SYSTEM PROCEDURES MANUAL

ISO 9001:2015

CONTENTS

1.0 Objective

1.1 To ensure control of documents that relate to the RTVM's Quality Management System (QMS); and

1.2 To ensure that all management system-related documents are identified, reviewed and approved for adequacy and that only the latest revisions are available at points of use.

2.0 Scope

This covers the creation, review, approval, issuance and retrieval, and protection of management system-related documents. This shall cover internal and external QMS documents.

3.0 Definition of Terms

DC	-	Document Controller
Document	-	Meaningful data and other information and its supporting medium, i.e., procedure, specification, drawing, report, standard, records, etc. The medium can be paper, magnetic, electronic or optical computer disc, photograph, or a combination thereof
Internal Documents	-	documents that are generated within the QMS of RTVM, such as the quality manual, system and operational procedures, work instructions and forms
External Documents	-	documents coming from organizations or entities outside of RTVM but within the scope of the QMS. These may include copies of management system standard, equipment manuals, or reference publications.

Prepared by:	Reviewed by:	Approved by:
MARIA ROXANNE ANGELYCA M. NAVARRETE Document Controller	DULCE AMOR D. QUINTANA QMR	DENNIS WILFRED P. PABALAN Executive Director
Date: July 5, 2021	Date: July 5, 2021	Date: July 5, 2021

4.0 Policies

Control of Electronic Documents

- Personnel are discouraged from saving copies of the procedures. Once procedures are saved in the local or external hard drives of personnel, they shall be considered uncontrolled.
- For easy access of viewing purposes, a google drive folder is created due to Work from Home arrangement. The google drive will be closed for access except to the Doc Controller and QMR, ISO members may request for their soft copies from the Doc Controller subject to the approval of the QMR.

Document Coding and Formatting

- **Document Header**

  All pages of documents, except forms, shall have the following header:

	PRESIDENTIAL BROADCAST STAFF-RTVM	Document code: RTVM-QMS-SP-01	
	SYSTEM PROCEDURES MANUAL	Effectivity date: September 1, 2020	
	CONTROL OF DOCUMENTS	Revision No.: 0	Page No.: 2 of 10

- **Document Coding System**

  Reference Number, Policy Number, Document Number or Document Code refers to the numbering system unique to a particular document.

  The coding system is: **AAAA-BBB-CC-00**

TEMPLATE	CODE	DEFINITION
AAAA (Agency ID)	**RTVM**	Radio Television Malacanang
BBB (Division ID)	**QMS**	Agency-wide Procedures, mainly refers to the Quality Manual and System Procedures Manual documents
	MPD	Media Production Division
	ENG	Engineering Division
	RAD	Research and Archives Division
	AFD	Administrative and Finance Division
CC (Type of Document)	**QM**	Quality Manual
	SP	System Procedure (Agency-wide)
	WP	Division Work Procedure
00	**01**	Document Serial Number

- **Document Contents**

1.0 **Objective** – states the objective of the document.

2.0 **Scope** – describes the activity function covered/affected by the procedure or instruction, including limitations, if any.

3.0 **Definition of Terms** – provides definitions or terms of unfamiliar terminology and abbreviations contained in the document.

4.0 **Policies** – describes the established policies and guidelines to be adhered to during the implementation of the procedure

5.0 **Procedure –** the guides, steps and formats in which to achieve the purpose of the document.

6.0 **References** – contain the materials used to develop the document, including related information, comments and other interfacing documents.

7.0 **Attachments** – enumerate appendices to the document

8.0 **Records** – indicate the records to be generated as a result of the procedure to be implemented

- **Document Format**

1. The paper size – A4 size (21cm x 29.7cm) bond paper must be used and must be consistent for a type of document. The font to be used shall be Arial Size 10.
2. Orientation – the preferred paper orientation is portrait, but landscape orientation may be used when it provides a clearer presentation or accommodates wider view, e.g. for drawings, tables and graphs.
3. The page format on headers and footers are retained whenever letter-sized paper or landscape orientation is used.

- **Reviewing and Approving Authorities**

Document	Reviewing Authority	Approving Authority
Quality Manual	QMR	Executive Director
System Procedures	QMR	Executive Director
Work Procedures	Division Head	Executive Director

- **Copy Control System**

1. Master Copies and Controlled Copies are stamped with the following:

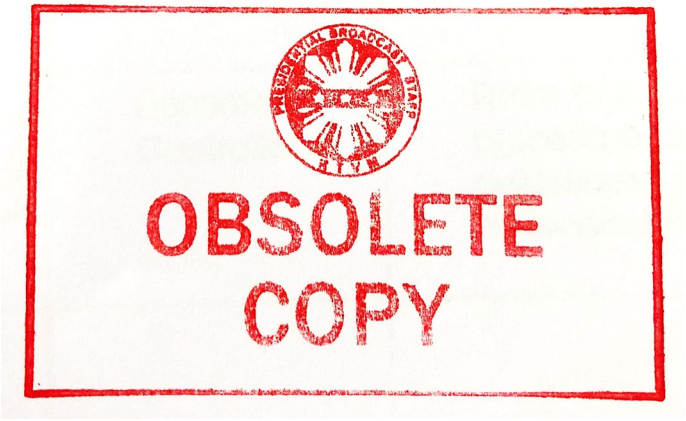
2. Issuance of Uncontrolled Copies

All printed part of the QMS documents shall be considered "UNCONTROLLED" unless stamped as controlled. The Document Controller is not required to update the copies of the holders of uncontrolled documents should new versions be made.

The following stamps indicate that the copies issued out are uncontrolled:

3. Retrieval of Obsolete Documents

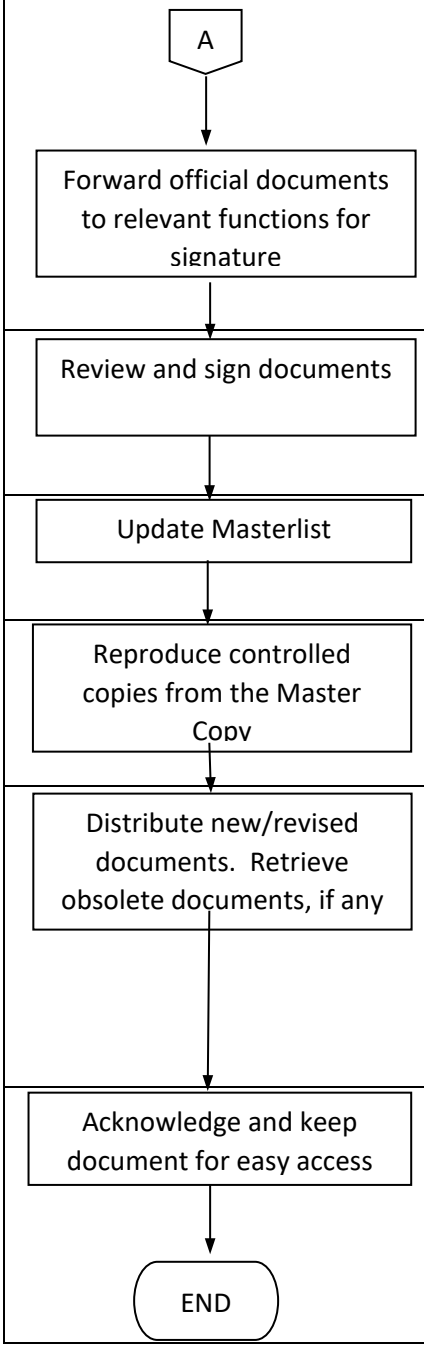
Obsolete documents retrieved from copyholders shall be marked with the following stamp:



5.0 Procedure:

5.1 Internal Documents

ACTIVITY	REPONSIBILITY	PROCEDURE DETAILS
START		
Identify need for creation, revision or deletion of documents	Document Owner	1. May be due to: • Management Review • Internal/External audit findings • Corrective action • Customer requirement • System enhancement • Introduction of new technology/system 2. Revision should be done within 30 working days after audit/notice.
Accomplish DCF and request for approval	Document Owner	3. Use RTVM-QMS-SP-01 F1 Document Control Form (DCF).
Review DCF and discuss details with document owner	Document Controller	4. Brainstorming and discussions with concerned personnel and Management may be necessary. Series of reviews and revisions may also take place at this stage.
Draft new document or revise existing document	Document Owner	
Arrange format, assign or revise document code	Document Controller	5. Refer to the earlier sections of this procedure for the formatting and coding guidelines. For revisions, italicize revised/added texts.
A		

	Document Controller Reviewing and Approving Authorities Document Controller Document Controller Document Controller Document Controller	6. Use RTVM-QMS-SP-01 F2 Masterlist of Internal Documents. 7. Stamp “Controlled Copy” on the first page of documents. Affix initials and date. 8. Distribution of new or revised documents and retrieval of obsolete and superseded documents should be done within a week upon approval. 9. All retrieved obsolete copies shall be disposed of properly. At least one copy shall be retained for future reference. It shall be marked as “Obsolete” and filed by the Document Controller. 10. Copyholder shall acknowledge receipt of document by signing RTVM-QMS-SP-01 F3 Document Issuance and Retrieval Form.

5.2 External Documents

ACTIVITY	RESPONSIBILITY	PROCEDURE DETAILS
START		
Obtain latest copy of external documents	Document Owner	1. Personnel tasked to obtain copies of external documents shall inform Document Controller whenever there are new or amended external documents. Copies may be in paper or electronic form.
Prepare / Update Masterlist	Document Controller	2. Use RTVM-QMS-SP-01 F4 Masterlist of External Documents. A Masterlist shall be kept by each department in RTVM.
Distribute controlled copies to authorized copyholders	Document Controller	3. The original document shall be maintained by the owner/ main user. Log the copyholders in the Masterlist.
Retrieve obsolete copies	Document Controller	4. Where applicable, Master Copy of the obsolete documents shall be marked “Obsolete” and filed for future reference.
END		

6.0 References

ISO 9001:2015 Clause 7.5 Documented Information

7.0 Attachments and Forms

RTVM-QMS-SP-01–F1	Document Control Form (DCF)
RTVM-QMS-SP-01-F2	Masterlist of Internal Documents
RTVM-QMS-SP-01–F3	Document Issuance and Retrieval Form
RTVM-QMS-SP-01–F4	Masterlist of External Documents

1.0 Objective

To ensure that all quality records are properly controlled in terms of identification, storage, maintenance, protection, retrieval, retention and disposal.

2.0 Scope

This procedure applies to all quality records generated during the implementation of the procedures.

3.0 Definition of Terms

Archiving	-	Retention of records for a defined period
Active filing	-	Keeping of records within easily accessible place within the current period
Record	-	type of document stating results achieved or providing evidence of activities performed

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MARIA ROXANNE ANGELYCA M. NAVARRETE Document Controller	DULCE AMOR D. QUINTANA QMR	DENNIS WILFRED P. PABALAN Executive Director
Date: May 14, 2021	Date: May 14, 2021	Date: May 14, 2021

4.0 Policies

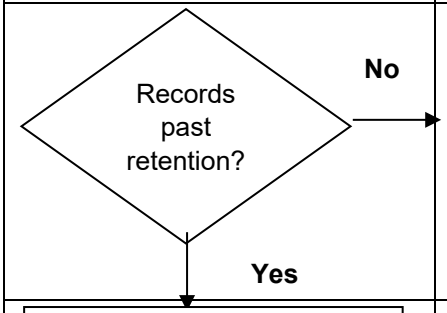
Quality Management System (QMS) records shall be maintained per section. Personnel shall be designated as records custodian who shall ensure that the QMS records are filed and stored properly, protected from damage or unauthorized use, and can be retrieved whenever necessary.

After the active filing period, records shall be arranged for archiving. Retention time and method of disposal shall be defined.

Confidential records shall be identified and tagged in order to protect records from loss of confidentiality and integrity or from improper use.

5.0 Procedure:

ACTIVITY	RESPONSIBILITY	DETAILED PROCEDURES
START		
Complete the record specified in each procedure	Record Generator	1. Fill up forms or prepare the reports. Ensure that: • Records are complete and legible, • All initials/signatures are affixed when necessary, • The information contained in the record is correct and is consistent with the procedure performed, • Incorrect entries are crossed-out with a single line, the correct entry written and certified by a signature and date of change, and • The record is traceable to the activity which has been performed.
Keep records in active file	Record Generator	2. Fill out Masterlist of Records or NAP Form 1 Records Inventory Appraisal. Observe the Active Retention Period specified in the masterlist. File records properly to ensure that records can be easily retrieved when needed.
Send to Archive Records and observe retention period ← B	Record Generator	3. Records which are past their Active Retention Period shall be sent to Records Archive Area for storage. Storage conditions shall prevent damage, deterioration and loss of records.
A		
A		4. Label boxes of records using RTVM-QMS-SP-02-F1. Indicate: • Department/Section Name

		• Title/Form Numbers/Period Covered • Date of Generation • Date sent to Archive Records • Archive Retention Time • Instructions for disposal
	Document Controller B	
Dispose records	Document Controller	5. Dispose records appropriately. Confidential records must be sorted out and shredded before disposal. Papers without confidential information may be re-used as scratch paper or for other purposes. If used as a scratch paper, cross out the used side.
END		

6.0 References

6.1 ISO 9001:2015 Clause 7.5 Documented Information
6.2 Republic Act 9470 - National Archives of the Philippines Act of 2007

7.0 Attachments and Forms

7.1 Records Inventory Appraisal	NAP Form 1
7.2 Records Disposition Schedule	NAP Form 2
7.3 Records for Archiving	RTVM-QMS-SP-02-F1

1.0 Objective

1. To provide guidelines in planning, preparing, and conducting Internal QMS Audit, including reporting and following up of audit results.
2. To determine conformance of actual practice against documented procedures and standards.
3. To verify compliance and effectiveness of corrective actions on non-conformances.

2.0 Scope

This procedure covers all processes, functions, and operational areas covered by the RTVM's QMS.

3.0 Definition of Terms

Audit	-	a systematic and documented process of obtaining objective evidence of conformity to a standard or criteria
Auditee	-	a person or function being audited
Internal Auditor	-	a person with competence to conduct quality management system audit
Nonconformity	-	non-fulfillment of a specified requirement of the standards, policies procedures, and other planned arrangements

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Date: July 2, 2021	Date: July 2, 2021	Date: July 2, 2021

4.0 Policies

4.1 Classifications of Nonconformities

Major Nonconformity - (System Breakdown) total failure to fulfill a specified requirement of the standard that is applicable to the whole organization. Examples of this are the following:

- Absence of a documented information required by the standard
- Non-implementation of an entire procedure
- Aggregation of minor nonconformities related to one particular requirement
- Repeating or widespread minor nonconformities of similar nature
- Major problems, e.g. delivery of bad quality of service to customer
- Failure to recognize and record when an objective or target is not met or defined programs are not implemented as planned

Minor Nonconformity - Lapse in the system that has limited deviation from the prescribed requirements of the QMS

Observation – potential source of non-conformity

- Potential non-conformity but:
    - cannot be related to the requirements of the QMS but if not rectified, it could pose a problem to RTVM's performance
    - No direct evidence of nonconformity/ failure
- A recommendation for improvement
- Suspect in terms of long-term sustainability of the system
- For further investigation on the next audit

4.2 **General Guidelines**

- The entire QMS shall be audited at least once a year, taking into consideration the status and importance of the processes, areas, and functions to be audited and results of previous audits.
- QMS policies and regulations at the area being audited shall be observed by the auditors and other audit participants at all times during the audit.
- Audit findings shall be addressed according to ORG-SP-05 Nonconformity and Corrective Action procedure.

4.3 Internal Auditors' Competence Program

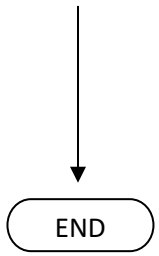
- Internal Auditors shall follow a training program to ensure their competence. Auditors' training shall be planned and monitored.
- Internal Auditors shall have an understanding of the following, as a minimum requirement:
  - Requirements of ISO 9001:2015
  - Basic internal auditing principles and techniques based on ISO 19011
  - Knowledge of the Organization's processes
    - Auditors shall be allowed to audit only the areas and processes where they have sufficient competence. Those who have training gaps shall:
  - Be allowed to audit under the supervision of an audit team leader
  - Be included in subsequent auditor training programs

5.0 Procedure:

ACTIVITY	RESPONSIBILITY	PROCEDURE DETAILS
START		
Prepare/Revise Annual Audit Itinerary/Program	IA Team Leader	1. Use form RTVM-QMS-SP-03-F1 Annual Audit Itinerary/Program. This shall be prepared or revised, preferably before the fiscal year ends. The audit shall be planned, taking into consideration the status and importance of processes, as well as results of previous audits
Organize/Identify Members of Audit Team	IA Team Leader	2. For internal audits, consider the auditor's skills, familiarity with the RTVM's operations and independence from the functions and/or processes to be audited.
Prepare Audit Plan	IA Team Leader	3. Audit Plan may be prepared for the whole system or per defined scope. This shall be communicated to the auditees at least one week before the audit. Use form RTVM-QMS-SP-03-F2 Audit Plan.
Prepare/ Review/ Revise Checklists	Auditors	4. Use form RTVM-QMS-SP-03-F3 Audit Checklist.
Conduct Opening Meeting	IA Team Leader	5. The Internal Audit Team shall meet the auditees for the opening meeting. The Team shall discuss the audit scope and audit objectives, among others.
A		

ACTIVITY	RESPONSIBILITY	PROCEDURE DETAILS
↓		
Conduct the Audit ↓	IA Team	6. The audit shall be done through interviews, discussion with personnel, observation of actual practices and examination of procedures and records.
With NC? No → Yes ↓		7. Review the results of audit. Agree on audit findings, including the NC(s) to be raised.
Prepare CAR ↓	IA Team	8. Refer to RTVM-QMS-SP-05 Nonconformity and Corrective Action Procedure. Refer to page 2 of this procedure for the Definition and Classifications of NC.
Conduct closing meeting ↓	IA Team Leader / Outsourced IA	9. Provide feedback on the results to the auditees, including details of findings and conclusion on the status and effectiveness of the QMS. 10. Obtain concurrence from auditees for the CARs to be raised in their respective areas.
Prepare audit report ↓	IA Team	
Review and improve audit tools used. ↓		11. Review and revise the audit plan for the following year based on new information resulting from audits.

ACTIVITY	RESPONSIBILITY	PROCEDURE DETAILS
↓		
Conduct the Audit ↓	IA Team	6. The audit shall be done through interviews, discussion with personnel, observation of actual practices and examination of procedures and records.
With NC? (No → ; Yes ↓)		7. Review the results of audit. Agree on audit findings, including the NC(s) to be raised.
Prepare CAR ↓	IA Team	8. Refer to RTVM-QMS-SP-05 Nonconformity and Corrective Action Procedure. Refer to page 2 of this procedure for the Definition and Classifications of NC.
Conduct closing meeting ↓	IA Team Leader / Outsourced IA	9. Provide feedback on the results to the auditees, including details of findings and conclusion on the status and effectiveness of the QMS. 10. Obtain concurrence from auditees for the CARs to be raised in their respective areas.
Prepare audit report ↓	IA Team	
Review and improve audit tools used. ↓		11. Review and revise the audit plan for the following year based on new information resulting from audits.

ACTIVITY	RESPONSIBILITY	PROCEDURE DETAILS
		12. Review tools used (checklist) and improve, if necessary. 13. Review time and frequency allocated for audits and revise, if necessary. 14. Review auditor effectiveness.

6.0 References

ISO 9001:2015 Clause 9.2 Internal Audit

ISO 19011 Guidelines on Auditing Management Systems

7.0 Attachments and Forms

RTVM-QMS-SP-03–F1	Annual Audit Itinerary/ Program
RTVM-QMS-SP-03-F2	Audit Plan
RTVM-QMS-SP-03-F3	Audit Checklist
RTVM-QMS-SP-03-F4	Internal Audit Report
RTVM-QMS-SP-03-F5	Effectiveness Evaluation Action Report

1.0 Objective

To provide a formal and regular review of the QMS in order to determine its continuing suitability and effectiveness in implementing the RTVM's policies, objectives, and Quality Management System.

2.0 Scope

This procedure covers the periodic review of the QMS and any other activities and developments in RTVM that affect the performance of its QMS.

3.0 Definition of Terms

Management Review _ management assessment of the continuing suitability and effectiveness of the QMS

Type t

Prepared by:	Reviewed by:	Approved by:
MARIA ROXANNE ANGELYCA M. NAVARRETE Document Controller	DULCE AMOR D. QUINTANA QMR	DENNIS WILFRED P. PABALAN Executive Director
Date: August 17, 2020	Date: August 19, 2020	Date: August 21, 2020

4.0 Policies

1. The Management Review shall be conducted at least twice a year.
2. Participants to the Management Review shall include the Top Management of RTVM, consisting of the Executive Director, QMR, and Division Heads. The Appointed Secretary shall serve as the Secretariat for the Management Review. Designated key personnel may be invited to join Management Review meetings.
3. All required management review inputs and outputs shall be discussed at least once a year.

5.0 Procedure:

ACTIVITY	RESPONSIBILITY	PROCEDURE DETAILS
START		
Set meeting and agenda	Executive Director or Appointed Secretary	1. A Management Review shall be conducted at least twice a year to review the suitability and effectiveness of the QMS. 2. Refer to the Quality Manual for the agenda items to be discussed during the Management Review. Refer to Section 3.0 of RTVM-QMS-QM-09 Leadership.
Notify participants	Appointed Secretary	3. Send meeting notification to concerned parties.
Call meeting to order	Executive Director	4. The Executive Director officially starts the meeting and a secretary is appointed, in case the absence of the Secretariat. Determine if all notified participants are present. If not, ensure that a representative for each division is around. 5. Read the minutes of the previous meeting. Review previously discussed issues and agreed upon action items.

ACTIVITY	RESPONSIBILITY	PROCEDURE DETAILS
Discuss agenda	Executive Director	6. Ensure that all required management review inputs and outputs are thoroughly discussed.
Adjourn the meeting	Executive Director	7. Set the schedule for the next meeting.
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A		
Prepare Minutes of the Meeting	Appointed Secretary	8. Ensure findings, outputs and action plans are properly documented and filed. 9. Include action plans in the minutes of the meeting. For identified problems needing corrective and/ or preventive action, use RTVM-QMS-SP-05 F1 CAR Form.
Reproduce and Distribute Minutes of the Meeting	Appointed Secretary	10. The attendees of the Management Review shall be given each a copy of the minutes and it shall be their responsibility to inform their respective staff of any action recommended by the meeting.
Follow-up Action Items END	Designated Personnel	11. Issued CARs shall be processed in accordance with procedure RTVM-QMS-SP-05 Nonconformity and Corrective Action Procedure.

6.0 References

ISO 9001:2015 Clause 9.3 Management Review

7.0 Attachments and Forms

Prescribed Format – Management Review Minutes

1.0 Objective

To describe the means by which actual nonconformities to the QMS are identified, investigated, and addressed to mitigate any quality-related consequences, and to serve as guidance in initiating. monitoring and completing corrective action.

2.0 Scope

This system procedure covers the application of corrective actions for actual nonconformities relating to the RTVM's QMS such as:

- Problems leading to bad quality of output or service to internal or external customers
- Complaints or concerns by internal or external interested parties
- Objectives and targets not being met
- Programs not implemented as planned
- Internal/ external audit findings
- Problems identified by the management
- Other system and operational nonconformities such as non-compliance to procedures and guidelines

3.0 Definition of Terms

Corrective Action Request (CAR)	-	a report describing an actual nonconformity, identifying its root cause and presenting appropriate corrective action
Nonconformity (NC)	-	non-fulfillment of a specified requirement of the standards, policy, procedures, and other planned arrangements
Corrective Action (CA)	-	action taken to eliminate the root cause of a nonconformity and prevent it from recurring

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Date: August 17, 2020	Date: August 19, 2020	Date: August 21, 2020

4.0 Policies

1.1 CAR is not needed in cases like the following:

- Non-compliance to procedures that can be corrected immediately.

1.2 CAR is needed in the following cases:

- Repeated non-compliance to procedures, as detected/ reported by immediate superior for at least three times in the area within three consecutive months.
- Valid and significant complaints from internal or external interested parties, especially from customers.
- Nonconformity raised during internal quality audits and certification audits. Refer to RTVM-QMS-SP-03 Internal Audit.
- A set quality objective and target is not met within the defined time frame, or an activity/ action, defined to meet an objective and target, is not implemented as planned.

1.3 CAR Coding System

CARs shall be coded as follows:

XX-YYY, where

XX - method of detecting NC such as:

- IA – Internal audit
- EA – External Audit
- CA – Corrective Action

YYY - Sequential number of nonconformity

5.0 Procedure:

ACTIVITY	RESPONSIBILITY	PROCEDURE DETAILS
START		
Describe/ Report nonconformity	Auditor / Manager	1. Use form RTVM-QMS-SP-05-F1 Corrective Action Request (CAR). Copy of issued CAR shall be forwarded to the designated functions defined in RTVM-QMS-SP-05-A1 Designated Functions and Responsibilities for CAR
Submit to process owner for appropriate action; escalate to superior, if necessary	Auditor / Manager	2. Process Owner shall acknowledge the CAR. 3. Review if similar NC exists or could potentially occur elsewhere.
Investigate / determine root cause	Process Owner	4. Where the cause of nonconformity is not readily known, initiate discussion with QMS Team or relevant personnel. 5. The investigation of the nonconformity, including the determination of appropriate corrective action must be completed within 7 working days after receipt of the CAR.
Recommend action	Process Owner	6. Corrective action, where necessary, must include mitigating action or correction of the ongoing issue and prevention of the recurrence of the problem. 7. Document proposed actions, responsible functions and commitment dates of implementation using the CAR form.
Approved? No / Yes → A	Refer to RTVM-QMS-SP-05-A1 Functions Responsible for CAR	

A		
Implement Corrective Action	Process Owner/ Designated Personnel	8. Corrective action shall be followed-up within 2 weeks after the committed completion date. 9. When corrective action results to a change in procedure, the Document Controller shall initiate a revision of the relevant document in accordance with the documented procedure on document control.
Follow-up Corrective Action	Auditor / Manager / Designated Personnel	10. Follow-up shall include evaluation of the implementation and effectiveness of the corrective action. 11. Update risks and opportunities register, where applicable.
Satisfactory? No / Yes		
Update / Re-issue CAR	Refer to RTVM-QMS-SP-05-A1 Functions Responsible for CAR	12. To update CAR: • Note whatever progress has been made • Ask for recommitment of actions and dates • Schedule another verification 13. To re-issue CAR: • Use a new CAR form but ensure traceability to previous CAR • Describe the recurrence of NC and additional details • Ask for commitment of actions and dates • Schedule verification
Close-out CAR		14. A CAR shall be closed out once the recommended corrective action has been implemented and found effective.
END		

6.0 References

ISO 9001:2015 Clause 10.2 Nonconformity and Corrective Action

7.0 Attachments and Forms

RTVM-QMS-SP-05-F1 Corrective Action Request (CAR)

RTVM-QMS-SP-05-A1 Functions Responsible for CAR

1.0 Objective

To establish procedures that will enable the company to monitor and measure the satisfaction level of RTVM's customers, and where appropriate, use the results in continually improving the quality of its operations and the effectiveness of its QMS.

2.0 Scope

This covers external customers which RTVM has provided outputs or services to since the establishment of the QMS.

3.0 Definition of Terms

None

4.0 Policies

The survey form shall be sent to external customers. As much as possible, RTVM shall ask those who are knowledgeable of the level of service provided by RTVM.

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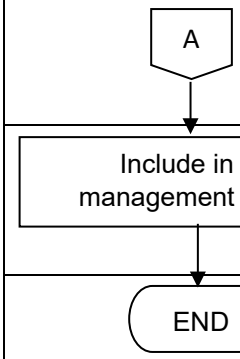
Date: August 17, 2020	Date: August 19, 2020	Date: August 21, 2020

5.0 Procedure:

ACTIVITY	RESPONSIBILITY	PROCEDURE DETAILS
START		
Send Customer Satisfaction Survey Form	QMR / RAD Personnel	1. List of respondents must be approved by the Quality Management Representative. 2. Document Controller shall send RTVM-QMS-SP-06-F1 Customer Satisfaction Survey Form to customer's representative. Monitoring of customer satisfaction shall be done at least twice a year.
Follow up response from customer, where applicable	Key Personnel	3. Should the customer not return the survey form after a week, Division Heads shall follow up with the customer's representative regularly.
Consolidate filled up forms and prepare report Review survey results	Document Controller	4. Prepare report indicating the level of customer satisfaction including comments/ suggestions and areas for improvement, if any. Forward the report to the Top Management for information and advice.
Rating below 3? No → B Yes		
Issue CAR A	Designated Staff	4. Whenever a customer gives a rating of below 3 (for any category or below 3 overall), a CAR shall be issued. Refer to RTVM-QMS-SP-05 Nonconformity and Corrective Action Procedure.

ACTIVITY	RESPONSIBILITY	PROCEDURE DETAILS
	Executive Director	5. Results of the survey shall be part of the agenda for the management review.

6.0 References

ISO 9001:2015 Clause 9.1.2 Customer Satisfaction

7.0 Attachments and Forms

RTVM-QMS-SP-06-F1 Customer Satisfaction Survey Form

1.0 Objective

To ensure that there is an established process on how to receive, document and respond to customer complaints.

2.0 Scope

This covers all formal complaints received from external customers of RTVM.

3.0 Definition of Terms

None

4.0 Policies

Complaints received shall be recorded properly, regardless if personnel from RTVM doubt the validity of the complaint. This is to ensure that all complaints are properly reviewed by the concerned Division Head and Top Management, when necessary, and acted upon in a timely manner.

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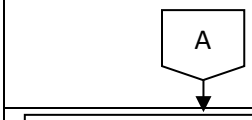
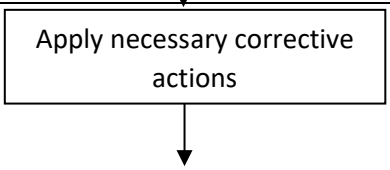
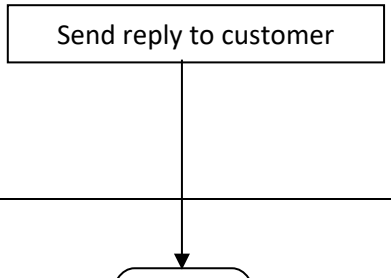
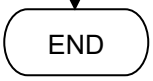
Date: August 17, 2020	Date: August 19, 2020	Date: August 21, 2020

5.0 Procedure:

ACTIVITY	RESPONSIBILITY	PROCEDURE DETAILS
START		
Receive complaint from customer	Document Controller	1. DC shall record the details of the complaint in the prescribed form.
Log/ Record Complaint	Document Controller	
Fill up Customer Complaint Form	Document Controller	2. Document Controller shall ensure that all necessary information be asked from the customer including, but not limited to, the following: • Date of receipt of complaint • Client Information • Nature of complaint Use RTVM-QMS-SP-07-F1 Customer Complaint Form.
Forward to Concerned Unit	Document Controller	
Investigate Complaint	Concerned Division / Top Management	
Complaint valid? (No → Inform Customer; Yes → A)	Document Controller	3. Complaint is valid when the cause of the complaint is due to RTVM personnel or services. Complaint is not valid if reason/s for the complaint is beyond the control of the RTVM. 4. A letter shall be sent to the customer explaining the results of the investigation.

ACTIVITY	RESPONSIBILITY	PROCEDURE DETAILS
		
	Concerned Division	5. Refer to RTVM-QMS-SP-05 Nonconformity and Corrective Action Procedure.
	Document Controller	6. QMR shall send communication to the customer detailing the corrective action taken to address their complaint. Where necessary, timeline for completion of corrective action shall be relayed to the customer.
		

6.0 References

ISO 9001:2015 Clause 8.2.1 Customer Communication

7.0 Attachments and Forms

RTVM-QMS-SP-07-F1 Customer Complaint Form

RTVM-QMS-SP-07-A1 Acknowledgment Letter

1.0 Objective

1.1 To establish the system for identifying high-level internal and external issues that may affect the performance and strategic direction of RTVM,

1.2 To guide the agency in identifying the needs and expectations of interested parties,

1.3 To establish the system for risk and opportunity identification, analysis, and prioritization, and

1.4 To set guidelines in the review and monitoring of risk and opportunity treatment plans.

2.0 Scope

This covers the risk and opportunity management processes of RTVM, from understanding of the organizational context until monitoring of effectiveness of treatment plans.

3.0 Definition of Terms

Interested Party – person or organization that can affect, can be affected by, or perceive themselves to be affected by a decision or activity of RTVM

Opportunity – Positive effect of uncertainty on objectives

Risk – Negative effect of uncertainty on objectives

Organizational Context – Combination of internal and external issues (both positive and negative) that can have an effect on RTVM's approach to its operations

Prepared by:	Reviewed by:	Approved by:
MARIA ROXANNE ANGELYCA M. NAVARRETE Document Controller	DULCE AMOR D. QUINTANA QMR	DENNIS WILFRED P. PABALAN Executive Director
Date: July 2, 2021	Date: July 2, 2021	Date: July 2, 2021

4.0 Policies

4.1. RTVM Divisions shall conduct review of internal and external issues at least twice a year using RTVM-QMS-SP-08-F1 SWOT Analysis Template.

4.2. Review of changes in the needs and expectations of RTVM's interested parties shall coincide with the review of the internal and external issues.

4.3. RTVM shall develop action plans or programs to address the identified top risks and opportunities. Status of the action plans shall be regularly reported during Management Review.

4.4. In cases where action plans or programs fail to address the risk or opportunity, concerned management shall raise a Corrective Action Request (CAR) to address the issue. Refer to RTVM-QMS-SP-05 Nonconformity and Corrective Action Procedure.

4.5. Risk Assessment Criteria

All risks shall be rated based on the formula below:

4.5.1. RISK RATING = LIKELIHOOD * SEVERITY

Likelihood rating shall be based on the table below:

Likelihood Value	Likelihood Rating	Probability	Frequency
4	Critical	76-100%	Occurred in the past 6 months
3	High	51-75%	Occurred in the past 18 months
2	Medium	26-50%	Rarely Occurs (3-5 years)
1	Low	0-25%	Never heard of in the industry

Note: For recurring risks, frequency shall be used. For potential risks that have not yet occurred in RTVM, probability shall be used.

- Severity rating shall be based on table below:

Severity Value	Severity Rating	Operational Impact	Legal Non-compliance	Negative Reputation
4	Critical	Risk may result in a failure to ingest, archive and release videos of presidential and non-presidential events	Legal non-compliance may lead to removal of key/top officers of RTVM	Risk may lead to damaged reputation of the President due to RTVM
3	High	Risk may result in ingestion, archiving and releasing of videos of presidential and non-presidential events with significant issues/glitches	Legal non-compliance may lead to suspension of RTVM personnel	Risk may lead to damaged reputation of RTVM/PCOO
2	Medium	Risk may result in ingestion, archiving and releasing of videos of presidential and non-presidential events with minor issues/glitches	Legal non-compliance may lead to a reprimand from Head of Agency	Risk may lead to brief negative media exposure
1	Low	No impact on RTVM's Operations	No legal requirements associated with this risk	Positive or no negative impact on reputation

			SEVERITY			
			LOW MINOR	MEDIUM MODERATE	HIGH SIGNIFICANT	CRITICAL SEVERE
			1	2	3	4
LIKELIHOOD	OCCURED IN THE PAST 6 MONTHS	4	4	8	12	16
	OCCURED IN THE PAST 18 MONTHS	3	3	6	9	12
	RARELY OCCURS (3-5 YRS)	2	2	4	6	8
	RARE	1	1	2	3	4

Risk Value	Classification	Evaluation	Action
1 – 3	Low Risk	No Impact on RTVM	No Action Needed
4 – 7	Medium Risk	Risk may result in minor issues/glitches	Monitoring by Core Process Owner and presentation to Division Heads/ Treatment action plan considered
8 – 12	High Risk	Risk may result in significant issues/glitches	For division review, evaluation, and presentation to Top Management/ Treatment action plan required
13-16	Critical	Risk might affect the reputation of the agency	For management evaluation and decision/ Treatment action plan required

4.6. Opportunity Assessment Criteria

- Opportunities shall be rated based on the potential benefits that may be realized. Refer to the table below:

Benefit Value	Benefit Rating	Operational Impact	Legal Compliance	Improved Reputation
4	Very High	Opportunity may result in significant commendations from the President or PCOO	May lead to certification of compliance or its equivalent from regulatory bodies or other agencies	Brief or prolonged national positive media exposure
3	High	Opportunity may result in significant improvement in ingestion, archiving and releasing of videos of presidential and non-presidential events	Opportunity may lead to compliance of new regulations	Prolonged positive perception in the media industry
2	Medium	Opportunity may result in some improvement ingestion, archiving and releasing of videos of presidential and non-presidential events	Opportunity may lead to compliance of existing regulations	Brief positive perception in the media industry
1	Low	No impact on RTVM's Operations	No legal requirements associated with this opportunity	Will result to neutral news for RTVM

5.0 Procedure:

ACTIVITY	RESPONSIBILITY	PROCEDURE DETAILS
START		
Identify high-level internal and external issues (organizational context)	Division Heads	1. Division Heads shall determine the high-level internal and external issues affecting the performance of their respective areas, using RTVM-QMS-SP-08-F1 SWOT Analysis Template. 2. The needs and expectations of interested parties shall be determined using RTVM-QMS-SP-08-F2 Requirements of Interested Parties.
Identify risks and opportunities	Division Heads	3. Conduct risk and opportunity identification, taking into consideration the identified internal and external issues, as well as the requirements of interested parties. 4. Risks shall be placed in RTVM-QMS-SP-08-F3 Risk Register, while opportunities are inputted in RTVM-QMS-SP-08-F4 Opportunity List.
Analyze Risks and Opportunities	Division Heads	5. Analyze the risks and opportunities based on the likelihood of occurrence and risk severity or opportunity benefit. Refer to the grading criteria mentioned in sections 4.5.1 and 4.6 of this procedure.
A		

ACTIVITY	RESPONSIBILITY	PROCEDURE DETAILS
A		
Identify top risks and opportunities	Division Heads	6. High and critical risk shall be identified based on ratings. A Treatment Action Plan must be developed. This shall be forwarded to the Top Management for approval.
Review list of top risks and opportunities	Top Management	7. Top Management shall determine the validity of the top risks and opportunities identified. The Top Management has the authority to approve or make changes to the identified top risks and opportunities.
Develop action plans	Division Heads	8. Division Heads shall develop action plans to address the finalized list of top risks and opportunities. Use RTVM-QMS-SP-08-F5 Risk and Opportunity Action Plans
Monitor effectiveness of action plans	Division Heads	9. Division Heads shall monitor the implementation and effectiveness of the action plans. This shall discussed during the Management Review.
END		

6.0 References

ISO 9001:2015 Clause 4.1 Understanding the Organization and Its Context

ISO 9001:2015 Clause 4.2 Needs and Expectations of Interested Parties

ISO 9001:2015 Clause 6.1 Actions to Address Risks and Opportunities

7.0 Attachments and Forms

RTVM-QMS-SP-08-F1	SWOT Template
RTVM-QMS-SP-08-F2	Stakeholder Analysis
RTVM-QMS-SP-08-F3	Risk Register
RTVM-QMS-SP-08-F4	Opportunity List
RTVM-QMS-SP-08-F5	Risk and Opportunity Treatment Action Plans