1.0 APPLICABLE POLICIES

1.1 All documents used within the Authority are controlled in accordance with these procedures.

1.2 Standard Formats and Guidelines in the Preparation of NHA Documents are adopted.

2.0 OBJECTIVES

2.1 To define the policies for controlling and maintaining NHA documents to ensure that appropriate versions are identified and made available at point of use.

2.2 To ensure that documents of internal and external origin are identified and their distribution is controlled.

2.3 To prevent further use of obsolete documents.

3.0 DEFINITION OF TERMS


3.2 NHA Board Resolutions. Resolutions which were passed upon and approved by the NHA Board of Directors and certified correct by the Corporate Secretary.

3.3 NHA Policies and Guidelines. Documents with dry seal approved by the NHA General Manager in relation to Authority’s administration and operations, usually referred to as Memorandum Circulars (MCs).

3.4 External Documents. Documents generated from external sources, which the Authority uses as guide and/or reference for its operations.

3.5 Original Copy. Document bearing original approval which is signed in blue ink and maintained by the respective Document Controller and General Services Department-Communications and Records Division (GSD-CRD).
3.6 **Controlled Copy.** Reproduced copy of the original documents such as NHA Policies and Guidelines, Quality Manual, Quality Procedures, Operations Manual and/or Functional Process Flow, stamped “Controlled Copy” in blue ink and are issued to duly identified recipients.

3.7 **Uncontrolled Copy.** Reproduced copy from the original copy of the document, stamped “Uncontrolled Copy” in black ink and used strictly for reference only and cannot be updated. Documents that do not bear fresh stamps and/or dry seal are considered uncontrolled.

3.8 **Obsolete Copy.** Superseded, no longer applicable and not relevant documents; stamped “Obsolete Copy” in red ink.

3.9 **Certified Copy.** Reproduced copy, stamped “Certified Copy” in purple ink.

3.10 **Document Review and Approval Request (DRAR).** Form to be used for creation/revision of documents.

3.11 **Document Tracking Form (DTF).** Form to be used by Process Owner and/or concerned Department/Office for transmittal/release of document.

3.12 **Document Master List.** List of documents being maintained by the respective Document Controller.

3.13 **Controlled Copy Distribution/Retrieval List.** List of recipients of controlled documents.

3.14 **Revision History Worksheet.** Worksheet maintained by the Document Controller to show any update, modification or revision of a QMS document.

4.0 **COVERAGE**

4.1 These procedures apply to all documents required by the Authority’s QMS as indicated in the Document Master List.

4.2 These procedures also cover the receipt and distribution of externally generated documents.
5.0 RESPONSIBILITIES

5.1 Document Controller (DC). The designated staff responsible for ensuring that all documents are properly identified, updated, approved, and made available at relevant areas for use; responsible for the maintenance and implementation of these procedures and for ensuring that obsolete documents are identified and stamped to prevent further usage. The Document Controllers are:

5.1.1 Office of the Corporate Secretary (OCS). For NHA Board Resolutions

5.1.2 Corporate Planning Office (CPO). For NHA Policies and Guidelines in the form of Memorandum Circulars.


5.2 Department Document Custodian (DDC). Designated staff in the Group/Department to coordinate with Document Controllers; maintains controlled copies of documents and distribute to copy holders; responsible for the receipt and distribution of documents from external sources.

5.3 Copy Holder (CH). Process Owner/Staff assigned for each Group/Department/Division to maintain controlled copies of documents; responsible for its use and upkeep. CH ensures that the copy is used only for reference and not for reproduction.

5.4 Process Owner (PO). Designated NHA Personnel or Head of Unit to initiate document creation/revision by filling-out the “Initiated by” portion of the DRAR; responsible for the monitoring and implementation thereof.

5.5 Office of the Corporate Secretary (OCS). Responsible for the preparation, assignment of control number, dissemination of copies to concerned Group/Department/Division and safekeeping of the original copies of board resolutions and original memorandum to the Board of Directors.

5.6 Corporate Planning Office (CPO). Responsible for the review and assignment of control number of NHA Policies and Guidelines and
Memorandum Circulars; acts as custodian of soft copies of said documents.


5.8 General Services Department (GSD). Responsible for the safekeeping of original signed hard copies and dissemination of controlled copies of NHA Memorandum Circulars through its Records Officer.

6.0 PROCEDURE OUTLINE/FLOW

<table>
<thead>
<tr>
<th>Ref. No.</th>
<th>Key Activities</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>Creation/Revision of Documents</td>
<td>Process Owner Group/Department Head CPO</td>
</tr>
<tr>
<td></td>
<td>Review and Acceptance of Draft Documents</td>
<td>QMR</td>
</tr>
<tr>
<td>6.2</td>
<td>Approval of Documents</td>
<td>General Manager</td>
</tr>
<tr>
<td>6.3</td>
<td>Registration and Stamping of Documents</td>
<td>Document Controller</td>
</tr>
<tr>
<td>6.4</td>
<td>Distribution of Copies</td>
<td>Document Controller</td>
</tr>
<tr>
<td>6.5</td>
<td>Maintenance of Controlled Copies</td>
<td>Process Owner</td>
</tr>
<tr>
<td>6.6</td>
<td>Document Revision / Updating</td>
<td>Process Owner</td>
</tr>
<tr>
<td>6.7</td>
<td>Control of External Documents</td>
<td>Department Document Custodian</td>
</tr>
</tbody>
</table>

Nature of Revision: Memorandum Circulars acts as custodian of soft copies of said documents. 
Document Distribution: Memorandum Circulars, acts as custodian of soft copies of said documents.
6.1 CREATION/REVISION OF DOCUMENTS; REVIEW AND ACCEPTANCE OF DRAFT DOCUMENT

6.1.1 NHA BOARD RESOLUTIONS

a. Through a Memorandum, the Process Owner (Group/Department/Office) submits proposal/agenda to the Office of the Corporate Secretary for discussion in a pre-board meeting and Board Committee meeting prior to endorsement to the Board of Directors for approval/consideration.

b. Proposals/agenda maybe deferred/referred back to Process Owner for further revisions/refinements. A DTF is used, indicating therein the instructions to cover any deficiency or additional staff work required.

c. The Process Owner (Group/Department/Office) complies with the instructions, revises/refines proposal and through a memorandum, resubmits proposal/agenda to the Office of the Corporate Secretary.

6.1.2 NHA POLICIES AND GUIDELINES

a. Group/Department Manager proposes the creation/revision of policies and guidelines via a Document Review and Approval Request (DRAR) and DTF addressed to the Process Owner copy furnished the CPO. Process Owner may also propose the creation/revision via a DRAR and DTF addressed to the CPO.

b. Process Owner facilitates the gathering of inputs through any of the following methods:
   - Meeting/Consultation
   - Research
   - Review of existing documents

c. Process Owner may request for inputs which shall be submitted by concerned Group/Departments within the prescribed period. Inputs submitted beyond the deadline may not be considered in the creation/revision of policies and guidelines.
d. Upon receipt of inputs/comments, the Process Owner incorporates the inputs to the draft document.

All proposed revisions are typed in italics.

This draft document is not official and must not be used as reference for work purposes.

e. The Process Owner routes/endorse the proposed document to the concerned group/departments labeled “DRAFT” for review prior to discussion.

f. Process Owner discusses the proposal with all concerned Groups/Departments and CPO.

g. As a result of the discussions, the Process Owner incorporates/consolidates the comments/inputs and finalizes the proposal and submits to CPO.

h. The CPO further reviews the finalized proposal and endorses the same for approval of the General Manager.

i. The Document Tracking Form (DTF) is used for every receipt/release of documents.

6.1.3 QUALITY MANUAL, QUALITY PROCEDURES, OPERATIONS MANUAL, PROCESS FLOW, STANDARDS/FORMS

a. NHA Personnel, through his/her Group/Department Head, proposes the creation/revision via DRAR and DTF addressed to the QMR.

b. Through the DTF, QMR instructs concerned Process Owner to lead in the gathering of inputs through any of the following methods:

   o Meeting/Consultation
   o Research
   o Review of existing documents

c. The Process Owner discusses the proposal with the concerned initiating Group/Department. Process Owner may request for inputs which shall be submitted within the required period set.
The required period is indicated in the DTF. Inputs submitted beyond the deadline may not be considered in the created/revised document.

d. Upon receipt of inputs/comments, the Process Owner incorporates the proposed changes to the draft document.

All proposed revisions are typed in italics.

This draft document is not official and must not be used as reference for work purposes.

The proposed document is watermarked “DRAFT”.

e. Process Owner submits proposed document to the Assistant General Manager. A DTF is used for this purpose.

f. The Assistant General Manager, through COSO Department Manager, instructs Document Controller to disseminate proposed document to concerned group/departments.

g. The Document Controller routes/endorses to the concerned departments the proposal for their comments and recommendations.

The required period within which to submit comments/recommendations is indicated in the DTF. Inputs submitted beyond the deadline may not be considered in the finalization of the created/revised document.

h. Upon receipt of the final inputs/comments from concerned Department, the Document Controller finalizes the created/revised document and submits to the QMR and AGM for final review and endorsement to the GM.

6.2 APPROVAL OF DOCUMENTS

6.2.1 Resolutions approved by the Board are signed by the Corporate Secretary in blue ink.

6.2.2 Final copy of Memorandum Circulars (MCs) and QMS documents are submitted to the General Manager for approval. Approved documents
bear the NHA dry seal and signature of the General Manager in blue ink.

6.2.3 Approving authority/ies, Process Owner and signatories to documents are as follows:

<table>
<thead>
<tr>
<th>Document</th>
<th>Process Owner</th>
<th>Review</th>
<th>Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHA Policies and Guidelines (Memorandum Circulars)</td>
<td>Concerned Group/Department</td>
<td>CPO</td>
<td>GM</td>
</tr>
<tr>
<td>NHA Board Resolutions</td>
<td>Concerned Group/Department</td>
<td>OCS</td>
<td>Corporate Secretary, as approved by the Board</td>
</tr>
<tr>
<td>Quality Manual</td>
<td>QMR</td>
<td>AGM</td>
<td>GM</td>
</tr>
<tr>
<td><strong>Quality Procedures</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Control of Documents</td>
<td>Documents and Records Control Team Head</td>
<td>AGM, QMR and Managers of CPO, OCS and COSO</td>
<td>GM</td>
</tr>
<tr>
<td>• Control of Records</td>
<td>Division Manager of GSD-Communications and Records Division</td>
<td>AGM, QMR and GSD Manager</td>
<td>GM</td>
</tr>
<tr>
<td>• Internal Quality Audit</td>
<td>Internal Quality Audit Team Head</td>
<td>AGM and QMR</td>
<td>GM</td>
</tr>
<tr>
<td>• Control of Nonconformity</td>
<td>Internal Quality Audit Team Head</td>
<td>AGM and QMR</td>
<td>GM</td>
</tr>
<tr>
<td>• Corrective &amp; Preventive Action</td>
<td>Internal Quality Audit Team Head</td>
<td>AGM and QMR</td>
<td>GM</td>
</tr>
</tbody>
</table>
### 6.3 REGISTRATION AND STAMPING OF DOCUMENTS

#### 6.3.1 BOARD RESOLUTIONS

a. Approved Board Resolutions shall bear the signature of the Corporate Secretary in blue ink.

b. OCS assigns the serial number of said Board Resolution

   The numbering system for Board Resolutions is as follows:

   NHA-BR-XXXX
   DD-Month-YYYY

   XXXX – document number in sequential order
   DD-Month-YYYY – date of resolution (date-month-year)

c. OCS registers the numbered Board Resolution in the Document Master List; maintains the Document Master List for NHA Board Resolutions.

d. OCS reproduces the original copy according to the number of Copy Holders specified in the Distribution List.

e. OCS stamps the resolution with “Certified Copy”, in purple ink, at the lower rightmost part of every page of the document.
6.3.2 NHA POLICIES AND GUIDELINES

a. Approved NHA policies and guidelines shall bear the dry seal of the Office of the General Manager and signature in blue ink.

b. Upon receipt of signed Memorandum Circulars, the CPO assigns the number of the approved Policies and Guidelines. The numbering system for Memorandum Circulars is as follows:

   NHA-MC-YYYY-XXXX

   YYYY – the year the document was approved
   XXXX – document number in sequential order, starting with 0001

c. CPO registers the numbered Memorandum Circular in the Document Master List.

   The CPO maintains the Document Master List for NHA Policies and Guidelines.

d. CPO forwards signed MC to GSD-CRD.

e. GSD-CRD reproduces the original copy according to the number of Copy Holders specified in the Document Distribution/Retrieval List Form.

f. GSD-CRD stamps all copies of the document with “Controlled Copy”, in blue ink, at the lower rightmost part of every page of the document.

6.3.3 QUALITY MANUAL, QUALITY PROCEDURES, OPERATIONS MANUAL, PROCESS FLOW

a. Upon approval of the document, the COSO assigns an identification number according to the following classification:

   a. Quality Manual - NHA-QM
   b. Quality Procedures - NHA-QP-XXX
   d. Functional Process Flow - NHA-DEPT-PF-XXX
   e. NHA Standards/Forms - NHA-DEPT-FORM-XXX
XXX – document number in sequential order, starting with 001
DEPT – assigned AMO/Department Code

b. COSO registers the numbered QMS documents in the Document Master List.

The COSO Document Controller maintains the Document Master List for the above documents.

c. COSO reproduces the original copy according to the number of Copy Holders specified in the Distribution/Retrieval List Form.

d. COSO stamps all copies of the document with “Controlled Copy”, in blue ink, at the lower rightmost part of every page of the document.

6.3.4 DOCUMENT CONTROL STAMPS

a. Document Control Stamps are maintained and used solely by the Document Controllers. (There are 3 sets of document control stamps to be used by the OCS, GSD-CRD and COSO)

<table>
<thead>
<tr>
<th>Specimen</th>
<th>Name</th>
<th>Description</th>
<th>Revision Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="CONTROLLED COPY" /></td>
<td>Controlled Copy</td>
<td>Color: Blue Stamp Area: Lower rightmost part of every page Date</td>
<td>00</td>
</tr>
<tr>
<td><img src="image" alt="OBSOLETE" /></td>
<td>Obsolete Copy</td>
<td>Color: Red Stamp Area: Center part of every page Date</td>
<td>00</td>
</tr>
</tbody>
</table>
## 6.4 DISTRIBUTION OF COPIES

<table>
<thead>
<tr>
<th>Document</th>
<th>Process Owner</th>
<th>Copy Holder</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHA Policies and Guidelines</td>
<td>Concerned Group/Department</td>
<td>Concerned Group/Department Manager</td>
</tr>
<tr>
<td>BR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality Manual</td>
<td>QMR</td>
<td></td>
</tr>
<tr>
<td>Quality Procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Control of Documents</td>
<td>Documents and Records Control Team Head</td>
<td></td>
</tr>
<tr>
<td>• Control of Records</td>
<td>Division Manager of GSD-CRD</td>
<td>GM, AGM, QMR, Group/Department Manager, Division Manager, Project Manager</td>
</tr>
<tr>
<td>• Internal Quality Audit</td>
<td>Internal Quality Audit Head</td>
<td></td>
</tr>
<tr>
<td>• Nonconformity</td>
<td>Internal Quality Audit Head</td>
<td></td>
</tr>
<tr>
<td>• Corrective &amp; Preventive Action</td>
<td>Internal Quality Audit Head</td>
<td></td>
</tr>
<tr>
<td>• Feedback Management</td>
<td>Manager of Information Division, Office of the General Manager</td>
<td></td>
</tr>
</tbody>
</table>
6.4.1 BOARD RESOLUTIONS

a. Using a DTF, OCS distributes the controlled copies, together with the General Manager's Memorandum to Board, its annexes and attachments; secures acknowledgment of receipt on the Distribution List.

b. AMOs/Departments may request the OCS for certified copies of approved Board Resolutions specifying the purpose/intended use of such board resolution.

c. The OCS shall only release certified copies of board resolutions upon request of AMO/Department. Certified copies of Board Resolutions shall be duly signed by the Corporate Secretary.

d. Original copy of Board Resolutions are printed/reproduced only by the OCS to protect documents from unauthorized copy and use.

6.4.2 NHA POLICIES AND GUIDELINES (Memorandum Circulars)

a. GSD-CRD distributes the controlled copies to Copy Holders through the Department Document Custodian;


c. Upon receipt, the Copy Holder initials on all the pages of the “CONTROLLED COPY” documents and signs on the list.

d. The Department Document Custodian forwards the signed Document Distribution/Retrieval List Form to the GSD-CRD.
e. Certified Copy of NHA Policies and Guidelines may be requested from the GSD-CRD to protect documents from unauthorized copy and use.

6.4.3 QUALITY MANUAL, QUALITY PROCEDURES, OPERATIONS MANUAL, PROCESS FLOW


1. COSO distributes the controlled copies to Copy Holders through Department Document Custodian;


3. Upon receipt, the Copy Holder initials on all the pages of the “CONTROLLED COPY” documents in the Controlled Copy and signs on the List.

4. The Department Document Custodian forwards the signed Document Distribution/Retrieval List Form to COSO.


c. Access to uploaded copies in the server shall be authorized only by the COSO Document Controller.

6.5 Maintenance of Controlled Copies

6.5.1 Controlled Copies are not for reproduction.

6.5.2 Any interested personnel not on the Distribution List may coordinate with the Document Controller, using a DTF, to secure copies of NHA Policies and Guidelines, Board Resolutions and other documents. The original copy may be reproduced upon approval of the Document Controller.
6.5.3 Reproduced copy is stamped in black with “UNCONTROLLED COPY” at the lower rightmost part of every page of the document, prior to release.

6.5.4 Documents that do not bear fresh stamps are considered uncontrolled.

6.6 Document Revision / Updating

6.6.1 A Revision History Worksheet is maintained and updated by the COSO Document Controller.

6.6.2 If there is a need to update, modify, or revise a QMS document, the DRAR is used. Changes made to the document are typed in italics for easy identification. The nature of revision is reflected in the footer of the document page.

6.6.3 Upon distribution of the revised/updated document, obsolete copies are retrieved using the Document Distribution/Retrieval List, where Copy Holders are to sign on the retrieval portion. Retrieved copies are stamped with “Obsolete Copy” in red ink.

6.6.4 The respective Document Controller maintains the obsolete original copy. Disposal of obsolete copies are in accordance with the procedures on Records Control.

6.7 Control of External Documents

6.7.1 An External Document Distribution List is maintained by the assigned Department Document Custodian and is used to register and monitor the receipt and distribution of documents from external sources such as, but not limited to the following:

- Regulatory and Legal Standards (MO, EO, AO, RA/IRR, Circulars, Guidelines)
- ISO and International Chamber of Commerce

6.7.2 Recording is done immediately upon receipt and turnover of documents to concerned Group/Department/Division and/or individual. The responsibility for the maintenance and updating of the External Document Distribution List is entrusted to the Department Document Custodian. Externally-generated documents received through e-mail are likewise recorded in the External Document Distribution List.
7.0 FORMS, RECORDS AND REPORTS

7.1 Attachment 1 - NHA-QP-01-F01 Document Master List
7.2 Attachment 2 - NHA-QP-01-F02 Controlled Copy Document Distribution/Retrieval List
7.3 Attachment 3 - NHA-QP-01-F03 Document Review and Approval Request (DRAR)
7.4 Attachment 4 - NHA-QP-01-F04 Revision History Worksheet
7.5 Attachment 5 - NHA-QP-01-F05 External Documents Distribution List
7.6 Attachment 6 - NHA-QP-01-F06 Document Tracking Form (DTF)

8.0 APPROVAL

Prepared by:

ARSENIA G. GERMAR
Documents and Records Control Team Head

Reviewed by:

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Office of the Corporate Secretary (OCS)

Ar. MARISSA B. MANIQUIS
Officer-In-Charge, Corporate Planning Office (CPO)

RENAITO F. TENGCO
Officer-In-Charge, Corporate Operations and Systems Office (COSO) and
Deputy Quality Management Representative (DQMR)

FROILAN R. KAMPITAN
Assistant General Manager and Quality Management Representative (QMR)

Approved by:

ATTY. SINFOROSO R. PAGUNSAN
General Manager
1.0 APPLICABLE POLICIES

1.1 The Control of Records within the NHA are in compliance with the provisions of Republic Act No. 9470, otherwise known as The National Archives of the Philippines (NAP) Act of 2007, and all applicable NHA policies and guidelines.

2.0 PURPOSE

2.1 The Procedures on Control of Records aim to provide a system of managing, controlling, disposing and archiving records within the NHA.

3.0 DEFINITION OF TERMS

3.1 Record. Refers to information, whether in its original form or otherwise, including documents, signages, seals, texts, images, sounds, speeches, or data complied, recorded, or stored, as the case may be:

a. in written form on any material; or
b. on film, negative, tape, or other medium so as to be capable of being reproduced; or
b. by means of any recording device or process, computer, or other electronic device or process.

3.2 Active/Current Records. Records being currently maintained, used and controlled

3.3 Inactive/Non-Current Records. Records that are very rarely or no longer referred to, and which must be transferred to another place. These records have already served its purpose but must be kept for legal requirements or some compelling reasons and/or destroyed the moment their retention periods have expired.

3.4 Valueless Records. Refer to all records that have reached the prescribed retention periods and outlived the usefulness to NHA.

3.5 Vital Records. Records containing information essential for: emergency operation during disaster; the resumption and/or continuation of operations; the re-establishment of the legal, financial and/or functional status of the organization; and the determination of the rights and obligations of individuals and corporate bodies with respect to the organization.

3.6 File. Collection of related data usually arranged or classified.

3.7 Filing System. Identification, arrangement and finding of records.
3.8 Records Retention Matrix. A listing of records showing their retention period and disposition schedule.

3.9 Retention Period. Specific period of time when records must be kept in accordance with the National Archives of the Philippines guidelines on records inventory and disposition.

3.10 Records Custodian. Designated personnel in a department/division responsible for maintaining records.

3.11 Records Disposition. The systematic transfer of non-current/inactive records from office to storage area, identification and preservation of archival records.

3.12 Records Disposal. The act of selling, landfill/burying, shredding, or any other way of discarding valueless records in accordance with the provision of R.A. 9470.

3.13 Archiving. The act of transferring records/data to a less frequently used storage space or medium for future use/reference.

3.14 Shredding. Refers to the destruction of records either through cutting or tearing into small pieces or narrow strips prior to disposal.

3.15 Recycling. The process or practice of re-using, converting, reinventing the records’ original state for other suitable purpose.

4.0 COVERAGE

4.1 The procedures cover the control needed for the identification, storage, protection, retrieval, retention, and disposition of records. It also covers the handling of externally generated data as well as those data provided by the external stakeholders.

5.0 RESPONSIBILITIES

5.1 Department Manager. Reviews and approves the retention and disposal schedule of records of their respective group/departments and ensures that related laws, issuances, policies and guidelines on records management are implemented.

5.2 Document and Records Control Team (DRCT). Responsible for the maintenance and implementation of these procedures. DRCT ensures that records beyond retention period are disposed of properly in accordance
with National Archives of the Philippines (NAP) guidelines on records inventory and disposition.

5.3 Records Custodian for each Group/Department (RC). Identified staff responsible over the Department/Group’s records in custody. RC shall ensure that all records are properly identified, protected and stored in safe locations and be made available for easy retrieval until its retention period and/or archival/disposal of the same in accordance with the NAP guidelines and procedures.

5.4 Records Management Improvement Committee (RMIC). Advisory body responsible for the development of records management. The RMIC, in compliance to NAP, shall formulate policies/guidelines/procedures and plans on records retention, storage, preservation, conservation, disposal and archival, safety and management of records.

6.0 PROCEDURE OUTLINE / FLOW

<table>
<thead>
<tr>
<th>Ref. No.</th>
<th>Key Activities</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>Creation</td>
<td>Concerned Group/Department/Office</td>
</tr>
<tr>
<td>6.2</td>
<td>Storage and Protection</td>
<td>GSD/Records Custodian/Concerned Group/Department/Offices</td>
</tr>
<tr>
<td>6.3</td>
<td>Maintenance</td>
<td>Records Custodian</td>
</tr>
<tr>
<td>6.4</td>
<td>Appraisal</td>
<td>RMIC</td>
</tr>
<tr>
<td>6.5</td>
<td>Disposition/Disposal</td>
<td>GSD/RMIC</td>
</tr>
<tr>
<td>6.6</td>
<td>Data Control</td>
<td>Group/Department’s Records Custodian</td>
</tr>
</tbody>
</table>
PROCEDURE DETAILS:

6.1 Creation

6.1.1 Records are generated in the implementation of processes and procedures.

6.1.2 Records are identifiable through any or combination of the following information, as appropriate:

a. NHA letterhead and logo
b. Name of Signatory(ies)
c. Title/Subject of Record
d. Date(s)
e. Control/Reference Number
f. Recipient of Records

6.1.3 Some records require the signature of authorized individuals. The concerned Group/Department ensures that records are legible and contain sufficient information as basis for its endorsement or approval. Hence, some records without the signature of approving authorities may be treated “unofficial”.

6.1.4 Original-approved record bears the signature of the approving authorities in blue ink.

6.2 Storage and Protection

6.2.1 Records are kept in appropriate locations to minimize physical deterioration, damage, and loss. As such, records may be protected in accordance with the following:

a. Use of folders, envelopes and file boxes
b. Stored in shelves/cabinets to prevent deterioration
c. Regular back-up of e-files
d. Access restriction, through password to soft copies and other security measures to avoid unauthorized use
e. use of fire and water-proof safety vault for records that are of high risk value
f. scanning of records
6.3 Maintenance

6.3.1 Records are maintained at different Group/Departments/Offices and filed/arranged according to ease of retrieval in any of the following order:

a. Alphabetical
b. Subject matter
c. Series no.
d. Geographical/location
e. Chronological

6.3.2 To ensure easy retrieval of records, filing cabinets/shelves, boxes, folders and envelopes are labelled/coded accordingly.

6.3.3 Records on project/technical plans, lot/technical descriptions, beneficiary folders (inactive), and other inactive records from other Departments/Offices are transferred/submitted to and maintained by the Communications and Records Division of the General Services Department which could be borrowed by transferring Departments upon request and are monitored and traced using a logbook.

6.3.4 Department/Division Records Custodian, assigned per Department, maintains their respective records on financial, legal, administrative/personnel both active/current and inactive/non-current.

6.3.5 Records borrowed from Departments by other Departments are traced and monitored using a logbook. For control and monitoring of records, only Department’s authorized staff are allowed to borrow records. The logbook shall indicate the following:

a. Borrowing Department/Division
b. Name of Borrower/Designation/Position
c. Record Title
d. Date Borrowed
e. Signature of Borrower
f. Date Returned
g. Signature of Record Custodian

6.3.6 Records are borrowed from and returned to the respective Groups/Departments’ Records Custodian only. Please refer to Records Retention Matrix (RRM). Borrowing of some records may be subject to approval of the Group/Department/Division Manager,
whichever is applicable. Borrowing of some records for presentation to a third party outside the premises of NHA is subject to the approval of the Group/Department or GM/AGM, as necessary.

6.3.7 For easier safekeeping, permanent records may be converted to e-files.

6.3.8 Electronic copies maintained in desktop computers and databases have restricted access and are backed-up regularly in the official NHA server and official external hard drives.

6.4 Inventory

6.4.1 The Records Custodian for each Department/Office/Division keeps/maintains an inventory of all records in their respective offices. The records are properly sorted, classified and arranged for easier control and monitoring.

6.4.2 The Records Custodian of NHA supervises the segregation of valueless records and safekeeps the same until their actual disposal/archival.

6.5 Disposition/Disposal

6.5.1 Maintenance and disposal of records are done in accordance with the Records Retention and Disposition Schedule of the Republic Act No. 9470, otherwise known as the National Archives of the Philippines (NAP) Act of 2007 and actual disposal shall be witnessed by authorized Representative from the NHA, National Archives of the Philippines (NAP) and Commission on Audit (COA) to ensure that records to be disposed of are the same records that were authorized for disposal.

6.5.2 The NHA shall dispose of, destroy or authorize the disposal or destruction of any of its records which are in the custody or under its control upon approval of the General Manager and with the written authority of NAP and COA which could either be in the form of:

a. Shredding. Use of shredding machine
b. Recycling. Reusing, converting, reinventing record original state for other suitable use.
c. Sell as scrap. Sale of valueless records, proceeds of which shall be remitted to either the revolving fund or trust fund.
d. Transfer. The movement of custody of records, upon the approval of the General Manager, to the National Archives of the Philippines.

e. Archiving. Provision of archive room/building/area assigned for filing, safekeeping and storage of permanent records.

6.6 Data Control

6.6.1 Use of pencil in entering data and use of correction tape or fluid on records are not allowed. Any corrected data shall bear the signature in blue ink of the authorized concerned staff who corrected it.

7.0 FORMS / RECORDS / REPORTS:

7.1 Attachment 1: NHA-QP-02-FO1 Records Retention Matrix

8.0 APPROVAL:

Prepared by:

CRESTITA S. TAYAO
Division Manager, GSD-CRD.

Reviewed by:

RENATO V. IBALLA
Manager, GSD

FROILAN R. KAMPITAN
Assistant General Manager and Quality Management Representative (QMR)

Approved By:

ATTY. SINFOROSO R. PAGUNSAN
General Manager
1.0 PURPOSE

1.1 The purpose of this procedure is to verify whether the Quality Management System conforms to the planned arrangements, requirements of ISO 9001 and the Quality Management System established by the National Housing Authority (NHA), and the same is effectively implemented and maintained.

2.0 COVERAGE

2.1 This procedure applies to NHA’s Management, Core and Support Processes included in the Quality Management System.

3.0 DEFINITION OF TERMS:

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Quality Audit</td>
<td>A systematic, independent and documented process for obtaining evidence and objectively evaluating the extent to which the audit criteria are fulfilled.</td>
</tr>
<tr>
<td>Auditee</td>
<td>The unit or person being audited</td>
</tr>
<tr>
<td>Auditor</td>
<td>The person with demonstrated personal attributes and competence to conduct an audit.</td>
</tr>
<tr>
<td>Audit Team</td>
<td>This is composed of more than one auditor who are assigned to conduct an audit in a particular office and prepare necessary report of findings to be led by an Audit Team Head. Technical experts may be invited when necessary.</td>
</tr>
<tr>
<td>Technical Expert</td>
<td>A person who provides specific knowledge or expertise to the Audit Team. A Technical Expert does not act as an auditor in the Audit Team.</td>
</tr>
<tr>
<td>Annual Audit Plan</td>
<td>Set of one or more audits planned for a specific timeframe directed towards a specific purpose.</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Audit Scope</td>
<td>Extent and boundaries of an audit.</td>
</tr>
<tr>
<td>Audit Itinerary</td>
<td>Specific details of an audit containing information on objective(s), scope, time, audit area(s), auditee(s), auditors.</td>
</tr>
<tr>
<td>Audit Checklist</td>
<td>A set of variables which serves as a guide to an auditor.</td>
</tr>
<tr>
<td>Audit Criteria</td>
<td>Set of policies, procedures, or requirements which are used as reference against which audit evidence is compared.</td>
</tr>
<tr>
<td>Audit Findings</td>
<td>Results of the evaluation of the collected audit evidence against audit criteria.</td>
</tr>
<tr>
<td></td>
<td>Findings include conformities, non-conformities and opportunities for improvement.</td>
</tr>
<tr>
<td>Audit Evidence</td>
<td>It refers to records, statements of facts or other information which are relevant to the audit criteria</td>
</tr>
<tr>
<td>Audit Conclusion</td>
<td>Overall findings/results of an audit provided by the Audit Team Head after consideration of the audit objectives and all audit findings.</td>
</tr>
<tr>
<td>Compliance</td>
<td>Used to signify whether an organization is meeting / statutory and regulatory requirements.</td>
</tr>
</tbody>
</table>
**Conformity**

Refers to the services or actions that conform to the policies, procedures, processes and standards established by NHA, requirements of ISO 9001, executive / legislative directives, statutes, laws, rules, regulations and professional / work ethics.

**Nonconformity (NC)**

Refers to the services or actions that do not conform to the policies, procedures, processes and standards established by NHA, requirements of ISO 9001, executive / legislative directives, statutes, laws, rules, regulations and professional / work ethics.

**Opportunity for Improvement (OFI)**

Does not make inference as failure in the QMS but expresses the need for improvement of a certain action or service.

**Root Cause Analysis**

A method being used to address a problem or non-conformity to get the root cause for it to be eliminated, thus preventing the problem/ non-conformity from recurring.

---

**4.0 RESPONSIBILITIES:**

**4.1 General Manager**

- Authorizes the Audit Team to conduct the audit and to have an unrestricted access to all functions, records, reports, documents, property and personnel involved in the implementation of the Quality Management System.
- Approves the Annual Audit Plan.
- Has the final decision for the disposition of IQA findings / conclusions elevated to the Top Management during Management Review.
4.2 Quality Management Representative (QMR)/Deputy QMR

- Reviews and recommends approval of the Annual Audit Plan.
- Approves the audit itinerary

4.3 IQA Team Head

- Responsible for the evaluation and selection of QMS Auditors with the appropriate educational background and equipped with personal qualities.
- Identifies auditors and members of IQA teams.
- Prepares and manages the audit plan and itinerary; coordinates the audit plan and itinerary with the auditee(s) and the QMR.

4.4 IQA Team Leader

- Leads the group of auditors in facilitating the efficient and effective conduct of the team deployed during the IQA.
- Provides strategies in securing required documents/information and conduct of the audit.

4.5 Observer(s)/Guide(s)

- Shall provide assistance to the team. Acts as witness in behalf of the Audit Team.

4.6 Internal Quality Auditor/Internal Quality Audit Team

- An individual/team who takes responsibility for preparing and carrying out internal quality audit work and activities within the organization.

4.7 Group/Department/Division/Sector/Regional/Division/Project Manager

- Responsible and accountable for all audit findings in their respective offices/unit and undertake actions to address said findings within the prescribed time-frame.

4.8 Auditee

- Provides audit evidence to the IQA Team; responds to audit findings as needed.
5.0 PROCEDURE OUTLINE:

<table>
<thead>
<tr>
<th>REF. NO.</th>
<th>KEY ACTIVITIES</th>
<th>RESPONSIBLE PERSON</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>Selection and management of Internal Quality Audit Team</td>
<td>QMR and IQA Team Leader</td>
</tr>
<tr>
<td>5.2</td>
<td>Planning for the IQA</td>
<td>IQA Team Leader</td>
</tr>
<tr>
<td>5.3</td>
<td>Preparing for the IQA</td>
<td>IQA Team Leader/IQA Team Leader/Internal Quality Audit Team</td>
</tr>
<tr>
<td>5.4</td>
<td>Conducting the IQA</td>
<td>IQA Team Leader/IQA Team Leader/Internal Quality Audit Team</td>
</tr>
<tr>
<td>5.5</td>
<td>Reporting the IQA Results</td>
<td>IQA Team Head and Team Leaders</td>
</tr>
<tr>
<td>5.6</td>
<td>Verifying Actions Taken</td>
<td>IQA Team Leader/Internal Quality Audit Team QMR</td>
</tr>
</tbody>
</table>

5.1 Selection and Management of Audit Team

5.1.1 Acceptance of candidate auditors into the internal quality auditor pool and selection of auditors for specific assignments should consider the following audit competencies.

a. Must be a regular employee
b. Knowledge on ISO 9001 requirements and the NHA QMS
c. Have undergone Training on Internal Quality Audit

5.1.2 The competencies in the performance of internal quality auditors are periodically evaluated to identify training and development needs. The IQA Team Head coordinates with the HRMD to plan and implement training and development programs for auditors.
5.1.3 Internal Quality Auditors’ performance is reviewed based on accomplished audit checklist, audit reports and actual conduct of audits. An annual Auditor’s Performance Evaluation shall be conducted.

5.2 Planning for the IQA

5.2.1 The Annual IQA Plan is prepared by the IQA Team Head before the start of a calendar year in consideration to the following:

   a. results of previous audits
   b. trends in process performance
   c. availability of the auditors and auditees

5.2.2 The ISO 9001:2008 standard serves as the primary audit criteria for the QMS audits. It also includes compliance with applicable laws, regulations, policies guidelines, procedures and processes.

5.2.3 The Internal Quality Audit Plan is translated into an Internal Quality Audit Itinerary where detailed activities of the IQA is specified. The IQA Plan is approved by the GM and the IQA Itinerary is approved by the QMR.

5.2.4 Whenever necessary, unplanned IQA may be initiated by the IQA Team Head based on, but not limited to the following:

   a. unusual increase of quality-related problems
   b. introduction of new policies and programs
   c. major changes in the QMS, personnel, and processes
   d. as instructed by the QMR and/or GM

5.2.5 The IQ Audit Itinerary is communicated through a Memorandum from the QMR to all concerned offices/units at least a week prior to the conduct of the audit activities.

The communication includes the following:

   a. Purpose/Objectives of the Audit
   b. IQA scope
   c. Offices / auditee to be audited
   d. Assigned Audit Team
   e. Date and Time of the IQA
5.3 Preparing for the IQA

5.3.1 The IQA Audit Team Leader with its Team Members review applicable documents of NHA such as the manuals, procedures, applicable standards and statutory and regulatory laws as well as records / reports.

5.3.2 An Audit Checklist (Form) is developed as guide based on the audit scope, objectives, and document review (to include relevant questions).

5.4 Conducting the IQA

5.4.1 The IQA Team Head conducts the Opening Meeting to:

a. confirm the audit plan to include audit objectives, scope, duration of the audit activities
b. provide short summary of how audit activities will be undertaken
c. confirm communication channels
d. introduce audit team
e. provide an opportunity for the auditees to ask questions

5.4.2 The Audit Team conducts audit to:

1) Verify, evaluate and audit the quality management system according to set objectives of each program, set standards and guidelines of related implementing policies;

2) Verify, evaluate and audit the system of delivery of all programs and services to ensure compliance to all policies, plans, procedures and regulation which are significant on the operations

5.4.3 The Auditors shall use the following methodologies:

a. Use of checklist
b. Sampling of records and documents
c. Observing actual activities and practices
d. Interview of concerned staff/process owner
e. Walkthrough of the process and activities

5.4.4 The IQA Team records facts as audit evidence and determines whether the said audit evidence objectively supports the audit findings.
5.4.5 The audit findings are classified as Conformity, NC or OFI. Commendations and strengths of the system are also reported and recorded.

5.4.6 A closing meeting is conducted wherein audit findings, conclusions and recommendations for improvement are presented to the audited office/unit.

5.4.7 If there are unresolved issues related to audit finding or result, the Auditee may raise the issue during the closing meeting. If unresolved at this level, the issue may be raised to the QMR. The QMR may call for a special meeting with the auditee and the auditor in order to discuss the findings and eventually resolve it.

5.5 Reporting the IQA Results

5.5.1 The auditors prepare and submit to the IQA Team Head their respective audit reports on assigned audit areas.

5.5.2 Summary of Audit findings are consolidated and documented in an Audit Summary Report Form by the IQA Team Head and submitted to the QMR.

5.5.3 The Request for Action Form (ReFA) containing NC or OFI is issued to the auditee within ten (10) working days after the closing meeting. The auditee acknowledges and signs the ReFA Form. Refer to CAPA procedure.

5.5.4 Control Numbers are assigned to issued ReFAs in accordance with the procedure on corrective and preventive action.

5.5.5 The auditee determines and implements appropriate corrective action in accordance to the Corrective and Preventive Action Procedures (NHA-QP-05). The auditee returns the accomplished ReFA Form to the IQA Team Leader within fifteen (15) working days upon receipt for purposes of monitoring the actions to be undertaken.
5.6 Verifying Actions Taken

a. Manpower – personnel competencies and their ability consistently perform their functions as required.

b. Machine – the availability of appropriate tools, equipment, and facilities to enable effective operation.

c. Methods – the availability and consistent application of appropriate procedures, guidelines and standards

d. Materials – the availability of the needed materials and supplies to enable effective operations

e. Environment – the availability of appropriate condition and environment in the office and other operations areas to ensure conformity to product/service requirements

5.6.4 Where several root causes are identified, they are prioritized relative to their contribution or impact to the nonconformity.

5.6.5 A follow-up audit shall be conducted within one (1) month after the completion date of corrective action or on the next IQA. The evidence shall be reviewed by the IQA Team and if sufficient, may deem the nonconformity to be closed. Otherwise, an inspection to verify actual implementation shall be conducted, after which the nonconformity may be deemed closed.

6.0 FORMS, RECORDS AND REPORTS

6.1 Attachment 1 - Audit Plan (NHA-QP-03-F01)
6.2 Attachment 2 - Audit Itinerary (NHA-QP-03-F02)
6.3 Attachment 3 - Audit Checklist (NHA-QP-03-F03)
6.4 Attachment 4 - Audit Report Form (NHA-QP-03-F04)
7.0 APPROVAL

Prepared by:

AMELIA I. ANONUEVO
IQA Team Head

Reviewed by:

FROILAN R. KAMPITAN
QMR/Asst. General Manager

Approved By:

ATTY. SINFOROSO R. PAGUNSAN
General Manager
1.0 PURPOSE

1.1 The Quality Procedure (QP) for the Control of Nonconformity describes the process of identifying, reviewing, analyzing, evaluating and documenting nonconformities and thereupon proceeds by suggesting / recommending corrective and preventive actions to mitigate their impact on the Quality Management System (QMS).

1.2 It ensures unintended use or delivery of Nonconformities (NC); if delivered, are prevented by controlling the services / actions by way of correction and / or corrective / preventive actions.

2.0 COVERAGE

2.1 This Quality Procedure applies to the services provided by NHA to its clients to include internal customers and project beneficiaries within the established Quality Management System (QMS).

3.0 DEFINITION OF TERMS:

3.1 Nonconformity (NC) refers to the services or actions that do not conform to the policies, procedures, processes and standards established by NHA, requirements of ISO 9001, executive / legislative directives, statutes, laws, rules, regulations and professional / work ethics.

3.2 Potential Nonconformity (PNC) is an event or action that are likely to happen in the future which shall be considered or possibly attributed as nonconformity to the policies, procedures, processes and standards established by NHA, requirements of ISO 9001 requirements, executive / legislative directives, statutes, laws, rules and regulations and professional / work ethics.

3.3 Opportunities for Improvement (OFI) does not make inference as failure in the QMS but expresses the need for improvement of a certain action or service.

3.4 Process Owner may be an individual, team of individuals / unit whom / where the process or activity being performed and attributed as nonconformity was detected and identified.

3.5 Initiator may be an individual, team of individuals or a unit who discovered and reported the detected nonconformity and caused the issuance of Request for Action.

3.6 Request for Action (ReFA) Form is a form used to record findings of nonconformities with root cause analysis and the corrective/preventive
actions to be undertaken within a given time frame. This is being accomplished by the initiator and process owner.

3.7 Disposition / Action refers to suggested / recommended remedial measure(s) or action(s) to be undertaken to correct nonconformities and prevent recurrence or the occurrence of another undesirable situations within the prescribed time-frame.

3.8 Corrective action refers to an action to eliminate the cause of detected nonconformity and other undesirable situation, and prevent recurrence.

3.9 Preventive action refers to an action to eliminate the cause of a potential nonconformity and other undesirable situation, and prevent occurrence.

3.10 Control of Nonconformity Matrix Form contains the summary of common nonconformities within a Department and the correction to be applied.

3.11 Professional ethics refers to professionally accepted standards or code of conduct for people in a specific profession.

3.12 Work ethics pertain to group of moral principles, standards of behavior, or set of values regarding proper conduct in the workplace.

4.0 RESPONSIBILITIES:

4.1 Initiator/Auditor – initiates the issuance of accomplished ReFA Form based on identified NC for corrective action through his/her knowledge or experience as to the effect of said NC.

4.2 Group/Department/Division/Sector/Regional/District/ProjectManager– ensures that all NCs in their respective Units are identified, properly recorded, verified and acted upon appropriately within the prescribed time-frame.

4.3 General Manager exercises the overall authority for the disposition of QMS-related NCs.

4.4 Department Document Custodian accomplishes and maintains monitoring logsheets for all issued or received Request for Action, as well as updates the Nonconformity Matrix.
5.0 PROCEDURE DETAILS:

<table>
<thead>
<tr>
<th>Ref. No.</th>
<th>Key Activities</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>Identification of Nonconformity</td>
<td>All Unit Heads</td>
</tr>
<tr>
<td>5.2</td>
<td>Verification of Nonconformity and Issuance of RFA Form</td>
<td>AMO/Department Unit Head</td>
</tr>
<tr>
<td>5.3</td>
<td>Correction of Nonconformity</td>
<td>AMO/Department Unit Head</td>
</tr>
<tr>
<td>5.4</td>
<td>Analysis of Appropriate Action</td>
<td>Refer to CAPA Procedure</td>
</tr>
<tr>
<td>5.5</td>
<td>Delivery of Corrective Action</td>
<td>Refer to CAPA Procedure</td>
</tr>
<tr>
<td>5.6</td>
<td>Verification of the Effectiveness of Corrective Action</td>
<td>Refer to CAPA Procedure</td>
</tr>
<tr>
<td>5.7</td>
<td>Resolution of Nonconformity</td>
<td>Refer to CAPA Procedure</td>
</tr>
</tbody>
</table>

5.1 Identification of Nonconformity

5.1.1 Any NHA personnel / unit may become an initiator for detected nonconformity / OFI / potential conformity that may arise from the implementation of Management, Core and Support Processes, such as, but not limited to the following:

a. Audits

- Nonconformities / OFIs / potential nonconformities are detected through the Internal Quality Audit (IQA) and external
audits conducted by certifying body and oversight government agencies.

b. Performance Reviews/Evaluation

- Nonconformities / OFIs / potential nonconformities are identified in project accomplishment reports, assessment reports, progress reports and actual implementation of activities. These identified nonconformities / OFIs / potential nonconformities to standards and processes resulting from failure to achieve targets or planned results.

c. Complaints

- Valid customer complaints received through the Public Assistance Desk (PAD), mail, media or other modes of communications.

d. Process Performance and/or Service Delivery

- Services and products which do not conform to existing laws, rules, regulations and NHA established standards and processes.

e. Benchmarking

- Potential nonconformities are determined through benchmarking in reference to applicable laws, rules, regulations, executive and legislative directives, and mandate of NHA.

f. Research

- The need for preventive action to potential nonconformities is initiated as a result of analyses of characteristics and new trends/best practices in housing development processes, technologies, and applicable laws/ executive or legislative directives and media interventions.

5.1.2 Potential nonconformities are discussed during the Management Review.

5.1.3 Customized identification is assigned per nonconformity as indicated in the ReFA Form and follows the Corrective and Preventive Action Procedure.
5.2 Verification of Nonconformity and Issuance of ReFA Form

5.2.1 Use of ReFA for NCs indicated in the Control of NC Matrix is determined by the AMO/Department Manager in consideration of the NC’s impact on the related/relevant process.

5.2.2 Reporting of nonconformities maybe initiated through accomplishment and issuance of ReFA Form by the following:

a. Personnel who identified said nonconformities through her / his Group/Department/Division/Sector/Regional/District/Project Manager who will facilitate transmittal of the accomplished ReFA Form to the concerned Department / AMOs for action.

b. QMS auditors through the IQA Team Head who issued accomplished ReFA Form to auditee during the conduct of audit.

c. On complaints-related NCs received through PAD, mail, media or other modes of communications, accomplished ReFA Forms are issued through the concerned Group/ Department/ Division/ Sector/ Regional/ District/Project Manager in accordance with applicable NHA procedures and guidelines on complaints handling.

5.2.3 The concerned Group / Department/ Division/ Sector/ Regional/ District/ Project Manager verifies the reported NC and undertakes disposition / correction to address the nonconformity.

5.2.4 The accomplished ReFA Form is returned to the initiating Group/Department/Division/Sector/Regional/District/Project Manager within fifteen (15) working days upon receipt for purposes of monitoring the actions to be undertaken.

5.2.5 The assigned Document Custodian in each Group / Department / Division / Sector / Regional / District / Project shall record in the ReFA Registry the received and issued accomplished ReFA Form.

5.2.6 The concerned personnel shall accomplish the ReFA Registry based on the Document Custodian Log Sheet / Log Book for the Group / Department / Division / Sector / Regional / District/Project Manager’s reference in monitoring the status of actions on nonconformities per initiator.
5.3 Correction of Nonconformity

5.3.1 The concerned Group/ Department/ Division/ Sector/ Regional/ District/ Project Manager shall refer to the Nonconformity Matrix to address the identified NCs by identifying courses of action and the responsible unit in his/her Department / AMO.

5.3.2 Should action plans as listed in the Nonconformity Matrix is not applicable or found to be ineffective to resolve the identified NC, the Group/Department/Division/Sector/Regional/District/Project Manager may use appropriate problem solving tools/techniques. The Corrective and Preventive Action (CAPA) Procedure is followed.

5.3.3 The Nonconformity Matrix may be updated in accordance with the Documented Control procedure.

5.4 Analysis of Appropriate Action

Refer to NHA-QP-05 Corrective and Preventive Action Procedure.

5.5 Delivery of Corrective Action

Refer to NHA-QP-05 Corrective and Preventive Action Procedure.

5.6 Verification of the Effectiveness of Corrective Action

Refer to NHA-QP-05 Corrective and Preventive Action Procedure.

5.7 Resolution of Nonconformity

Refer to NHA-QP-05 Corrective and Preventive Action Procedure.

6.0 ATTACHMENTS

6.1 Attachment 1 - Nonconformity Matrix (NHA-QP-04-F01)
7.0 APPROVAL

Prepared by:

AMELIA I. ANONUEVO  
IQA Team Head

Reviewed by:

FROILAN R. KAMPITAN  
QMR/Asst. General Manager

Approved By:

ATTY. SINFOROSO R. PAGUNSAN  
General Manager
1.0 COVERAGE

1.1 The Quality Procedure (QP) applies to corrective and preventive actions for all identified nonconformities found in the implementation of the NHA’s Quality Management System.

2.0 PURPOSE

2.1 The Quality Procedure (QP) on Corrective and Preventive action ensures that causes of detected nonconformities are eliminated in order to prevent recurrence, and causes of potential nonconformities are eliminated in order to prevent occurrence.

3.0 DEFINITION OF TERMS

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CORRECTIVE AND PREVENTIVE ACTION

NHA–QP–005

Quality Procedure

Effectivity: 16 Nov 2015

<table>
<thead>
<tr>
<th>Auditee</th>
<th>The unit or person being audited</th>
</tr>
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<tbody>
<tr>
<td>Auditor</td>
<td>The person with demonstrated personal attributes and competence to conduct an audit</td>
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4.0 RESPONSIBILITIES:

4.1 Initiator/Auditor – initiates the issuance of accomplished ReFA Form based on identified NC for corrective action through his/her knowledge or experience as to the effect of said NC.

4.2 Group/Department/Division/Sector/Regional/District/Project Manager as Process Owner – ensures that all NCs in their respective Units are identified, properly recorded, verified and acted upon appropriately within the prescribed time-frame.

4.3 Department Document Custodian – accomplishes and maintains monitoring logsheet for all issued or received ReFAs as well as updates the nonconformity matrix.

4.4 Internal Quality Audit (IQA) Team Head – is responsible for the conduct of follow-up audits to verify implementation and effectiveness of corrective action stated in the ReFA and monitor the status of IQA-related ReFAs.

4.5 Auditee – responds to audit findings as needed

5.0 PROCEDURE DETAILS

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</table>
## 5.6 Verification of the Effectiveness of Correct Action

Refer to Control of Nonconformity procedure

## 5.7 Resolution of Nonconformity

### 5.1 Identification of Nonconformity

#### 5.1.1

Any NHA personnel / unit may become an initiator for detected nonconformity / OFI / potential conformity that may arise from the implementation of Management, Core and Support Processes, such as, but not limited to the following:

- **a. Audits**
  - Nonconformities / OFIs / Potential Nonconformities are detected through the internal quality audit (IQA) and external audits conducted by certifying body and oversight government agencies.

- **b. Performance Reviews / Evaluation**
  - Nonconformities / OFIs / Potential Nonconformities are identified in project accomplishment reports, assessment reports, progress reports and actual implementation of activities. These identified Nonconformities/OFIs/ Potential Nonconformities to standards and processes resulting from failure to achieve targets or planned results.

- **c. Complaints**
  - Valid customer complaints received through the Public Assistance Desk (PAD), mail, media or other modes of communications.

- **d. Process Performance and/or Service Delivery**
  - Services and products which do not conform to existing laws, rules, regulations and NHA established standards and processes.

- **e. Benchmarking**
  - Potential nonconformities are determined through benchmarking in reference to applicable laws, rules, regulations, executive and legislative directives, and mandate of NHA.
f. Research

- The need for preventive action to potential nonconformities is initiated as a result of analyses of characteristics and new trends/best practices in housing development processes, technologies, and applicable laws/executive or legislative directives and media interventions.

5.1.2 Potential nonconformities are discussed during the Management Review.

5.1.3 Customized identification is assigned per Nonconformity as indicated in the ReFA Form. The recipient office/unit assigns a series number (reset per year) using the following format:

ReFA-Initiator Office Code – Recipient Office Code-year-series number
(ReFA-WWW-ZZZ-YYYY-xxx)

Example:
ReFA-IAD-OCS-2015-001
ReFA-IQA-GSD-2016-001

5.2 Verification of Nonconformity and Issuance of ReFA Form

5.2.1 Use of the ReFA for NCs indicated in the Control of NC Matrix is determined by the AMO/Department Manager in consideration of the NC’s impact on the related/relevant process.

5.2.2 Reporting of nonconformities may be initiated through accomplishment and issuance of ReFA Form by the following:

a. Personnel who identified said nonconformities through her / his Group / Department / Division / Sector / Regional / District / Project Manager who will facilitate transmittal of the accomplished ReFA Form to the concerned Department / AMOs for action.

b. QMS auditors through the IQA Team Head who issued accomplished ReFA Form to auditee during the conduct of audit.

c. On complaints-related NCs received through PAD, mail, media or other modes of communications, accomplished ReFA Form are issued through the concerned Department / AMOs in accordance with applicable NHA procedures and guidelines on complaints handling.

5.2.3 The concerned Group / Department / Division / Sector / Regional / District / Project Manager verifies the reported NC and undertakes disposition / correction to address the nonconformity.
5.2.4 The accomplished ReFA Form is returned to the initiating Group / Department / Division / Sector / Regional / District / Project Manager within fifteen (15) working days upon receipt for purposes of monitoring the actions to be undertaken.

5.2.5 The assigned Document Custodian in each Group / Department / Division / Sector / Regional / District / Project shall record in the ReFA Registry the received and issued accomplished ReFA Form.

5.2.6 The concerned personnel shall accomplish the ReFA Registry based on the Document Custodian Log Sheet / Log Book for the Group / Department / Division / Sector / Regional / District / Project Manager’s reference in monitoring the status of actions on non-conformities per initiator.

5.3 Correction of Nonconformity

5.3.1 The concerned Group / Department / Division / Sector / Regional / District / Project Manager shall refer to the Nonconformity Matrix to address the identified NCs by identifying courses of action and the responsible unit in his/her Department / AMO.

5.3.2 Should action plans as listed in the Nonconformity Matrix is not applicable or found to be ineffective to resolve the identified NC, the Group / Department / Division / Sector / Regional / District / Project Manager may use appropriate problem solving tools/techniques.

5.3.3 The Nonconformity Matrix may be updated in accordance with the Documented Control procedures.

5.4 Analysis of Appropriate Action

5.4.1 The process owner analyzes and evaluates the need for the appropriate corrective/preventive action through risk assessment.

5.4.2 The process owner completes all the remaining sections of the ReFA.

5.4.3 Corrections may suffice for detected nonconformities, except when the items are those identified in the IQA.

5.4.4 Potential NCs require preventive action.

5.5 Delivery of Corrective Action

5.5.1 The process owner concerned conducts a Root Cause Analysis to identify the major factors that contributed to the occurrence of detected nonconformities.
5.5.2 Root Cause Analysis considers the different factors contributing to the nonconformity, including:

a. Manpower – personnel competencies and their ability consistently perform their functions as required.

b. Machine – the availability of appropriate tools, equipment, and facilities to enable effective operation.

c. Methods – the availability and consistent application of appropriate procedures, guidelines and standards

d. Materials – the availability of the needed materials and supplies to enable effective operations

e. Environment – the availability of appropriate condition and environment in the office and other operations areas to ensure conformity to product/service requirements

5.5.3 Where several root causes are identified, they are prioritized relative to their contribution or impact to the nonconformity.

5.6 Verification of the Effectiveness of Corrective Action

5.6.1 The implementation status and effectiveness of corrective/preventive actions is periodically reviewed, verified and evaluated by the QMR or as delegated by the QMR to the Deputy QMR; any related issues are primarily addressed.

5.6.2 The result of the monitoring and verification activities is recorded on the ReFA form, ReFA Monitoring Logsheet per department and ReFA Registry which is maintained by the IQA team Head.

5.6.3 Corrective/Preventive actions are collectively reviewed by the QMR or as delegated by the QMR to the Deputy QMR. Depending on the nature of the solution and the associated nonconformity, monitoring shall be conducted to ensure that the corrective/preventive action is deemed completed.

5.6.4 Verification of the implementation of the corrective/preventive action is done by the IQA Team up to maximum of two (2) times only. If on the second verification, the action plans indicated in the ReFA are still not completed and/or the actions taken were found to be ineffective, the ReFA will be reported to the QMR for appropriate action.
5.7 Resolution of Nonconformity

5.7.1 Process owner plans the corrective/preventive actions (solutions) which involves the following:

a. identification of possible solutions
b. selection of the best solution
c. Identification of activities, resources, responsibilities and timelines needed to implement the selected solution.

5.7.2 Best solution/s with corresponding activities, resources, responsibilities and timelines are recorded in the ReFA.

5.7.3 The corrective/preventive action plans are approved by the Manager of the concerned Group / Department / Division / Sector / Regional / District / Project within ten (10) working days upon receipt of the ReFA.

5.7.4 The officially designated Document Custodian logs the receipt and informs the initiator of the action of the part of the process owner. The implementation of the action plan is monitored by the IQA Team Head through the following:

a. conduct of the next audit
b. follow-up the verification on the committed date of completion of implementation

5.7.5 NCs are considered resolved or closed only when the required action is completed and found effective.

5.7.6 Preventive Actions are effective if the potential NC did not occur.

6.0 FORMS, RECORDS AND REPORTS

6.1 Attachment 1 - Request for Action Form (ReFA) (NHA-QP-05 F01)
6.2 Attachment 2 - ReFA Registry (NHA-QP-05 F02)
6.3 Attachment 3 - ReFA Logsheet (NHA-QP-05 F03)
7.0 APPROVAL

Prepared by: 

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Reviewed by: 

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Approved By: 

ATTY. SINFOROSO R. PAGUNSAN  
General Manager
1.0 PURPOSE

This procedure defines how to handle complaints or expression of dissatisfaction by an individual customer or groups of people made to the Authority. Gathering and compiling these complaints would aid the NHA to properly and timely address complaints, requests, queries and feedbacks, leading to a systematic and improved service delivery. Complaints/feedback form will be utilized in this process to effectively document and capture complaint data. All the while securing proper delegation to tasks to identified responsible department/unit which will deal with said concerns and extend resolutions.

Applying the Customer Feedback Handling Procedure in NHA undertaking will enable the Authority to be more client-focused, accessible, committed, and accountable. Being responsive to the needs of NHA clients will also lead to learning opportunities and further improvements.

2.0 SCOPE

Specifically, the Customer Feedback Handling Procedure will cover various NHA stakeholders:

a) Internal to NHA—complaints and/or feedbacks from employees;

b) External to NHA—complaints and/or feedbacks from researchers, media, housing beneficiaries/clients, NHA Partners (Local Inter-Agency Committee—LIAC), non-government organizations, People's Organization and even from the international clients.

3.0 REFERENCES

a) Citizen’s Charter

b) Public Assistance Desk (PAD) Memorandum Circular (creation of PAD)
4.0 DEFINITIONS

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Customer</td>
<td>A person who purchases goods or services from another party or parties.</td>
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<tr>
<td>Feedback</td>
<td>A reaction or response to a particular process or activity; evaluate information derived from such a reaction or response.</td>
</tr>
<tr>
<td>Information Dissemination</td>
<td>An act of spreading news, information and the sources of documents to another person or persons.</td>
</tr>
<tr>
<td>Procedure</td>
<td>An act or a manner of proceeding in any action or process; conduct a particular course or mode of action.</td>
</tr>
<tr>
<td>Complaints</td>
<td>An expression of discontent, regret, censure, faultfinding.</td>
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</tbody>
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5.0 PROCEDURE OUTLINE

<table>
<thead>
<tr>
<th>Reference Number</th>
<th>Key Activities</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>1. Implement the use of Customer Feedback form</td>
<td>Administrative Staff of all Departments/Units and Public Assistance Desk (PAD) Officers</td>
</tr>
<tr>
<td></td>
<td>2. Gather submitted Customer and Feedback forms</td>
<td>Information Officers-PAD</td>
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<tr>
<td></td>
<td>3. Segregate complaints/ feedbacks by themes</td>
<td>Information Officers-PAD</td>
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<tr>
<td></td>
<td>4. Use basic statistical tools for tallying and producing quantitative data</td>
<td>Information Officers-PAD</td>
</tr>
<tr>
<td></td>
<td>5. Produce qualitative data from the themes of the complaints/feedbacks</td>
<td>Information Officers-PAD</td>
</tr>
</tbody>
</table>
6.0  PROCEDURE DETAILS: MANAGING CUSTOMER FEEDBACK DATA

1. For recording and tracking of complaints, a centralized system should be applied.

2. Complaints officers should be identified. He/she must be well-versed in the programs and projects of the Authority, and familiar with the laws, policies and regulations of the office.

3. Implementing a record keeping plan and updating. A monthly or quarterly collation of customer complaints/feedback forms will ease data extraction at the end of the year.

4. Actions taken by each department and the consultations held with complainants and other parties must be well documented and be part of the report for each case.

5. Complaints officers/supervisors must consolidate customer complaints and feedback reports, share insights and learnings to NHA staff during related activities.

6.1 SPECIFICS

1. Ask the client to fill out Customer and Feedback form.
2. Review the Customer and Feedback form and refer the client to specific department which can address his/her needs. 16 Nov 2015

3. If a discussion is needed, listen to the complainant and take notes of his/her concern. Audio record the conversation of the complainant would allow it.

4. Provide alternative solutions for the complainant to choose from.

5. Ask the Department’s supervisor to talk to the complainant and try to settle his needs if the Information Officer can no longer handle the complaint.

6. If the complaint cannot be processed/addressed within the day, provide the complainant with the Department’s contact number or update the complaint on the status of his complaint once it is solved. Use the contact number he provided in the Customer Feedback form.

7.0 APPROVAL

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