Office of the Management Representative

Report for the CUEA Lang'ata Campus Internal Quality Management System Audit

June, 2016

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Audit Client: The Catholic University of Eastern Africa, CUEA Lang'ata Campus

Audit Number: CUEA/VC/MR/03/2016-01

Audit Type: First Party (Internal) Quality Audit

Audit Objective: (a) Assess the effectiveness of the CUEA QMS; and
(b) Identify areas that require improvement

Audit Dates: Monday, 30th May 2016 – Friday, 10th June 2016

Audit Criteria: (a) ISO 9001:2008 Standard
(b) CUEA QMS Documentation

1.0 Introduction

These Internal Quality Audits were carried out as a requirement of the Procedure for Internal Quality Audits CUEA/VC/MR/03 at the CUEA Lang'ata Campus between Monday, 30th May 2016 and Friday, 10th June 2016. The objective of the quality audits was to evaluate the effectiveness of the CUEA QMS and identify areas that required improvement. A total of 276 findings were raised from the audit as follows:

(a)	Positives	169
(b)	Opportunities for improvement	93
(c)	Non-conformities	14

The report that follows has been arranged in the following sequence: Audit Findings, QMS Effectiveness, Areas of Strengths and Weaknesses, Summary (Uncertainty or Obstacles), Conclusions and Recommendations.

Table 3.1 provides the areas under review.

2.0 Audit Findings

The audit findings that follow have been classified into three major categories: positives, opportunities for improvement and non-conformities. The non-conformities raised have further been categorized as either major or minor.

The findings are detailed below:

2.1 CATERING DEPARTMENT

2.1.1 Positives

(a) General Findings: The Auditees were quite receptive and cooperative throughout the audit period.

(b) Quality Policy: The Auditee had prominently displayed the University Quality Policy Statement. The Auditee was conversant with the Policy.

(c) Quality Objectives: The Auditee had developed three quality objectives which had been displayed. These were found to be SMART and had been linked to the overall University Quality Policy Statement. The Quality Objectives had been cascaded down from the Corporate Quality Objectives.

(d) Control of Documents: Documents and records were available at point of need.

(e) Control of Records: Records were well kept and maintained. The filing system as commendable, there was evidence of referencing, indexing and numbering.

(f) Audit of Procedure: The Auditee was conversant with the sampled and audited standard operating procedure for 'preparation and serving of food at the multi-purpose hall, CUEA/DVC ADM/CTR/02 which was adhered to. There was evidence that the Auditee was operating two registers for signing after the staff had been served with food. The registered were one for staff and the other the Resident Religious Staff.

(g) Internal Communication: Auditee communicate with their customers mostly through: notices, telephones, and orally.

2.1.2 Opportunities for Improvement

(a) Management Review: Management Review meeting had been held as per the minutes of 14th March 2016. However, the format for the ISO Standard 9001:2008 clause 5.6.1 had not been followed.

(b) Resource Management: For provision of resources and especially on tools used by the department to provide quality and efficient services to the customers, some of the Auditee's cooking Jikos and fridge were found to be out of order. There is need to either repair or replace them whichever option would be cost effective.

(c) Quality Objective: The first quality objective 'increase community service activity by 10% by year 2015/16'. This had yet to be achieved / acted upon yet the time frame was almost over.

(d) Corrective Action: The Auditee had acted on the CAR's report of the previous audit on the filing system. However, it was noted that the file containing copies of LPO's had completedly been done for ease of the reference and traceability.

2.2 COMMUNITY SERVICE

2.2.1 Positives

(a) General Findings: The Auditees were receptive, cooperative, quite positive and seemed well aware of their systems and procedures.

(b) Quality Policy: Auditees were aware of the CUEA quality policy and the role of the Department in contributing to the realization of the QPS.

(c) Control of Documents: Documents were easily and readily available and retrievable at the point of use, except that some policy documents were under review like the statutory policy guidelines.

(d) Control of Records: Records on budgets and community service events and accounting were available and fully analyzed.

(e) Corrective Action: Previous CARs had been fully corrected.

2.2.2 Opportunities for Improvement

(a) Internal Quality Audits: The Head of the Community Service department should attend internal quality audits just like external ones since he/she is responsible for the unit.

(b) Quality Objectives:
  (i) Quality Objectives should be signed by the HOD and stamped for authenticity.

  (ii) The Department Quality Objectives should be updated periodically, and a monitoring tool be designed for assessing whether they were being achieved or not.

(c) Community Service:
  (i) There is need to ensure that the community service activities were all long term in nature and focus.

  (ii) Establish more partnerships to support.

2.3 CORPORATE COMMUNICATIONS DEPARTMENT

2.3.1 Positives

(a) General Findings: The Auditees were receptive, cooperative, quite positive and seemed well aware of their systems and procedures.

(b) Quality Policy: Auditees were aware of the CUEA quality policy and the role of the Department in contributing to the realization of the QPS.

(c) Control of Documents: Documents were easily and readily available and retrievable at the point of use, except that some policy documents were under review like the statutory policy guidelines.

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(c) Community Service:

(i) There is need to ensure that the community service activities were all long term in nature and focus.

(ii) Establish more partnerships to support.

2.4 CUEA PRESS

2.4.1 Positives

(a) General Findings:

(i) The Auditees were welcoming and they accorded the Auditor necessary cooperation during the audit.

(ii) At the time of the audit the Corporate Communications Department (CCD) had been incorporated into a larger docket – Communication and International Relations. Due to this restructuring, the procedures and processes were undergoing some changes making it had for the CCD to operate effectively.

(iii) There was a very clear understanding of the CUEA QMS and its operation.

(b) Quality Policy: The Quality Policy Statement was on display at the time of the audit and there was a general awareness and right attitude towards the QMS.

(c) Customer Complaints: There was evidenced that customer complaints were being handled.

(d) Follow up on Previous Audits: There was evidence that the CCD had followed up on some of Corrective Action Requests of the previous audits done in the Department.

(e) Communications: Both Internal and External Communication was evident in the Department and the CCD Staff had the right attitude about doing more in order to market the University.

(f) Control of Records: Record keeping and the filing system were satisfactory at the time of the Audit.

2.4.2 Opportunities for Improvement

(a) Customer Complaint: There were very few documented customer complaints as much as there was evidence that there were complaints from Departments.

(b) Community Service: This ought to be taken seriously by the CCD given that it could be used as a platform to market the University.

2.5 DEPUTY VICE CHANCELLOR: ACADEMIC AFFAIRS AND RESEARCH

2.5.1 Positives

(a) General Findings: All the DVC AAR Staff were present, receptive and worked together as a team throughout the audit period providing Auditor with request audit evidence as available.

(b) Work Environment: The work environment was conducive and work resources were well utilized.

(c) Internal Communication: The DVC Academic Affairs and Research Office plays an important supervisory role and communicates with the other departments mostly through memos, CUEA/DVC ACD/ACPD/pos2015-03 among other presented as evidence. Follow up of Deans Committee meetings communication from Deans Committee including follow up on action points as evidenced in minutes of 14th June 2016 meeting was being done.

(d) Quality Objectives: The functional area's quality objectives were well displayed and were being reviewed in light of the ongoing restructuring process.

(e) Authorities and Responsibilities: The Office has job descriptions for respective office holders articulating their roles in achieving the quality objectives

(f) Process Improvement: The functional area had decentralized examinations for Kisumu and Eldoret Campuses.

(g) Control of Records: Records were impeccably kept for meetings. Records and documents were secured well in files and cabinets and the Office computers.

(h) Management Review: The DVC Academic Affairs Office conducts management review meetings according to the guidelines of the ISO 9001:2008 Standard. MRM Minutes were signed for circulation.

(i) Customer Complaint Handling: There was evidence that the Office attends to customer complaints. Customer Feedback was received in many forms, emails and appreciation of service by customers. Most complaints were on exam marks and harassment. Complaints not directly linked to the office were forwarded to the other offices for information.

2.5.2 Opportunities for Improvement

(a) The Programme of Studies for CUEA: Though a communication CUEA/DVCACD/ACPD/pos2015-03 dated March 20th 2015 indicated efforts to have the Programme of studies prepared were underway this should be pursued to completion.

(b) Research: Promotion of Research Culture should be done by developing in conjunction with Research, Innovation and Graduate Department an agenda on way forward for internal and collaborative stakeholders.

(c) Procedure for Graduation: Convocation and graduation procedure should be developed in conjunction with relevant stakeholders.

(d) Customer Complaint Handling: Integrate use of the Customer Complaint Handling Procedure (CUEA/VC/MR/08) into its customer complaint handling processes.

(e) Resource Management: Address for the Examination Officer for Gaba and Lang'ata Campuses.

2.6 DEPUTY VICE CHANCELLOR: ADMINISTRATION, FINANCE AND PLANNING

2.6.1 Positives

(a) General Findings: The Auditees were corporative and positive about the audit. The provided the Auditor with evidence where it was available.

(b) Quality Policy: The staff of the function were aware of the new quality policy and were able to articulate their function and role towards its achievement.

(c) Audit of Procedure: CUEA/VC ADM/01 – Procedure for Approval: There was evidence that the procedure was being followed:

(i) There was evidence that requests were received for approval – request transport for Rugby Team to play in Machakos.

(ii) The forms were duly completed by requesting parties.

(iii) Requests were reviewed by the DVC APF and approved within two days of receipt of the requests.

(iv) Where applications or requests for approval were rejected there was evidence that communication to the relevant parties was done.

(d) Control of Documents:

(i) Documents from the Office of the DVC APF were forwarded to the various recipients using Delivery Books.

(ii) Documents used in the Office of the DVC APF were properly uniquely identified as per requirement of the ISO 9001 Standard.

(iii) Documents quickly and easily retrievable.

(iv) Soft documents in the Office of the DVC APF were well filed and archived, making them easy to locate on the computer.

(e) Risk Management:

(i) There were mechanisms in place to follow up on evaluation of opportunities, threats that may be internal or external to CUEA.

(ii) Information acquired was used to manage risk within the University.

(f) Strategic Plan: Monitoring of the Implementation of the Strategic Plan had previously been under a different Office. The University Management Board having seen the need to review the strategic plan had been put in place a Committee to carry out the review and they had been given a timeline of 3 months.

(g) Analysis of Data: The Office of the DVC APF does receive reports from different functions in regard to their work.

(h) Internal Communication: Internal Communication takes place through emails. Emails to all staff were usually forwarded to the Office of the DVC APF at the email admin@cuea.edu and then they are forwarded to all staff. Communication also took place using telephone.

2.6.2 Opportunities for Improvement

(a) Corrective Action: There was need to prepare a schedule of how the faulty communication equipment (telephones) will be addressed and this should be communicated to the Office currently in charge of the facilities. This was still pending.

(b) Quality Objectives: Quality objectives displayed in the office were obsolete. There was need to develop new Quality Objectives in line with the current Corporate Quality Objectives that would take into consideration the restructure process and the combination (merger) of the three functions: Administration, Planning and Finance.

(c) Audit of Procedure: CUEA/VC ADM/01 – Procedure for Approvals: Clause 6.2 on Approvals for Contractual Works requires to be reviewed to reflect what was currently happening on the ground as the Function of the Senior Administrative Officer no longer exists due to restructure.

(d) Control of Documents:
   (i) Files need to be properly labeled. Labels should include: a unique identifier, the file title, the department, the duration the file was in use and the authorizing officer.

   (ii) Delivery books were records, they needed to be uniquely identified.

(e) Risk Management: CUEA should use tools such as the SWOT and PESTLE to evaluate the environment both internally and externally and results should be used to manage risks. Records of such actions should be kept.

(f) Data Analysis: Reports submitted to the DVC APF should form input for decisions made. This would encourage continual improvement not only at the function that submitted the report but at CUEA in general.

(g) Compliance to Statutory, Regulatory and Legal Requirements: There was need to have a master compliance schedule in place.

(h) Management Review: Management Review needed to be conducted and records kept.

2.6.3 Non-Conformities

Minor

Management Review: There was no evidence of management review having been conducted by the section since September 2012.

2.7 DEVELOPMENT STUDIES DEPARTMENT

2.7.1 Positives

(a) General Findings: The Auditees were very cooperative and provided the Auditor with evidence as requested where it was available.

(b) Corrective Action Raised During Previous Audits: Corrective Action was reviewed and the following was noted:

(i) Quality Objectives: These have been developed. They were displayed. The corrective action taken was effective.

(ii) Approval of Management Review Minutes: The Minutes for the Management Review meeting held on 19th November 2014 and that held on 16th February 2016 had been appropriately signed for circulation. Corrective action taken was effective.

(c) Quality Policy: The revised Quality Policy was available. Members who participated in the audit had a good understanding of the policy and vere able to articulate their roles in ensuring that the policy was achieved.

(d) Audit of Procedure: Procedure – CUEA/DVC ACD/FAS/01 – Procedure for Social Work / Field Attachment Practice for FASSc Students: There was evidence that the procedure was being adequately followed:

(i) The Coordinator contacts the organization / agencies to seek for confirmation of placement of students for attachment mostly by telephone.

(ii) The Attachment Schedule was prepared and disseminated to all involved parties on time. It included all the information prescribed by the Procedure.

(iii) A meeting for the Students and Supervisors was convened by email and notice on 25th April 2016. It took place on 5th May 2016.

(iv) Record of the proceedings of the meeting was kept.

(v) Documents required for the exercise were availed to students during the meeting for Students and Supervisors. They had also been posted in an email – field.attachments@gmail.com and the students had the account password.

(vi) There was evidence that students prepared their reports and submitted them to the supervisors within the stipulated timeframe.

(vii) Mark Sheets were submitted to the HOD by the supervisors. They were endorsed and forwarded to the Dean who also endorsed them. They were then forwarded to the University Registry for entry into the system.

(e) Control of Documents:

(i) Minutes of Departmental Meetings had been prepared.

(ii) There was a filing system in place.

(f) Analysis of Data: Data was collected and analyzed. Reports such as the annual reports were generated. There was evidence that reports were disseminated to the relevant users. There was also evidence that action was taken on the issues raised in the reports and that they were also used for decision making.

(g) Internal Communication: Internal Communication was done through emails, memorandums, letter and telephone.

(h) Compliance to Statutory and Regulatory Requirements: The Department ensured that postgraduate students had their proposal documents properly approved and signed after corrections to enable them get a permit to carry out their data collection.

(i) Management Review: Management Review as last carried out on 16th February 2016. Minutes of the meeting were available.

2.7.2 Opportunities for Improvement

(a) Corrective Action:
  (i) Scientific Research:
    – Document specifying requirements for scientific research proposal defense for Undergraduate students has yet to be finalized.
    – There was need to follow up on the requirement document for postgraduate students with the Research, Innovation and Graduate Training.
  (ii) Monitoring and Measurement of Processes: There was need to revisit the development of a tool to monitor the progress of students research supervision.

(b) Audit of Procedure: Procedure – CUEA/DVC ACD/FAS/01 – Procedure for Social Work / Field Attachment Practice for FASSc Students:
  (i) Contact between the CUEA and Organizations or Agencies needed to be documented either by official letters or email communication.

  (ii) Meetings for Students and Supervisors should be convened within the timeline stipulated by the procedure.

  (iii) Minutes of the Meeting for Students and Supervisors needed to be prepared, approved and disseminated on time.

  (iv) Procedure should reflect what was currently happening on the ground.

(c) Internal Communication: There was need to submit the mark sheets to the University Registry with written communication to ensure a record was kept.

2.7.3 Non-Conformities

Minor

(a) Control of Documents: All documents should have proper approval, and so have unique identifiers.

(b) Control of Records: Filing system needed to be reviewed. Documents lack proper filing. Documents lack unique identifiers, titles, department name, person authorizing the use of files and the period the files were in use. There was no filing index in place.

(c) Management Review: The Management Review meetings were not conducted in the format laid out by the ISO 9001:2008 Standard Clause 5.6.1 and 5.6.2.

2.8 EVENING PROGRAMME DEPARTMENT

2.8.1 Positives

(a) General Findings: The Auditees were very cooperative and punctual at the time of the audit.

(b) Quality Objectives: The department did not have the quality objectives but claim to share with the registry department.

(c) Quality Policy: The CUEA quality policy statement was displayed on their notice.

(d) Monitoring of Processes: There was evidence of lecturers attendance register.

(e) Control of Records: There was evidence that records in forms of receipts are kept.

(f) Customer Complaint Handling: There was evidence that the students complaints were well handled well by the way they attend to them evidence available in the internet.

(g) Audit of Procedures: The criteria used for choosing invigilators was well done by those who set the exams as they were the ones who would invigilate their examinations.

2.8.2 Opportunities for Improvement

(a) Quality Policy: The staff in the department were not aware of what the quality policy statement stated.

(b) Quality Objectives: These had not been cascaded to their Departments.

(c) Community Service: Community service was a pillar of the University but the department had never done one due to understaffing.

(d) Analysis of Data: The register for lecturer attendance is only used for their claims. The data collected had yet to be analyzed to find out how many lecturers missed classes and if make ups were done to compensate for the missed classes.

(e) Management Review: There was no evidence that management review had been carried out by the Department since 2nd May 2011. Reason given was that the Department only had two staff in the Office.

(f) Control of Records: Storage of records is poor because transcripts were laying on the floor.

2.8.3 Non Conformities

Minor

(a) Control of Records: The Department does not have proper filing indexing system and therefore records and documents are not easily identifiable and retrievable.

(b) Management Review: There was no evidence that the Department hold Management Review meetings. The last meeting held was on 2nd May 2011.

(c) Community Service: Though Community Service is one of the pillars of the University, the Department had never participated in any.

Major

(d) Analysis of Data: There was that data on lecturers attendance was collected but no evaluation had been done on the data collected to see how many missed classes and if makeup were compensated.

2.9 EXAMINATIONS OFFICE

2.9.1 Positives

(a) Quality Policy: There was awareness among the staff of the University quality policy. The staff also appreciated the role of the Examination Office in the attainment of the quality objectives of the University.

(b) Departmental Quality Objectives: There was evidence of the existence of Quality Objectives for the Department. These were well displayed in the Examination Office.

(c) Customer Feedback: The staff in the Examination Officer properly identified their customers as the lecturers, HODs, as well as the students.

(d) Control of Documents and Records: The Department records were well kept and easily retrievable. Files were uniquely labeled in line with the ISO requirements. A good example was the file containing lists of exams forwarded to the office by the teaching department labeled CUEA/ACD/EXM/Dec. 2024(05). However, examination office does not an index, list or register of files to facilitate retrieval.

(e) Procedure for Examination Setting and Administration (CUEA/DVC/EXM/01): The following evidence was available to show that the procedure was being followed – copy of letter from the Dean submitted to the Examination Office units on offer for the August to December 2015 semester, dated, 25th May 2016.

2.9.2 Opportunities for Improvement

Control of Records: The Department requires to create a list / index or register of files to facilitate efficient retrieval of documents.

2.9.3 Non-conformities

Minor

(a) Management Review: The Department had not held Management Review since 4th February 2015 in line with the relevant procedure.

(b) Data Analysis: There was no evidence of data being analyzed on customer feedback.

Major

(c) Corrective Action: Procedure for Examination Setting and Administration (CUEA/DVC/EXM/01): There was an outstanding corrective action request concerning Procedure for Examination Setting and Administration (CUEA/DVC ACD/EXM/01) whereby it needed to be reviewed. This matter had not been completed. It is recommended that since the procedure cuts most of the teaching Departments, the Directorate of Quality Assurance calls a stakeholders forum on the way forward.

2.10 FACULTY OF COMMERCE

2.10.1 Positives

(a) General Findings: The Auditee was very cooperative and participated in the Audit process and provided all the necessary information for the audit.

(b) Quality Policy: The Auditees were conversant with the new quality policy. They were able to articulate and establish their role in achieving it. The quality policy statement had been clearly been displayed.

(c) Quality Objectives: The Department had developed its quality objectives cascaded from the cooperate level.

(d) Control of Documents: The Department recently, relocated to new offices and they were still settling down. The documentation and filling was still ongoing and being re-organized. There was an attempt to ensure documents were well filed and preserved through the offices were small and had to be shared.

(e) Analysis of Data: Even though the Department carried out data analysis there was still a lot to be done to ensure data analysis was carried out in all the areas of the Department to assist in decision making, for example, the number of students admitted per trimester, lecturer attendance etc.

(f) Provision of Resources: Faculty had recently relocated from the previous offices and had been allocated offices. Lecturers had been given common staffroom to share.

(g) Customer Complaint and Feedback Handling: Auditees were aware of the Procedure for Customer Complaint and Feedback Handling.

(h) Previous Audit: The areas that had been raised during the previous audits had been addressed and preventive action plan implemented was still in progress.

2.10.2 Opportunities for Improvement

(a) Preventive Action Plan: The preventive action plan for February 2016 audits had not been completed.

(b) Provision of Resources:

(i) The Offices that the Faculty recently moved into were a smaller space than they earlier had. Two secretaries have to share one internet point and there is only one phone extension.

(ii) There is not enough space for the files and some had to be up in the Lecturers' staff room where they were not locked.

(iii) Payments to part-time lecturers had not been made in a long time and this might have unnecessary negative effects on the quality of teaching. Some lecturers declined to take up units during the trimester due to the non-payment of claims.

(c) Management Review: The Faculty had not carried out management review meetings as required. Even though there was a meeting with the agenda of ISO requirements, it was not clear on whether it was a Management Review. There were no minutes available to support it.

(d) Customer Complaint Handling: There was no evidence that the Procedure for Customer Complaints and Feedback had been fully adapted into the Faculties operations. There was need for awareness to be made on how to use the form. Auditees informed the auditor that customers were reluctant to fill the form and give feedback.

(e) Control of Records: The Logbook provided for registration of complaints and requests at the Faculty had not been uniquely identified.

(f) Authority and Responsibility: The Faculty had recently become the School of Business. However, there was no evidence showing the request for change, reasons and communication and approval of change of name. due to the restructuring that was ongoing, the same had been effected in the reassignment of duties to the staff but some letters issued still bore the name Faculty of Commerce, causing confusion. There was need to formalize the process.

2.11 FACULTY OF EDUCATION

2.11.1 Positives

(a) General Findings: The Auditees were cooperative, polite and had positive attitude towards the audit exercise. They were well knowledgeable concerning the procedures and requirements for quality management system.

(b) Quality Objectives: These were clear and achievable.

(c) Internal Communication: There was evidence of various communications done in the Department to improve customer services, evidenced by various messages written to student.

(d) Processes: (i) There was evidence that the faculty was making effort to improve the customer services through recent review of the faculty objectives, seminars and interdisciplinary session, (ii) There was evidence that follow up was being done to ensure that the examinations were set after the completion of the syllabus/course outline, and (iii) There was evidence that in order to improve supervision of the Med thesis and PhD dissertations a committee was established to review the format for projects, theses and dissertations and help students improve in writing documents of better quality.

2.11.2 Opportunities for Improvement

(a) Management Review: Management Review meetings could be done after every Internal Quality Audit or the KEBS Audits.

(b) Customer Feedback: Need to look for new ways of getting feedback from customers since the previous feedback form had not been used by customers hence there is no data for analysis.

2.12 FACULTY OF LAW

2.12.1 Positives

(a) General Findings: The Auditees were receptive, cooperative and quite positive and seemed well aware of their systems and procedures particularly the one on Juridical Attachment. Auditees were aware of the CUEA quality policy and the role of the Faculty in contributing to its realization.

(b) Control of Documents: Documents were uniquely labeled and easily identifiable and retrievable at the point of use.

(c) Control of Records: Records were well organized and orderly.

(d) Quality Objectives: Departmental Quality Objectives were displayed, smart and measurable except Quality Objective No. 2.

(e) Audit of Procedure: The Judicial Attachment student list, minutes and budgets were available.

2.12.2 Opportunities for Improvement

(a) Quality Objective: Urgent need to re-organize quality objective No.2 to make it smart and measurable.

(b) Customer Feedback: Need to look for new ways of getting feedback from customers since the previous feedback form had not been used by customers hence there is no data for analysis.

(c) Procedure for Judicial Attachment:

(i) There is need to review the procedure for Judicial Attachment to reflect the new Titles, e.g. CFO and the actual timelines in accordance with the trimester system which was followed during the attachment.

(ii) Although Judicial Attachment had began 3 weeks ago around 6th June 2016, supervisors had not began supervision due to lack of financial facilitation.

(d) Monitoring and Evaluation: Design and establish a framework tool for monitoring the implementation of the Departmental Quality Objectives.

2.13 FACULTY OF SCIENCE

2.13.1 Positives

(a) General Findings: Auditee was corporative hence facilitating a smooth audit process. They were in touch with the QMS and the role they had to play towards meeting the overall institution objectives. There was objective evidence of implementation of procedures.

(b) Quality Policy: The Quality Policy statement was displayed.

(c) Quality Objectives: Departmental quality objectives had been revised and were displayed and the department was committed to departmental quality issues. There was evidence of implementation of quality objectives through set work plans/schedules. (Faculty Quality

objectives, Schdule fo Faculty activities, signed and authorized were available, Faculty report of April 2013 – present also the schedule for FAB / FEB meetings)

(d) Control of Records: Documents were well organized and easily retrievable. Files were neatly arranged.

(e) Programme Implementation: The Auditor observed that there was implementation of new programmes in progress.

(f) Processes: Faculty Academic staff members published as evidenced in the list of data base for publications in soft copy.

(g) Customer Satisfaction: The Faculty addressed customer satisfaction through evaluation of lecturers' performance, Faculty Board Meetings, Student Assemblies (Student Assembly held on 9th February 2016), open door policy, and spot checks. Customer complaints were handled immediately they were raised.

(h) Management Review: There was evidence that matters pertaining to management review were discussed in the Faulty Management Review meeting held on 16th February 2016. The Management Review meeting minutes were forwarded to the Management Representative's Office by email.

(i) Previous Corrective Action: Efforts had been to do corrective action for nonconformities raised during the audits of October 2015 as follows:
   (i) Faculty quality objectives had been approved, signed and circulated
   (ii) Change amendment on procedures had been sent to the Office of the Management Representative, the changes had been effected on the documents, they had been approved ad uploaded on the CUEA Website.

2.13.2 Opportunities for Improvement

(a) Monitoring and Evaluation: Evaluation of lecturers for the courses that were taken during the last trimester had not be done due to lack of photocopy paper.

(b) Procedures: There had been challenges in implementing Faculty procedures due to lack of resources and movement of personnel.

(c) Analysis of Data: Analysis of data was not being done has no staff had yet been identified to do it.

2.14 FACULTY OF THEOLOGY

2.14.1 Positives

(a) General Findings: Auditees were cooperative during the Auditor providing requested evidence were it was available.

(b) Quality Management System: The Auditees were aware of the QMS and there was evidence that it was being implemented accordingly.

(c) Control of Documents: The Department's documents were easily retrievable and legible.

(d) Previous Audits: the Department had taken into account the last Audit's areas of improvement and had acted on them by working on the preventive action plan.

(e) Quality Policy: The Quality Policy Statement was available and the staff members were aware of it and their role towards its achievement.

(f) Collaborations / Partnerships: The Auditees had held collaborations / Partnerships with other institutions through the various inter-disciplinary Theological Sessions that the Faculty had held.

(g) The Faculty had been holding the Management Review Meetings accordingly.

2.14.2 Opportunities for Improvement

(a) Audit of Procedures:

(i) The two Department's procedures were not in line with what they do, however, the Department had held a meeting to review the procedures that were audited and they had filled up the amendment form ready for submission to Directorate of Quality Assurance's Office (evidenced by the Minutes of 6th June 2016).

(ii) The Procedure for outreach programmes / community services had no timelines.

(b) Analysis of Data: The Faculty / Auditees needed to avail the service feedback forms for use by students. These will eventually help in the compilation of the data analysis for the customer Complaints and Feedback.

2.12.3 Non-Conformities

Minor

Analysis of Data – The Faculty collects a lot of data which when analyzed could be very useful in terms of monitoring and measurement but it lacks means to analyze.

2.15 HOUSEKEEPING DEPARTMENT

2.15.1 Positives

(a) General Findings: The Auditee was welcoming, accommodating and provided evidence in support of the activities and operations of the department during the audit.

(b) Corrective Action (Effectiveness): Non conformity on monitoring of Quality Objectives – the Auditee had attended the monitoring and evaluation training and monitoring was now done of the quality objectives.

(c) QMS Awareness: The Auditee was aware of the functional procedures applicable at department level and the link with the CUEA QMS. There was evidence of implementation of these procedures.

(d) Quality Policy: The Auditees was aware of the reviewed Quality Policy statement and was able to articulate her roles in contributing to its general achievement. The Auditee could locate it on the web and had a copy in the office.

(e) Quality Objectives: They had been reviewed and discussed in previous audits and found adequate. The Auditee had also monitored and achievement so far.

2.15.2 Opportunities for Improvement

Review of Procedure: CUEA/DVC ADM/HSK/01: Procedure for Accommodation:

(i) Review of the procedure to take into consideration
- the shared procedure number (procedure for accommodation and procedure for laundry services),
- the procedure is silent concerning the terms and conditions for accommodation especially in regards to security, customer and institutional property and claims of customer property damage (there was need to attach the document that customers were given upon arrival that contained the terms and conditions for accommodation [rules and regulation] currently known as Appendix F – University Hostel; rules and regulations [residents]).
- Any other amendments as will be seen adequate for the Department.

(ii) The procedure to reflect what happened in Lang'ata Campus e.g. in Clause 6.9 on matters monies, the introduction trimesters had made the hostels more of student residents than workshops and seminars hence currently the Auditee did not give invoices and receipts.

(iii) The procedure should have a clause to reflect the current category of clients in Lang'ata Campus as Clause 6.2 did not mention the student category; who are the majority in Lang'ata Campus.

2.16 HUMAN RESOURCE DEPARTMENT

2.16.1 Positives

(a) General Findings: The Auditees were cooperative throughout the exercise.

(b) Corrective Action: Correction and Corrective Action from the previous audit from audits of 11th February, 2015 had been done.

(c) Internal Communication: There was evidence that the Department had communicated with the Deputy Vice Chancellor in regard to the procurement of a backup system. There was evidence of a letter written on 3rd March 2015.

(d) Control of Documents: NHIF Register had been uniquely identified.

(e) Management Review: There was evidence that the Department held Management Review Meetings. There were records of a meeting that took place on 3rd June, 2015.

(f) Audit of Procedure:

(i) Procedure for Loan Application: The procedure was well understood by Departmental staff. Awareness of the procedure to the rest of the staff was done through the HR Manual where each staff had a copy and also during induction. The Department adhered to the 2/3 rule when implementing the procedure which was also a regulatory mandatory requirement.

(ii) Procedure for Disciplinary Action: This procedure was also well understood by the Departmental Staff. The Department adhered to the Employment Act of 2007 in implement this procedure. Due process (disciplinary hearings) had to be followed in an event of gross misconduct before summary dismissal was done.

(iii) Procedure for Staff Development: There was evidence that communication was made to all employees inviting them to make applications.

(g) Customer Complaint Handling: Complaint received through emails were handled as they were they came. The Department also hold a form for the recording of complaints.

(h) Analysis of Data: There was evidence that medical data was collected and analyzed.

2.16.2 Opportunities for Improvement

(a) Quality Objectives: The quality objectives that were on display were different from those understood by the staff members of the Department.

(b) Analysis of Data: There was evidence that record of those benefiting from staff development was being kept, however, analysis of that data was not done.

(c) Customer Complaint Handling: The form for capturing customer complaints had yet to be utilized. The Department needed to come up with a proper way of capturing customer complaints.

2.17 ICT DEPARTMENT

2.17.1 Positives

(a) General findings: The Auditee was quite receptive and cooperative throughout the audit.

(b) Quality Policy Statement: It had been prominently displayed and the Auditee was conversant with the policy statement.

(c) Quality Objectives: these were well displayed. They were found to be SMART and were linked to the overall University Quality Policy Statement. They had also been cascaded from the corporate quality objectives.

(d) Control of Documents: Documents and records were available at point need and/or use. The filing system was quite smart and recommendable. There was evidence of referencing, indexing and numbering.

(e) Monitoring and Measurement: Monitoring of the departments' quality objectives is done and the Auditee is within the time frame which had been planned.

(f) Previous Corrective Action: These had been acted upon: ICT policy was under review, user support register had been labeled and data was collected and analyzed.

(g) Internal Communication: Internal communication to the various departments (customers) was done through telephone, E-mail and notices; for instance evidence vide email to the Dean

Faculty of Arts and Social Sciences (FASSc) done on 8th June 2016 with subject FAB/FEB meeting.

(h) Audit of Procedure: The Auditee was conversant with the sampled and audited Standard Operating Procedure for user support services: CUEA/DVC ADM/ICT/02.

2.17.2 Opportunities for Improvement

(a) Management Review: Last Management Review Meeting had been done on 11th November 2015, minutes were available and endorsed, however, the minutes and agenda of the meeting were not as per the ISO format, Ref: ISO 9001:2008 clause 5.6.1.

(b) Effectiveness of Corrective Action: The ICT Policy was under review during the last audit was found still not yet finalized.

2.18 IMMIGRATION AND INSURANCE DEPARTMENT

2.18.1 Positives

(a) General Findings: The Auditee was cooperative and facilitated a smooth audit process. The function owner was in touch with the QMS and the role he had to play towards meeting the overall institutional objectives.

(b) Quality Objectives: Departmental Quality Objectives were available at the point of use and there was evidence that the Auditee was committed to Department Quality issues. There was also evidence that set objectives were being implemented through set work plans/schedules. Available for collection were pupil's passes and work permits for staff duly processed from the Ministry of Immigration in line with quality objective number two.

(c) Control of Records: There was objective evidence that there was a laid down structure for record keeping. Records were well organized and easily retrievable and kept in filing cabinets and on shelves.

(d) Customer Satisfaction: There was evidence that customer satisfaction was addressed through open door policy, liaising with the various cognate departments (Finance, Admissions Office and the Dean of Students and the Ministry concerned)

(e) Internal Communication: Communication on Immigration and Insurance Services was done through written notifications through the Registrar's Office and the Dean of Students Office during admission and orientation processes. Follow up on clients was done through phone to remind them of their status so that they could take the necessary action on due processes of renewal of their papers.

(f) Previous Corrective Action Requests: Efforts had been made to follow up on corrective action for non-conformities that had been raised during the previous audits.

2.18.2 Opportunities for Improvement

(a) Resource Management: Occasional delay with delivery of customer documents as a result of challenges with the Finance Office (delay of release of funding for follow up of processes). There was also delay from the Ministry of Immigration and Registrar of Persons with processing and releasing of the customers documents.

(b) Corrective Action: One of the nonconformities raised during the last audit was not relevant to the Section. Follow up to be done by the MR Office.

2.19 OFFICE OF THE VICE CHANCELLOR

2.19.1 Positives

(a) General Findings: The Auditees were very cooperative, polite and had positive attitude towards the audit exercise. They were well knowledgeable concerning the procedures and requirements for quality management system.

(b) Quality Objectives: These were clear and achievable.

(c) Internal Communication: There was evidence of various communications done in the department to improve customer services, evidenced by various letters written for the assignment of duties.

(d) Management Commitment: There was evidence that the department was making efforts to implement KEBS findings for the positive change in the institution.

(e) Control of Documents: These were easily retrieved from files.

(f) Procedures: There was evidence that policies and procedures were being followed through evaluation and monitoring reports.

(g) Relationship Management: There was evidence of establishing partnership with other institutions; MOU had been signed for the interest of the University.

(h) Customer Focus: Efforts at this level were being made in order to give students the services they deserve.

2.19.2 Opportunities for Improvement

(c) Quality Policy: The Quality Policy Statement had not been displayed in the office, it was necessary to follow up for this with the Office of the Management Representative.

(d) Risk Management: There was need to be more keen to help the University avoid risks.

2.20 OPEN AND DISTANCE e-LEARNING

2.20.1 Positives

(a) General Findings: The Auditees were welcoming, responsive and accommodating. They provided evidence in support of their activities and operations during the audit.

(b) Quality Policy Statement: The Auditees were aware of the Quality Policy Statement and could locate it online.

(c) Internal Communication: There was evidence of Internal Communication evidenced by communication to the Campus Directors, Deans, Heads of Departments and Heads of Section Ref: CUEA/DVC Acad/ODeL/LET/021/16 dated 17th May 2016.

(d) Control of Records: There was evidence of improvement of control of records and documents and approval of work report Ref CUEA/DVC Acad/ODeL/RPT/02/2016 for circulation.

(e) Data Analysis: The e-Learning management system generates data and can avail analysis. There was evidence of analytics such as that of student assignments, student engagements among others in a report from the assistant systems administrator to the coordinator dated 19th January 2016.

(f) Procedures: There was evidence of an attempt to implement a coordinated process for the centre in its activities within the current set up. The Department supports various faculties in implementation of their online courses. To this the centre had an open and distance e-learning policy (published June 2014) that guides on matters e-learning.

2.20.2 Opportunities for Improvement

(a) CUEA QMS Awareness: The Auditees lack awareness of the CUEA QMS, the Functional procedures and how they should interlink with other functions following the QMS procedures. Thus calling for urgent attention for the centre to comply and conform to the CUEA QMS system.

(b) Quality Objectives: The centre had developed quality objectives but they were not measurable not time bound. The objectives also did not reflect the connection with the corporate quality objectives and hence the need to consider cascading the corporate ones and customize as per the activities and mandate of the centre.

(c) Audit of Procedures

i) At time of the audit it was noted that there was no documented procedure or evidence of any procedure being implemented.
ii) There was no awareness of the QMS and how the activities of the centre relate to it.
iii) However, it was notable that there was a lot on coordination and facilitation of various aspects to various faculties, these faculties were implementing various procedures. These particular procedures were silent on the role, mandate and responsibility of the ODeL Centre.
iv) There were challenges on the actualization and smooth running of certain activities that depended on certain input from the faculty level to the Centre due to lack of specific procedural guidelines.
v) It was thus evident that they were not aware of the QMS procedures that affect the department.

(d) Document Management: It was noted that some records such as reports were hard to retrieve or take long to trace, other had not been labeled to indicate status such as draft / working document or report. However, other aspects were well documented.

(e) Customer Feedback: There was need for retraining on the use of the customer complaint and feedback procedure. This would help in understanding and planning for data collection and analysis that would guide decision making.

(f) Management Review: There was an attempt to have a management review as observed during the audit. It was noted however, that the meeting did not follow the laid down procedure nor did the output of the meeting outline an elaborate preventive action plan of the raised opportunities for improvement.

(g) Customer Complaints:
   i) The procedure for customer complaint had not been implemented. However, there had been attempts to carry out a customer survey and respond to customer complaints forwarded to the centre through emails.
   ii) The teaching procedure had not been implemented too and hence no course evaluation had been carried out as outlined by the procedure. However, owing to the dynamics of the platform certain forms of feedback on lecturers' output could be monitored by the Assistant System Administrator.

(h) Compliance to statutory, regulatory and legal requirements: The centre was not sure of the statutory, regulatory and legal requirements for its functions. There was need to clarify the mandate of the centre so as to make it easy to acquire all that pertains to its mandate.

2.21 PROCUREMENT DEPARTMENT

2.21.1 Positives

(a) General Findings: The Auditees was cooperative and participated in the audit process and provided all the necessary information for the audit.

(b) Quality Policy: The Auditees were conversant with the new quality policy. They were able to articulate and establish their role in achieving it. The quality policy statement had been clearly displayed.

(c) Quality Objectives: The Department had developed its quality objectives. They had been cascaded from the Corporate Quality Objectives. The Department had tried to monitor but there was still need to improve on them.

(d) Control of Documents: The documents had been filed and clearly labeled. One of the impressive aspects of the Department was that files had been well organized on the shelves. This made retrieval of documents easy.

(e) Data Analysis: The Department collected and did basic data analysis. They had collected and analyzed data on re-evaluation of suppliers. Feedback from the users of the products/services.

(f) Management Review: The Department conducted its management review on 24/02/2016 and minutes were availed to the Auditor. The issue of Campus Store that had been raised had not been fully cleared. There was need for the Department to clear up with the Finance Department as it was a policy matter. The agreed form should be uploaded on the website and the new one replaced and documented.

(g) Customer Feedback and Complaints: The Auditees were aware of the procedure and what needed to be done. However, there was no evidence of use of customer complaint form that had been filled and analyzed. The Auditee informed the auditor that a filled form had been sent to the Corporate Communications Department for action and no feedback had been given.

(h) Provision of Resources: The Department had been supported by the University by being allocated funds through a budget to enable them run their operation smoothly.

2.21.2 Opportunities for Improvement

(a) Analysis of Data:

(i) The Department needed to collect more data and to analyze it for better decision making.

(ii) The Department should establish how findings in the Re-evaluation of Suppliers Reports were being used for decision making.

(b) Customer Complaint and Feedback Handling: The Department to fully utilize the customer feedback procedure to improve on its services.

(c) Working Environments and Provision of Resources:

(i) The Function required more spacious offices to enable them execute their mandate. This was due to the fact that they handle bulk documents which required proper storage over a long period of time.

(ii) Due to the nature of the work, there was need to have additional staff to support the Department. Currently there were only 3 staff members in the Department.

(iii) Payment of suppliers had been an issue as they had taken long to receive their payments, (case of Security Company that withdrew their services on this day). This will affect the delivery and quality of services if not addressed. University needed to improve on its services.

2.22 SCHOOL OF CONTINUING PROFESSIONAL STUDIES

2.22.1 Positives

(a) General Findings: The school had only one staff who was also the co-coordinator. The school works in liaison with faculties whose courses were offered e.g. the Faculty of Commerce, and Centre for Social Justice and Ethics. The school fully runs the pre-university programme.

(b) Policy Statement: The staff was aware of the quality policy and how he contributed towards its achievement.

(c) Control of Records: The Department was in the process of creating computerized filing system.

(d) QMS Documentation: The staff knew where the CUEA Quality documents were found as well as how to access them.

2.22.2 Opportunities for Improvement

(a) Quality Policy: The quality policy statement was not displayed.

(b) Quality Objective: The Department needed to have its quality objectives displayed conspicuously.

(c) Control of Documents: Quality policy documents will be controlled and uniquely labeled for easy identification. It was noted that files were not properly labeled.

(d) Customer Complaints and Feedback: customer feedback and other important data needs to be gather, analyzed and reports prepared. These reports need to communicated to the relevant parties. There was no evidence that this was being done.

2.23 UNIVERSITY CHAPLAINCY

2.23.1 Positives

(a) General Findings: The Auditees were cooperative. The Office was very neat.

(b) Control of Documents: Document were well labeled and easily retrievable.

(c) Analysis of Data: Data was being collected and analyzed.

(d) Management Review: Management Review Meetings had been held.

(e) Customer Feedback: These were being done through various means for example, Memorandums, Phone Calls and also Meetings.

2.23.2 Opportunities for Improvement

(a) Standard Operating Procedure: University Chaplaincy needed to be harmonized between the Appendix – Cash Procurement Form. This should be taken to the specific department where it originated from.

(b) The Office needs some repairs and painting.

2.24 UNIVERSITY COUNSELLOR

2.24.1 Positives

(a) General Findings: The two members of staff audited were very welcoming and cooperative through the entire session and availed all the required evidence for the internal audit purpose. The office was ambient and spacious enough for the various activities to be conducted at the Department.

(b) Quality Policy: The revised version of the CUEA quality policy statement was well displayed at the Department and the Auditees were well vast with the policy statement.

(c) Analysis of Data: The Department collects and analyses feedback as evidenced on form CUEA/DVC ADM/DOS/08/fm4 the 'client exit survey form' in file CUEA/DOS/FCMM/VOL.1/2011 Customer Feedback Client Exit Survey Forms & Reports. The analysis reports were in file CUEA/DOS/FCMM/VOL.1/2011 Counselling Centre Yearly Reports.

(d) Audit of Procedures: The QMS procedures were implemented as evidenced on the notice issued to invite applicants for peer counseling of 17/08/15 in file CUEA/DOS/PCSP/VOL.1/2011 Peer Counselling Training List.

2.24.2 Opportunities for Improvement

(a) Quality Objectives: The Department was in the process of cascading the Dean of Students' objectives as availed at the time of audit but they were yet to formulate one that was focused to activities undertaken by the Department.

(b) Control of Records:

(i) Though the Department kept well labeled files it was noted that two files had the same reference that a file named Counselling Centre Yearly Reports and Customer Feedback Client Exit Survey Forms and Reports were both referenced CUEA/DOS/FCMM/VOL.1/2011.

(ii) The Attendance List filed in File CUEA/COS/PCSP/VOL.1/2011 Peer Counselling Training List was not uniquely identified and did not have a CUEA Letterhead.

(c) Analysis of Data: The Department had been audited as part of Dean of Student function and an issue on analysis of recurrent cases arising from the recent KEBS surveillance audits had been addressed as evidenced by a report titled 'data analysis to demonstrate regular recurring cases in Counselling Office 2015' filed in CUEA/DOS/FCMM/VOL.1/2011 Counselling Centre Yearly Reports. However the Department did not keep a record of ISO Audits and the related documentation for reference.

2.25 UNIVERSITY LIBRARY

2.25.1 Positives

(a) General Findings: The audit was attended by the Senior Librarians and the University Librarian who were welcoming and involved in the internal audit process. The Department senior staff of five members were well organized and its staff members work as a team.

(b) Quality Objectives: The Department has well defined Quality Objectives which are SMART. These objectives were monitored as evidenced on Application form for Library Subscription for Onderi Brian Nyabuti of 5th April 2016 on file CUEA/DVC-LIB/19 and analyzed in a report filed in the same file.

(c) Planning: The Department was active and conducted regular meetings as evidenced in file CUEA/DVC-LIB/22 "Staff General Meetings" on minutes dated 6th June 2016 for evaluating and reviewing Library Objectives.

(d) Control of Documents: The library also had an elaborate policy approved and controlled by the Vice Chancellor as was seen as a PDF Scan copy on fie://C:users/prof%20kavulya/downloads/library%20policy%20(2).pdf controlled on 10th November 2015. The Official published document was awaiting release from publication.

2.25.2 Opportunities for Improvement

(a) Quality Policy: The Department had a well displayed CUEA Quality Policy Statement, however, the version displayed had been reviewed and was therefore obsolete.

(b) QMS Implementation: It was also noted that the senior librarians had not been trained on CUEA QMS implementation.

(c) Control of Records: Customer Feedback was being collected and analyzed as evidenced on form referenced CUEA/DVC ACD/LIB/05/fm01 whose analysis was seen as a mailed report to the University Librarian. The customer feedback form had not been filed and the report seen did not have a CUEA Letterhead and signature as required.

(d) Corrective Action from Previous Audits: Arising from the previous audit a change of Procedure CUEA/DVC ACD/LIB/10 Procedure for Weeding Library Stock, the Department had sort advice from the DQA but was yet to fill a Change Amendment Request Form.

2.25.3 Non conformities

Minor

Management Review: The Department conducted Management Review Meetings as evidenced on minutes of 27th May 2016 for audit done on 18th November 2015 in file CUEA/DVC-LIB/15B ISO (LIBRARY) INTERNAL QUALITY AUDIT. The minutes however, did not conform to the format prescribed the ISO 9001:2008 standard. The time for review was also too long.

2.26 UNIVERSITY REGISTRY

2.26.1 Positives

(a) General Findings: The Auditees were cooperative and participated in the audit process and provided the necessary information based on available evidence.

(b) Working Environment: It was generally conducive and customer friendly with appropriate referrals done.

(c) Quality Policy: The Auditee was conversant with the University quality policy statement and could be able to locate in the website. He was able to articulate their role and contribution in its achievement. This was critical as he was to provide clear route from implementation in the functional areas.

(d) Quality Objectives: The Department developed its quality objectives well related to the University corporate objectives.

(e) Control of Documents: Documents were maintained and filing system established for retrieval and use as required by the filing system. The Departmental audit file was readily available as well as admissions file well labeled in terms of academic program and specific intake.

(f) Internal Communication: There was evidence of internal communication by use of timely notices and intercom services. The Auditee was responsive to internal inquiries using the phone as well as direct inquiries related to general operations of the Department.

(g) Customer Feedback: The Department has adopted e-ticketing statement one officer was charged to monitor the same for timely response to customer needs.

(h) Compliance to Regulatory / Legal Requirements: The Auditee and the function are guided by the Commission of University of Education in consideration of applications and academic background for admission and placement of candidates to various faculties.

2.26.2 Opportunities for Improvement

(a) Infrastructure: The function has well determined, provided the infrastructure to achieve conformity of support services in implementation of department procedures. Communication and related support services need to be controlled. Evidence of a notice dated 30/05/2015 'Notice to May, 2016 graduates was not approved for circulation by either signature, stamp of even logo. The document through in admissions files cannot be claimed to belong even to the function.

(b) Opportunities for improvement from the previous audit:
   i) Management Review: The management review meeting was prioritized from Minutes dated March 1, 2016 but not need to be carried out. This need to be done and the information shared with the related parties for continual improvement.
   ii) Temper proof cabinets: The function had no evidence at the time of audit to respond to the need to procure a temper proof cabinets required to store sensitive documents including certificates for the graduands susceptible to weather changes.

(c) Data Analysis: There was need to analyze data on the applications and customer complaints/feedback to guide in decision making.

(d) Procedure for Graduation: From the past audit carried out in February 11, 2015 need to harmonize the process and complete the procedure. In addition there was requirement to clearly define point of entry of the Campuses for effectiveness and consistent implementation. At the time of Audit, there was no evidence of step taken to ensure compliance.

2.26.3 Non Conformities

Minor

Revision of the Procedure for Graduation: This is to enhance implementation of the procedure and smooth learning of the University Campuses.

2.27 RESEARCH, INNOVATIONS AND GRADUATE TRAINING

2.27.1 General Report

General Findings: Auditee was punctual, warm and open for discussion. However, the audit did not take place for the following reasons:

(a) The Director had just been appointed and required time to familiarize with the procedures and previous audit reports.

(b) A number of the staff in the Department were also new.

(c) The Department had been merged with the School of Graduate Studies during the restructure process.

3.0 QMS Effectiveness

The number of audit findings raised as indicated above is 256 with 14 of them being non conformities and 88 being opportunities for improvement.

It can therefore be concluded that:

(a) Number of Non Conformities as per Categorization

From a total of 14 non conformities raised, 2 of them were major, while12 were minor.

Major non conformities include:
(i) Data Analysis
(ii) Corrective Action

Minor nonconformities are in the areas of:
(i) Control of Records
(ii) Control of Documents
(iii) Graduation Procedure
(iv) Management Review
(v) Data Analysis
(vi) Community Service

(b) Number of Non Conformities based on:

(i) Document Audit

Document audit gave rise to a total of 5 non conformities as listed below:
- Development Studies (Control of Document - document identification)
- Development Studies (Control of Records - review of filing system)
- Evening Programme (Control of Records - No proper filing index)
- University Registry (Procedure for Graduation – Not reflect what is currently happening)

(ii) Implementation Audit

Non-conformities raised in relation to implementation were as follows:

– Control of Documents, ISO 9001:2008, cls 4.2.3	1
– Control of Records, ISO 9001:2008, cls 4.2.4	2
– Management Review, ISO 9001:2008, cls 5.6	5
– Data Analysis, ISO 9001:2008, cls 8.4	3
– Corrective Action, ISO 9001:2008, cls 8.5.2	1
– Community Service, Mission Statement, Quality Policy	1
– Procedure for Graduation, CUEA/DVC ACD/REG/03	1

(iii)Clauses as per the Criteria Document (ISO 9001:2008 Standard)

Below is outlined the general and specific clauses of the ISO 9001:2008 standard, contravened:

Table 3.1: Criteria Document Contravened

	General Clause	Specific Clauses	Number	Subtotal
1.	4.0 Quality Management	4.2.3 Control of Documents 4.2.4 Control of Records	1 2	3
2.	5.0 Management Responsibility	5.6 Management Review	5	5
3.	8.0 Measurement, Analysis and Improvement	8.4 Analysis of Data 8.5.2 Corrective Action	3 1	4
	Total			**12**

(iv) CUEA QMS Documents Contravened

Non conformities were raised in contravention to the following CUEA documentation:

- CUEA QMM
- CUEA/VC/DQA/01
- CUEA/VC/DQA/02
- CUEA/VC/DQA/07
- CUEA/DVC ACD/REG/03
- CUEA/VC/MR/05

(v) General Positives and Opportunities for Improvement at CUEA

The audit findings bring out the general positives and opportunities for Improvement for the CUEA QMS:

General Positives

- Management has demonstrated its commitment toward ensuring quality through the Quality Management System;
- All people who were audited were cooperative and provided evidence where it was available;
- Staff in areas that were audited were aware of the ISO requirements for the Quality Management System;
- Staff were aware of the Quality Policy and understood their roles towards its achievement;
- Top management has established the Corporate Quality Objectives and has cascaded them to the functions below;
- Control of Documents is being adhered to by most of the functions that were sampled for audit;
- Control of Records is also being implemented in many of the functions that were audited;
- Areas that were audited had evidence of internal communication;
- Top management carryout management review meetings at regular basis;
- Most of the areas that were audited had conducive working environment;
- There was evidence of compliance to statutory and regulatory requirements;
- Analysis of data was being done at almost all areas that were audited;
- There was evidence of strategic planning and a committee had been set up to review the current strategic plan;
- There was evidence that Departments were carrying out operational planning through departmental meetings;
- Monitoring and evaluation of processes is being done;
- There was evidence that the Office of the Vice Chancellor is carrying out relationship management;

- There was evidence that authority and responsibilities are defined at CUEA; and
- There was evidence of collaborations and partnership at the University.

Opportunities for Improvement

- Some functional staff required training on QMS;
- The Quality Policy was not displayed in the following offices:
  - Vice Chancellor's Office, and
  - University Library;
- Some areas had yet to complete the process of establishing their quality objectives;
- Functions need to work to achieve the objectives they set up. Evidence needs to be maintained in this regard.
- Control of documents needed to be enhanced at the following functions:
  - DVC, Administration, Planning and Finance,
  - Open Distance and e-Learning, and
  - School of Continuing Professional Studies;
- Control of records needed to be enhanced in the following function
  - Evening programme,
  - Examinations Office,
  - Faculty of Commerce,
  - University Counsellor's Office, and
  - University Library;
- There is need to monitor Quality Objectives to establish their level of achievement;
- There is need to ensure that resources are provided for the achievement of the set quality objectives;
- There was need for non-conformities raised at the following areas to be addressed:
  - Catering Department,
  - DVC, Administration, Planning and Finance,
  - ICT Department, and
  - University Library;
- Management review needed to be conducted at the following functions:
  - Catering Department,
  - CUEA Press,
  - DVC, Administration, Planning and Finance,
  - Evening Programme,
  - Faculty of Commerce,
  - Faculty of Education,
  - ICT Department, and
  - ODeL;
- There was need to ensure that resources were provided to ensure process and objective achievement in the following areas:
  - Catering Department,
  - Faculty of Commerce,
  - Procurement Office, and
  - University Registry;
- Areas raised for improvements at the following functions have yet to be addressed:
  - CUEA Press,
  - Faculty of Commerce, and
  - University Registry;

- There was need for the Office of the DVC, Administration, Planning and Finance to maintain a Master Register of Compliance;
- There was need for reports to be prepared and disseminated to the relevant information users for decision making in the following audited areas:
  - DVC, Administration, Planning and Finance,
  - Faculty of Theology,
  - Human Resource,
  - Open and Distance eLearning,
  - University Counsellor, and
  - University Registry
- Faculties of Commerce and Law still required to have authorities and responsibilities needed to be defined;
- Customer feedback needs managed to ensure improvement of processes, products and services in the following functions:
  - Faculty of Commerce,
  - Faculty of Education,
  - Faculty of Law,
  - Human Resources,
  - Open and Distance eLearning,
  - Procurement, and
  - School of Continuing Professional Studies.
- Some functions require to ensure that their procedures need reviewing:
  - Procedure for Graduation,
  - Procedure for Approval, and
  - Procedure for Outreach Programme / Community (timelines); and
- Procedures for Open and Distance e-Learning need to be developed.

4.0 Assessment of Audits

The sample that was selected covered all areas within the scope of the QMS. Audits were carried out in academic and administrative functions. All faculties were represented. The research and community service functions were also represented in the audit. Below are tables summarizing the audit finding for two successive audits February and October 2015:

4.1 AUDIT OF MAY 2016 – CUEA/VC/DQA/03/2016/1

Table 4.1: Summary of Audit No – CUEA/VC/MR/03/2015/2, October 2015

	Particulars	Numbers	Percentage (%)
(a)	Departments sampled for audits	41	100%
(b)	Departments Audited	26	63.41%
(c)	Positive Findings	169	61.23%
(d)	Opportunities for Improvement	93	33.70%
(e)	(i) Major Non conformities	2	0.72%
	(ii) Minor Non conformities	12	4.35%
	Total Non conformities	14	5.07%
	Total Findings	**276**	**100.0%**
	Total Negative Findings	107	38.77%

4.2 AUDIT OF OCTOBER 2015 – CUEA/VC/DQA/03/2015/2

Table 4.1: Summary of Audit No – CUEA/VC/MR/03/2015/2, October 2015

	Particulars	Numbers	Percentage (%)
(f)	Departments sampled for audits	58	100%
(g)	Departments Audited	42	72.41%
(h)	Positive Findings	288	64.1%
(i)	Opportunities for Improvement	137	30.5%
(j)	(i) Major Non conformities	3	0.67%
	(ii) Minor Non conformities	21	4.68%
	Total Non conformities	24	5.35%
	Total Findings	**449**	**100.0%**
	Total Negative Findings	155	35.85%

4.3 COMPARISON OF AUDITS

Table 4.1 illustrates that a total of 63.41% of the 41 functions sampled for audit had been audited. Findings showed that there was a drop of about 9% from the previous audit of October 2015. During these audits a higher percentage of Departments was not audited than in the previous audits. Areas that were not audited include: Office of the Management Representative, Directorate of Quality Assurance, Academic Programmes Department, AIDs Control Unit, Centre for Social Justice and Ethics, Dean of Students Office, Finance Department, Office of the Chief Finance Officer, Institute for Regional Integration and Development, Internal Audit Department, Legal Officer, Department of PGDE / PGDTHE, Research, Innovation and Graduate Training and University Infirmary.

Opportunities for Improvement raised during this audit were at 33.7% up from 30.5% during the October 2015 audits.

Number of non conformities raised was 5.07%, down by 0.28% of those raised in October 2015. Of these non conformities, 0.72% were major non conformities and 4.35% were minor non conformities.

The findings of this audit show a slight downward trend with a slight increase in percentage Opportunities for Improvement but a drop in Non Conformities raised.

5.0 Audit Plan

The Audit Plans were prepared by respective Audit Teams in line with the requirement of the procedure for Internal Audit (CUEA/VC/DQA/03, clause 5.4 and 6.2.3.5)

6.0 Summary (Uncertainty or Obstacles)

Key grounds that could diminish the reliability of this Internal Quality Audit conclusions consist of, lack of reports due to the fact that some sections were not audited because assigned auditors were not in a position to conduct the audits or Auditees were unavailable, and reports for functions that were audited that had not been submitted by the auditors. Also challenges in categorization of audit findings, has a potential to greatly hinder effective Corrective and Preventive Actions to address the non conformities and opportunities for improvements raised.

7.0 Conclusion

From the audit reports and documentation received from the audit teams, positive were 289, opportunities for improvement 136 and non conformities 24. Total number of negative findings was 160 (35.63%). A conclusion can be made that based on the areas that were sampled, the CUEA QMS is effective and the areas of improvement that have been identified will make it possible for continual improvement when the corrective and preventive actions have been implemented as appropriate.

8.0 Recommendations for Improvement

The following are suggestions for improvement of the Quality Management System:

8.1 **Corrective and Preventive Action**: Heads of Function to be sensitized on the importance of Corrective and Preventive Action and the implementation of Procedure for Corrective and Preventive Action

8.2 **Management Review**: Heads of Function at all levels to be sensitized on carrying out Management reviews and the need to follow the guidelines as laid out by the ISO 9001:2008 standard, clause 5.6 and the Procedure for Management Review, CUEA/VC/MR/07.

8.3 **Provision of Resources**: Management to ensure the prioritization and provision of resources for achievement of quality objectives.

8.4 **Compliance of Statutory and Regulatory Requirements**: The Office of the Deputy Vice Chancellor, Administration, Finance and Planning should maintain a Register of Compliance.

8.5 **Risk Management**: Heads of Function to be trained on risk management. The University to assess and manage risk at all levels. The Office of the Vice Chancellor to ensure that a Register of Risks is maintained.

8.6 **Policies**: The Office of the Vice Chancellor to maintain a Register of Policies. This should be updated regularly.

8.7 **University Customer Charter**: The Office of Communication and International Relations to coordinate the preparation of a Customer Charter and to sensitize all staff on it.

8.8 **Authorities and Responsibilities**: Following the restructuring process at CUEA all areas of authority and responsibilities to be defined and well communicated throughout the University.

8.9 **Customer Feedback Management**: Heads of Function to ensure that customer feedback within their functions is well maintained. Feedback should be analyzed and reports prepared. Reports should be disseminated and decisions made using information from the reports.

8.10 **Quality Management Systems Awareness**: Need to continue trainings on various aspects of the QMS for all staff at the University.

8.11 **Quality Policy**: Ensure that staff are well aware of the quality policy and understand their role in its achievement. In addition, the Policy Statement should be displayed.

8.12 **Quality Objectives**: Heads of Divisions to ensure that all Heads of Function in their divisions have established relevant quality objectives, are working to implement them and are monitoring their achievement. Records on level of achievement to be maintained.

8.13 **Control of Documents**: Heads of Function to ensure that documents in their functions are well controlled following the Procedure for Control of Documents.

8:14 **Control of Records**: Proper record management be done at all functional levels.

9.0 Appendices

9.1 APPENDIX A: DEFINTION OF TERMS USED

Audit Client: Organization or person requesting an audit

Audit Scope: Boundaries of the audit e.g. physical locations such as departments, procedures, activities

Audit Team: One or more auditors conducting an audit supported if needed by technical experts

Audit Criteria: Set of policies, procedures or requirements

Audit Findings: Results of the evaluation of the collected audit evidence against audit criteria

Audit Evidence: Records of statements of fact or other information, which are relevant to the audit Criteria

Evidence: Data supporting the existence or verity of something

Non conformity: Non fulfillment of a requirement

Major Non Conformity: Contravention requirements of ISO 9001:2008 Standard and / or the QMS documentation and has a significant effect on the QMS and / or product / service.

Minor Non Conformity: May not contravene requirements of ISO 9001:2008 but has the potential to affect the quality of the product / services or effectiveness of QMS.

Opportunity for Improvement: A potential non-conformity.

Critical Non Conformity: Non fulfillment of requirements that is under no circumstance acceptable.

9.2 APPENDIX B: DEPARTMENTS SAMPLED FOR THE AUDIT

1.	Top Management - Briefing
2.	Management Representative
3.	Directorate of Quality Assurance
4.	Academic Programmes Development
5.	AIDS Control Unit
6.	Catering Department
7.	Centre for Social Justice and Ethics
8.	Community Service
9.	Corporate Communications
10.	CUEA Press
11.	Dean of Students
12.	Development Studies – FASSc
13.	Evening Programme
14.	Examinations Office
15.	Faculty of Arts and Social Sciences
16.	Faculty of Commerce
17.	Faculty of Education
18.	Faculty of Law
19.	Faculty of Sciences
20.	Faculty of Theology
21.	Finance Department
22.	Chief Finance Officer – Finance
23.	Housekeeping Department
24.	Human Resources Department
25.	ICT Department
26.	Institute of Regional Integration and Development
27.	Insurance and Immigration Department
28.	Internal Audit and Risk Management
29.	Legal Officer
30.	Open and Distance e-Learning (ODeL)
31.	PGDE / PGTHE Department

32.	Procurement Department
33.	Research, Innovations and Graduate Training
34.	School of Continuing Professional Studies - Commerce
35.	University Chaplaincy
36.	University Counsellor
37.	University Infirmary
38.	University Library
39.	University Registry
40.	Vice Chancellor
41.	DVC Academic Affairs and Research
42.	DVC Administration, Planning and Finance
43.	CUEA Kisumu Campus
44.	CUEA Gaba Campus Eldoret
45.	CUEA Nairobi City Campus

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OFFICE OF THE MANAGEMENT REPRESENTATIVE

Signed: .....
for Prof Mary N GETUI
MANAGEMENT REPRESENTATIVE