CAUVERY COLLEGE FOR WOMEN (Autonomous)

(Nationally Accredited (3rd Cycle) with 'A' Grade by NAAC)

TRICHY

QUALITY MANAGEMENT SYSTEM PROCEDURES

(Established to the requirement of ISO 9001:2015)

Prepared by	**Document Controller**
Approved by	**Principal**
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ESTABLISHED WITH THE REQUIREMENTS OF ISO 9001:2015 QUALITY MANAGEMENT SYSTEM

PROCEDURE APPROVAL

	Name	Signature	Position	Date
Prepared by				
Reviewed by				
Approved by				

AMENDMENT RECORD

Sl.No	Page No	Context	Revision	Date

TABLE OF CONTENTS

1. PROCEDURE FOR CONTROL OF DOCUMENTED INFORMATION

(Refer to Clause 7.5.3 of ISO 9001:2015)

1.0 PURPOSE

To establish and maintain documented procedures and to ensure that the documents and data relating to the Quality Management System (QMS) are reviewed and approved for adequacy by authorized personnel prior to issue and that the changes / revisions are carried out in a controlled manner.

To ensure that all documents are established and properly maintained to provide evidence of conformity for effective operation of QMS

2.0 SCOPE

This covers all the documents that come under the purview of Quality Management System at CCW and demonstrate conformance to specified requirements of QMS

3.0 DEFINITIONS:

"Master Document" is the original which bears the original signature of the approving authority and used for making photocopies for distribution. "Controlled Copy" means copy of the master document. Its circulation is controlled. "Uncontrolled Copy" means all those copies that need not be controlled for distribution and revision status.

"Superseded Document" is an obsolete version of the Master Document, Controlled copy or uncontrolled copy.

4.0 RESPONSIBILITIES

1) OR prepares Quality Manual (QSAM) in accordance with the ISO standards
2) OR in consultation with Principal and HODs prepares Quality Management System Procedures (QSP) and work instructions to realize the objectives of the Institution
3) While preparing the above documents, due care is exercised to take into account statutory, regulatory and legal obligations
4) Principal approves above documents
5) The documents are reviewed and updated by OR as needed
6) Principal's approval is obtained for the revised documents

7) All employees at CCW are responsible for proper upkeep of respective documents. OR is responsible for designing the quality record formats and specifying the retention period for the records

5.0 PROCEDURE

1) Organization Representative shall control & maintain Quality Management Documents and ensure the availability of relevant versions of documents at points of use.

2) Principal/HOD keep OR informed of all standards, Specifications, References and any other document of External origin.

3) OR is authorized to release Revision Record incorporating changes in documentation after due consultation with HOD / Other staff Members of originating Department and re-approval by the Principal.

4) One copy of superseded document with due stamping only is retained by OR.

5) All documents approval status, Issue, revision status, Page No. and date of issue. All Master copies of documents and formats will be maintained by OR.

6) Any request for change will go through the approval procedure and approved by the same authority that approved the original issue. Amendment will be issued and relevant record is maintained by OR.

7) All controlled documents will be duly stamped with respect to the status. OR will maintain the distribution register.

8) If whole content of the document changes then the issue number will be changed.

9) Documented information reports, data generated to provide objective evidence for effective operation of the QMS requirements of ISO 9001:2015 in line with the stipulations of affiliating University and Approving body.

10) Documented information's are maintained in suitable formats / registers. The formats carry unique Identification reference, Name of record, and signature of the concerned signatories. Documented information's shall be legible

11) The identification adopted for all documents is in the form of DI/AAAA/XX or DI/AAAA/BBB/XX where DI represents documented information, in the form of files/registers/other documents, AAAAA or AAA or AA represents functional area, BBB or BB represents sub functional area and XX represents control number.

12) DI in standard formats are filed or kept as book copies. Some of the records may be in the form of registers. The records are filled and suitably stored to enable speedy retrieval and to prevent damage and deterioration

13) The retention period for the DI is as indicated in the Master List of Records

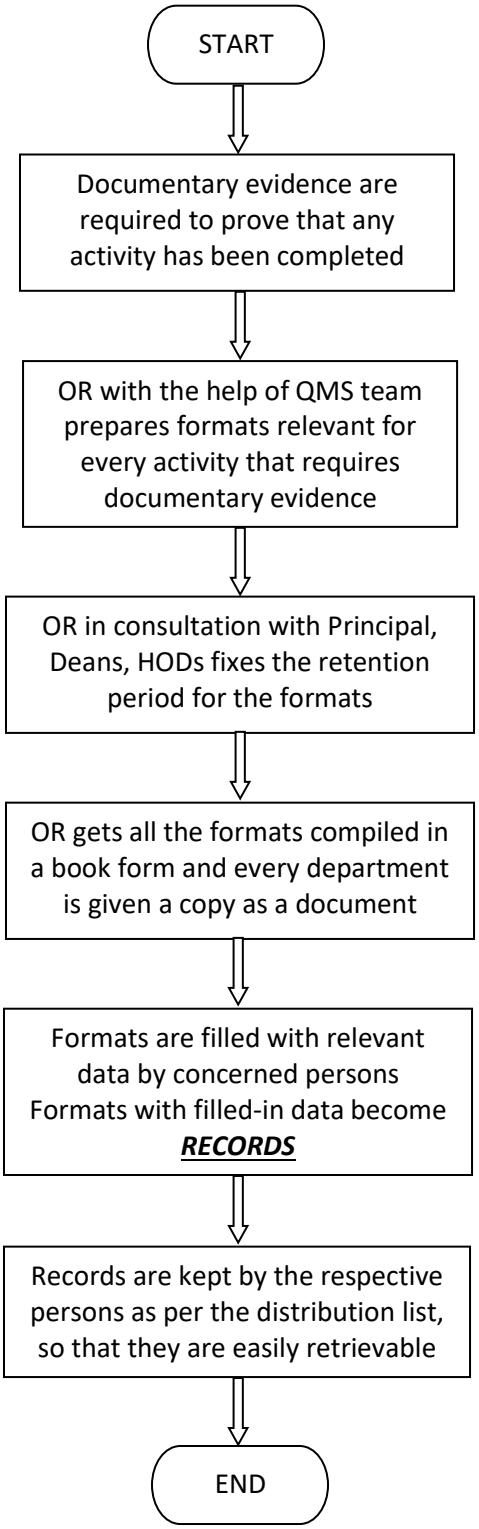
14) OR shall review the retention period after interaction with HODs

15) A master list of standard formats with latest amendments is maintained by OR and distributed to HODs and Internal Auditors so that they can ensure that latest formats are used

6.0 REFERENCE

Name of the Quality Record	**Record Reference**	**Responsibility**
Amendment Record	DI/QMS/01	OR
Distribution Register	DI/QMS/02	OR
Master List of Formats and Records	DI/QMS/08	OR

5.0 PROCESS FLOW CHART



2. PROCEDURE FOR INTERNAL AUDIT

(Refer to **Clause 9.2 of ISO 9001:2015)**

1.0 PURPOSE

To ensure conduct of internal audits at planned intervals to determine whether the Quality Management System conforms to the elements of QMS requirements of ISO 9001:2015 and whether the same is effectively implemented and maintained.

2.0 SCOPE

This Procedure applies to internal audit of educational processes and other supporting processes and records that fall within the scope of QMS.

3.0 RESPONSIBILITIES

1) OR prepares the list of Internal auditors and Principal approves the same
2) OR is responsible for overall planning, scheduling and executing internal audits
3) Internal auditors are responsible for conducting Internal Quality Audit (IQA), as per plan, reporting the observations, non-conformances and verification of corrective actions
4) Auditees are responsible for effective implementation of the corrective actions
5) OR should also ensure that internal auditors are adequately trained for effective implementation of IQAs

4.0 PROCEDURE

1) A team of members from out of the Faculty, who have got an aptitude for maintenance of quality system, proposed as Internal Quality Auditors by the OR and approved by the Principal.
2) Internal auditors may be given training in house or may be sent for external training as per requirements. The auditors who have been trained by external agencies should be retained as auditors till their service in the college so that they can fine tune the system through periodically carrying out the internal audit and also share their expertise with new auditors.
3) The list of such trained Internal Auditors shall be maintained as documented information.

PLANNING THE AUDIT:

1) Internal quality audits will be carried out at least once in 6 months as per annual audit calendar, audit plan and schedules.
2) External auditors may also be used as required for the purpose of internal audit.
3) It should be ensured that auditors do not audit their own department work.
4) Audit schedule is prepared by OR indicating the week / month of the proposed audit and department/function to be audited. Auditors & auditee are informed of the proposed audit well in advance.
5) The auditors shall prepare check list based on previous audit reports, QMS standards, quality management system procedures, work Instructions and University regulations.
6) HOD shall present the latest list of faculty, which will indicate the additional responsibilities of the faculty like Class Teacher, Faculty Advisor, Lab-in-charge, etc. This will be helpful to the auditor to ascertain the scope of audit in respect of each faculty.

EXECUTION OF AUDIT:

1) Scope of audit is explained by the auditors to the auditee prior to commencement of the audit
2) Objective evidence is collected for the conformance / the non-conformances if any by perusal of records, observation of processes and interviewing the auditee. Audit reports are prepared and a copy is given to HOD
3) Non-conformances are brought to the notice of the auditee and auditee is given an opportunity to offer his/her explanations.
4) If the explanation is not convincing, the non-conformances are recorded in the Non-conformance Report (NCR) format No.

AUDIT REPORTING:

1) Each NCR is allotted a serial number. The auditor explains the non-conformance and the signature of the auditee are obtained. Details of proposed corrective and preventive action and the target date for its completion are recorded by the auditee.

2) NCR is prepared in triplicate. One copy is given to the HOD, one to OR and the third is retained by the auditor after completion of audit.

3) A status report on the number of non-conformities observed in each department is prepared by OR.

CORRECTIVE ACTION:

1) The auditee shall ensure that actions are taken without undue delay to eliminate detected non-conformities and their causes.

2) The auditor reviews all the proposed corrective actions as agreed to by the auditee in the NCR either soon after the reported completion of the corrective action by the auditee or during the subsequent audit depending on the significance of the corrective actions.

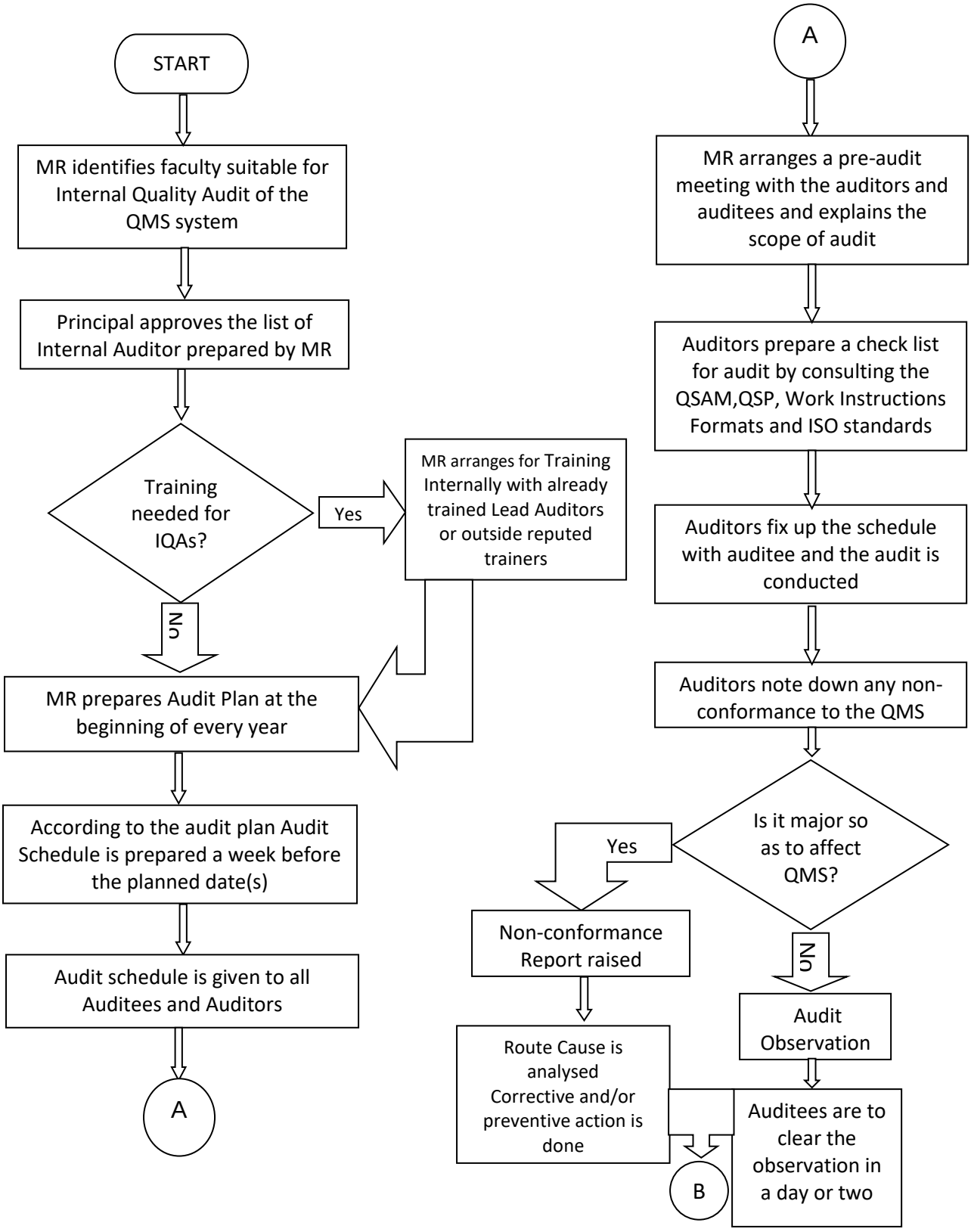
3) If the corrective action has been effectively implemented, the auditor closes the NCR by signing in all the copies of the NCR.

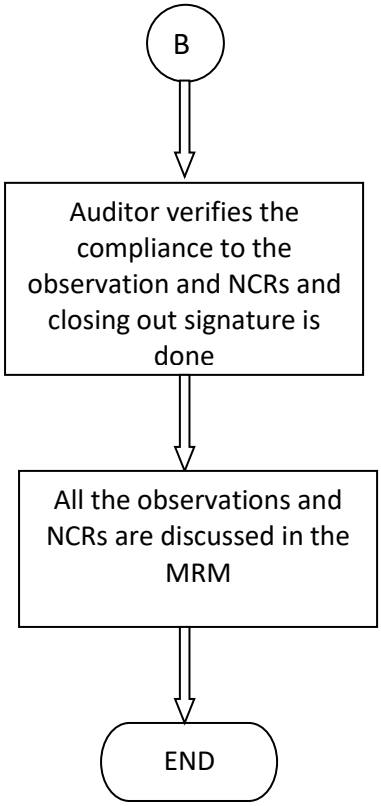
4) A statement on NCRs pending completion is prepared by MR and submitted to the Management for review during MRM.

5.0 REFERENCE

Name of Quality Record	Record Reference	Responsibility
List of Faculty	DI/HR/SER/02	HOD
List Of Internal Auditors	DI/QMS/02	OR
Annual audit calendar	DI/QMS/xxx	OR
Internal Audit Schedule	DI/QMS/03	OR
Audit Observation Report	DI/QMS/04	Auditor/OR
Non-Conformance Reports	DI/QMS/05	Auditor/OR
NCR Status Record	DI/QMS/06	OR
Management Review	DI/QMS/07	OR

6.0 FLOW CHART




B
Auditor verifies the compliance to the observation and NCRs and closing out signature is done
All the observations and NCRs are discussed in the MRM
END

3. PROCEDURE FOR CONTROL OF NON-CONFORMANCE

(Refer to **Clause 8.7 of ISO 9001:2015)**

1.0 PURPOSE:

To ensure that processes not conforming to specified requirements are identified and controlled.

2.0 SCOPE:

Applicable for control of non-conformities encountered during the administration of educational processes.

3.0 RESPONSIBILITY:

1) HOD is responsible for allocating the subjects to faculty.
2) Faculty is responsible for preparing the material and course delivery.
3) HOD is responsible for monitoring and controlling of non-conformance (NC) during the administration of educational process and final outcome.
4) Purchase officer and estate officer is responsible for the control of non-conformances in purchase process and maintaining the general amenities
5) OR is responsible for the control of non-conformances observed during the internal audit.

4 PROCEDURE:

1) HOD goes through the lesson plan and lesson notes prepared by the faculty for the courses concerned with their department and ascertain whether they are adequate and complete in conformance with the syllabus provided by the affiliating university. If not the non-conformance is eliminated by proper action

2) During the course delivery, HOD monitors, whether the course content is delivered as per lesson plan and whether the students are able to follow the content delivered by faculty by
   a) Visiting the classes and labs frequently
   b) Interacting with the faculty and students

c) Going through attendance and assessment record (AARD) for theory and lab

d) Class committee meetings

3) If any non-conformance is observed the same is eliminated appropriately.

4) Similarly HOD also monitors the students in respect of the following

a) Internal assignment and assessment marks

b) Maintenance of attendance as stipulated by the affiliating university

c) Behavior of the students with faculty and peers in the class and campus

d) University results

e) Payment of fees

f) Commitment of students for achieving academic performance and follow up

5) If any non-conformance is observed the same is eliminated appropriately.

6) In case of purchases, non-conformances observed in the material quality, supply process and service provided is monitored by purchase officer and eliminated appropriately.

7) In case of general amenities (like water facility, rest room facility, class room, lighting and fans, cleanliness of campus etc.,) non-conformance is observed and eliminated by Estate officer.

8) During internal audit, the auditor will identify non-conformance which will be reported to OR

4. PROCEDURE FOR CORRECTIVE ACTIONS

Refer to **Clause 10.2 of ISO 9001:2015**

1.0 PURPOSE

To ensure that effective corrective actions are carried out at the appropriate time to eliminate the causes of actual or potential non-conformities in the management of educational processes.

2.0 SCOPE

The scope of this procedure is to identify and implement corrective actions for non-conformances encountered.

3.0 RESPONSIBILITIES

1) HODs are responsible for corrective actions pertaining to educational process.
2) Purchase officer is responsible for corrective actions pertaining to purchase process.
3) Estate officer is responsible for corrective actions pertaining to general amenities.
4) MR is responsible for corrective action pertaining to findings of internal audit.
5) Principal shall be responsible for verification and approval of corrective actions proposed by the concerned in charges.

4.0 PROCEDURE

1) The sources for all non-conformances warranting corrective actions are observed by HOD on educational process, acts of student indiscipline, poor performance, feedback from students, observation by purchase officer, estate officer, internal audit reports, management review outputs, complaints/suggestions from customer and interested parties like parents and employers.

2) HODs and other concern in-charges may suggest suitable corrective actions, which will be reviewed and approved by the Principal and implemented by the HOD and concern in charges.

3) Planned / Surprise audit shall be undertaken by internal auditors to locate major / recurring non-conformities as per the instruction of principal.

4) MR may suggest suitable corrective actions for the non-conformance observed during the internal audit, which will be reviewed and approved by the principal.

5) Principal reviews the effectiveness of corrective action during MRM. Progress of implementation of the proposed corrective actions is periodically reviewed by OR and cases of non-compliances are brought to the notice of the Principal.

5.0 REFERENCE

Name of Quality Record	Record Reference	Responsibility
Analysis of Student feedback on teaching faculty-Theory, Practical and Course Completion	In the concern department	HOD
Customer complaint		HOD
Log Book for Lab		Lab in charge
Stores receipt and Inspection Report		Store inchrge
Supplier Appraisal		PO
Attendance & Assessment record		Faculty/HOD
Class/Course committee meeting Register		HOD
Corrective actions - non academic		HOD
Audit Observation Report		Auditor/MR
Non Conformance Reports		Auditor/MR
Management Review		MR

6.0 FLOW CHART

CORRECTIVE ACTIONS