelihood X Detection					

Prepared By:	Prepared By:	Reviewed By:	Recommending Approval:	Approved By:
Process Owner	Division Chief	Risk Review Team Head	QMR	Top Management

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RISK REGISTER (PROCESS)

Document Code		
RRP-QP Code		
Rev No.	Eff. Date	Page
00	**10.01.17**	**1 of 2**

DIVISION/OPERATING UNIT	
QUALITY PROCEDURE TITLE	

PROCESS STEP (Based on the procedure's key process steps)	**POTENTIAL RISK**	**RISK TRIGGER**	**CONSEQUENCE** *(Positive or Negative)*	**EXISTING RISK CONTROL MEASURE**	**RISK ASSESSMENT**								**RISK CONTROL PLAN**			
					IMPACT	**LIKELIHOOD**	**DETECTION**	**RATING**	**RISK LEVEL** (L, M, H)	**S, NS**	**RPN** *(Risk Priority No.)*	**RISK CONTROL ACTION**	**ACTION PLAN (if risk rating is significant)**	**RESPONSIBLE**	**TIMELINE**	**RESOURCE**

RISK ASSESSMENT:	**RISK RATING**	**RISK LEVEL**	**RISK**	**ACTION REQUIRED**	**RPN**
IMPACT: 1-Insignificant; 2-Minor; 3-Moderate; 4-Major; 5-Extreme	1 - 25	LOW	Not Significant	**No further action required** (Retain risk by informed decision)	**3**
LIKELIHOOD: 1-Rare; 2-Unlikely; 3-Moderate; 4-Likely; 5-Almost Certain	26-40	MODERATE	Not Significant	**Alert** level but no further action required for now	**2**
DETECTION: 1 - Very likely, 2 - Likely; 3 - Low, 4 -	>40	HIGH	Significant	**Control** (e.g.. Treat/Mitigate Transfer, Terminate)	**1**
Risk Rating = Impact X Likelihood X Detection					

Prepared By:	Prepared By:	Reviewed By:	Recommending Approval:	Approved By:
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RISK CRITERIA MATRIX

Document Code		
FM-SP-RO1-07-01		
Rev No.	Eff. Date	Page
00	10.01.17	1 of 1

Risk Rating		Impact	Probability			
SCALE	**RATING**	**SEVERITY (Negative Effect)**	**SCALE**	**LIKELIHOOD** of occurrence - the chance that the harm will occur; also referred to as probability	**SCALE**	Likelihood of **DETECTION** - the chance that the occurrence of harm will be detected to enable prompt action or response
5	**Extreme**	Can result to discontinuity/stoppage of operations; Legal noncompliance, loss of customer, financial loss which can result to closure; or severe damage to organization's reputation	**5**	**Almost certain** – Very high probability of occurrence is expected; happened more than once in a year	**5**	**Very remote** – absolutely no chance of detection of occurrence
4	**Major**	Can result in nonconforming product, delayed delivery, customer complaint, disruption of operations	**4**	**Likely** – Probability of occurrence is expected; happened once in the previous year	**4**	**Remote** – probability of detection is not expected
3	**Moderate**	Can result to the inconsistent implementation of QMS processes in a certain degree, resulting to inconsistent quality	**3**	**Moderate –** Probability of occurrence is reasonably expected; happened once in the last 3 years	**3**	**Low –** there's a low chance or probability of detection of failure
2	**Minor**	Minimal negative impact to the iorganization; can be possibly accepted as it is	**2**	**Unlikely** – Probability of occurrence is low; happened once in the last 5 years	**2**	**Likely** – probability of detection is expected
1	**Insignificant**	No negative impact at all	**1**	**Rare** - Almost not possible to occur at all	**1**	**Almost certain** – very high probability of detection is expected

Risk Assessment Matrix			
Rating	Risk Level	Color	Action
10 -25	High		Control Plan/Action Plan is Required
8-10	Moderate		Alert level but no action required
< 8	Low Risk		No action is required

Prepare by	Reviewed by	Approved By:
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DILG REGIONAL OFFICE I

OPPORTUNITY MANAGEMENT PLAN

Document Code		
FM-SP-RO1-07-03		
Rev No.	Eff. Date	Page
00	10.01.17	1 of 1

OFFICE										
NO.	OPPORTUNITY	POTENTIAL BENEFIT:(S)	ACTIVITIES	RESPONSIBLE	TIMELINES		RESOURCE NEEDED	MONITORING		
					Start	End		FREQUENCY	WHO	RECORD

Prepare by	Reviewed by	Approved By:
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DILG REGIONAL OFFICE I

RISK CONTROL/ OPPORTUNITY PLAN STATUS MONITORING

Document Code		
FM-SP-RO1-07-02		
Rev No.	Eff. Date	Page
00	10.01.17	1 of 1

PERIOD COVERED: _____

DIVISION / SECTION: _____

RISK CONTROL _____

ITEM	ACTIVITY	Responsible	Date Started	Date Completed	REMARKS - Status, Constraints, Other Actions Taken, if any

Prepared By:		Reviewed By:	Recommendiing Approval:	Approved By:
Process Owner	Division Chief	Risk Review Team Head	QMR	Top Management

Prepare by	Reviewed by	Approved By:
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Head, QMS Secretariat	QMR	Top Management

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PROCEDURE TITLE	**QMS PLANNING**
SCOPE	Covers the activities from the review of the existing QMS scope up to the communication of approved quality operating procedures to all concerned.
PURPOSE	To define an effective QMS planning process for setting QMS scope, objectives and targets as basis for assessing its effectiveness.

PROCESS DESCRIPTION

INPUT	PROCESS	OUTPUT
Regional QMR → QMS Scope Review	QMS Planning	Communicate Quality Operating Procedures → QMS Secretariat/ Process Owners

DESCRIPTIVE STATEMENT: The Regional QMR will conduct the QMS Scope review. Upon finalizing the needed preparations, the QMS Secretariat and Process Owners will start preparing for the QMS Planning. The final output will be the enhanced quality operating procdure manuals to be communicated by the QMS Secretariat and the Process Owners within their respective division/ unit.

Step No.	Responsible Personnel	Process/Activity	Details	References
1	**Regional QMR**	Review QMS Scope	• Review current processes in the QMS in relation to the agency's Major Final Outputs (MFOs)/ Major Programs/ Projects/ Activities (PPAs) and the Top Management Objectives (TMO) for any possible enhancements. • In case of inclusion/ exclusion of other processes/services to the QMS, seek approval from the Regional Director.	• Quality Manual (Scope, Planning - Top Management Objectives) • List of QMS processes
2	**QMS Secretariat; Process Owners**	Prepare QMS Planning	QMS Secretariat: • Prepare the necessary documents for the conduct of the QMS Planning Workshop inclusive of budgetary requirements, dates, participants and venue. • Secure approval of concerned signatories. • Upon approval of the activity, communicate with all concerned. • Provide all concerned the	• Activity Design, Memo/ Advisory, Regional Order, as appropriate • QMS Planning forms (e.g Quality Objectives, QME) • Supporting Documents

Step No.	Responsible Personnel	Process/Activity	Details	References

			applicable forms and guidelines, if any, as basis for their preparation to the QMS planning workshops.
			Process Owners:
			• Prepare the following, as appropriate, duly signed by identified signatories:
			  • Summary of previous year's performance results / accomplishment vs. quality objectives;
			  • Proposed functional / process quality objectives and targets for the new calendar year.
			  • Quality action plan (QAP) where necessary.
			• Supporting documents for the goals / objectives / targets.	

3	**R/DQMR; All Process Owners**	Conduct the QMS Planning	• **R/DQMR:** Facilitate the QMS Planning workshop under direct supervision of the QMR. • **Al Process Owners:** Present the quality objectives and targets for the ensuing year. Provide basis of targets using the previous year's performance results. Align with OPB, SPMS and other relevant documents showing performance targets of the Region. ***Note:*** *Consider the top management objectives in the setting of functional / process objectives and targets.* • **Secretariat:** Document proceedings and Collect all quality objectives and targets.	• Proposed QOs • QO-RO1-QMS • QOs

Step No.	Responsible Personnel	Process/Activity	Details	References
4	**QMS Secretariat**	Consolidate the submitted QMS Planning outputs	**QMS Secretariat:** • Consolidate the proposed quality objectives and targets. • Submit to QMR for review and to the Regional Director for approval.	• QOs • QOs
5	**QMR; Top Management**	Review and sign the proposed quality objectives / targets	• Review and sign the Quality Objectives (QO), as appropriate.	• QOs
6	**QMS Secretariat, Process Owners**	Communicate the quality objectives	• **QMS Secretariat:** Provide concerned Process Owners of the Regional Office/Divisions copies of their approved QMS objectives. • **Process Owners:** Communicate the approved quality objectives/ targets and other agreements made in the planning workshop within their respective Division.	• Copies of QOs • Bulletin Posting/ Memo
7	**Process Owners, QMS Secretariat**	Retain records	• Retain records in accordance with the Control of Retained Documented Information procedure.	• Masterlist of Retained Documented Information

Prepared By	Reviewed By	Approved By
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DILG REGIONAL OFFICE 1

QUALITY OBJECTIVE (QO)

Document Code		
QO-QP Code		
Rev. No.	Eff. Date	Page
00	10.01.17	1 of 1

DIVISION/ OPERATING UNIT	**ALL DIVISIONS AND OPERATING UNITS**
QUALITY PROCEDURE TITLE	QMS Planning

Function	Key Performance Indicators (KPI)			Frequency of Monitoring Results	Responsible for Monitoring	Applicable Documents
	Objective	Target	Indicator/Formula (if applicable)			

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QUALITY PROCEDURE (QP)

Document Code		
QP Code		
Rev. No.	Eff. Date	Page
00	10.01.17	1 of 1

PROCEDURE TITLE	
SCOPE	
PURPOSE	

PROCESS DESCRIPTION

INPUT	PROCESS	OUTPUT
Source → Input	Procedure Title	Output → Receiver

DESCRIPTIVE STATEMENT

Step No.	Responsible Personnel	Process/Activity	Details	References
1				
2				
3				

Resources:

Definition of Terms:

Prepared By	Reviewed By	Approved By
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DILG REGIONAL OFFICE 1

QUALITY ACTION PLAN (QAP)

Document Code		
QAP-QP Code		
Rev. No.	Eff. Date	Page
00	10.01.17	1 of 1

PROCEDURE TITLE	
OBJECTIVE STATEMENT	

Activity	Responsibility	Timeline	Resources (Put "None" if there is no resource requirement)
Area 1 Concern:			
Strategy:			
1			
2			
Area 2 Concern			
Strategy:			
1			
2			
3			
4			

Prepared By	Reviewed By	Approved By
Process Owner	Division Chief	QMR

Prepared By	Reviewed By	Approved By
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QMS Secretariat Head	QMR	Top Management

PROCEDURE TITLE	**EXTERNAL CLIENT SATISFACTION SURVEY**
SCOPE	This procedure covers the activities from the conduct of client satisfaction survey up to the issuance of analysis and summary of client satisfaction report to management.
PURPOSE	To define the process for conducting client satisfaction surveys (CSS) and analyzing results to confirm that client satisfaction objective is achieved.

PROCESS DECSRIPTION:

INPUT	PROCESS	OUTPUT
Core Process → Process Output	EXTERNAL CLIENT SATISFACTION SURVEY	Customer Satisfaction Survey Rating report → Regional Management

DESCRIPTIVE STATEMENT:

The concerned Process Owner determine the method for the conduct of customer satisfaction using the Client Satisfaction Survey Matrix. Once identified, the concerned Process Owner prepare the survey tool, conduct the survey, collect and summarize the filled up survey tool, and submit to the QMS Secretariat. QMS Secretariat analyze the report and issue Corrective Action Report, as appropriate.

Step No.	Responsible Personnel	Process/Activity	Details	References
1	**Concerned Process Owner**	Determine the method for the conduct of customer satisfaction	• Determine the method for the conduct of customer satisfaction including the type of client, mode of survey and the relevant survey tool using the Client Satisfaction Survey Matrix. • Determine the sample size and frequency.	• Client Satisfaction Survey Matrix
2	**Concerned Process Owner**	Prepare the survey tool	• Prepare the survey tool relevant to the type of service provided or adopt the general Client Satisfaction Survey (CSS) Form	• Survey tool/ CSS form
3	**Concerned Process Owner**	Conduct the CS survey	• Issue/send the survey tool/CSS form to the identified respondent who received DILG services	• Survey tool/ CSS form
4	**Concerned Process Owner**	Collect and summarize the filled-up survey tool/CSS forms	• Retrieve the filled-up survey tools/CSS Forms tool from the concerned respondent	• Accomplished Survey tool/ CSS form

Step No.	Responsible Personnel	Process/Activity	Details	References
			• Record the ratings in the Process Summary Logsheet (PSL), and CSS Summary incorporating the feedbacks/comments if any, duly approved by the concerned Division Chief. • Summarize the results in the Process Quality Monitoring and Evaluation (QME) duly approved by the concerned Division Chief/Head of Office and submit. • Submit the PSL and QME Reports and CSS Summary to the QMS Secretariat on or before the 10th working day of the ensuing month of the current period in accordance with the Performance Monitoring and Evaluation Procedure. *Note: Provincial Office Process Owners submit CSS Summary to the Provincial QMS Focal Person. Provincial QMS Focal Person submits the CSS Summary to the QMS Secretariat on or before the 5th working day of the ensuing month of the current period.*	• Process Summary Log Sheet/CSS Summary Log Sheet • Process QME • Performance Monitoring and Evaluation Procedure
5	**QMS Secretariat**	Analyze the CSS results	• Consolidate the PSL, QME and CSS Summary with analysis and submit the same to the Deputy QMR. • Prepare Corrective Action Report (CAR) for unmet customer satisfaction target and recorded complaint in the CSS form, if any, in accordance with Nonconformity and Corrective Action Procedure.	• Process Summary Log Sheet/CSS Summary • Process QME • CAR • Nonconformity and Corrective Action

Step No.	Responsible Personnel	Process/Activity	Details	References
				• Process Performance Monitoring and Measurement • QMS-PSL • QMS-QME
6	**QMS Secretariat; Concerned Process Owners**	Retain Records	• Retain records in accordance with Control of Retained Documented Information Procedure and Master List of Records.	• Control of Retained Documented Information Procedure • Master List of Records

Prepared By	Reviewed By	Approved By
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DILG REGIONAL OFFICE 1

CSS SUMMARY LOG SHEET

Document Code		
FM-SP-RO1-09-01		
Rev. No.	Eff. Date	Page
00	10.01.17	1 of 1

DIVISION/OPERATING UNIT/PO	

Month	Quality Procedure	TOTAL CSS Received	Unsatisfactory and Below (2, 1)	Satisfactory or Above rating (3, 4, 5)	Comments/Suggestions
TOTAL					

Prepared By:	Approved by:
Process Owner/QMS Focal Person/QMS Secretariat	Immediate Supervisor/QMR

Prepared By	Reviewed By	Approved By
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DILG REGIONAL OFFICE 1
Sevilla, City of San Fernando, La Union

Document Code		
FM-SP-R01-09-02		
Rev. No.	Eff. Date	Page
00	10.01.17	1 of 1

Client Satisfaction Survey (CSS) Form

Name: (Optional) _____ Date: _____

Service/Assistance Requested/Received: _____

Office Concerned: _____

Dear Client,

We at DILG-Regional Office 1 endeavors to consistently provide effective services to meet our client's needs. In this regard, may we request you to help us improve our services by allowing us to hear your voice.

Kindly fill-out this survey form and reflect your impressions about our services. Encircle the rating that corresponds to your satisfaction level.

Rating Scale	Description of Level of Satisfaction
5	Excellent
4	Very Satisfactory
3	Satisfactory
2	Fair
1	Low

A. Service Parameter	Client Satisfaction	Remarks
1. Service Quality	5 4 3 2 1	_____
2. Service Timeliness	5 4 3 2 1	_____
3. Staff Responsiveness	5 4 3 2 1	_____
B. Overall Impression	5 4 3 2 1	_____

C. Comments/ Suggestions: _____

Prepared By	Reviewed By	Approved By
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PROCEDURE TITLE	**PROCESS PERFORMANCE MONITORING AND MEASUREMENT**
SCOPE	This procedure covers the activities from the monitoring of relevant process parameters to summarizing monthly results and initiating needed corrections and corrective actions for unmet objectives, where applicable.
PURPOSE	To define the process for the periodic monitoring, measurement and reporting of process performance against specified quality objectives or planned results of each process.

PROCESS DESCRIPTION

INPUT	PROCESS	OUTPUT
Operating units → Process performance results	Process Performance Monitoring And Measurement	QMS Performance Analysis Report → RD

DESCRIPTIVE STATEMENT: The operating units as process owners implement the Monitoring and Measurement Procedures; Record the actual process parameters and indicators; Summarize the process performance results; Validate the Monitoring & Measurement Process result; Validate and Consolidate QME Report; Continue process monitoring and conduct data analysis and retain records.

Step No.	Responsible Personnel	Process/Activity	Details	References
1	Process Owner	Implement the Process	• Implement the process as per documented procedures.	• Quality Procedure (QP) of the process
2	Process Owner	Record process parameters/ indicators	• Record the actual process parameters/ indicators as per specified monitoring frequency as basis for evaluating the attainment or non-attainment of committed quality objectives.	• Specific monitoring tool per process
3	Process Owner	Summarize and report the process performance results	• Summarize and print the Process Summary Log Sheet (PSL), as appropriate, showing the consolidated results for the current period. • Compute and record the process performance results for the current period using the Process Quality Monitoring and Evaluation (QME), print and submit for validation/approval by the Provincial Director/ Division Chief	• Process Summary Log Sheet, if any • Process Quality Monitoring and Evaluation (QME)

4	Immediate Supervisor (Provincial Director/ Division Chiefs)	Validate/ approve the Monitoring & Measurement Process result	• Validate/ approve the Quality Monitoring and Evaluation (QME) result • PDs/DCs Communicate within the operating unit the process performance results and return to Process Owner for submission to QMS Secretariat	• Bulletin Posting or Minutes of Meeting or Memo-transmittal
5	Process Owner	Submit the approved Monitoring and Measurement Process result	• Submit the PSL, if any and QME Report to the QMS Secretariat on or before the 10th working day of the ensuing month of the current period. *Note: Provincial Office Process Owners submit PSL, if any and QME to Provincial QMS Focal Person. Provincial QMS Focal Person summarizes the QME into a provincial report by encoding in the Provincial QME template shared thru Google Drive on or before the 5th working day of the ensuing month of the current period. The Regional Office QMS Secretariat integrates the provincial performance per quality procedure in the regional performance.*	• PSL, if any • QME-RO1-QMS
6	QMS Secretariat	Monitor and Consolidate QME Report	• Monitor the submission of the PSL and QME Report. Review results based on available information submitted. • Consolidate QME Results and evaluate performance against top management objectives. • Submit QME report, PSL, and QME results to Regional QMR. • Note: If with unmet targets, follow the Corrective Action System Procedure (SP-RO1-03) for the issuance of Corrective Action Report (CAR)	• QME Report and Supporting Document/s • QME Report, PSL • Corrective Action Report (CAR)
7	Operating Units	Continue process monitoring and conduct data analysis	• Continue process monitoring on succeeding period. • Analyze data and trends every three (3) consecutive	• Process Monitoring Tool/s • QMS Performanc

			performance reporting periods and submit to the QMS Secretariat on the 10th working day of the ensuing month.	e Analysis Report
8	QMS Secretariat	Retain Records	• Retain records in accordance with control of retained documented information procedure and the Masterlist of Retained Documented Information.	• Control of Documented Information Procedure • Masterlist of Retained Documented Information

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Head, QMS Secretariat	QMR	Top Management

DILG REGIONAL OFFICE 1

PROCESS QUALITY MONITORING AND EVALUATION (QME)

Document Code		
QME-QP Code		
Rev. No.	Eff. Date	Page
00	10.01.17	1 of 1

DIVISION/OPERATING UNIT	
QUALITY PROCEDURE TITLE	
OBJECTIVE STATEMENT	
CURRENT PERIOD	

INDICATORS		**Period 1**	**Period 2**	**Period 3**	**Period 4**	**Period 5**	**Period 6**	**Period 7**	**Period 8**	**Period 9**	**Period 10**	**Period 11**	**Period nth**	**Total**
Objective 1														
A														
B														
X	Formula: | Target Result:													
X	Gap Analysis: In case the objective is not met, put your analysis why it is not met													
Objective nth:														
A														
B														
X	Formula: | Target Result:													
X	Gap Analysis: In case the objective is not met, put your analysis why it is not met													

Note: For unmet targets, the QMS Secretariat will issue duly signed Corrective Action Report (CAR).

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QMS PERFORMANCE ANALYSIS REPORT

Document Code		
FM-SP-RO1-10-02		
Rev. No.	Eff. Date	Page
00	10.01.17	1 of 1

PROCEDURE TITLE				
QUALITY OBJECTIVE				
COVERED PERIOD	**FROM:**		**TO:**	

PART I: OVERALL ANALYSIS

PART II: GRAPHICAL PRESENTATION

PART III: IDENTIFIED GAPS/CONSTRAINTS/WEAKNESS AND ACTION PLAN

GAPS/CONSTRAINTS WEAKNESS	**ACTION PLAN**			
	ACTIVITY	**RESPONSIBLE PERSON**	**TIMELINE**	
			FROM	**TO**
	(Identified Strategy)			

Prepared By	Reviewed By	Approved By
Name:	**Name:**	**Name:**
Date:	**Date:**	**Date:**
Position:	Position:	Position:

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