Organisation Name:	
NHSLA Membership Number:	
Services Provided:	
Day 1 of Assessment:	
Day 2 of Assessment:	
Existing NHSLA Level:	
Level Applied For:	
Level Achieved:	
Assigned Assessor:	
Chief Executive:	
Email address	
Organisation Contact Name:	
Designation	
Email address	

Evidence Template for use with
NHSLA Risk Management Standards for NHS Trusts providing Acute, Community or Mental Health & Learning Disability Serivces and Non-NHS Providers of NHS Care 2012/13

This evidence template has been produced to assist organisations in preparing for assessment and is based on the relevant NHSLA Standards.
In the event of any discrepancy between the text in this template and the NHSLA standards, the

Evidence Template Guidance to support organisations when using this template and preparing electronic evidence for an assessment can be downloaded from:
www.nhsla.com/Publications || Risk Management Publications / Evidence Templates

The scores table below will be populated automatically from information entered on subsequent worksheets.

Level Summary

Key

Yes - Compliant | **No** - Non- Compliant | **NR** - Not Reviewed | **NA** - Not Applicable at this Assessment

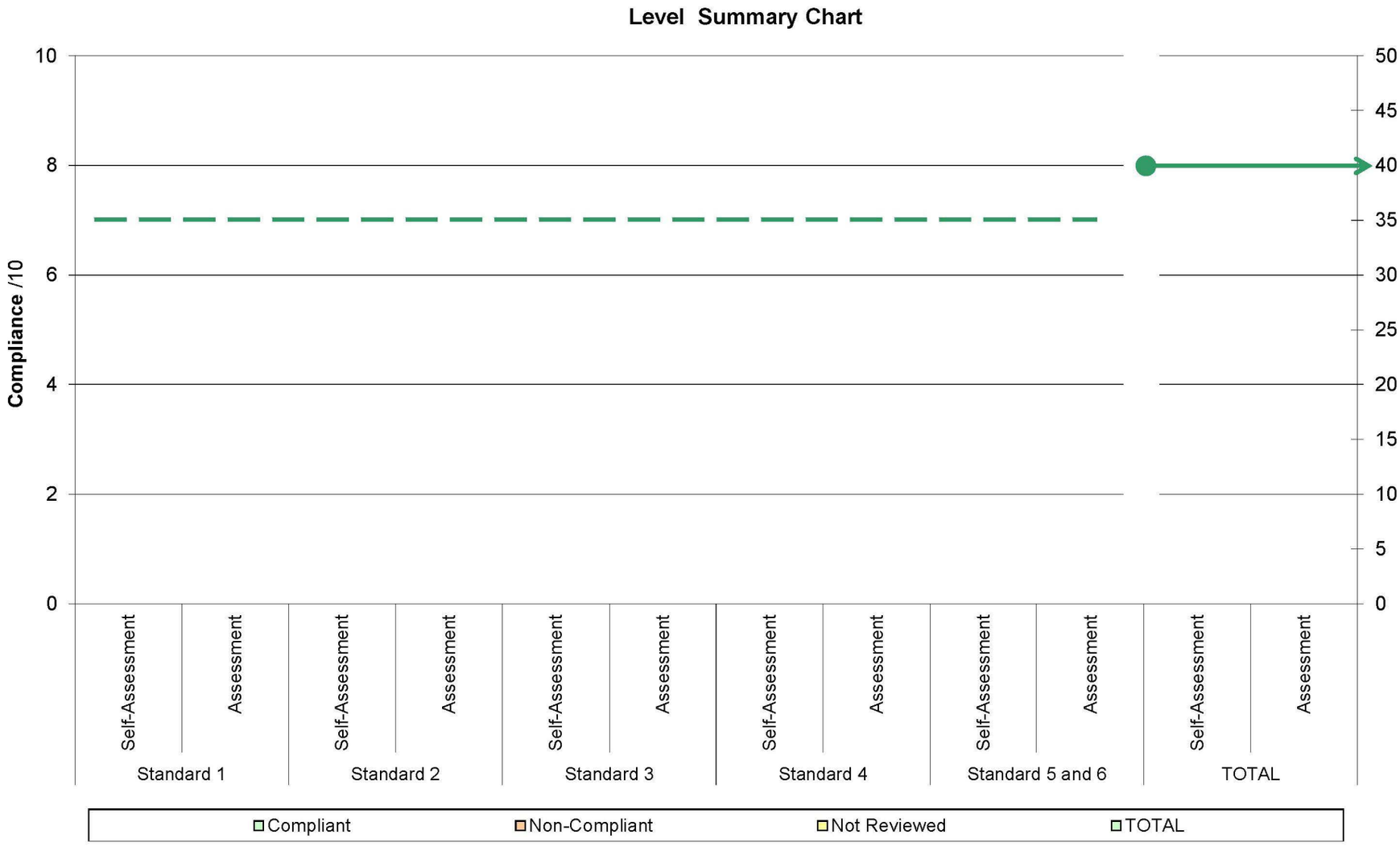
	Standard 1		Standard 2		Standard 3		Standard 4		Standard 5		MH&LD Trusts		Total	
	Self-Assessment	Assessment	Self-Assessment	Assessment	Self-Assessment	Assessment	Self-Assessment	Assessment	Self-Assessment	Assessment	Self-Assessment	Assessment	Self-Assessment	Assessment
1.1			2.1		3.1		4.1		5.1		6.1			
1.2			2.2		3.2		4.2		5.2		6.2			
1.3			2.3		3.3		4.3		5.3		6.3			
1.4			2.4		3.4		4.4		5.4		6.4			
1.5			2.5		3.5		4.5		5.5		6.5			
1.6			2.6		3.6		4.6		5.6		6.6			
1.7			2.7		3.7		4.7		5.7		6.7			
1.8			2.8		3.8		4.8		5.8		6.8			
1.9			2.9		3.9		4.9		5.9		6.9			
1.10			2.10		3.10		4.10		5.10		6.10			
Total	0	0	**Total**	0	0	**Total**	0	0	**Total**	0	0	**Total**	0	0	0	0

Cell: E7
Comment: The navigation facility from the matrix below may function incorrectly until the appropriate assessment level is selected here.

Cell: E8
Comment: Assessor Use
post assessment

Cell: W21
Comment: NB: Standard 5 is applicable to organisations providing Acute or Community services or Non-NHS providers of NHS care.

NHSLA Risk Management Standards
Evidence Template



Standard ⇨	1	2	3	4	5	6
Criterion ⇩	Governance	Learning from Experience	Competent & Capable Workforce	Safe Environment	Acute & Community	MH&LD
1	Risk Management Strategy	Clinical Audit	Corporate Induction	Secure Environment	Supervision of Medical Staff in Training	Clinical Supervision
2	Policy on Procedural Documents	Incident Reporting	Local Induction of Permanent Staff	Violence & Aggression	Patient Information & Consent	Patient Information
3	High Level Risk Committee(s)	Concerns & Complaints	Local Induction of Temporary Staff	Slips, Trips & Falls (Staff & Others)	Consent Training	Clinical Risk Assessment
4	Risk Management Process	Claims Management	Risk Management Training	Slips, Trips & Falls (Patients)	Maintenance of Medical Devices & Equipment	Physical Assessment & Examination of Patients
5	Risk Register	Investigations	Training Needs Analysis	Moving & Handling	Medical Devices Training	Observation of Patients
6	Dealing with External Recommendations	Analysis & Improvement	Risk Awareness Training for Senior Management	Hand Hygiene Training	Screening Procedures	Dual Diagnosis
7	Health Records Management	Learning Lessons from Claims	Moving & Handling Training	Inoculation Incidents	Diagnostic Testing Procedures	Rapid Tranquilisation
8	Health Record-Keeping Standards	Best Practice - NICE	Harassment & Bullying	The Deteriorating Patient	Transfusion	Absent Without Leave (AWOL)
9	Professional Clinical Registration	Best Practice - National Confidential Enquiries & Inquiries	Supporting Staff Involved in an Incident, Complaint or Claim	Clinical Handover of Care	Venous Thromboembolism	Medicines Management Training
10	Employment Checks	Being Open	Stress	Discharge	Medicines Management	Medicines Management

Criterion number	Index	Criterion and minimum requirements	Paper or Electronic copy	Name of approved document	Electronic file hyperlink/name	Location of relevant information	Document version no. and approved date	Initials of contact name for document	Compliant? (Self-Assessment)	Organisation's comments	Compliant? (Assessor)	Comment in report	Assessor's comments	Proposed future change	Rationale	Actions required to achieve compliance	Person/ committee responsible	Target date	Associated cost
1.1.1	1010	All organisations must have an approved risk management strategy.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		Your documented process must include:																	
a	1011	the organisation's risk management structure, detailing all those committees and groups which have some responsibility for risk	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
b	1012	how the board or high level risk committee(s) review the organisation-wide risk register	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
c	1013	**how risk is managed locally**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
d	1014	duties of the key individuals for risk management activities	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
e	1018	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	**#N/A**	**Compliant**									
1.1.2	1020	All organisations must have an approved documented process for developing organisation-wide procedural documents.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		Your documented process must include:																	
a	1021	style and format	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
b	1022	an explanation of any terms used	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
c	1023	consultation process	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
d	1024	**ratification process**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
e	1025	review arrangements	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
f	1026	**control, including archiving arrangements**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
g	1027	associated documents	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
h	1027.1	supporting references	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
i	1028	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	**#N/A**	**Compliant**									
1.1.3	1030	All organisations must have approved documented terms of reference for the high level committee(s) with overarching responsibility for risk.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		Your terms of reference must include:																	
a	1031	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
b	1032	who the members are, including nominated deputies where appropriate	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
c	1033	how often members must attend	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
d	1034	requirements for a quorum	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
e	1035	how often meetings take place	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
f	1036	**reporting arrangements into the high level risk committee(s)**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
g	1037	**reporting arrangements into the board from the high level risk committee(s)**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
h	1038	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	**#N/A**	**Compliant**									
1.1.4	1040	All organisations must have approved documentation which describes the organisation-wide systematic risk management process.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		Your documented process must include:																	
a	1041	**how all risks are assessed**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
b	1042	how risk assessments are conducted consistently	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
c	1043	authority levels for managing different levels of risk within the organisation	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
d (Pilot)	1044	how risks are escalated through the organisation	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
e	1048	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	**#N/A**	**Compliant**									
1.1.5	1050	All organisations must have an approved organisation-wide risk register.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		Your organisation-wide risk register must include:																	
a	1051	***source of the risk (including, but not limited to, incident reports, risk assessments, local risk registers, and external recommendations)***	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
b	1052	description of the risk	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
c	1053	risk score	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
d	1054	summary risk treatment plan	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
e	1055	date of review	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
f	1056	residual risk rating.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	**#N/A**	**Compliant**									
1.1.6	1060	All organisations must have an approved documented process for dealing with external recommendations specific to the organisation.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		Your documented process must include:																	
a (Pilot)	1061	process for reviewing external recommendations specific to the organisation	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									

b (Pilot)	1062	process for reporting on external recommendations specific to the organisation	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A																					
c	1063	**how action plans are developed as a result of external recommendations**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A																					
d	1064	**how action plans are followed up**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A																					
e	1068	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A																					
								Compliant	**#N/A**	**Compliant**																					

1.1.7	1070	All organisations must have an approved documented process for managing the risks associated with paper and electronic health records.	E	#N/A	#N/A	#N/A	#N/A	#N/A			
		Your documented process must include:									
a	1071	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
b	1072	legal obligations that apply to records	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
c	1073	how a new record is created	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
d	1074	**how health records are tracked when in current use**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
e	1075	how health records are retrieved from storage	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
f	1076	process for retention, disposal and destruction of records	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
g	1078	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
								Compliant	**#N/A**	**Compliant**	
1.1.8	1080	All organisations must have an approved documented process for health record-keeping.	E	#N/A	#N/A	#N/A	#N/A	#N/A			
		Your documented process must include:									
a	1081	**basic record-keeping standards, which must be used by all staff**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
b	1082	process for making sure a contemporaneous record of care is completed	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
c	1083	how the organisation trains staff, in line with the training needs analysis	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
d	1088	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
								Compliant	**#N/A**	**Compliant**	
1.1.9	1090	All organisations must have an approved documented process for making sure that all clinical staff are registered with the appropriate professional body.	E	#N/A	#N/A	#N/A	#N/A	#N/A			
		Your documented process must include:									
a	1091	duties, both on initial appointment and on an ongoing basis	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
b	1092	***how the organisation checks registration with the relevant professional body, in accordance with their recommendations, for all directly employed clinical staff, both on initial appointment and on an ongoing basis***	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
c	1093	**how the organisation makes sure that registration checks are being carried out by all external agencies (such as NHS Professionals, recruitment agencies, etc.) used by the organisation in respect of all clinical staff**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
d	1094	how the organisation follows up those directly employed clinical staff who fail to satisfy the validation of registration process	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
e	1098	how the organisation monitors compliance with all of the above	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
								Compliant	**#N/A**	**Compliant**	

1.1.10	1100	All organisations must have an approved documented process for making sure that all relevant employment checks are undertaken for all staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A					
		Your documented process must include:											
a	1101	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A			
b	1102	**types of check required**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A			
c	1103	how checks are made	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A			
d	1104	how the organisation follows up those staff who fail to satisfy the checking arrangements	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A			
e	1105	how the organisation makes sure that checks are being carried out by all external agencies (such as NHS Professionals, recruitment agencies, etc.) used by the organisation in respect of all staff	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A			
f	1108	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A			
								Compliant	**#N/A**	**Compliant**			
								1.1.1	#N/A		0		
								1.1.2	#N/A		0		
								1.1.3	#N/A		0		
								1.1.4	#N/A		0		
								1.1.5	#N/A		0		
								1.1.6	#N/A		0		
								1.1.7	#N/A		0		
								1.1.8	#N/A		0		
								1.1.9	#N/A		0		
								1.1.10	#N/A		0		**All Standards Total**
								Total	**0**		**0**		**0**

Cell: B1
Comment: Admin Use Only

Cell: G1
Comment: E.g. page number, paragraph or bullet number.
This needs to be completed in case hyperlinks do not work, and where evidence is submitted in paper form.

Cell: L1
Comment: Assessor Use Only

Cell: M1
Comment: Assessor Use Only

Cell: N1
Comment: Assessor Use Only

Cell: I105
Comment: Risk Management Strategy

Cell: I106
Comment: Policy on Procedural Documents

Cell: I107
Comment: Risk Management Committee(s)

Cell: I108
Comment: Risk Awareness Training for Senior Management

Cell: I109
Comment: Risk Management Process

Cell: I110
Comment: Risk Register

Cell: I111
Comment: Responding to External Recommendations Specific to the Organisation

Cell: I112
Comment: Health Records Management

Cell: I113
Comment: Professional Clinical Registration

Cell: I114
Comment: Employment Checks

Criterion number	Index	Criterion and minimum requirements	Paper or Electronic copy	Name of approved document	Electronic file hyperlink/name	Location of relevant information	Document version no. and approved date	Initials of contact name for document	Compliant? (Self-Assessment)	Organisation's comments	Compliant? (Assessor)	Comment in report	Assessor's comments	Proposed future change	Rationale	Actions required to achieve compliance	Person/ committee responsible	Target date	Associated cost
1.2.1	2010	All organisations must have an approved documented process for making sure that all clinical audits are undertaken, completed and reported on in a systematic manner.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		Your documented process must include:																	
a	2011	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
b	2012	how the organisation sets priorities for audit, including local and national requirements	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
c	2013	**requirement that audits are conducted in line with the approved process for audit**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
d	2014	how audit reports are shared	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
e	2015	format for all audit reports, including methodology, conclusions, action plans, etc.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
f	2016	**how the organisation makes improvements**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
g	2017	how the organisation monitors action plans and carries out re-audits	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
h	2018	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	#N/A	**Compliant**									
1.2.2	2020	All organisations must have an approved documented process for internal and external reporting of all incidents and near misses.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		Your documented process must include:																	
a	2021	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
b	2022	**how all incidents and near misses involving staff, patients and others are reported**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
c	2023	**how the organisation reports incidents to external agencies**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
d	2024	how staff can raise concerns, for example, whistle blowing, open disclosure, etc.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
e	2028	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	#N/A	**Compliant**									
1.2.3	2030	All organisations must have an approved documented process for listening, responding and improving when patients, their relatives and carers raise concerns and complaints.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		Your documented process must include:																	
a	2031	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
b	2032	**how the organisation listens and responds to concerns and complaints from patients, their relatives and carers**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
c	2033	how joint complaints are handled between organisations	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
d	2034	how the organisation makes sure that patients, their relatives and carers are not treated differently as a result of raising a concern or complaint	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
e	2035	**how the organisation makes improvements as a result of a concern or complaint**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
f	2038	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	#N/A	**Compliant**									
1.2.4	2040	All organisations must have an approved documented process for managing all claims in accordance with NHSLA requirements.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		Your documented process must include:																	
a	2041	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
b	2042	NHSLA schemes relevant to the organisation (CNST, LTPS and PES)	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
c	2043	**action to be taken, including timescales**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
d	2044	**how the organisation communicates with relevant stakeholders, such as staff, claimants, NHSLA, solicitors, HM Coroner, etc.**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
e	2048	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	#N/A	**Compliant**									
1.2.5	2050	All organisations must have an approved documented process for investigating all incidents, complaints and claims to enable learning.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		Your documented process must include:																	
a	2051	duties																	
b	2052	how the organisation trains staff, in line with the training needs analysis	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
c	2053	**different levels of investigation appropriate to the severity of the event**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									

d	2054	how the organisation shares safety lessons with internal and external stakeholders	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
e	2055	**how action plans are followed up**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
f	2058	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
								Compliant	**#N/A**	**Compliant**
1.2.6	2060	All organisations must have an approved documented process for the analysis of incidents, complaints and claims to enable learning and improvement.	E	#N/A	#N/A	#N/A	#N/A	#N/A		
		Your documented process must include:								
a	2061	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
b	2062	how incidents, complaints and claims are analysed	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
c	2063	how this information is combined to provide a risk profile for the organisation	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
d	2064	***a report template which includes qualitative and quantitative analysis***	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
e	2065	how this information will be shared with relevant individuals or groups	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
f	2066	**how action plans are followed up**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
g	2067	timescales for minimum requirements b) to f)	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
h	2068	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
								Compliant	**#N/A**	**Compliant**
1.2.7	2070	All organisations must evidence that action has been taken to learn lessons from claims.*	E	#N/A	#N/A	#N/A	#N/A	#N/A		
		*With particular reference to the issues contained in the NHSLA Solicitors' Risk Management Reports on Claims where these have been received.								
	2071	You must evidence that action has been taken to improve safety in response to incidents giving rise to clinical negligence (CNST) claims. Where Solicitors' Risk Management Reports on Claims have been prepared, you must demonstrate that the risk issues identified have been considered and action taken (if any). If action has not been taken, the reasons why and how this decision was made must be clearly documented.								
		The assessor will select three Solicitors' Risk Management Reports on Claims to assess compliance with this criterion. Where fewer or no reports have been prepared, the assessment will be based on other CNST claims notified to the NHSLA. If fewer than three claims have been notified to the NHSLA, the assessment will be based on learning from Serious Untoward Incidents.								
								Compliant	**#N/A**	**Compliant**
1.2.8	2080	All organisations must have an approved documented process for taking into account agreed best practice as defined in NICE clinical guidelines.	E	#N/A	#N/A	#N/A	#N/A	#N/A		
		Your documented process must include:								
a	2081	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
b	2082	how the organisation identifies which NICE guidelines are relevant to its services	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
c	2083	**how a gap analysis is conducted to identify shortfalls**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
d	2084	**how action plans are created to address any shortfalls, including recording decisions not to implement NICE guidelines**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
e	2088	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
								Compliant	**#N/A**	**Compliant**
1.2.9	2090	All organisations must have an approved documented process for taking into account agreed best practice, as defined in National Confidential Enquiries and Inquiries, in the context of the clinical services provided by the organisation.	E	#N/A	#N/A	#N/A	#N/A	#N/A		
		Your documented process must include:								
a	2091	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
b	2092	how the organisation responds to requests for data	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
c	2093	how the organisation identifies which National Confidential Enquiry/Inquiry recommendations are relevant to its services	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
d	2094	**how a gap analysis is conducted to identify shortfalls**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
e	2095	**how action plans are developed to address any shortfalls, including recording decisions not to implement National Confidential Enquiry/Inquiry recommendations**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
f	2098	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
								Compliant	**#N/A**	**Compliant**

1.2.10	2100	All organisations must have an approved documented process for open and honest communication following an incident, complaint or claim.	E	#N/A	#N/A	#N/A	#N/A	#N/A																								
		Your documented process must include:																														
a	2101	how communication between healthcare organisations, healthcare teams, staff, patients, their relatives and carers is encouraged	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A																						
b	2102	**how staff acknowledge, apologise and explain when things go wrong**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A																						
c	2103	requirements for truthfulness, timeliness and clarity of communication	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A																						
d	2104	how additional support is provided	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A																						
e	2105	**how all communication is recorded**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A																						
f	2108	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A																						
								Compliant	**#N/A**	**Compliant**																						

1.2.1	#N/A	0	
1.2.2	#N/A	0	
1.2.3	#N/A	0	
1.2.4	#N/A	0	
1.2.5	#N/A	0	
1.2.6	#N/A	0	
1.2.7	#N/A	0	
1.2.8	#N/A	0	
1.2.9	#N/A	0	
1.2.10	#N/A	0	**All Standards Total**
Total	**0**	**0**	**0**

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Cell: G1
Comment: E.g. page number, paragraph or bullet number.
This needs to be completed in case hyperlinks do not work, and where evidence is submitted in paper form.

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Comment: Assessor Use Only

Cell: N1
Comment: Assessor Use Only

Cell: I102
Comment: Corporate Induction

Cell: I103
Comment: Local Induction of Permanent Staff

Cell: I104
Comment: Local Induction of Temporary Staff

Cell: I105
Comment: Supervision of Medical Staff in Training

Cell: I106
Comment: Risk Management Training

Cell: I107
Comment: Training Needs Analysis

Cell: I108
Comment: Medical Devices Training

Cell: I109
Comment: Hand Hygiene Training

Cell: I110
Comment: Moving & Handling Training

Cell: I111
Comment: Consent Training

Criterion number	Index	Criterion and minimum requirements	Paper or Electronic copy	Name of approved document	Electronic file hyperlink/name	Location of relevant information	Document version no. and approved date	Initials of contact name for document	Compliant? (Organisation)	Organisation's comments	Compliant? (Assessor)	Comment in report	Assessor's comments	Proposed future change	Rationale	Actions required to achieve compliance	Person/ committee responsible	Target date	Associated cost
1.3.1	3010	All organisations must have an approved documented corporate induction process for all new permanent staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		Your documented process must include:																	
a	3011	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
b	3012	minimum content of corporate induction	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
c	3013	process for booking all new permanent staff onto corporate induction	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
d (Pilot)	3014	timescales for completion of corporate induction	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
e	3015	**how the organisation records that all new permanent staff complete corporate induction**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
f	3016	**how the organisation follows up those who do not complete corporate induction.**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
g	3018	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	**#N/A**	**Compliant**									
1.3.2	3020	All organisations must have an approved documented local induction process for all new permanent staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		Your documented process must include:																	
a	3021	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
b	3022	minimum content of local induction	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
c (Plot)	3023	timescales for completion of local induction	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
d	3024	**how the organisation records that all new permanent staff complete local induction**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
e	3025	**how the organisation follows up those who do not complete local induction.**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
f	3028	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	**#N/A**	**Compliant**									
1.3.3	3030	All organisations must have an approved documented local induction process for all temporary staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		Your documented process must include:																	
a	3031	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
b	3032	minimum content of local induction	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
c (Pilot)	3033	timescales for completion of local induction	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
d	3034	**how the organisation records that all temporary staff complete local induction**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
e	3035	**how the organisation follows up those who do not complete local induction.**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
f	3038	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	**#N/A**	**Compliant**									
1.3.4	3040	All organisations must have an approved documented risk management training process for all permanent staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		Your documented process must include:																	
a	3041	process for developing a training needs analysis, which must include all those topics referred to in the TNA Minimum Data Set	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
b	3042	how action plans are developed to deliver the training identified within the training needs analysis	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
c	3043	how an annual training prospectus is developed which reflects the training needs analysis	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
d	3044	**how the organisation records that all permanent staff complete relevant training, in line with the training needs analysis**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
e	3045	**how the organisation follows up those who do not complete relevant training programmes**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
f (Pilot)	3046	action to be taken in the event of persistent non-attendance	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
g	3048	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	**#N/A**	**Compliant**									
1.3.5	3050	All organisations must have a documented training needs analysis to identify the risk management training requirements for all permanent staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		The training needs analysis for all permanent staff must include:																	
a	3051	a list of topics defined as risk management training by the organisation, which must include all those topics referred to in the TNA Minimum Data Set	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
b	3052	which staff groups are required to attend each type of training	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									

c	3053	frequency of updates required for each type of training.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
								Compliant	#N/A	Compliant	
1.3.6	3060	All organisations must have an approved documented process for delivering risk management awareness training to all board members and senior managers.	E	#N/A	#N/A	#N/A	#N/A	#N/A			
		Your documented process must include:									
a	3061	**how risk management awareness training is delivered to board members and senior managers, in line with the training needs analysis**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
b	3062	how attendance is recorded	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
c	3063	**how non-attendance is followed up**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
d	3068	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
								Compliant	#N/A	Compliant	
1.3.7	3070	All organisations must have an approved documented process which sets out the moving and handling training requirements for all permanent staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A			
		Your documented process must include:									
a	3071	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
b	3072	**how the organisation records that all permanent staff complete moving and handling training, in line with the training needs analysis**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
c	3073	**how the organisation follows up those who do not complete moving and handling training.**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
d (Pilot)	3074	action to be taken in the event of persistent non-attendance	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
e	3078	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
								Compliant	#N/A	Compliant	
1.3.8	3080	All organisations must have an approved documented process for dealing with the harassment or bullying of staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A			
		Your documented process must include:									
a	3081	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
b	3082	statement by the organisation that harassment and bullying are not acceptable	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
c	3083	**how concerns about harassment or bullying can be raised**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
d	3084	**what should be done once a concern has been raised**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
e	3085	how the organisation trains staff, in line with the training needs analysis	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
f	3088	how the organisation monitors compliance with all of the above	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
								Compliant	#N/A	Compliant	
1.3.9	3090	All organisations must have an approved documented process for making sure that all staff involved in traumatic or stressful incidents, complaints or claims are adequately supported.	E	#N/A	#N/A	#N/A	#N/A	#N/A			
		Your documented process must include:									
a	3091	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
b	3092	immediate support offered to staff (internally and, if necessary, externally)	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
c	3093	ongoing support offered to staff (internally and, if necessary, externally)	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
d	3094	advice available to staff (internally and, if necessary, externally) in the event of their being called as a witness	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
e	3095	**action for managers or individuals to take if the staff member is experiencing difficulties associated with the event**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
f	3098	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
								Compliant	#N/A	Compliant	
1.3.10	3100	All organisations must have an approved documented process for managing the risks associated with work-related stress.	E	#N/A	#N/A	#N/A	#N/A	#N/A			
		Your documented process must include:									
a	3101	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
b	3102	how staff can access information on the management of work-related stress	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
c	3103	**how workplace stressors are identified**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
d	3104	**how the organisation carries out risk assessments for the prevention and management of work-related stress**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
e	3108	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
								Compliant	#N/A	Compliant	
								1.3.1	#N/A		0
								1.3.2	#N/A		0

1.3.3	#N/A	0	
1.3.4	#N/A	0	
1.3.5	#N/A	0	
1.3.6	#N/A	0	
1.3.7	#N/A	0	
1.3.8	#N/A	0	
1.3.9	#N/A	0	
1.3.10	#N/A	0	**All Standards Total**
Total	**0**	**0**	**0**

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This needs to be completed in case hyperlinks do not work, and where evidence is submitted in paper form.

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Cell: N1
Comment: Assessor Use Only

Cell: I100
Comment: Secure Environment

Cell: I101
Comment: Slips, Trips & Falls
(Staff & Others)

Cell: I102
Comment: Slips, Trips & Falls
(Patients)

Cell: I103
Comment: Moving & Handling

Cell: I104
Comment: Inoculation Incidents

Cell: I105
Comment: Maintenance of Medical
Devices & Equipment

Cell: I106
Comment: Harassment & Bullying

Cell: I107
Comment: Violence & Aggression

Cell: I108
Comment: Supporting Staff Involved in an
Incident, Complaint or Claim

Cell: I109
Comment: Stress

Criterion number	Index	Criterion and minimum requirements	Paper or Electronic copy	Name of approved document	Electronic file hyperlink/name	Location of relevant information	Document version no. and approved date	Initials of contact name for document	Compliant? (Organisation)	Organisation's comments	Compliant? (Assessor)	Comment in report	Assessor's comments	Proposed future change	Rationale	Actions required to achieve compliance	Person/ committee responsible	Target date	Associated cost
1.4.1	4010	All organisations must have an approved documented process for managing the risks associated with the physical security of premises and assets.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		Your documented process must include:																	
a	4011	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
b	4012	**how the organisation risk assesses the physical security of premises and assets**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
c	4013	**how action plans are developed as a result of risk assessments**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
d	4014	**how action plans are followed up**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
e	4018	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	**#N/A**	**Compliant**									
1.4.2	4020	All organisations must have an approved documented process for the prevention and management of violence and aggression.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		Your documented process must include:																	
a	4021	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
b	4022	**how the organisation carries out risk assessments for the prevention and management of violence and aggression**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
c (Pilot)	4023	timescales for review of risk assessments	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
d (Pilot)	4024	how action plans are developed as a result of risk assessments	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
e (Pilot)	4025	how action plans are followed up	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
f	4026	**arrangements for making sure lone workers are safe**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
g	4027	how the organisation trains staff, in line with the training needs analysis	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
h	4028	how the organisation monitors compliance with all of the above	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	**#N/A**	**Compliant**									
1.4.3	4030	All organisations must have has an approved documented process for managing the risk of slips, trips and falls involving staff and others.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		Your documented process must include:																	
a	4031	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
b	4032	**how the organisation assesses the risk of slips, trips and falls involving staff and others (including falls from height)**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
c	4033	how the organisation trains staff, in line with the training needs analysis	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
d	4034	how the organisation raises awareness about preventing and reducing the number of slips, trips and falls involving staff and others	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
e	4038	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	**#N/A**	**Compliant**									
1.4.4	4040	All organisations must have an approved documented process for managing the risk of slips, trips and falls involving patients.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		Your documented process must include:																	
a	4041	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
b	4042	**how the organisation assesses the risk of slips, trips and falls involving patients (including falls from height)**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
c	4043	how the organisation trains staff, in line with the training needs analysis	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
d	4044	how the organisation raises awareness about preventing and reducing the number of slips, trips and falls involving patients	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
e	4048	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	**#N/A**	**Compliant**									
1.4.5	4050	All organisations must have an approved documented process for managing the risks associated with moving and handling.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		Your documented process must include:																	
a	4051	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
b	4052	techniques to be used in the moving and handling of patients and objects, including the use of appropriate equipment	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
c	4053	arrangements for access to appropriate specialist advice	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
d	4054	**how the organisation risk assesses the moving and handling of patients and objects**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
e	4055	**how action plans are developed as a result of risk assessments**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
f	4056	**how action plans are followed up**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
g	4058	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	**#N/A**	**Compliant**									

1.4.6	4060	All organisations must have an approved documented process which sets out the hand hygiene training requirements for all permanent staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A				
		Your documented process must include:										
a	4061	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
b	4062	**how the organisation records that all permanent staff complete hand hygiene training, in line with the training needs analysis**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
c	4063	**how the organisation follows up those who do not complete hand hygiene training**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
d (Pilot)	4064	action to be taken in the event of persistent non-attendance	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
e	4068	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
								Compliant	#N/A	Compliant		
1.4.7	4070	All organisations must have an approved documented process for managing the risks associated with inoculation incidents.	E	#N/A	#N/A	#N/A	#N/A	#N/A				
		Your documented process must include:										
a	4071	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
b	4072	how inoculation incidents are reported	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
c	4073	**process for the management of an inoculation incident (including prophylaxis)**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
d	4074	how the organisation trains staff, in line with the training needs analysis	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
e	4078	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
								Compliant	#N/A	Compliant		
1.4.8	4080	All organisations must have an approved documented process for managing the risks associated with the deteriorating patient.	E	#N/A	#N/A	#N/A	#N/A	#N/A				
		Your documented process must include:										
a (Pilot)	4081	requirement for a documented plan for vital signs monitoring that identifies which variables need to be measured, including the frequency of measurement	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
b	4082	**use of an early warning system within the organisation to recognise patients at risk of deterioration**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
c	4083	actions to be taken to minimise or prevent further deterioration in patients	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
d	4084	**do not attempt resuscitation orders (DNAR)**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
e	4085	how the organisation documents that resuscitation equipment is checked, stocked and fit for use	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
f	4088	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
								Compliant	#N/A	Compliant		
1.4.9	4090	All organisations must have an approved documented process for the handover of care of patients.	E	#N/A	#N/A	#N/A	#N/A	#N/A				
		Your documented process must include:										
a	4091	handover requirements between all care settings, to include both giving and receiving of information	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
b (Pilot)	4092	how handover is recorded	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
c	4093	**out of hours handover process**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
d	4098	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
								Compliant	#N/A	Compliant		
1.4.10	4100	All organisations must have an approved documented process for the discharge of patients.	E	#N/A	#N/A	#N/A	#N/A	#N/A				
		Your documented process must include:										
a	4101	discharge requirements for all patients	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
b	4102	***information to be given to the receiving healthcare professional***	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
c	4103	***information to be given to the patient when they are discharged***	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
d (Pilot)	4104	how a patient's medicines are managed on discharge	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
e	4105	***how the organisation records the information given in minimum requirements b) and c)***	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
f	4106	out of hours discharge process	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
g	4108	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
								Compliant	#N/A	Compliant		
								1.4.1	#N/A		0	
								1.4.2	#N/A		0	
								1.4.3	#N/A		0	
								1.4.4	#N/A		0	
								1.4.5	#N/A		0	
								1.4.6	#N/A		0	
								1.4.7	#N/A		0	
								1.4.8	#N/A		0	
								1.4.9	#N/A		0	
								1.4.10	#N/A		0	**All Standards Total**
								Total	**0**		**0**	**0**

Cell: B1
Comment: Admin Use Only

Cell: G1
Comment: E.g. page number, paragraph or bullet number.
This needs to be completed in case hyperlinks do not work, and where evidence is submitted in paper form.

Cell: L1
Comment: Assessor Use Only

Cell: M1
Comment: Assessor Use Only

Cell: N1
Comment: Assessor Use Only

Cell: I101
Comment: Patient Information & Consent

Cell: I102
Comment: Health Record-Keeping Standards

Cell: I103
Comment: Screening Procedures

Cell: I104
Comment: Diagnostic Screening Procedures

Cell: I105
Comment: Medicines Management

Cell: I106
Comment: Transfusion

Cell: I107
Comment: Resuscitation

Cell: I108
Comment: Venous Thromboembolism

Cell: I109
Comment: Transfer of Patients

Cell: I110
Comment: Discharge of Patients

Criterion number	Index	Criterion and minimum requirements	Paper or Electronic copy	Name of approved document	Electronic file hyperlink/name	Location of relevant information	Document version no. and approved date	Initials of contact name for document	Compliant? (Organisation)	Organisation's comments	Compliant? (Assessor)	Comment in report	Assessor's comments	Proposed future change	Rationale	Actions required to achieve compliance	Person/ committee responsible	Target date	Associated cost
1.5.1	5010	Organisations providing acute services must have met the GMC minimum requirements for supervision.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		To assess part of this criterion the NHSLA takes assurance from the organisation's compliance with the General Medical Council's (GMC) minimum requirements for clinical supervision set out in Domain 6 of the GMC Generic Standards for Training.																	
Acute only	5011	Your organisation has GMC approval, but there are minor concerns about supervision of medical staff in training identified through GMC's evidence.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	**#N/A**	**Compliant**									
1.5.2	5020	Organisations providing acute and community services and non-NHS providers must have an approved documented process for obtaining consent.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		Your documented process must include:																	
a	5021	process for obtaining consent	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
b	5022	how information is provided to patients to support their decision making, including risks, benefits and alternatives where appropriate	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
c	5023	**how the discussion and provision of information to patients is recorded**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
d	5024	process for recording that consent has been given	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
e	5025	**archiving arrangements for any information given to patients to support their decision making**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
f	5028	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	**#N/A**	**Compliant**									
1.5.3	5030	Organisations providing acute and community services and non-NHS providers must have an approved documented process which sets out the consent training requirements for all relevant staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		Your documented process must include:																	
a	5031	how the organisation trains clinical staff on the consent process, in line with the training needs analysis	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
b	5032	how the organisation identifies clinical staff who are not capable of performing the procedure, but who are authorised to obtain consent for that procedure	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
c	5033	**how the organisation provides procedure-specific training on consent for clinical staff who are not capable of performing the procedure, but who are authorised to obtain consent for that procedure**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
d	5034	**how the organisation follows up where an individual has obtained consent without the authorisation to do so**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
e (Pilot)	5035	**how the organisation notifies the GMC via the required form, of any individual who has obtained consent without the authorisation to do so**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
f	5038	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	**#N/A**	**Compliant**									
1.5.4	5040	Organisations providing acute and community services and non-NHS providers must have an approved documented process for managing the maintenance of reusable diagnostic and therapeutic equipment.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		Your documented process must include:																	
a	5041	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
b (Pilot)	5042	how the organisation includes all items of diagnostic and therapeutic equipment on an inventory	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
c	5043	**how reusable diagnostic and therapeutic equipment is maintained**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
d	5044	**how reusable diagnostic and therapeutic equipment is repaired**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
e	5048	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	**#N/A**	**Compliant**									

1.5.5	5050	Organisations providing acute and community services and non-NHS providers must have an approved document which sets out the training requirements of all permanent staff in relation to the use diagnostic and therapeutic equipment.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		Your documented process must include:							#N/A	#N/A									
a	5051	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
b (Pilot)	5052	how the organisation includes all items of diagnostic and therapeutic equipment on an inventory	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
c	5053	**how the organisation identifies which permanent staff are authorised to use the equipment listed on the inventory**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
d	5054	**how the organisation decides the training required**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
e	5055	**how the organisation decides the frequency of updates required**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
f	5056	**how the organisation records that all permanent staff complete training**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
g (Pilot)	5057	how the organisation follows up those who fail to complete training	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
h (Pilot)	5057.1	action to be taken in the event of persistent non-attendance	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
i	5058	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	**#N/A**	**Compliant**									
1.5.6	5060	Organisations providing acute and community services and non-NHS providers must have a documented process for managing the risks associated with screening procedures.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		Your documented process must include:																	
a (Pilot)	5061	a list of the screening procedures carried out on the organisation's own patients	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
b (Pilot)	5062	how the organisation risk assesses screening procedures	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
		For each of the screening procedures listed, your documented process must include:																	
c (Pilot)	5063	how the screening procedure is requested	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
d	5064	***how the clinician treating the patient is informed of the result, including timescales***	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
e	5065	***how the patient is informed of the result, including timescales***	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
f (Pilot)	5066	how the patient is followed-up or referred, including timescales	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
g	5067	***how minimum requirements c) to f) are recorded***	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
h	5068	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
		Where the organisation has developed an overarching document, this will be assessed along with one screening-specific procedure. Where the organisation has not developed an overarching document, two screening-specific procedures will be assessed.																	
		For the purpose of the assessment, you should provide evidence for those screening procedures you have assessed as being highest risk.																	
								Compliant	**#N/A**	**Compliant**									
1.5.7	5070	Organisations providing acute and community services and non-NHS providers must have an approved documented process for managing the risks associated with diagnostic testing procedures.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		Your documented process must include:							#N/A	#N/A									
a (Pilot)	5071	a list of the diagnostic tests carried out on the organisation's own patients	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
b (Pilot)	5072	how the organisation risk assesses diagnostic testing procedures	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
		For each of the diagnostic tests listed, your documented process must include:																	
c	5073	how the diagnostic test is requested	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
d	5074	***how the clinician treating the patient is informed of the result, including timescales***	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
e	5075	***how the patient is informed of the result, including timescales***	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
f (Pilot)	5076	actions to be taken by the clinician, including timescales	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
g	5077	***how minimum requirements c) to f) are recorded***	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
h	5078	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
		Where organisations have developed an overarching document, this will be assessed along with one diagnostic test-specific document. Where the organisation has not developed an overarching document, two diagnostic test-specific documents will be assessed.																	
		For the purpose of the assessment, you should provide evidence for those diagnostic tests you have assessed as being highest risk.																	
								Compliant	**#N/A**	**Compliant**									

1.5.8	5080	Organisations providing acute and community services and non-NHS providers must have an approved documented process for transfusion.	E	#N/A	#N/A	#N/A	#N/A	#N/A				
		Your documented process must include:										
a	5081	how blood samples are requested for pre-transfusion compatibility testing	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
b	5082	**how transfusions are administered, including patient identification**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
c	5083	**care of patients receiving a transfusion**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
d	5084	how the organisation trains staff, in line with the training needs analysis	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
e	5085	how the organisation assesses the competency of all staff involved in the transfusion process	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
f	5088	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
								Compliant	**#N/A**	**Compliant**		
1.5.9	5090	Organisations providing acute and community services and non-NHS providers must have an approved documented process for the prevention and management of venous thromboembolism (VTE).	E	#N/A	#N/A	#N/A	#N/A	#N/A				
		Your documented process must include:										
a	5091	**how patients are assessed for their risk of developing venous thromboembolism (VTE), including timescales**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
b	5092	prophylactic treatment regime for high risk patients	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
c	5093	**procedure to be followed if VTE is suspected**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
d	5094	management of the patient once a positive diagnosis has been made	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
e	5095	how the organisation trains staff, in line with the training needs analysis	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
f	5098	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
								Compliant	**#N/A**	**Compliant**		
1.5.10	5100	Organisations providing acute and community services and non-NHS providers must have an approved documented process for learning from medication errors.	E	#N/A	#N/A	#N/A	#N/A	#N/A				
		Your documented process must include:										
a	5101	how medicines are prescribed	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
b	5102	**how the organisation makes sure that all prescription charts are accurate**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
c	5103	**how medication errors are reported**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
d (Pilot)	5104	how the organisation learns from medication errors	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
e (Pilot)	5105	how a patient's medicines are managed on handover between care settings	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
f	5106	how the organisation trains staff, in line with the training needs analysis	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
g	5108	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
								Compliant	**#N/A**	**Compliant**		
								1.5.1	#N/A		0	
								1.5.2	#N/A		0	
								1.5.3	#N/A		0	
								1.5.4	#N/A		0	
								1.5.5	#N/A		0	
								1.5.6	#N/A		0	
								1.5.7	#N/A		0	
								1.5.8	#N/A		0	
								1.5.9	#N/A		0	
								1.5.10	#N/A		0	**All Standards Total**
								Total	**0**		**0**	**0**

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Comment: E.g. page number, paragraph or bullet number.
This needs to be completed in case hyperlinks do not work, and where evidence is submitted in paper form.

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Cell: I113
Comment: Clinical Audit

Cell: I114
Comment: Incident Reporting

Cell: I115
Comment: Concerns/Complaints

Cell: I116
Comment: Claims

Cell: I117
Comment: Investigations

Cell: I118
Comment: Analysis

Cell: I119
Comment: Improvement

Cell: I120
Comment: Best Practice - NICE

Cell: I121
Comment: Best Practice - National Confidential Enquiries/Inquiries

Cell: I122
Comment: Being Open

Criterion number	Index	Criterion and minimum requirements	Paper or Electronic copy	Name of approved document	Electronic file hyperlink/name	Location of relevant information	Document version no. and approved date	Initials of contact name for document	Compliant? (Organisation)	Organisation's comments	Compliant? (Assessor)	Comment in report	Assessor's comments	Proposed future change	Rationale	Actions required to achieve compliance	Person/ committee responsible	Target date	Associated cost
1.6.1	6010	Organisations providing MH&LD services must have an approved documented process for making sure that all clinical staff receive appropriate supervision.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		Your documented process must include:																	
a	6011	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
b (Pilot)	6012	how clinical supervision is provided	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
c	6013	**how the organisation makes sure that all clinical staff receive appropriate clinical supervision**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
d	6014	how the organisation makes sure that all clinical staff receive management supervision	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
e	6015	how the organisation trains staff, in line with the training needs analysis	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
f	6018	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	#N/A	Compliant	NA								
1.6.2	6020	Organisations providing MH&LD services must have an approved documented process for managing the risks associated with patient information.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		Your documented process must include:																	
a	6021	how information is provided to patients to support their decision making, including risks, benefits and alternatives	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
b	6022	**how the discussion and provision of information to patients is recorded**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
c	6023	**archiving arrangements for any information given to patients to support their decision making**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
d	6028	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	#N/A	Compliant	NA								
1.6.3	6030	Organisations providing MH&LD services must have an approved documented process for making sure that all clinical staff who undertake assessments of patients are competent in the assessment and management of clinical risk.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		Your documented process must include:																	
a	6031	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
b	6032	**how the organisation trains staff, in line with in the training needs analysis**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
c	6033	**tools and processes authorised for use within the organisation, including timescales for use**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
d (Pilot)	6034	how clinical risk assessments are reviewed, including timescales	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
e	6038	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	#N/A	Compliant	NA								
1.6.4	6040	Organisations providing MH&LD services must have an approved documented process for managing the risks associated with the physical assessment and examination of patients.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		Your documented process must include:																	
a	6041	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
b	6042	**physical assessment of patients when they are admitted to a service, including timeframes**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
c	6043	how appropriate follow-up of physical symptoms takes place	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
d	6044	**ongoing assessment of physical needs for all patients, including timeframes**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
e (Pilot)	6045	how the organisation assesses the competency of all staff involved in the physical assessment and examination of patients	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
f	6048	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	#N/A	Compliant	NA								
1.6.5	6050	Organisations providing MH&LD services must have an approved documented process for the observation and engagement of patients.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		Your documented process must include:																	
a	6051	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
b	6052	***observation at differing levels***	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
c	6053	how the organisation trains staff, in line with the training needs analysis	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
d	6054	***how observation is recorded***	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
e	6058	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	#N/A	Compliant	NA								

1.6.6	6060	Organisations providing MH&LD services must have an approved documented process for addressing the needs of patients who present with a dual diagnosis of mental health problems and substance misuse.	E	#N/A	#N/A	#N/A	#N/A	#N/A			
		Your documented process must include:									
a	6061	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
b	6062	**how the organisation addresses the needs of this group of patients**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
c	6063	**details of internal and external joint working arrangements**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
d	6064	procedure to be followed where there is a difference of opinion between professionals	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
e	6065	how the organisation trains staff, in line with the training needs analysis	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
f	6068	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
								Compliant	**#N/A**	**Compliant**	**NA**
1.6.7	6070	Organisations providing MH&LD services must have an approved documented process for rapid tranquilisation.	E	#N/A	#N/A	#N/A	#N/A	#N/A			
		Your documented process must include:									
a	6071	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
b	6072	**prescribing guidelines for rapid tranquilisation**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
c	6073	**how observations are recorded, including timeframes when patients have received rapid tranquilisation**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
d	6074	how the organisation trains staff, in line with the training needs analysis	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
e	6078	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
								Compliant	**#N/A**	**Compliant**	**NA**
1.6.8	6080	Organisations providing MH&LD services must have an approved documented process for managing the risks associated with patients who are absent without leave (AWOL).	E	#N/A	#N/A	#N/A	#N/A	#N/A			
		Your documented process must include:									
a	6081	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
b	6082	**what should be done when a patient absents themselves from an inpatient setting**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
c	6083	**what should be done when a patient fails to return from a period of leave of absence**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
d	6084	how the organisation learns from AWOL incidents	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
e	6088	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
								Compliant	**#N/A**	**Compliant**	**NA**
1.6.9	6090	Organisations providing MH&LD services must have an approved documented process which sets out the medicines management training requirements for all permanent staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A			
		Your documented process must include:									
a	6091	duties	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
b	6092	**how the organisation records that all permanent staff complete relevant medicines management training, in line with the training needs analysis**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
c	6093	**how the organisation follows up those who do not complete relevant medicines management training**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
d (Pilot)	6094	action to be taken in the event of persistent non-attendance	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
e	6098	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
								Compliant	**#N/A**	**Compliant**	**NA**
1.6.10	6100	Organisations providing MH&LD services must have an approved documented process for medicines management in all care settings.	E	#N/A	#N/A	#N/A	#N/A	#N/A			
		Your documented process must include:									
a	6101	how medicines are prescribed	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
b	6102	**how the organisation makes sure that all prescription charts are accurate**	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
c	6103	how the side effects of prescribed medication are monitored	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
d (Pilot)	6104	how the organisation learns from medication errors	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
e	6105	how medication is administered, including patient identification	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
f	6106	patient self-administration	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
g (Pilot)	6107	how a patient's medicines are managed on handover between care settings	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
h	6107.1	how drugs are disposed of safely	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
i	6108	how the organisation monitors compliance with all of the above.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
								Compliant	**#N/A**	**Compliant**	
								1.6.1	#N/A		NA
								1.6.2	#N/A		NA

1.6.3	#N/A	NA		
1.6.4	#N/A	NA		
1.6.5	#N/A	NA		
1.6.6	#N/A	NA		
1.6.7	#N/A	NA		
1.6.8	#N/A	NA		
1.6.9	#N/A	NA		
1.6.10	#N/A	0		**All Standards Total**
Total	**0**	**0**		**0**

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Cell: I103
Comment: Concerns/Complaints

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Cell: I106
Comment: Analysis

Cell: I107
Comment: Improvement

Cell: I108
Comment: Best Practice - NICE

Cell: I109
Comment: Best Practice - National Confidential Enquiries/Inquiries

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Comment: Being Open

NHSLA Risk Management Standards
Evidence Template

Criterion number	Index	Criterion and minimum requirements	Paper or Electronic copy	Evidence submitted	Electronic file hyperlink/name	Location of relevant information	Version / data collection period / date of evidence submitted	Initials of contact name for evidence	Compliant? (Organisation)	Organisation's comments	Compliant? (Assessor)	Comment to report	Assessor's comments	Proposed future change	Rationale	Actions required to achieve compliance	Person/ committee responsible	Target date	Associated cost
2.1.1	1010	All organisations must have an approved risk management strategy.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence implementation of your documented process in relation to:																	
Level 1	1013	how risk is managed locally.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	**#N/A**	**Compliant**									
2.1.2	1020	All organisations must have an approved documented process for developing organisation-wide procedural documents.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence implementation of your documented process in relation to:																	
Level 1	1024	ratification process	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	1026	control of documents, including archiving arrangements.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	**#N/A**	**Compliant**									
2.1.3	1030	All organisations must have approved documented terms of reference for the high level committee(s) with overarching responsibility for risk.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence implementation of the terms of reference in relation to:																	
Level 1	1036	reporting arrangements into the high level risk committee(s)	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	1037	reporting arrangements into the board from the high level risk committee(s).	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	**#N/A**	**Compliant**									
2.1.4	1040	All organisations must have approved documentation which describes the organisation-wide systematic risk management process.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence implementation of your documented process in relation to:											The assessor will select two risk categories, from those defined within the organisation's documentation, to assess compliance with this minimum requirement.						
	214.1																		
	214.2																		
Level 1	1041	how all risks are assessed.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
		The assessor will select two risk categories, from those defined within the organisation's documentation, to assess compliance with this minimum requirement.																	
								Compliant	**#N/A**	**Compliant**									
2.1.5	1050	All organisations must have an approved organisation-wide risk register.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence that the organisation-wide risk register is populated with risks from the following sources:											The assessor will select two sources of risk, from the above list, to assess compliance with these minimum requirements.						
	215.1																		
	215.2																		
Level 1	1051	- incident reports - risk assessments - local risk registers - external recommendations.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
		The assessor will select two sources of risk, from the above list, to assess compliance with these minimum requirements.																	
								Compliant	**#N/A**	**Compliant**									
2.1.6	1060	All organisations must have an approved documented process for dealing with external recommendations specific to the organisation.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence implementation of your documented process in relation to:																	
Level 1	1063	how action plans are developed as a result of external recommendations	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	1064	how action plans are followed up.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	**#N/A**	**Compliant**									
2.1.7	1070	All organisations must have an approved documented process for managing the risks associated with paper and electronic health records.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence implementation of your documented process in relation to:																	
Level 1	1074	how health records are tracked when in current use.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
		The assessor will look at between 10 and 30 health records in current use in order to assess compliance. This will typically be equivalent to 10% of all daily admission numbers.																	
		To award a score the assessor will need to be assured that 75% of the records presented for this criterion meet the above minimum requirement.																	
								Compliant	**#N/A**	**Compliant**									
2.1.8	1080	All organisations must have an approved documented process for health record-keeping.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence implementation of your documented process in relation to:																	
Level 1	1081	basic record-keeping standards, which must be used by all staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
		The assessor will look at between 10 and 30 health records in current use in order to assess compliance. This will be typically equivalent to 10% of all daily admission numbers.																	
		To award a score the assessor will need to be assured that 75% of the records presented for this criterion meet the above minimum requirement.																	
								Compliant	**#N/A**	**Compliant**									
2.1.9	1090	All organisations must have an approved documented process for making sure that all clinical staff are registered with the appropriate professional body.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence implementation of your documented process in relation to:																	
Level 1	1092.1	how the organisation checks registration with the relevant professional body, in accordance with their recommendations, for all directly employed clinical staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	**#N/A**	**Compliant**									

2.1.10	1100	All organisations must have an approved documented process for making sure that all relevant employment checks are undertaken for all staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A					
	2110 2110	You must evidence implementation of your documented process in relation to:											The assessor will select two elements of the Employment Checks Minimum Data Set at random to assess compliance with this minimum requirement.
Level 1	1102	types of check required.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A			
		The assessor will select two elements of the Employment Checks Minimum Data Set at random to assess compliance with this minimum requirement.											
								Compliant	#N/A	Compliant			
								2.1.1	#N/A		0		
								2.1.2	#N/A		0		
								2.1.3	#N/A		0		
								2.1.4	#N/A		0		
								2.1.5	#N/A		0		
								2.1.6	#N/A		0		
								2.1.7	#N/A		0		
								2.1.8	#N/A		0		
								2.1.9	#N/A		0		
								2.1.10	#N/A		0		All Standards Total
								Total	0		0		0

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Comment: Data collection period must be one of the following:
- 12 calendar months preceding the assessment;
- the financial year immediately preceding the assessment; or
- the calendar year immediately preceding the assessment

Cell: L1
Comment: Assessor Use Only

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Comment: Assessor Use Only

Cell: N1
Comment: Assessor Use Only

Cell: I71
Comment: Risk Management Strategy

Cell: I72
Comment: Policy on Procedural Documents

Cell: I73
Comment: Risk Management Committee(s)

Cell: I74
Comment: Risk Awareness Training for Senior Management

Cell: I75
Comment: Risk Management Process

Cell: I76
Comment: Risk Register

Cell: I77
Comment: Responding to External Recommendations Specific to the Organisation

Cell: I78
Comment: Health Records Management

Cell: I79
Comment: Professional Clinical Registration

Cell: I80
Comment: Employment Checks

Choice number	Status	Criterion and minimum requirements	Report or Electronic data?	Evidence submitted	Electronic file hyperlink/name	Location of relevant information	Date(s) of data or proposed date of evidence collation	Initials of contact name for evidence	Compliant (Y/Compensated)	Organisation's comments	Compliant (Assessor) Optional to Expert	Assessor's comments	Proposed future change	Rationale	Actions required to achieve compliance	Person/ committee responsible	Target date	Associated cost
2.2.1	2010	All organisations must have an approved documented process for making sure that all clinical audits are undertaken, completed and reported on in a systematic manner.	E	#N/A	#N/A	#N/A	#N/A	#N/A										
		You must evidence implementation of your documented process in relation to:																
Level 1	2013	requirement that audits are conducted in line with the approved process for audit	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
Level 1	2016	how the organisation makes improvements.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
									Compliant	#N/A		Compliant						
2.2.2	2020	All organisations must have an approved documented process for internal and external reporting of all incidents and near misses.	E	#N/A	#N/A	#N/A	#N/A	#N/A										
		You must evidence implementation of your documented process in relation to:																
Level 1	2022	how all incidents and near misses involving staff, patients and others are reported	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
Level 1	2023	how the organisation reports to external agencies.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
									Compliant	#N/A		Compliant						
2.2.3	2030	All organisations must have an approved documented process for listening, responding and improving when patients, their relatives and carers raise concerns and complaints.	E	#N/A	#N/A	#N/A	#N/A	#N/A										
		You must evidence implementation of your documented process in relation to:																
Level 1	2032	how the organisation listens and responds to concerns and complaints from patients, their relatives and carers	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
Level 1	2035	how the organisation makes improvements as a result of a concern or complaint.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
									Compliant	#N/A		Compliant						
2.2.4	2040	All organisations must have an approved documented process for managing all claims in accordance with NHSLA requirements.																
		You must evidence implementation of your documented process in relation to:																
Level 1	2043	action to be taken, including timescales	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
Level 1	2044	how the organisation communicates with relevant stakeholders, such as staff, claimants, NHSLA, solicitors, HM Coroner, etc.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
									Compliant	#N/A		Compliant						
2.2.5	2050	All organisations must have an approved documented process for investigating all incidents, complaints and claims to enable learning.	E	#N/A	#N/A	#N/A	#N/A	#N/A										
		You must evidence implementation of your documented process in relation to:																
Level 1	2053	different levels of investigation appropriate to the severity of the event	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
Level 1	2056	how action plans are followed up.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
									Compliant	#N/A		Compliant						
2.2.6	2060	All organisations must have an approved documented process for the analysis of incidents, complaints and claims to enable learning and improvement.	E	#N/A	#N/A	#N/A	#N/A	#N/A										
		You must evidence implementation of your documented process in relation to:																
Level 1	2063	reports, including qualitative and quantitative analysis	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
Level 1	2066	how action plans are followed up.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
									Compliant	#N/A		Compliant						
2.2.7	2070	All organisations must evidence that action has been taken to learn lessons from claims."	E	#N/A	#N/A	#N/A	#N/A	#N/A										
		"With particular reference to the issues contained in the NHSLA Solicitors' Risk Management Reports on Claims where these have been received:																
Level 1	2071	You must evidence that action has been taken to improve safety in response to incidents giving rise to clinical negligence CNST) claims. Where Solicitors' Risk Management Reports on Claims have been prepared, you must demonstrate that the risk issues identified have been considered and action taken (if any). If action has not been taken, the reasons why and how this decision was made must be clearly documented.																
		The assessor will select three Solicitors' Risk Management Reports on Claims to assess compliance with this criterion. Where fewer or no reports have been prepared, the assessment will be based on other CNST claims notified to the NHSLA. If fewer than three claims have been notified to the NHSLA, the assessment will be based on learning from Serious Untoward Incidents.																
									Compliant	#N/A		Compliant						
2.2.8	2080	All organisations must have an approved documented process for taking into account agreed best practice as defined in NICE clinical guidelines.	E	#N/A	#N/A	#N/A	#N/A	#N/A										
		You must evidence implementation of your documented process in relation to:										The assessor will select two guidelines from the NICE Guidelines Minimum Data Set to assess compliance with these minimum requirements.						
	2081																	
	2082																	
Level 1	2083	how a gap analysis is conducted to identify shortfalls	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
Level 1	2084	how action plans are created to address any shortfalls, including recording decisions not to implement NICE guidelines	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
		The assessor will select two guidelines from the NICE Guidelines Minimum Data Set to assess compliance with these minimum requirements.																
		Guidance specific support tools are available on the NICE website at www.nice.org.uk/useguidance.																
									Compliant	#N/A		Compliant						
2.2.9	2090	All organisations must have an approved documented process for taking into account agreed best practice, as defined in National Confidential Enquiries and Inquiries, in the context of the clinical services provided by the organisation.	E	#N/A	#N/A	#N/A	#N/A	#N/A										
		You must evidence implementation of your documented process in relation to:																
Level 1	2094	how a gap analysis is conducted to identify shortfalls	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
Level 1	2095	how action plans are developed to address any shortfalls, including recording decisions not to implement National Confidential Enquiry/Inquiry recommendations.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
									Compliant	#N/A		Compliant						
2.2.10	2100	All organisations must have an approved documented process for open and honest communication following an incident, complaint or claim.	E	#N/A	#N/A	#N/A	#N/A	#N/A										
		You must evidence implementation of your documented process in relation to:																
Level 1	2102	how staff acknowledge, apologise and explain when things go wrong	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
Level 1	2105	how all communication is recorded	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
									Compliant	#N/A		Compliant						
								221	#N/A		0							
								222	#N/A		0							
								223	#N/A		0							
								224	#N/A		0							
								225	#N/A		0							
								226	#N/A		0							
								227	#N/A		0							
								228	#N/A		0							
								229	#N/A		0							

2.2.10	#N/A	0	All Standards Total
Total	0	0	0

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Cell: L1
Comment: Assessor Use Only

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Comment: Assessor Use Only

Cell: N1
Comment: Assessor Use Only

Cell: I69
Comment: Corporate Induction

Cell: I70
Comment: Local Induction of Permanent Staff

Cell: I71
Comment: Local Induction of Temporary Staff

Cell: I72
Comment: Supervision of Medical Staff in Training

Cell: I73
Comment: Risk Management Training

Cell: I74
Comment: Training Needs Analysis

Cell: I75
Comment: Medical Devices Training

Cell: I76
Comment: Hand Hygiene Training

Cell: I77
Comment: Moving & Handling Training

Cell: I78
Comment: Consent Training

Criterion number	Index	Criterion and minimum requirements	Proof is Electronic Only	Evidence submitted	Electronic file hyperlink/name	Location of relevant information	Where there is more than one piece of evidence submitted, please provide an index of contents name for each	Compliant (Organisation)	Organisation's comments	Compliant (Assessor) Compliant/ Partial/	Assessor's comments	Proposed future change	Rationale	Actions required to achieve compliance	Person/ committee responsible	Target date	Associated cost
2.3.1	3010	All organisations must have an approved documented corporate induction process for all new permanent staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A									
		You must evidence implementation of your documented process in relation															
Level 1	3015	how the organisation records that all new permanent staff complete corporate induction	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
Level 1	3016	how the organisation follows up those who do not complete corporate induction.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
								Compliant	#N/A	Compliant							
2.3.2	3020	All organisations must have an approved documented local induction process for all new permanent staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A									
		You must evidence implementation of your documented process in relation															
Level 1	3025	how the organisation records that all new permanent staff complete local induction	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
Level 1	3026	how the organisation follows up those who do not complete local induction.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
								Compliant	#N/A	Compliant							
2.3.3	3030	All organisations must have an approved documented local induction process for all temporary staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A									
		You must evidence implementation of your documented process in relation															
Level 1	3034	how the organisation records that all temporary staff complete local induction	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
Level 1	3035	how the organisation follows up those who do not complete local induction.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
								Compliant	#N/A	Compliant							
2.3.4	3040	All organisations must have an approved documented risk management training process for all permanent staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A									
		You must evidence implementation of your documented process in relation to:									The assessor will randomly select two elements of risk management training from the TNA Minimum Data Set to assess the organisation's compliance with the above						
	2.3.4.1																
	2.3.4.2																
Level 2	3044	how the organisation records that all permanent staff complete relevant training, in line with the training needs	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
Level 2	3045	how the organisation follows up those who do not complete relevant training programmes	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
		The assessor will randomly select two elements of risk management training from the TNA Minimum Data Set to assess the organisation's compliance with the above															
								Compliant	#N/A	Compliant							
2.3.5	3050	All organisations must have a documented training needs analysis to identify the risk management training requirements for all permanent	E	#N/A	#N/A	#N/A	#N/A	#N/A									
		You must evidence the provision of the risk management training for all permanent staff by:															
Level 2	3054	producing an annual training prospectus which reflects the training needs analysis	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
								Compliant	#N/A	Compliant							
2.3.6	3060	All organisations must have an approved documented process for delivering risk management awareness training to all board members and senior managers.	E	#N/A	#N/A	#N/A	#N/A	#N/A									
		You must evidence implementation of your documented process in relation															
Level 2	3061	how risk management awareness training is delivered to all board members and senior managers, in line with the	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
Level 2	3062	how non-attendance is followed	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
								Compliant	#N/A	Compliant							
2.3.7	3070	All organisations must have an approved documented process which sets out the moving and handling training requirements for all permanent staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A									
		You must evidence implementation of your documented process in relation															
Level 2	3077	how the organisation records that all permanent staff, as listed in the training needs analysis, complete moving and	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
Level 2	3078	how the organisation follows up those who do not complete moving and handling training.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
								Compliant	#N/A	Compliant							
2.3.8	3080	All organisations must have an approved documented process for dealing with the harassment or bullying of staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A									
		You must evidence implementation of your documented process in relation															
Level 2	3083	how concerns about harassment or bullying can be raised	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
Level 2	3084	what should be done once a concern has been raised.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
								Compliant	#N/A	Compliant							
2.3.9	3090	All organisations must have an approved documented process for making sure that all staff involved in traumatic or stressful incidents, complaints or claims are adequately supported.	E	#N/A	#N/A	#N/A	#N/A	#N/A									
		You must evidence implementation of your documented process in relation															
Level 2	3095	action for managers or individuals to take if the staff member is experiencing difficulties associated with the	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
								Compliant	#N/A	Compliant							
2.3.10	3100	All organisations must have an approved documented process for managing the risks associated with work-related	E	#N/A	#N/A	#N/A	#N/A	#N/A									
		You must evidence implementation of your documented process in relation															
Level 2	3103	how workplace stressors are identified	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
Level 2	3104	how the organisation carries out risk assessments for the prevention and management of	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A								
								Compliant	#N/A	Compliant							

2.3.1	#N/A	0	
2.3.2	#N/A	0	
2.3.3	#N/A	0	
2.3.4	#N/A	0	
2.3.5	#N/A	0	
2.3.6	#N/A	0	
2.3.7	#N/A	0	
2.3.8	#N/A	0	
2.3.9	#N/A	0	
2.3.10	#N/A	0	All Standards Total
Total	0	0	0

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Comment: Assessor Use Only

Cell: M1
Comment: Assessor Use Only

Cell: N1
Comment: Assessor Use Only

Cell: I68
Comment: Secure Environment

Cell: I67
Comment: Slips, Trips & Falls
(Staff & Others)

Cell: I68
Comment: Slips, Trips & Falls
(Patients)

Cell: I69
Comment: Moving & Handling

Cell: I70
Comment: Inoculation Incidents

Cell: I71
Comment: Maintenance of Medical
Devices & Equipment

Cell: I72
Comment: Harassment & Bullying

Cell: I73
Comment: Violence & Aggression

Cell: I74
Comment: Supporting Staff Involved in an
Incident, Complaint or Claim

Cell: I75
Comment: Stress

NHSLA Risk Management Standards
Evidence Template

Criterion number	Index	Criterion and minimum requirements	Paper or Electronic copy	Evidence submitted	Electronic file hyperlink/name	Location of relevant information	Version / date collection period / date of evidence submitted	Initials of contact name for evidence	Compliant? (Organisation)	Organisation's comments	Compliant? (Assessor)	Comment in report	Assessor's comments	Proposed future change	Rationale	Actions required to achieve compliance	Person/ committee responsible	Target date	Associated cost
2.4.1	4010	All organisations must have an approved documented process for managing the risks associated with the physical security of premises and assets.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence implementation of your documented process in relation to:																	
Level 1	4012	how the organisation risk assesses the physical security of premises and assets	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	4013	how action plan are developed as a result of risk assessments	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	4014	how action plans are followed up.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	#N/A	Compliant									
2.4.2	4020	All organisations must have an approved documented process for the prevention and management of violence and aggression.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence implementation of your documented process in relation to:																	
Level 1	4022	how the organisation carries out risk assessments for the prevention and management of violence and aggression	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	4026	arrangements for making sure lone workers are safe.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	#N/A	Compliant									
2.4.3	4030	All organisations must have has an approved documented process for managing the risk of slips, trips and falls involving staff and others.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence implementation of your documented process in relation to:																	
Level 1	4032	how the organisation assesses the risk of slips, trips and falls involving staff and others (including falls from height).	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	#N/A	Compliant									
2.4.4	4040	All organisations must have an approved documented process for managing the risk of slips, trips and falls involving patients.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence implementation of your documented process in relation to:																	
Level 1	4042	how the organisation assesses the risk of slips, trips and falls involving patients (including falls from height).	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
		The assessor will look at between 10 and 30 health records in current use in order to assess compliance. This will typically be equivalent to 10% of all daily admission numbers.																	
		To award a score the assessor will need to be assured that 75% of the records presented for this criterion meet the above minimum requirement.																	
								Compliant	#N/A	Compliant									
2.4.5	4050	All organisations must have an approved documented process for managing the risks associated with moving and handling.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence implementation of your documented process in relation to:																	
Level 1	4054	how the organisation risk assesses the moving and handling of patients and objects	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	4055	how action plans are developed as a result of risk assessments	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	4056	how action plans are followed up.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	#N/A	Compliant									
2.4.6	4060	All organisations must have an approved documented process which sets out the hand hygiene training requirements for all permanent staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence implementation of your documented process in relation to:																	
Level 1	4062	how the organisation records that all permanent staff complete hand hygiene training, in line with the training needs analysis	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	4063	how the organisation follows up those who do not complete hand hygiene training.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	#N/A	Compliant									
2.4.7	4070	All organisations must have an approved documented process for managing the risks associated with inoculation incidents.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence implementation of your documented process in relation to:																	
Level 1	4073	process for the management of an inoculation incident (including prophylaxis).	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	#N/A	Compliant									
2.4.8	4080	All organisations must have an approved documented process for managing the risks associated with the deteriorating patient.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence implementation of your documented process in relation to:																	
Level 1	4082	use of an early warning system within the organisation to recognise patients at risk of deterioration	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	4084	do not attempt resuscitation orders (DNAR).	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
		The assessor will look at between 10 and 30 health records in current use in order to assess compliance. This will typically be equivalent to 10% of all daily admission numbers.																	
		To award a score the assessor will need to be assured that 75% of the records presented for this criterion meet all of the above minimum requirements.																	
								Compliant	#N/A	Compliant									
2.4.9	4090	All organisations must have an approved documented process for the handover of care of patients.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence implementation of your documented process in relation to:																	
Level 1	4093	out of hours handover process.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
		The assessor will look at between 10 and 30 health records in current use in order to assess compliance. This will typically be equivalent to 10% of all daily admission numbers.																	

		To award a score the assessor will need to be assured that 75% of the records presented for this criterion meet the above minimum requirement.											
								Compliant	#N/A	Compliant			
2.4.10	4100	All organisations must have an approved documented process for the discharge of patients.	E	#N/A	#N/A	#N/A	#N/A	#N/A					
		You must evidence implementation of your documented process in relation to:											
Level 1	4102	information to be given to the receiving healthcare professional	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A			
Level 1	4103	information to be given to the patient when they are discharged.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A			
		The assessor will look at between 10 and 30 health records in current use in order to assess compliance. This will typically be equivalent to 10% of all daily admission numbers.											
		To award a score the assessor will need to be assured that 75% of the records presented for this criterion meet all of the above minimum requirements.											
								Compliant	#N/A	Compliant			
								2.4.1	#N/A		0		
								2.4.2	#N/A		0		
								2.4.3	#N/A		0		
								2.4.4	#N/A		0		
								2.4.5	#N/A		0		
								2.4.6	#N/A		0		
								2.4.7	#N/A		0		
								2.4.8	#N/A		0		
								2.4.9	#N/A		0		
								2.4.10	#N/A		0		**All Standards Total**
								Total	**0**		**0**		0

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Cell: I70
Comment: Patient Information & Consent

Cell: I71
Comment: Health Record-Keeping Standards

Cell: I72
Comment: Screening Procedures

Cell: I73
Comment: Diagnostic Screening Procedures

Cell: I74
Comment: Medicines Management

Cell: I75
Comment: Transfusion

Cell: I76
Comment: Resuscitation

Cell: I77
Comment: Venous Thromboembolism

Cell: I78
Comment: Transfer of Patients

Cell: I79
Comment: Discharge of Patients

Criterion number	Index	Criterion and minimum requirements	Paper or Electronic copy	Evidence submitted	Electronic file hyperlink/name	Location of relevant information	Version / data collection period of evidence submitted	Initials of contact name for evidence	Compliant? (Organisation)	Organisation's comments	Complaint? (Assessor)	Comment in report	Assessor's comments	Proposed future change	Rationale	Actions required to achieve compliance	Person/ committee responsible	Target date	Associated cost
2.5.1	5010	Organisations providing acute services must have met the GMC minimum requirements for supervision	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		To assess part of this criterion the NHSLA takes assurance from the organisation's compliance with the General Medical Council's (GMC) minimum requirements for clinical supervision set out in Domain 6 of the GMC Generic																	
Acute only	2012	Your organisation has GMC approval and no concerns about supervision of medical staff in training have been identified	E	#N/A	#N/A	#N/A	#N/A	#N/A	####	#N/A									
(Pilot)	5013	In addition, you must evidence that issues relating to the supervision of medical staff in training are reported to, and discussed, at least quarterly at a	E	#N/A	#N/A	#N/A	#N/A	#N/A	####	#N/A									
								Compliant	#N/A	Compliant									
2.5.2	5020	Organisations providing acute and community services and non-NHS providers must have an approved documented process for obtaining consent	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence implementation of your documented process in relation																	
Level 1	5023	how the discussion and provision of information to patients is	E	#N/A	#N/A	#N/A	#N/A	#N/A	####	#N/A									
Level 1	5025	archiving arrangements for any information given to patients to support their decision making	E	#N/A	#N/A	#N/A	#N/A	#N/A	####	#N/A									
		The assessor will look at between 10 and 30 health records in current use in order to assess compliance. This will typically be equivalent to 10%																	
		To award a score the assessor will need to be assured that 75% of the records presented for this criterion meet all of the above minimum requirements.																	
								Compliant	#N/A	Compliant									
2.5.3	5030	Organisations providing acute and community services and non-NHS providers must have an approved documented process which sets out the consent training requirements for	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence implementation of your documented process in relation																	
Level 1	5033	how the organisation provides procedure specific training on consent for staff who are not capable of performing the procedure, but who are authorised to obtain consent for	E	#N/A	#N/A	#N/A	#N/A	#N/A	####	#N/A									
Level 1	5034	how the organisation follows up where an individual has obtained consent without the authorisation to do so	E	#N/A	#N/A	#N/A	#N/A	#N/A	####	#N/A									
(Pilot)	5035	how the organisation notifies the GMC via the required form, of any individual who has obtained consent without the authorisation	E	#N/A	#N/A	#N/A	#N/A	#N/A	####	#N/A									
								Compliant	#N/A	Compliant									
2.5.4	5040	Organisations providing acute and community services and non-NHS providers must have an approved documented process for managing the maintenance of reusable diagnostic and therapeutic	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence implementation of your documented process in relation to:											The assessor will review the organisation's incident database and select two items to assess the organisation's compliance with the above minimum						
	254.1																		
	254.2																		
Level 1	5043	how reusable diagnostic and therapeutic equipment is	E	#N/A	#N/A	#N/A	#N/A	#N/A	####	#N/A									
Level 1	5044	how reusable diagnostic and therapeutic equipment is	E	#N/A	#N/A	#N/A	#N/A	#N/A	####	#N/A									
		The assessor will review the organisation's incident database and select two items to assess the organisation's compliance with the above minimum																	
								Compliant	#N/A	Compliant									
2.5.5	5050	Organisations providing acute and community services and non-NHS providers must have an approved document which sets out the training requirements of all permanent staff in relation to the use diagnostic and therapeutic	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence implementation of your documented process in relation to:											The assessor will review the organisation's incident database and select two items to assess the organisation's compliance with the above minimum						
	255.1																		
	255.2																		
Level 1	5053	how the organisation identifies which permanent staff are authorised to use the equipment listed on the inventory	E	#N/A	#N/A	#N/A	#N/A	#N/A	####	#N/A									
Level 1	5054	how the organisation decides the training required	E	#N/A	#N/A	#N/A	#N/A	#N/A	####	#N/A									
Level 1	5055	how the organisation decides the frequency of updates required	E	#N/A	#N/A	#N/A	#N/A	#N/A	####	#N/A									
Level 1	5056	how the organisation records that all permanent staff complete	E	#N/A	#N/A	#N/A	#N/A	#N/A	####	#N/A									
		The assessor will review the organisation's incident database and select two items to assess the organisation's compliance with the above minimum																	
								Compliant	#N/A	Compliant									
2.5.6	5060	Organisations providing acute and community services and non-NHS providers must have a documented process for managing the risks associated with screening procedures	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence implementation of your documented process in relation to:											The assessor will select two screening-specific procedures, from the organisation's list, to assess compliance with these minimum requirements						
	256.1																		
	256.2																		
Level 1	5064	how the clinician treating the patient is informed of the result, including timescales	E	#N/A	#N/A	#N/A	#N/A	#N/A	####	#N/A									
Level 1	5065	how the patient is informed of the result, including timescales.	E	#N/A	#N/A	#N/A	#N/A	#N/A	####	#N/A									
		The assessor will select two screening-specific procedures, from the organisation's list, to assess compliance with these minimum requirements																	
		For the purpose of the assessment, you should provide evidence for those screening procedures you have assessed as being highest risk.																	
								Compliant	#N/A	Compliant									
2.5.7	5070	Organisations providing acute and community services and non-NHS providers must have an approved documented process for managing the risks associated with diagnostic	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence implementation of your documented process in relation to:											The assessor will select two diagnostic test-specific documents, from the organisation's list, to assess compliance with these minimum						
	257.1																		
	257.2																		
Level 1	5074	how the clinician treating the patient is informed of the result, including timescales	E	#N/A	#N/A	#N/A	#N/A	#N/A	####	#N/A									
Level 1	5075	how the patient is informed of the result, including timescales.	E	#N/A	#N/A	#N/A	#N/A	#N/A	####	#N/A									

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		The assessor will select two diagnostic test-specific documents, from the organisation's list, to assess compliance with these minimum										
		For the purpose of the assessment, you should provide evidence for those diagnostic tests you have assessed as										
								Compliant	#N/A	Compliant		
2.5.8	5080	Organisations providing acute and community services and non-NHS providers must have an approved documented process for transfusion	E	#N/A	#N/A	#N/A	#N/A	#N/A				
		You must evidence implementation of your documented process in relation										
Level 1	5082	how transfusions are administered, including patient	E	#N/A	#N/A	#N/A	#N/A	#N/A	####	#N/A		
Level 1	5083	care of patients receiving a transfusion.	E	#N/A	#N/A	#N/A	#N/A	#N/A	####	#N/A		
		The assessor will look at between 10 and 30 health records in current use in order to assess compliance. This will typically be equivalent to 10%										
		To award a score the assessor will need to be assured that 75% of the records presented for this criterion meet all of the above minimum requirements.										
								Compliant	#N/A	Compliant		
2.5.9	5090	Organisations providing acute and community services and non-NHS providers must have an approved documented process for the prevention and management of venous	E	#N/A	#N/A	#N/A	#N/A	#N/A				
		You must evidence implementation of your documented process in relation										
Level 1	5091	how patients are assessed for their risk of developing venous thromboembolism (VTE), including timescales	E	#N/A	#N/A	#N/A	#N/A	#N/A	####	#N/A		
Level 1	5093	procedure to be followed if VTE is suspected.	E	#N/A	#N/A	#N/A	#N/A	#N/A	####	#N/A		
		The assessor will look at between 10 and 30 health records in current use in order to assess compliance. This will typically be equivalent to 10%										
		To award a score the assessor will need to be assured that 75% of the records presented for this criterion meet all of the above minimum requirements.										
								Compliant	#N/A	Compliant		
2.5.10	5100	Organisations providing acute and community services and non-NHS providers must have an approved documented process for learning from	E	#N/A	#N/A	#N/A	#N/A	#N/A				
		You must evidence implementation of your documented process in relation										
Level 1	5102	how the organisation makes sure that all prescription charts are accurate	E	#N/A	#N/A	#N/A	#N/A	#N/A	####	#N/A		
Level 1	5103	how medication errors are	E	#N/A	#N/A	#N/A	#N/A	#N/A	####	#N/A		
		The assessor will look at between 10 and 30 health records in current use in order to assess compliance. This will typically be equivalent to 10%										
		To award a score the assessor will need to be assured that 75% of the records presented for this criterion meet all of the above minimum requirements.										
								Compliant	#N/A	Compliant		
								2.5.1	####		0	
								2.5.2	####		0	
								2.5.3	####		0	
								2.5.4	####		0	
								2.5.5	####		0	
								2.5.6	####		0	
								2.5.7	####		0	
								2.5.8	####		0	
								2.5.9	####		0	
								2.5.10	####		0	All Standards Total
								Total	0		0	0

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Comment: Analysis

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Evidence Template

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2.6.1	6010	Organisations providing MH&LD services must have an approved documented process for making sure that all clinical staff receive appropriate supervision.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence implementation of your documented process in relation to:																	
Level 1	6013	how the organisation makes sure that all clinical staff receive appropriate clinical supervision.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	#N/A	Compliant									
2.6.2	6020	Organisations providing MH&LD services must have an approved documented process for managing the risks associated with patient information.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence implementation of your documented process in relation to:																	
Level 1	6022	how the discussion and provision of information to patients is recorded	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	6023	archiving arrangements for any information given to patients to support their decision making.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
		The assessor will look at between 10 and 30 health records in current use in order to assess compliance. This will typically be equivalent to 10% of all daily admission numbers.																	
		To award a score the assessor will need to be assured that 75% of the records presented for this criterion meet all of the above minimum requirements.																	
								Compliant	#N/A	Compliant									
2.6.3	6030	Organisations providing MH&LD services must have an approved documented process for making sure that all clinical staff who undertake assessments of patients are competent in the assessment and management of clinical risk.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence implementation of your documented process in relation to:																	
Level 1	6032	how the organisation trains staff, in line with in the training needs analysis	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	6033	tools and processes authorised for use within the organisation, including timescales for use.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	#N/A	Compliant									
2.6.4	6040	Organisations providing MH&LD services must have an approved documented process for managing the risks associated with the physical assessment and examination of patients.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence implementation of your documented process in relation to:																	
Level 1	6042	physical assessment of patients when they are admitted to a service, including timeframes	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	6044	ongoing assessment of physical needs for all patients, including timeframes.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	#N/A	Compliant									
2.6.5	6050	Organisations providing MH&LD services must have an approved documented process for the observation and engagement of patients.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence implementation of your documented process in relation to:																	
Level 1	6052	recording observation at differing levels.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
		The assessor will look at between 10 and 30 health records in current use in order to spot check the organisation's monitoring results. This will typically be equivalent to 10% of all daily admission numbers.																	
		If the spot check of health records does not demonstrate 75% compliance, these findings will override the evidence provided by the organisation and will result in no score being awarded for this criterion.																	
								Compliant	#N/A	Compliant									
2.6.6	6060	Organisations providing MH&LD services must have an approved documented process for addressing the needs of patients who present with a dual diagnosis of mental health problems and substance misuse.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence implementation of your documented process in relation to:																	
Level 1	6062	how the organisation addresses the needs of this group of patients	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	6063	details of internal and external joint working arrangements.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
		The assessor will look at between 10 and 30 health records in current use in order to assess compliance. This will typically be equivalent to 10% of all daily admission numbers.																	
		To award a score the assessor will need to be assured that 75% of the records presented for this criterion meet all of the above minimum requirements.																	
								Compliant	#N/A	Compliant									
2.6.7	6070	Organisations providing MH&LD services must have an approved documented process for rapid tranquillisation.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence implementation of your documented process in relation to:																	
Level 1	6072	prescribing guidelines for rapid tranquillisation	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	6073	how observations are recorded, including timeframes when patients have received rapid tranquillisation	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
		The assessor will look at between 10 and 30 health records in current use in order to assess compliance. This will typically be equivalent to 10% of all daily admission numbers.																	
		To award a score the assessor will need to be assured that 75% of the records presented for this criterion meet all of the above minimum requirements.																	
								Compliant	#N/A	Compliant									

2.6.8	6080	Organisations providing MH&LD services must have an approved documented process for managing the risks associated with patients who are absent without leave (AWOL).	E	#N/A	#N/A	#N/A	#N/A	#N/A				
		You must evidence implementation of your documented process in relation to:										
Level 1	6082	what should be done when a patient absents themselves from an inpatient setting	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
Level 1	6083	what should be done when a patient fails to return from a period of leave of absence.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
								Compliant	**#N/A**	**Compliant**		
2.6.9	6090	Organisations providing MH&LD services must have an approved documented process which sets out the medicines management training requirements for all permanent staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A				
		You must evidence implementation of your documented process in relation to:										
Level 1	6092	how the organisation records that all permanent staff complete relevant medicines management training, in line with the training needs analysis	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
Level 1	6093	how the organisation follows up those who do not complete relevant medicines management training	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
								Compliant	**#N/A**	**Compliant**		
2.6.10	6100	Organisations providing MH&LD services must have an approved documented process for medicines management in all care settings.	E	#N/A	#N/A	#N/A	#N/A	#N/A				
		You must evidence implementation of your documented process in relation to:										
Level 1	6102	how the organisation makes sure that all prescription charts are accurate.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
		The assessor will look at between 10 and 30 health records in current use in order to spot check the organisation's monitoring results. This will typically be equivalent to 10% of all daily admission numbers.										
		If the spot check of health records does not demonstrate 75% compliance, these findings will override the evidence provided by the organisation and will result in no score being awarded for this criterion.										
								Compliant	**#N/A**	**Compliant**		
								2.5.1	#N/A		0	
								2.5.2	#N/A		0	
								2.5.3	#N/A		0	
								2.5.4	#N/A		0	
								2.5.5	#N/A		0	
								2.5.6	#N/A		0	
								2.5.7	#N/A		0	
								2.5.8	#N/A		0	
								2.5.9	#N/A		0	
								2.5.10	#N/A		0	**All Standards Total**
								Total	**0**		**0**	**0**

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3.1.1	1010	All organisations must have an approved risk management strategy.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:																	
Level 1	1013	how risk is managed locally.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	1019	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	#N/A	Compliant									
3.1.2	1020	All organisations must have an approved documented process for developing organisation-wide procedural documents.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:																	
Level 1	1024	ratification process.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	1026	control of documents, including archiving arrangements.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	1029	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	#N/A	Compliant									
3.1.3	1030	All organisations must have approved documented terms of reference for the high level committee(s) with overarching responsibility for risk.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of the terms of reference in relation to:																	
Level 1	1036	reporting arrangements into the high level risk committee(s)	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	1037	reporting arrangements into the board from the high level risk committee(s).	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	1039	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	#N/A	Compliant									
3.1.4	1040	All organisations must have approved documentation which describes the organisation-wide systematic risk management process.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:											The assessor will select two risk categories, from those defined within the organisation's documentation, to assess compliance with this minimum requirement.						
	214.1																		
	214.2																		
Level 1	1041	how all risks are assessed	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	1049	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
		The assessor will select two risk categories, from those defined within the organisation's documentation, to assess compliance with this minimum requirement.										No	FALSE						
								Compliant	#N/A	Compliant									
3.1.5	1050	All organisations must have an approved organisation-wide risk register.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
Level 1	1057	You must evidence that the organisation-wide risk register is being monitored.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	1059	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	#N/A	Compliant									
3.1.6	1060	All organisations must have an approved documented process for dealing with external recommendations specific to the organisation.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:																	
Level 1	1063	how action plans are developed as a result of external recommendations	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	1064	how action plans are followed up.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	1069	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	#N/A	Compliant									
3.1.7	1070	All organisations must have an approved documented process for managing the risks associated with paper and electronic health records.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:																	
Level 1	1074	how health records are tracked when in current use.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	1079	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
		The assessor will look at between 10 and 30 health records in current use in order to spot check the organisation's monitoring results. This will typically be equivalent to 10% of all daily admission numbers.																	
		If the spot check of health records does not demonstrate 75% compliance, these findings will override the evidence provided by the organisation and will result in no score being awarded for this criterion.																	
								Compliant	#N/A	Compliant									
3.1.8	1080	All organisations must have an approved documented process for health record-keeping.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:																	
Level 1	1081	basic record-keeping standards, which must be used by all staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	1089	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
		The assessor will look at between 10 and 30 health records in current use in order to spot check the organisation's monitoring results. This will typically be equivalent to 10% of all daily admission numbers.																	

		If the spot check of health records does not demonstrate 75% compliance, these findings will override the evidence provided by the organisation and will result in no score being awarded for this criterion.											
								Compliant	#N/A	Compliant			
3.1.9	1090	All organisations must have an approved documented process for making sure that all clinical staff are registered with the appropriate professional body.	E	#N/A	#N/A	#N/A	#N/A	#N/A					
		You must evidence monitoring of your documented process in relation to:											
Level 1	1092	how the organisation checks registration with the relevant professional body, in accordance with their recommendations, for all directly employed clinical staff both on initial appointment and on an ongoing basis	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A			
Level 1	1093	how the organisation makes sure that registration checks are being carried out by all external agencies (such as NHS Professionals, recruitment agencies, etc.) used by the organisation in respect of all clinical staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A			
	1099	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A			
								Compliant	#N/A	Compliant			
3.1.10	1100	All organisations must have an approved documented process for making sure that all relevant employment checks are undertaken for all staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A					
	2110.1 2110.2	You must evidence monitoring of your documented process in relation to:											The assessor will select two elements of the Employment Checks Minimum Data Set at random to assess the organisation's compliance with the above minimum requirement.
Level 1	1102	types of check required.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A			
	1109	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A			
		The assessor will select two elements of the Employment Checks Minimum Data Set at random to assess compliance with this minimum requirement.											
								Compliant	#N/A	Compliant			
								3.1.1	#N/A		0		
								3.1.2	#N/A		0		
								3.1.3	#N/A		0		
								3.1.4	#N/A		0		
								3.1.5	#N/A		0		
								3.1.6	#N/A		0		
								3.1.7	#N/A		0		
								3.1.8	#N/A		0		
								3.1.9	#N/A		0		
								3.1.10	#N/A		0		**All Standards Total**
								Total	**0**		**0**		**0**

Cell: B1
Comment: Admin Use Only

Cell: D1
Comment: Insert either:
E for Electronic
P for Paper
N/A for not available

Cell: G1
Comment: E.g. page number, paragraph or bullet number.
This needs to be completed in case hyperlinks do not work, and where evidence is submitted in paper form.

Cell: L1
Comment: Assessor Use Only

Cell: M1
Comment: Assessor Use Only

Cell: N1
Comment: Assessor Use Only

Cell: I78
Comment: Risk Management Strategy

Cell: I79
Comment: Policy on Procedural Documents

Cell: I80
Comment: Risk Management Committee(s)

Cell: I81
Comment: Risk Awareness Training for Senior Management

Cell: I82
Comment: Risk Management Process

Cell: I83
Comment: Risk Register

Cell: I84
Comment: Responding to External Recommendations Specific to the Organisation

Cell: I85
Comment: Health Records Management

Cell: I86
Comment: Professional Clinical Registration

Cell: I87
Comment: Employment Checks

NHSLA Risk Management Standards
Evidence Template

Criterion number	Index	Criterion and minimum requirements	Paper or Electronic copy	Evidence submitted	Electronic file hyperlink/name	Location of relevant information	Version / date of evidence submitted	Initials of contact name for evidence	Compliant? (Organisation)	Organisation's comments	Compliant? (Assessor)	Comment in report	Assessor's comments	Proposed future change	Rationale	Actions required to achieve compliance	Person/ committee responsible	Target date	Associated cost
3.2.1	2010	All organisations must have an approved documented process for making sure that all clinical audits are undertaken, completed and reported on in a systematic manner.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:																	
Level 1	2013	requirement that audits are conducted in line with the approved process for audit	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	2016	how the organisation makes improvements.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	2019	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	**#N/A**	**Compliant**									
3.2.2	2020	All organisations must have an approved documented process for internal and external reporting of all incidents and near misses.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:																	
Level 1	2022	how all incidents and near misses involving staff, patients and others are reported	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	2023	how the organisation reports to external agencies.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	2029	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	**#N/A**	**Compliant**									
3.2.3	2030	All organisations must have an approved documented process for listening, responding and improving when patients, their relatives and carers raise concerns and complaints.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:																	
Level 1	2032	how the organisation listens and responds to concerns and complaints from patients, their relatives and carers	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	2035	how the organisation makes improvements as a result of a concern or complaint.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	2039	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	**#N/A**	**Compliant**									
3.2.4	2040	All organisations must have an approved documented process for managing all claims in accordance with NHSLA requirements.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:																	
Level 1	2043	action to be taken, including timescales	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	2044	how the organisation communicates with relevant stakeholders, such as staff, claimants, NHSLA, solicitors, HM Coroner, etc.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	2049	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	**#N/A**	**Compliant**									
3.2.5	2050	All organisations must have an approved documented process for investigating all incidents, complaints and claims to enable learning.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:																	
Level 1	2053	different levels of investigation appropriate to the severity of the event	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	2055	how action plans are followed up.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	2059	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	**#N/A**	**Compliant**									
3.2.6	2060	All organisations must have an approved documented process for the analysis of incidents, complaints and claims to enable learning and improvement.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:																	
Level 1	2064.1	reports, including qualitative and quantitative analysis	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	2066	how action plans are followed up.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	2069	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	**#N/A**	**Compliant**									
3.2.7	2070	All organisations must evidence that action has been taken to learn lessons from claims.*	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		*With particular reference to the issues contained in the NHSLA Solicitors' Risk Management Reports on Claims where these have been received.																	

Level 1	2071	You must evidence that action has been taken to improve safety in response to incidents giving rise to clinical negligence (CNST) claims. Where Solicitors' Risk Management Reports on Claims have been prepared, you must demonstrate that the risk issues identified have been considered and action taken (if any). If action has not been taken, the reasons why and how this decision was made must be clearly documented.																		
		The assessor will select three Solicitors' Risk Management Reports on Claims to assess compliance with this criterion. Where fewer or no reports have been prepared, the assessment will be based on other CNST claims notified to the NHSLA. If fewer than three claims have been notified to the NHSLA, the assessment will be based on learning from Serious Untoward Incidents.																		
								Compliant	**#N/A**	**Compliant**										
3.2.8	2080	All organisations must have an approved documented process for taking into account agreed best practice as defined in NICE clinical guidelines.	E	#N/A	#N/A	#N/A	#N/A	#N/A												
		You must evidence monitoring of your documented process in relation to:																		
Level 1	2083	how a gap analysis is conducted to identify shortfalls	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A										
Level 1	2084	how action plans are created to address any shortfalls, including recording decisions not to implement NICE guidelines.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A										
	2089	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A										
								Compliant	**#N/A**	**Compliant**										
3.2.9	2090	All organisations must have an approved documented process for taking into account agreed best practice, as defined in National Confidential Enquiries and Inquiries, in the context of the clinical services provided by the organisation.	E	#N/A	#N/A	#N/A	#N/A	#N/A												
		You must evidence monitoring of your documented process in relation to:																		
Level 1	2094	how a gap analysis is conducted to identify shortfalls	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A										
Level 1	2095	how action plans are developed to address any shortfalls, including recording decisions not to implement National Confidential Enquiry/Inquiry recommendations.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A										
	2099	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A										
								Compliant	**#N/A**	**Compliant**										
3.2.10	2100	All organisations must have an approved documented process for open and honest communication following an incident, complaint or claim.	E	#N/A	#N/A	#N/A	#N/A	#N/A												
		You must evidence monitoring of your documented process in relation to:																		
Level 1	2102	how staff acknowledge, apologise and explain when things go wrong	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A										
Level 1	2105	how all communication is recorded.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A										
	2109	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A										
								Compliant	**#N/A**	**Compliant**										

3.2.1	#N/A	0	
3.2.2	#N/A	0	
3.2.3	#N/A	0	
3.2.4	#N/A	0	
3.2.5	#N/A	0	
3.2.6	#N/A	0	
3.2.7	#N/A	0	
3.2.8	#N/A	0	
3.2.9	#N/A	0	
3.2.10	#N/A	0	**All Standards Total**
Total	**0**	**0**	**0**

Cell: B1
Comment: Admin Use Only

Cell: D1
Comment: Insert either:
E for Electronic
P for Paper
N/A for not available

Cell: G1
Comment: E.g. page number, paragraph or bullet number.
This needs to be completed in case hyperlinks do not work, and where evidence is submitted in paper form.

Cell: L1
Comment: Assessor Use Only

Cell: M1
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Cell: N1
Comment: Assessor Use Only

Cell: I74
Comment: Corporate Induction

Cell: I75
Comment: Local Induction of Permanent Staff

Cell: I76
Comment: Local Induction of Temporary Staff

Cell: I77
Comment: Supervision of Medical Staff in Training

Cell: I78
Comment: Risk Management Training

Cell: I79
Comment: Training Needs Analysis

Cell: I80
Comment: Medical Devices Training

Cell: I81
Comment: Hand Hygiene Training

Cell: I82
Comment: Moving & Handling Training

Cell: I83
Comment: Consent Training

Criterion number	Index	Criterion and minimum requirements	Paper or Electronic copy	Evidence submitted	Electronic file hyperlink/name	Location of relevant information	Version / date of evidence submitted	Index / reference name for evidence	Compliant? (Organisation)	Organisation's comments	Compliant? (Assessor)	Comment on report	Assessor's comments	Proposed future change	Rationale	Actions required to achieve compliance	Person/ committee responsible	Target date	Associated cost
3.3.1	3310	All organisations must have an approved documented corporate induction process for all new permanent staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:																	
Level 1	3315	how the organisation records that all new permanent staff complete corporate induction	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	3318	how the organisation follows up those who do not complete corporate induction.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	3319	Where the monitoring has identified less than 95% completion of induction, you must evidence that changes have been made to address this.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
									Compliant	**#N/A**		**Compliant**							
3.3.2	3320	All organisations must have an approved documented local induction process for all new permanent staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:																	
Level 1	3324	how the organisation records that all new permanent staff complete local induction	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	3325	how the organisation follows up those who do not complete local induction.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	3329	Where the monitoring has identified less than 95% completion of induction, you must evidence that changes have been made to address this.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
									Compliant	**#N/A**		**Compliant**							
3.3.3	3330	All organisations must have an approved documented local induction process for all temporary staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:																	
Level 1	3334	how the organisation records that all temporary staff complete local induction	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	3335	how the organisation follows up those who do not complete local induction.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	3339	Where the monitoring has identified less than 95% completion of induction, you must evidence that changes have been made to address this.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
									Compliant	**#N/A**		**Compliant**							
3.3.4	3340	All organisations must have an approved documented risk management training process for all permanent staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:											The assessor will randomly select two elements of risk management training from the TNA Minimum Data Set to assess the organisation's compliance with the above minimum requirements.						
	234.1																		
	234.2																		
Level 1	3344	how the organisation records that all permanent staff complete relevant training, in line with the training needs analysis	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	3345	how the organisation follows up those who do not complete relevant training programmes.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	3349	Where the monitoring has identified less than 95% completion of training , you must evidence that changes have been made to address this.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
		The assessor will randomly select two elements of risk management training from the TNA Minimum Data Set to assess the organisation's compliance with the above minimum requirements.																	
									Compliant	**#N/A**		**Compliant**							
3.3.5	3350	All organisations must have a documented training needs analysis to identify the risk management training requirements for all permanent staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of the risk management training needs analysis for all permanent staff by:																	
Level 1	3355	producing an annual training report covering all the topics identified within the TNA Minimum Data Set.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	3359	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
									Compliant	**#N/A**		**Compliant**							
3.3.6	3360	All organisations must have an approved documented process for delivering risk management awareness training to all board members and senior managers.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:																	
Level 1	3361	how risk management awareness training is delivered to all board members and senior managers, in line with the training needs analysis	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	3363	how non-attendance is followed up.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	3369	Where the monitoring has identified less than 95% completion of training , you must evidence that changes have been made to address this.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
									Compliant	**#N/A**		**Compliant**							
3.3.7	3370	All organisations must have an approved documented process which sets out the moving and handling training requirements for all permanent staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:																	
Level 1	3372	how the organisation records that all permanent staff, as listed in the training needs analysis, complete moving and handling training	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	3373	how the organisation follows up those who do not complete moving and handling training.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	3379	Where the monitoring has identified less than 95% completion of training , you must evidence that changes have been made to address this.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
									Compliant	**#N/A**		**Compliant**							
3.3.8	3380	All organisations must have an approved documented process for dealing with the harassment or bullying of staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:																	
Level 1	3383	how concerns about harassment or bullying can be raised	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	3384	what should be done once a concern has been raised.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	3389	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
									Compliant	**#N/A**		**Compliant**							
3.3.9	3390	All organisations must have an approved documented process for making sure that all staff involved in traumatic or stressful incidents, complaints or claims are adequately supported.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:																	

Level 1	3095	action for managers or individuals to take if the staff member is experiencing difficulties associated with the event.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
	3099	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
								Compliant	#N/A	Compliant		
3.3.10	3100	All organisations must have an approved documented process for managing the risks associated with work-related stress.	E	#N/A	#N/A	#N/A	#N/A	#N/A				
		You must evidence monitoring of your documented process in relation to:										
Level 1	3103	how workplace stressors are identified	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
Level 1	3104	how the organisation carries out risk assessments for the prevention and management of work-related stress.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
	3109	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
								Compliant	#N/A	Compliant		
								3.3.1	#N/A		0	
								3.3.2	#N/A		0	
								3.3.3	#N/A		0	
								3.3.4	#N/A		0	
								3.3.5	#N/A		0	
								3.3.6	#N/A		0	
								3.3.7	#N/A		0	
								3.3.8	#N/A		0	
								3.3.9	#N/A		0	
								3.3.10	#N/A		0	All Standards Total
								Total	0		0	0

Cell: B1
Comment: Admin Use Only

Cell: D1
Comment: Insert either:
E for Electronic
P for Paper
N/A for not available

Cell: G1
Comment: E.g. page number, paragraph or bullet number.
This needs to be completed in case hyperlinks do not work, and where evidence is submitted in paper form.

Cell: L1
Comment: Assessor Use Only

Cell: M1
Comment: Assessor Use Only

Cell: N1
Comment: Assessor Use Only

Cell: I76
Comment: Secure Environment

Cell: I77
Comment: Slips, Trips & Falls
(Staff & Others)

Cell: I78
Comment: Slips, Trips & Falls
(Patients)

Cell: I79
Comment: Moving & Handling

Cell: I80
Comment: Inoculation Incidents

Cell: I81
Comment: Maintenance of Medical
Devices & Equipment

Cell: I82
Comment: Harassment & Bullying

Cell: I83
Comment: Violence & Aggression

Cell: I84
Comment: Supporting Staff Involved in an
Incident, Complaint or Claim

Cell: I85
Comment: Stress

NHSLA Risk Management Standards
Evidence Template

Criterion number	Index	Criterion and minimum requirements	Paper or Electronic copy	Evidence submitted	Electronic file hyperlink/name	Location of relevant information	Version / date of evidence submitted	Initials of contact name for evidence	Compliant? (Organisation)	Organisation's comments	Compliant? (Assessor)	Comment in report	Assessor's comments	Proposed future change	Rationale	Actions required to achieve compliance	Person/ committee responsible	Target date	Associated cost
3.4.1	4010	All organisations must have an approved documented process for managing the risks associated with the physical security of premises and assets.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:																	
Level 1	4012	how the organisation risk assesses the physical security of premises and assets	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	4013	how action plan are developed as a result of risk assessments	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	4014	how action plans are followed up.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	4019	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	#N/A	Compliant									
3.4.2	4020	All organisations must have an approved documented process for the prevention and management of violence and aggression.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:																	
Level 1	4022	how the organisation carries out risk assessments for the prevention and management of violence and aggression	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	4026	arrangements for making sure lone workers are safe.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	4029	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	#N/A	Compliant									
3.4.3	4030	All organisations must have has an approved documented process for managing the risk of slips, trips and falls involving staff and others.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:																	
Level 1	4032	how the organisation assesses the risk of slips, trips and falls involving staff and others (including falls from height).	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	4039	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	#N/A	Compliant									
3.4.4	4040	All organisations must have an approved documented process for managing the risk of slips, trips and falls involving patients	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:																	
Level 1	4042	how the organisation assesses the risk of slips, trips and falls involving patients (including falls from height).	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	4049	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
		The assessor will look at between 10 and 30 health records in current use in order to spot check the organisation's monitoring results. This will typically be equivalent to 10% of all daily admission numbers.																	
		If the spot check of health records does not demonstrate 75% compliance, these findings will override the evidence provided by the organisation and will result in no score being awarded for this criterion.																	
								Compliant	#N/A	Compliant									
3.4.5	4050	All organisations must have an approved documented process for managing the risks associated with moving and handling.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:																	
Level 1	4054	how the organisation risk assesses the moving and handling of patients and objects	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	4055	how action plans are developed as a result of risk assessments	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	4056	how action plans are followed up.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	4059	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	#N/A	Compliant									
3.4.6	4060	All organisations must have an approved documented process which sets out the hand hygiene training requirements for all permanent staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:																	
Level 1	4062	how the organisation records that all permanent staff complete hand hygiene training, in line with the training needs analysis	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	4063	how the organisation follows up those who do not complete hand hygiene training.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	4069	Where the monitoring has identified less than 95% completion of training, you must evidence that changes have been made to address this.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	#N/A	Compliant									
3.4.7	4070	All organisations must have an approved documented process for managing the risks associated with inoculation incidents.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:																	
Level 1	4073	process for the management of an inoculation incident (including prophylaxis).	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	4079	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	#N/A	Compliant									
3.4.8	4080	All organisations must have an approved documented process for managing the risks associated with the deteriorating patient.	E	#N/A	#N/A	#N/A	#N/A	#N/A											

		You must evidence monitoring of your documented process in relation to:																		
Level 1	4082	use of an early warning system within the organisation to recognise patients at risk of deterioration	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A										
Level 1	4084	do not attempt resuscitation orders (DNAR).	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A										
	4089	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A										
		The assessor will look at between 10 and 30 health records in current use in order to spot check the organisation's monitoring results. This will typically be equivalent to 10% of all daily admission numbers.																		
		If the spot check of health records does not demonstrate 75% compliance, these findings will override the evidence provided by the organisation and will result in no score being awarded for this criterion.																		
								Compliant	#N/A	Compliant										
3.4.9	4090	All organisations must have an approved documented process for the handover of care of patients.	E	#N/A	#N/A	#N/A	#N/A	#N/A												
		You must evidence monitoring of your documented process in relation to:																		
Level 1	4093	out of hours handover process	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A										
	4099	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A										
		The assessor will look at between 10 and 30 health records in current use in order to spot check the organisation's monitoring results. This will typically be equivalent to 10% of all daily admission numbers.																		
		If the spot check of health records does not demonstrate 75% compliance, these findings will override the evidence provided by the organisation and will result in no score being awarded for this criterion.																		
								Compliant	#N/A	Compliant										
3.4.10	4100	All organisations must have an approved documented process for the discharge of patients.	E	#N/A	#N/A	#N/A	#N/A	#N/A												
		You must evidence monitoring of your documented process in relation to:																		
Level 1	4102	information to be given to the receiving healthcare professional	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A										
Level 1	4103	information to be given to the patient when they are discharged.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A										
	4109	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A										
		The assessor will look at between 10 and 30 health records in current use in order to spot check the organisation's monitoring results. This will typically be equivalent to 10% of all daily admission numbers.																		
		If the spot check of health records does not demonstrate 75% compliance, these findings will override the evidence provided by the organisation and will result in no score being awarded for this criterion.																		
								Compliant	#N/A	Compliant										

	3.4.1	#N/A	0	
	3.4.2	#N/A	0	
	3.4.3	#N/A	0	
	3.4.4	#N/A	0	
	3.4.5	#N/A	0	
	3.4.6	#N/A	0	
	3.4.7	#N/A	0	
	3.4.8	#N/A	0	
	3.4.9	#N/A	0	
	3.4.10	#N/A	0	**All Standards Total**
	Total	**0**	**0**	**0**

Cell: B1
Comment: Admin Use Only

Cell: D1
Comment: Insert either:
E for Electronic
P for Paper
N/A for not available

Cell: G1
Comment: E.g. page number, paragraph or bullet number.
This needs to be completed in case hyperlinks do not work, and where evidence is submitted in paper form.

Cell: L1
Comment: Assessor Use Only

Cell: M1
Comment: Assessor Use Only

Cell: N1
Comment: Assessor Use Only

Cell: I80
Comment: Patient Information & Consent

Cell: I81
Comment: Health Record-Keeping Standards

Cell: I82
Comment: Screening Procedures

Cell: I83
Comment: Diagnostic Screening Procedures

Cell: I84
Comment: Medicines Management

Cell: I85
Comment: Transfusion

Cell: I86
Comment: Resuscitation

Cell: I87
Comment: Venous Thromboembolism

Cell: I88
Comment: Transfer of Patients

Cell: I89
Comment: Discharge of Patients

Criterion number	Index	Criterion and minimum requirements	Paper or Electronic copy	Evidence submitted	Electronic file hyperlink/name	Location of relevant information	Version / date of evidence submitted	Initials of contact name for evidence	Compliant? (Assessor)	Organisation's comments	Compliant? (Assessor) Comment in report	Assessor's comments	Proposed future change	Rationale	Actions required to achieve compliance	Person/ committee responsible	Target date	Associated cost
3.5.1	5010	Organisations providing acute services must have met the GMC minimum requirements for supervision	E	#N/A	#N/A	#N/A	####	#N/A										
		To assess part of this criterion the NHSLA takes assurance from the organisation's compliance with the General Medical Council's (GMC) minimum requirements for clinical supervision set out in Domain 6 of the GMC Generic																
Acute only	5014	Your organisation has GMC approval and has demonstrated notable practice in some areas of the supervision of medical staff in training	E	#N/A	#N/A	#N/A	####	#N/A	####	#N/A								
(Pilot)	5015	In addition you must evidence that shortfalls identified within the quarterly reports on issues relating to the supervision of medical staff in training are	E	#N/A	#N/A	#N/A	####	#N/A	####	#N/A								
								Compliant	#N/A	Compliant								
3.5.2	5020	Organisations providing acute and community services and non-NHS providers must have an approved documented process for obtaining consent	E	#N/A	#N/A	#N/A	####	#N/A										
		You must evidence monitoring of your documented process in relation to:																
Level 1	5023	how the discussion and provision of information to patients is	E	#N/A	#N/A	#N/A	####	#N/A	####	#N/A								
Level 1	5025	archiving arrangements for any information given to patients to support their decision making	E	#N/A	#N/A	#N/A	####	#N/A	####	#N/A								
	5029	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them	E	#N/A	#N/A	#N/A	####	#N/A	####	#N/A								
		The assessor will look at between 10 and 30 health records in current use in order to spot check the organisation's monitoring results. This will typically be equivalent to 10%																
		If the spot check of health records does not demonstrate 75% compliance, these findings will override the evidence provided by the organisation and will result in no score being awarded for this criterion																
								Compliant	#N/A	Compliant								
3.5.3	5030	Organisations providing acute and community services and non-NHS providers must have an approved documented process which sets out the consent training requirements for	E	#N/A	#N/A	#N/A	####	#N/A										
		You must evidence monitoring of your documented process in relation to:																
Level 1	5033	how the organisation provides procedure specific training on consent for staff who are not capable of performing the procedure, but who are authorised to obtain consent for	E	#N/A	#N/A	#N/A	####	#N/A	####	#N/A								
Level 1	5034	how the organisation follows up where an individual has obtained consent without the authorisation to do so	E	#N/A	#N/A	#N/A	####	#N/A	####	#N/A								
(Pilot)	5035	how the organisation notifies the GMC via the required form, of any individual who has obtained consent without the authorisation	E	#N/A	#N/A	#N/A	####	#N/A	####	#N/A								
	5039	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	####	#N/A	####	#N/A								
								Compliant	#N/A	Compliant								
3.5.4	5040	Organisations providing acute and community services and non-NHS providers must have an approved documented process for managing the maintenance of reusable diagnostic and therapeutic	E	#N/A	#N/A	#N/A	####	#N/A										
		You must evidence monitoring of your documented process in relation to:										The assessor will review the organisation's incident database and select two items to assess the organisation's compliance with the above minimum						
	254																	
	254																	
Level 1	5043	how reusable diagnostic and therapeutic equipment is	E	#N/A	#N/A	#N/A	####	#N/A	####	#N/A								
Level 1	5044	how reusable diagnostic and therapeutic equipment is	E	#N/A	#N/A	#N/A	####	#N/A	####	#N/A								
	5049	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	####	#N/A	####	#N/A								
		The assessor will review the organisation's incident database and select two items to assess the organisation's compliance with the above minimum																
								Compliant	#N/A	Compliant								
3.5.5	5050	Organisations providing acute and community services and non-NHS providers must have an approved document which sets out the training requirements of all permanent staff in relation to the use diagnostic and therapeutic	E	#N/A	#N/A	#N/A	####	#N/A										
		You must evidence monitoring of your documented process in relation to:										The assessor will review the organisation's incident database and select two items to assess the organisation's compliance with the above minimum						
	255																	
	255																	
Level 1	5053	how the organisation identifies which permanent staff are authorised to use the equipment listed on the inventory	E	#N/A	#N/A	#N/A	####	#N/A	####	#N/A								
Level 1	5054	how the organisation decides the training required	E	#N/A	#N/A	#N/A	####	#N/A	####	#N/A								
Level 1	5055	how the organisation decides the frequency of updates required	E	#N/A	#N/A	#N/A	####	#N/A	####	#N/A								
Level 1	5058	how the organisation records that all permanent staff complete	E	#N/A	#N/A	#N/A	####	#N/A	####	#N/A								
	5059	Where the monitoring has identified less than 95% completion of training, you must evidence that changes have been made to address this	E	#N/A	#N/A	#N/A	####	#N/A	####	#N/A								
		The assessor will review the organisation's incident database and select two items to assess the organisation's compliance with the above minimum																
								Compliant	#N/A	Compliant								
3.5.6	5060	Organisations providing acute and community services and non-NHS providers must have a documented process for managing the risks associated with screening procedures	E	#N/A	#N/A	#N/A	####	#N/A										
		You must evidence monitoring of your documented process in relation to:										The assessor will select two screening-specific procedures, from the organisation's list, to assess compliance with these minimum requirements						
	256																	
	256																	
Level 1	5064	how the clinician treating the patient is informed of the result, including timescales	E	#N/A	#N/A	#N/A	####	#N/A	####	#N/A								
Level 1	5065	how the patient is informed of the result, including timescales.	E	#N/A	#N/A	#N/A	####	#N/A	####	#N/A								
	5069	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	####	#N/A	####	#N/A								
		The assessor will select two screening-specific procedures, from the organisation's list, to assess compliance with these minimum requirements																

		For the purpose of the assessment, you should provide evidence for those screening procedures you have assessed as being highest risk.											
								Compliant	#N/A	Compliant			
3.5.7	5070	Organisations providing acute and community services and non-NHS providers must have an approved documented process for managing the risks associated with diagnostic	E	#N/A	#N/A	#N/A	####	#N/A					
	257 257	You must evidence monitoring of your documented process in relation to:											The assessor will select two diagnostic test-specific documents, from the organisation's list, to assess compliance with these minimum
Level 1	5074	how the clinician treating the patient is informed of the result, including timescales	E	#N/A	#N/A	#N/A	####	#N/A	####	#N/A			
Level 1	5075	how the patient is informed of the result, including timescales.	E	#N/A	#N/A	#N/A	####	#N/A	####	#N/A			
	5079	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	####	#N/A	####	#N/A			
		The assessor will select two diagnostic test-specific documents, from the organisation's list, to assess compliance with these minimum											
		For the purpose of the assessment, you should provide evidence for those diagnostic tests you have assessed as											
								Compliant	#N/A	Compliant			
3.5.8	5080	Organisations providing acute and community services and non-NHS providers must have an approved documented process for transfusion	E	#N/A	#N/A	#N/A	####	#N/A					
		You must evidence monitoring of your documented process in relation to:											
Level 1	5082	how transfusions are administered, including patient	E	#N/A	#N/A	#N/A	####	#N/A	####	#N/A			
Level 1	5083	care of patients receiving a transfusion.	E	#N/A	#N/A	#N/A	####	#N/A	####	#N/A			
	5089	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	####	#N/A	####	#N/A			
		The assessor will look at between 10 and 30 health records in current use in order to spot check the organisation's monitoring results. This will typically be equivalent to 10%											
		If the spot check of health records does not demonstrate 75% compliance, these findings will override the evidence provided by the organisation and will result in no score being awarded for this criterion.											
								Compliant	#N/A	Compliant			
3.5.9	5090	Organisations providing acute and community services and non-NHS providers must have an approved documented process for the prevention and management of venous	E	#N/A	#N/A	#N/A	####	#N/A					
		You must evidence monitoring of your documented process in relation to:											
Level 1	5091	how patients are assessed for their risk of developing venous thromboembolism (VTE), including timescales	E	#N/A	#N/A	#N/A	####	#N/A	####	#N/A			
Level 1	5093	procedure to be followed if VTE is suspected.	E	#N/A	#N/A	#N/A	####	#N/A	####	#N/A			
	5099	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	####	#N/A	####	#N/A			
		The assessor will look at between 10 and 30 health records in current use in order to spot check the organisation's monitoring results. This will typically be equivalent to 10%											
		If the spot check of health records does not demonstrate 75% compliance, these findings will override the evidence provided by the organisation and will result in no score being awarded for this criterion.											
								Compliant	#N/A	Compliant			
3.5.10	5100	Organisations providing acute and community services and non-NHS providers must have an approved documented process for learning from	E	#N/A	#N/A	#N/A	####	#N/A					
		You must evidence monitoring of your documented process in relation to:											
Level 1	5102	how the organisation makes sure that all prescription charts are accurate	E	#N/A	#N/A	#N/A	####	#N/A	####	#N/A			
Level 1	5103	how medication errors are	E	#N/A	#N/A	#N/A	####	#N/A	####	#N/A			
	5109	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	####	#N/A	####	#N/A			
		The assessor will look at between 10 and 30 health records in current use in order to spot check the organisation's monitoring results. This will typically be equivalent to 10%											
		If the spot check of health records does not demonstrate 75% compliance, these findings will override the evidence provided by the organisation and will result in no score being awarded for this criterion.											
								Compliant	#N/A	Compliant			
								3.5.1	####		0		
								3.5.2	####		0		
								3.5.3	####		0		
								3.5.4	####		0		
								3.5.5	####		0		
								3.5.6	####		0		
								3.5.7	####		0		
								3.5.8	####		0		
								3.5.9	####		0		
								3.5.10	####		0		All Standards Total
								Total	0		0		0

Cell: B1
Comment: Admin Use Only

Cell: D1
Comment: Insert either:
E for Electronic
P for Paper
N/A for not available

Cell: G1
Comment: E.g. page number, paragraph or bullet number.
This needs to be completed in case hyperlinks do not work, and where evidence is submitted in paper form.

Cell: L1
Comment: Assessor Use Only

Cell: M1
Comment: Assessor Use Only

Cell: N1
Comment: Assessor Use Only

Cell: I99
Comment: Clinical Audit

Cell: I100
Comment: Incident Reporting

Cell: I101
Comment: Concerns/Complaints

Cell: I102
Comment: Claims

Cell: I103
Comment: Investigations

Cell: I104
Comment: Analysis

Cell: I105
Comment: Improvement

Cell: I106
Comment: Best Practice - NICE

Cell: I107
Comment: Best Practice - National Confidential Enquiries/Inquiries

Cell: I108
Comment: Being Open

NHSLA Risk Management Standards
Evidence Template

Criterion number	Index	Criterion and minimum requirements	Paper or Electronic copy	Evidence submitted	Electronic file hyperlink/name	Location of relevant information	Version / date of evidence submitted	Initials of contact name for evidence	Compliant? (Organisation)	Organisation's comments	Compliant? (Assessor)	Comment in report	Assessor's comments	Proposed future change	Rationale	Actions required to achieve compliance	Person/ committee responsible	Target date	Associated cost
3.6.1	6010	Organisations providing MH&LD services must have an approved documented process for making sure that all clinical staff receive appropriate supervision.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:																	
Level 1	6013	how the organisation makes sure that all clinical staff receive appropriate clinical supervision.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	6019	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	#N/A	Compliant									
3.6.2	6020	Organisations providing MH&LD services must have an approved documented process for managing the risks associated with patient information.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:																	
Level 1	6022	how the discussion and provision of information to patients is recorded	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	6023	archiving arrangements for any information given to patients to support their decision making.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	6029	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
		The assessor will look at between 10 and 30 health records in current use in order to spot check the organisation's monitoring results. This will typically be equivalent to 10% of all daily admission numbers.																	
		If the spot check of health records does not demonstrate 75% compliance, these findings will override the evidence provided by the organisation and will result in no score being awarded for this criterion.																	
								Compliant	#N/A	Compliant									
3.6.3	6030	Organisations providing MH&LD services must have an approved documented process for making sure that all clinical staff who undertake assessments of patients are competent in the assessment and management of clinical risk.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:																	
Level 1	6032	how the organisation trains staff, in line with in the training needs analysis	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	6033	tools and processes authorised for use within the organisation, including timescales for use.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	6039	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
		Where the monitoring has identified less than 95% completion of training, you must evidence that changes have been made to address this.																	
								Compliant	#N/A	Compliant									
3.6.4	6040	Organisations providing MH&LD services must have an approved documented process for managing the risks associated with the physical assessment and examination of patients.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:																	
Level 1	6042	physical assessment of patients when they are admitted to a service, including timeframes	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	6044	ongoing assessment of physical needs for all patients, including timeframes.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	6049	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
								Compliant	#N/A	Compliant									
3.6.5	6050	Organisations providing MH&LD services must have an approved documented process for the observation and engagement of patients.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:																	
Level 1	6052	recording observation at differing levels.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	6059	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
		The assessor will look at between 10 and 30 health records in current use in order to spot check the organisation's monitoring results. This will typically be equivalent to 10% of all daily admission numbers.																	
		If the spot check of health records does not demonstrate 75% compliance, these findings will override the evidence provided by the organisation and will result in no score being awarded for this criterion.																	
								Compliant	#N/A	Compliant									
3.6.6	6060	Organisations providing MH&LD services must have an approved documented process for addressing the needs of patients who present with a dual diagnosis of mental health problems and substance misuse.	E	#N/A	#N/A	#N/A	#N/A	#N/A											
		You must evidence monitoring of your documented process in relation to:																	
Level 1	6062	how the organisation addresses the needs of this group of patients	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
Level 1	6063	details of internal and external joint working arrangements.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									
	6069	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A									

		The assessor will look at between 10 and 30 health records in current use in order to spot check the organisation's monitoring results. This will typically be equivalent to 10% of all daily admission numbers.										
		If the spot check of health records does not demonstrate 75% compliance, these findings will override the evidence provided by the organisation and will result in no score being awarded for this criterion.										
								Compliant	#N/A	Compliant		
3.6.7	6070	Organisations providing MH&LD services must have an approved documented process for rapid tranquilisation.	E	#N/A	#N/A	#N/A	#N/A	#N/A				
		You must evidence monitoring of your documented process in relation to:										
Level 1	6072	prescribing guidelines for rapid tranquilisation	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
Level 1	6073	how observations are recorded, including timeframes when patients have received rapid tranquilisation	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
	6079	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
		The assessor will look at between 10 and 30 health records in current use in order to spot check the organisation's monitoring results. This will typically be equivalent to 10% of all daily admission numbers.										
		If the spot check of health records does not demonstrate 75% compliance, these findings will override the evidence provided by the organisation and will result in no score being awarded for this criterion.										
								Compliant	#N/A	Compliant		
3.6.8	6080	Organisations providing MH&LD services must have an approved documented process for managing the risks associated with patients who are absent without leave (AWOL).	E	#N/A	#N/A	#N/A	#N/A	#N/A				
		You must evidence monitoring of your documented process in relation to:										
Level 1	6082	what should be done when a patient absents themselves from an inpatient setting	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
Level 1	6083	what should be done when a patient fails to return from a period of leave of absence.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
	6089	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
								Compliant	#N/A	Compliant		
3.6.9	6090	Organisations providing MH&LD services must have an approved documented process which sets out the medicines management training requirements for all permanent staff.	E	#N/A	#N/A	#N/A	#N/A	#N/A				
		You must evidence monitoring of your documented process in relation to:										
Level 1	6092	how the organisation records that all permanent staff complete relevant medicines management training, in line with the training needs analysis	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
Level 1	6093	how the organisation follows up those who do not complete relevant medicines management training	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
	6099	Where the monitoring has identified less than 95% completion of training, you must evidence that changes have been made to address this.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
								Compliant	#N/A	Compliant		
3.6.10	6100	Organisations providing MH&LD services must have an approved documented process for medicines management in all care settings.	E	#N/A	#N/A	#N/A	#N/A	#N/A				
		You must evidence monitoring of your documented process in relation to:										
Level 1	6102	how the organisation makes sure that all prescription charts are accurate.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
	6109	Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.	E	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		
		The assessor will look at between 10 and 30 health records in current use in order to spot check the organisation's monitoring results. This will typically be equivalent to 10% of all daily admission numbers.										
		If the spot check of health records does not demonstrate 75% compliance, these findings will override the evidence provided by the organisation and will result in no score being awarded for this criterion.										
								Compliant	#N/A	Compliant		
								3.5.1	#N/A		0	
								3.5.2	#N/A		0	
								3.5.3	#N/A		0	
								3.5.4	#N/A		0	
								3.5.5	#N/A		0	
								3.5.6	#N/A		0	
								3.5.7	#N/A		0	
								3.5.8	#N/A		0	
								3.5.9	#N/A		0	
								3.5.10	#N/A		0	**All Standards Total**
								Total	**0**		**0**	**0**

Cell: B1
Comment: Admin Use Only

Cell: D1
Comment: Insert either:
E for Electronic
P for Paper
N/A for not available

Cell: G1
Comment: E.g. page number, paragraph or bullet number.
This needs to be completed in case hyperlinks do not work, and where evidence is submitted in paper form.

Cell: L1
Comment: Assessor Use Only

Cell: M1
Comment: Assessor Use Only

Cell: N1
Comment: Assessor Use Only

Cell: I83
Comment: Clinical Audit

Cell: I84
Comment: Incident Reporting

Cell: I85
Comment: Concerns/Complaints

Cell: I86
Comment: Claims

Cell: I87
Comment: Investigations

Cell: I88
Comment: Analysis

Cell: I89
Comment: Improvement

Cell: I90
Comment: Best Practice - NICE

Cell: I91
Comment: Best Practice - National Confidential Enquiries/Inquiries

Cell: I92
Comment: Being Open

Daily admission numbers:														
Criterion Number	Criterion	Compliant	1% of daily admission numbers	Number of Records Checked	Total Compliant	Compliance %	Record 1	Record 2	Record 3	Record 4	Record 5	Record 6	Record 7	Record 8
1.7	Health Records Management	No	0	0	0									
1.8	Health Record-Keeping Standards	No	0	0	0									
4.4	Slips, Trips & Falls (Patients)	No	0	0	0									
4.8	The Deteriorating Patient	No	0	0	0									
4.9	Clinical Handover of Care	No	0	0	0									
4.10	Discharge	No	0	0	0									
5.2	Patient Information & Consent	No	0	0	0									
5.8	Transfusion	No	0	0	0									
5.9	Venous Thromboembolism	No	0	0	0									
5.10	Medicines Management	No	0	0	0									
6.2	Patient Information	No	0	0	0									
6.5	Observation of Patients	No	0	0	0									
6.6	Dual Diagnosis	No	0	0	0									
6.7	Rapid Tranquilisation	No	0	0	0									
6.10	Medicines Management	No	0	0	0									

PHO119576-0067

		Record 30														
		Record 29														
		Record 28														
		Record 27														
		Record 26														
		Record 25														
		Record 24														
		Record 23														
		Record 22														
		Record 21														
		Record 20														
		Record 19														
		Record 18														
		Record 17														
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		Record 15														
		Record 14														
		Record 13														
		Record 12														
		Record 11														
		Record 10														
		Record 9														

Cell: C3
Comment: This will change to Yes once 75% has been reached

Cell: D3
Comment: This is calculated from the number of deliveries entered in cell C1

Cell: E3
Comment: This is just for information - doesn't affect the calculations

Cell: F3
Comment: Number compliant can be manually entered or picks up from number of 'Y' in the columns

Cell: G3
Comment: This picks up the 'Total Compliant' as a percentage of whatever 0.5% works out as

At all levels the evidence presented at assessment must be in use and reflective of day to day practice
To test this, the assessor(s) will randomly select ten documents from the organisation's evidence portfolio and ask to see evidence of their approval. Additionally, the assessor(s) will review the organisation's intranet and/or policy folders to ensure that the ten documents are readily available for use by staff.
If the organisation is unable to evidence that a document has been approved and is in use, compliance

	Name of approved document	Criterion	Format	Approval	Availability	Compliant
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
				TOTAL compliant		0

Cell: B7
Comment: The assessor will use this table to record ten documents, evidence of their approval, and that they are readily available for staff.

Allocate Software ET Extenstion
This 'spare' tab has been added to the ET for use by Allocate Software to facilitate the import of links from HealthAssure. Enal
Instructions: 1) Logon to HA and export the links to a CSV file and save locally. 2) Press CTL + SHIFT + i to import the CSV f

Filename:	[Copy of NHSLAEvidenceTemplate201213.xls]spare
ble the Web toolbar to activate the 'back' button.	
ile. 3) The ET cells will auto-populate.	