| ganisation N                 | lame:          |       |   |            |                           |                        |            |               |                                   |                 |             |              |             |            |        |
|------------------------------|----------------|-------|---|------------|---------------------------|------------------------|------------|---------------|-----------------------------------|-----------------|-------------|--------------|-------------|------------|--------|
| ISLA Membe                   | ership Number: |       |   |            |                           |                        |            |               |                                   |                 |             |              |             |            |        |
| HS or Founda                 | ation trust    |       |   |            |                           |                        |            |               |                                   | e Template      |             |              |             |            |        |
|                              |                |       |   |            |                           |                        |            |               | for u                             | se with         |             |              |             |            |        |
| ay 1 of Asses                | ssment:        |       |   |            |                           |                        | NH         | HSLA Risk N   | lanagement Sta                    | andards for Pr  | rimary Car  | e Trusts     |             |            |        |
| ay 2 of Asses                | sment:         |       |   |            |                           | -                      |            |               | 2009/1                            | 0 version       |             |              | ł           |            |        |
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| evel Applied                 | For:           |       |   |            |                           |                        |            |               |                                   |                 |             |              |             |            |        |
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| Assigned Asse                |                |       |   |            |                           | In t                   |            |               | epancy betwe                      |                 |             |              | ISLA        |            |        |
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| eman auure                   | 855            |       |   |            |                           | www.nr                 | nsia.com/F | Publications  | / Risk manager                    | nent publicatio | ons / Evide | nce remplati | 35          |            |        |
|                              |                |       |   | Data be    | elow will be populated at | utomatically from      | informatio | on entered or | n subsequent wo                   | rksheets.       |             |              |             |            |        |
|                              |                |       |   |            |                           | No. 1990 Participation |            |               |                                   |                 |             |              |             |            |        |
|                              | Standard 1     |       |   | Standa     | ard 2                     |                        | Standa     | ard 3         |                                   | Standard 4      |             | Star         | ndard 5     |            | Total  |
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| 1.4                          |                |       |   | 2.4        |                           | 3.4                    |            |               | 4.4                               |                 |             | 5.4          | +           |            |        |
| 1.5                          |                |       |   | 2.5        |                           | 3.5                    |            |               | 4.5                               |                 |             | 5.5          |             |            | 1      |
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| 1.8                          |                |       |   | 2.8<br>2.9 |                           | 3.8<br>3.9             |            |               | 4.8                               |                 |             | 5.8<br>5.9   | +           |            |        |
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## NHSLA Risk Management Standards for Primary Care Trusts Evidence Template Summary

| Summary |  |
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| post assessment Cell: B20   |
| Comment: Risk management strategy Cell: G20   |
| Comment: Corporate induction Cell: L20  |
| Comment: Secure environment   |
| Cell: Q20<br>Comment: Patient identification  |
| Cell: V20<br>Comment: Incident reporting  |
| Cell: B21<br>Comment: Policy on procedural documents  |
| Cell: G21<br>Comment: Local induction of permanent staff  |
| Cell: L21<br>Comment: Sickness absence  |
| Cell: Q21<br>Comment: Patient information   |
| Cell: V21   |
| Comment: Raising concerns Cell: 822   |
| Comment: Risk management committee(s) Cell: G22   |
| Comment: Local induction of temporary staff   |
| Cell: L22<br>Comment: Safeguarding adults   |
| Cell: Q22<br>Comment: Consent   |
| Cell: V22<br>Comment: Complaints  |
| Cell: B23<br>Comment: Risk management committee(s)  |
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| Cell: L23   |
| Comment: Moving & handling Cell: Q23  |
| Comment: Clinical record-keeping standards Cell: V23  |
| Comment: Claims Cell: B24   |
| Comment: Risk management committee(s)   |
| Cell: G24<br>Comment: Risk management training  |
| Cell: L24<br>Comment: Slips, trips & falls  |
| Cell: Q24<br>Comment: Transfer of patients  |
| Cell: V24<br>Comment: Investigations  |
| Cell: B25<br>Comment: Risk management committee(s)  |
| Cell: G25   |
| Comment: Training needs analysis Cell: L25  |
| Comment: Inoculation incidents Cell: Q25  |
| Comment: Medicines management   |
| Cell: V25<br>Comment: Analysis  |
| Cell: B26<br>Comment: Responding to external recommendations specific to the organisation   |
| Cell: G26<br>Comment: Medical devices training  |
| Cell: L26<br>Comment: Maintenance of medical devices & equipment  |
| Cell: Q26<br>Comment: Blood transfusion   |
| Cell: V26<br>Comment: Improvement   |
| Cell: B27   |
| Comment: Clinical records management Cell: G27  |
| Comment: Hand hygiene training Cell: L27  |
| Comment: Harassment & bullying  |
| Cell: Q27<br>Comment: Resussitation   |
| Cell: V27<br>Comment: Best practice - NICE  |
| Cell: B28<br>Comment: Professional clinical registration  |
| Cell: G28<br>Comment: Moving & handling training  |
| Celi: L28<br>Comment: Violence & aggression   |
| Cell: Q28<br>Comment: Infection control   |
| Cell: V28   |
| Comment: Best practice - NSFs, NCEs & High Level Enquiries Cell: B29  |
| Comment: Employment checks Cell: G29  |
| Comment: Supporting staff involved in an incident, complaint or claim   |
| Cell: L29<br>Comment: Stress  |
| Cell: Q29   |

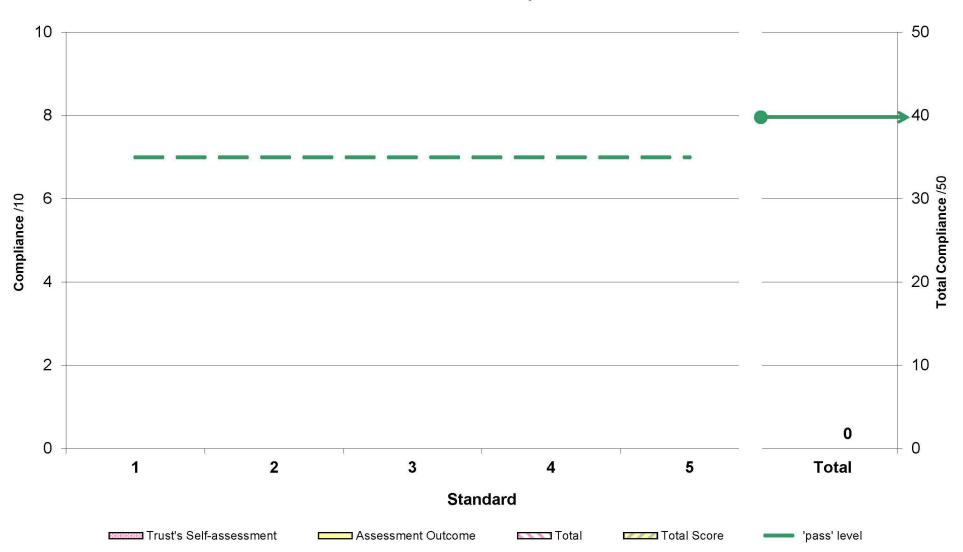
Cell: Q29

Comment: Diagnostic testing and screening procedures

Cell: V29 Comment: Being open

[Date]

## NHSLA Risk Management Standards for Acute Trusts Evidence Template



Level Summary Chart

## NHSLA Risk Management Standards for Primary Care Trusts Evidence Template Overview of Risk Areas

| Standard<br>⇔  | 1   | 2  | 3  | 4   | 5   |
|----------------|---|--|--|---|---|
| Criterion<br>₽ | Governance  | Competent & Capable Workforce                                | Safe<br>Environment                        | Clinical Care                             | Learning from Experience                          |
| 1              | Risk management strategy  | Corporate induction  | Secure environment                         | Patient identification                    | Incident reporting                                |
| 2              | Policy on procedural documents                                      | Local induction of permanent staff                           | Sickness absence                           | Patient information                       | Raising concerns                                  |
| 3              | Risk management committee(s)  | Local induction of temporary staff                           | Safeguarding adults                        | Consent                                   | Complaints  |
| 4              | Risk awareness training for senior management                       | Fitness to practice  | Moving & handling                          | Clinical record-keeping standards         | <u>Claims</u>                                     |
| 5              | Risk management process   | Risk management training                                     | Slips, trips & falls                       | Transfer of patients                      | Investigations                                    |
| 6              | Risk register   | Training needs analysis                                      | Inoculation incidents                      | Medicines management                      | Analysis  |
| 7              | Responding to external recommendations specific to the organisation | Medical devices training                                     | Maintenance of medical devices & equipment | Blood transfusion                         | Improvement                                       |
| 8              | Clinical records management   | Hand hygiene training  | Harassment & bullying                      | Resuscitation                             | Best practice - NICE                              |
| 9              | Professional clinical registration                                  | Moving & handling training                                   | Violence & aggression                      | Infection control                         | Best practice - NSFs, NCEs & High Level Enquiries |
| 10             | Employment checks   | Supporting staff involved in an incident, complaint or claim | Stress                                     | Diagnositc testing & screening procedures | Being open  |
|                |   |  |  |   |   |
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| Criterion number | Index | Criterion and minimum requirements   | aper or Electronic copy | Electronic file hyperlink/name | Document version name,<br>no. and approved and<br>review date | Initials of contact name<br>for document | Compliant?<br>(Organisation) | Reference | Organisation's comments   | Compliant? (Assessor) | Comment in Report | Assessor's comments | Proposed Future Change Rationale |
|------------------|-------|--|-------------------------|--------------------------------|---|--|------------------------------|-----------|---|-----------------------|-------------------|---------------------|----------------------------------|
|                  |       |  | Pa                      |                                | ů č   | <u> </u>                                 |                              |           |   | 0                     |                   |                     |                                  |
| 1.1.1            |       | There is an organisation-wide risk<br>management strategy which has been<br>approved by the board.   |                         |                                |   |  |                              |           |   |                       |                   |                     |                                  |
|                  |       | As a minimum, the approved<br>documentation must include a<br>description of the:  |                         |                                |   |  |                              |           |   |                       |                   |                     |                                  |
| а                |       | organisational risk management<br>structure detailing all those<br>committees/sub-committees/groups<br>which have some responsibility for risk |                         |                                |   |  | No                           |           | Risk Management Strategy and<br>Business Assurance Strategy need<br>review and currently reflect PCT<br>structure and arrangements before<br>TCS/Kaleido                  |                       |                   |                     |                                  |
| b                |       | process for board or high level<br>committee review of the organisation-<br>wide risk register   |                         |                                |   |  | No                           |           | Business Assurance Strategy needs<br>review and currently reflect PCT<br>structure and arrangements before<br>TCS/Kaleido   |                       |                   |                     |                                  |
| С                |       | process for the management of risk<br>locally, which reflects the<br>organisation-wide risk management<br>strategy                             |                         |                                |   |  | No                           |           | Risk Management Strategy needs<br>review, COR/010, COR/011 &<br>COR/006 currently reflect PCT<br>structure and arrangements before<br>TCS/Kaleido                         |                       |                   |                     |                                  |
| d                | 1014  | duties of the key individual(s) for risk<br>management activities  |                         |                                |   |  | No                           |           | Business Assurance & Risk<br>Management Strategies need review,<br>COR/010, COR/011 and COR/006<br>currently reflect PCT structure and<br>arrangements before TCS/Kaleido |                       |                   |                     |                                  |
| e                | 1015  | authority of all managers with regard to managing risk   |                         |                                |   |  | No                           |           | Business Assurance & Risk<br>Management Strategies need review,<br>COR/010, COR/011 and COR/006<br>currently reflect PCT structure and<br>arrangements before TCS/Kaleido |                       |                   |                     |                                  |
| f                |       | process for monitoring compliance with<br>all of the above.  |                         |                                |   |  | No                           |           | Business Assurance & Risk<br>Management Strategies need review,<br>COR/010, COR/011 and COR/006<br>currently reflect PCT structure and<br>arrangements before TCS/Kaleido |                       |                   |                     |                                  |
|                  |       |  |                         |                                |   | Compliant                                | No                           |           | Compliant   |                       |                   |                     |                                  |
| 1.1.2            |       | The organisation has approved<br>documentation which describes the<br>process for developing organisation-<br>wide procedural documents.       |                         |                                |   |  |                              |           |   |                       |                   |                     |                                  |
|                  |       | As a minimum, the approved<br>documentation must include a<br>description of the following<br>requirements:                                    |                         |                                |   |  |                              |           |   |                       |                   |                     |                                  |
| а                |       | style and format   |                         |                                |   |  | Yes                          |           | GOV/003 Provider Policy on Policies<br>approved Provider Committee October<br>2009  |                       |                   |                     |                                  |
| b                |       | an explanation of any terms used in documents developed  |                         |                                |   |  | Yes                          |           | GOV/003 Provider Policy on Policies<br>approved Provider Committee October<br>2009  |                       |                   |                     |                                  |
| с                | 1023  | consultation process   |                         |                                |   |  | Yes                          |           | GOV/003 Provider Policy on Policies<br>approved Provider Committee October<br>2009  |                       |                   |                     |                                  |

| d     | 1024   | ratification process  |  |           | Yes | GOV/003 Provider Policy on Policies                                      |  |  |
|-------|--------|---|--|-----------|-----|--|--|--|
|       |        |   |  |           |     | approved Provider Committee October<br>2009                              |  |  |
| е     | 1025   | review arrangements   |  |           | Yes | GOV/003 Provider Policy on Policies                                      |  |  |
|       |        |   |  |           |     | approved Provider Committee October 2009                                 |  |  |
| f     | 1026   | control of documents, including                                     |  |           | Yes | GOV/003 Provider Policy on Policies                                      |  |  |
|       |        | archiving arrangements  |  |           |     | approved Provider Committee October 2009                                 |  |  |
| g     | 1027   | associated documents  |  |           | Yes | GOV/003 Provider Policy on Policies                                      |  |  |
|       |        |   |  |           |     | approved Provider Committee October<br>2009                              |  |  |
| h     | 1027.1 | supporting references   |  |           | Yes | GOV/003 Provider Policy on Policies                                      |  |  |
|       |        |   |  |           |     | approved Provider Committee October 2009                                 |  |  |
| i     | 1028   |   |  |           | Yes | GOV/003 Provider Policy on Policies                                      |  |  |
|       |        | with all of the above.  |  |           |     | approved Provider Committee October 2009                                 |  |  |
|       |        |   |  | Compliant | Yes | Compliant  |  |  |
|       |        |   |  |           |     |  |  |  |
| 1.1.3 | 1030   | The organisation has approved terms of reference for the high level |  |           |     |  |  |  |
|       |        | committee(s) with overarching                                       |  |           |     |  |  |  |
|       |        | responsibility for risk.<br>As a minimum, the terms of reference    |  |           |     |  |  |  |
|       |        | must include a description of the:                                  |  |           |     |  |  |  |
| а     | 1031   | duties  |  |           | No  | Strategy must dictate which committee                                    |  |  |
|       |        |   |  |           |     | this is. ToR need to be prepared.  |  |  |
|       |        |   |  |           |     | Interim RM &Assurance Strategy 0910<br>to IGC in Jan'10                  |  |  |
| b     | 1032.1 | reporting arrangements to the board                                 |  |           | No  | Strategy must dictate which committee                                    |  |  |
|       |        |   |  |           |     | this is. ToR need to be prepared.<br>Interim RM &Assurance Strategy 0910 |  |  |
|       |        |   |  |           |     | to IGC in Jan'10   |  |  |
| с     | 1033   | membership, including nominated deputy where appropriate            |  |           | No  | Strategy must dictate which committee this is. ToR need to be prepared.  |  |  |
|       |        |   |  |           |     | Interim RM &Assurance Strategy 0910<br>to IGC in Jan'10                  |  |  |
| d     | 1034   | required frequency of attendance by                                 |  |           | No  | Strategy must dictate which committee                                    |  |  |
|       |        | members   |  |           |     | this is. ToR need to be prepared.<br>Interim RM &Assurance Strategy 0910 |  |  |
|       |        |   |  |           |     | to IGC in Jan'10   |  |  |
| е     | 1035   | reporting arrangements into the                                     |  |           | No  | Strategy must dictate which committee this is. ToR need to be prepared.  |  |  |
|       |        | high level committee(s)   |  |           |     | Interim RM & Assurance Strategy 0910                                     |  |  |
|       | 4000   |   |  |           | Ne  | to IGC in Jan'10   |  |  |
| T     | 1036   | requirements for a quorum   |  |           | No  | Strategy must dictate which committee this is. ToR need to be prepared.  |  |  |
|       |        |   |  |           |     | Interim RM &Assurance Strategy 0910<br>to IGC in Jan'10                  |  |  |
| g     | 1037   | frequency of meetings   |  |           | No  | Strategy must dictate which committee                                    |  |  |
|       |        |   |  |           |     | this is. ToR need to be prepared.  |  |  |
|       |        |   |  |           |     | Interim RM &Assurance Strategy 0910<br>to IGC in Jan'10                  |  |  |
| h     | 1038   |   |  |           | No  | Strategy must dictate which committee                                    |  |  |
|       |        | all of the above.   |  |           |     | this is. ToR need to be prepared.<br>Interim RM &Assurance Strategy 0910 |  |  |
|       |        |   |  |           |     | to IGC in Jan'10   |  |  |
| ļ     |        |   |  | Compliant | No  | Compliant  |  |  |
| 1.1.4 | 1041   | The organisation has approved                                       |  |           |     |  |  |  |
|       |        | documentation which describes the process for delivering risk       |  |           |     |  |  |  |
|       |        | management awareness training for all                               |  |           |     |  |  |  |
|       |        | board members, executives and senior managers.                      |  |           |     |  |  |  |
|       |        | As a minimum, the approved  |  |           |     |  |  |  |
|       |        | documentation must include a  |  |           |     |  |  |  |
|       |        | description of the process for:                                     |  |           |     |  |  |  |

| a 1042            | ensuring that all board members,<br>and senior managers receive<br>relevant risk management<br>awareness training              |   |           | No | Probably should be part of Risk<br>Management Policy which needs to be<br>updated to reflect TCS/Kaleido. TNA<br>must also reflect this.  |  |  |
|-------------------|--|---|-----------|----|---|--|--|
| b 1043            | recording attendance   |   |           | No | Probably should be part of Risk<br>Management Policy which needs to be<br>updated to reflect TCS/Kaleido. L&D<br>Policy must state these arrangements.  |  |  |
| c 1044            | following up non-attendance  |   |           | No | Probably should be part of Risk<br>Management Policy which needs to be<br>updated to reflect TCS/Kaleido. L&D<br>Policy must state these arrangements.  |  |  |
| d 1048            | monitoring compliance with all of the above.   |   |           | No | Probably should be part of Risk<br>Management Policy which needs to be<br>updated to reflect TCS/Kaleido. L&D<br>Policy must also give information for<br>this criterion.   |  |  |
|                   |  |   | Compliant | No | Compliant   |  |  |
| <b>1.1.5</b> 1051 | The organisation has approved  |   |           |    |   |  |  |
| 1.1.3             | documentation which describes the<br>organisation-wide systematic risk<br>management process.                                  |   |           |    |   |  |  |
|                   | As a minimum, the approved<br>documentation must include a<br>description of the:  |   |           |    |   |  |  |
| a 1052            | process for assessing <u>all types of</u><br><u>risk</u>   |   |           | No | Risk Management Strategy and<br>possibly Business Assurance Strategy<br>which need updating for TCS and<br>Kaleido. Draft amalgamated interim<br>0910 strategy going to IGC in Jan10.<br>COR/006 and Risk Assessment Pack.<br>Possibly COR/012 and COR/045. |  |  |
| b 1053            | process for ensuring a continual,<br>systematic approach to all risk<br>assessments is followed throughout<br>the organisation |   |           | No | Risk Management Strategy and<br>possibly Business Assurance Strategy<br>which need updating for TCS and<br>Kaleido. Draft amalgamated interim<br>0910 strategy going to IGC in Jan10.<br>COR/006 and Risk Assessment Pack.<br>Possibly COR/012 and COR/045. |  |  |
| c 1054            | assignment of management<br>responsibility for different levels of risk<br>within the organisation                             |   |           | No | Risk Management Strategy and<br>possibly Business Assurance Strategy<br>which need updating for TCS and<br>Kaleido. Draft amalgamated interim<br>0910 strategy going to IGC in Jan10.<br>COR/006 and Risk Assessment Pack.<br>Possibly COR/012 and COR/045. |  |  |
| d 1058            | process for monitoring compliance with all of the above.   |   |           | No | Risk Management Strategy and<br>possibly Business Assurance Strategy<br>which need updating for TCS and<br>Kaleido. Draft amalgamated interim<br>0910 strategy going to IGC in Jan10.<br>COR/006 and Risk Assessment Pack.<br>Possibly COR/012 and COR/045. |  |  |
|                   |  |   | Compliant | No | Compliant   |  |  |
|                   |  |   |           |    |   |  |  |
| <b>1.1.6</b> 1061 | The organisation has an approved   |   |           |    |   |  |  |
|                   | organisation-wide risk register.   | • | I         |    |   |  |  |

| 5         Model         Mod   |       |                      |   |         |       |   |  |
|---|-------|----------------------|---|---------|-------|---|--|
| Image: Section of Sectio | а     |                      | <i>limited to, incident reports, risk<br/>assessment and directorate risk<br/>registers)</i>  |         |       | possibly Business Assurance Strategy,<br>Draft amalgamated interim 0910<br>strategy going to IGC in Jan10.<br>COR/006 which need updating for<br>TCS and Kaleido. |  |
| Image: Section of the section of th | b     |                      |   |         |       | possibly Business Assurance Strategy,<br>Draft amalgamated interim 0910<br>strategy going to IGC in Jan10.<br>COR/006 which need updating for<br>TCS and Kaleido. |  |
| -       Image: Section of the comparison of           | с     | 1064                 | risk score  |         | No    | possibly Business Assurance Strategy,<br>Draft amalgamated interim 0910<br>strategy going to IGC in Jan10.<br>COR/006 which need updating for                     |  |
| a       Image: Second Strategy on the           | d     | 1065                 | summary risk treatment plan   |         | No    | possibly Business Assurance Strategy,<br>Draft amalgamated interim 0910<br>strategy going to IGC in Jan10.<br>COR/006 which need updating for                     |  |
| Image: Section of the process of present and the section of the process of present and the process of the proc | e     | 1066                 | date of review  |         | No    | possibly Business Assurance Strategy,<br>Draft amalgamated interim 0910<br>strategy going to IGC in Jan10.<br>COR/006 which need updating for                     |  |
| Image: series of the organisation has approved documentation which describes the process for preparing and responding to the recommendations and requirements arising from external agency withs, inspections and accordinates and documentation which describes the process for preparises of preparises of the preview carried out by external agency withs, inspections and accordinates and reports of a resultable individual (s) to concluse the advection of an ary review carried out by external agency with instead of a section of a section of the process for the process of the process for the process of the process for the process for the process of the process for the pro | f     | 1068                 | residual risk rating.   |         | No    | possibly Business Assurance Strategy,<br>Draft amalgamated interim 0910<br>strategy going to IGC in Jan10.<br>COR/006 which need updating for                     |  |
| a       documentation which describes the process for presenting from external agency wits, inspections and requirements asing from external agency wits, inspections and agency with agency           |       |                      |   | Complia | nt No | Compliant   |  |
| i       documentation which describes the process for presenting from stemal agency vists, inspections and requirements arising from stemal agency vists, inspections and accorditions generation must include a description of the process for the organisation.       i <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>  |       |                      |   |         |       |   |  |
| documentation must include a description of the process for:       documentation must include a description of the process for:       documentation must include a description of the process for:       documentation must include a description of the process for:       documentation must include a description of the process for:       documentation must include a description of the process for:       documentation must include a description of the process for:       documentation must include a description of the process for:       documentation must include a description of the process for:       documentation must include a description of date in Jan 2010       documentation must include a description of date in Jan 2010       documentation must include a description of date in Jan 2010       documentation must include a description date in Jan 2010       documentation must include a description date in Jan 2010       documentation must include a description date in Jan 2010       documentation must include a description date in Jan 2010       documentation must include a description date in Jan 2010       documentation must include a description date in Jan 2010       documentation must include a description date in Jan 2010       documentation must include a description date in Jan 2010       documentation must include a description date in Jan 2010       documentation must include a description date in Jan 2010       documentation date in Jan 2010       docum   | 1.1.7 |                      | documentation which describes the<br>process for preparing and responding<br>to the recommendations and<br>requirements arising from external<br>agency visits, inspections and<br>accreditations specific to the<br>organisation.      |         |       |   |  |
| Image: Individual(s) to coordinate and report on any reviews carried out by external agencies       Image: Im          |       |                      | documentation must include a description of the process for:  |         |       |   |  |
| Image: Section plans to implement any recommendations made as a result of reviews       Image: Section plans to implement any recommendations made as a result of reviews       Image: Section plans to implement any recommendations made as a result of reviews       Image: Section plans to implement any recommendations made as a result of reviews       Image: Section plans to implement any recommendations made as a result of reviews       Image: Section plans to implement any recommendations made as a result of reviews       Image: Section plans to implement any recommendations made as a result of reviews       Image: Section plans to implement any recommendations made as a result of reviews       Image: Section plans to implement any recommendations made as a result of reviews       Image: Section plans to implement any recommendations made as a result of reviews       Image: Section plans to implement any recommendations made as a result of reviews       Image: Section plans to implement any recommendations made as a result of reviews       Image: Section plans to implement any recommendations made as a result of reviews       Image: Section plans to implement any recommendations made as a result of reviews       Image: Section plans to implement any recommendation plans to implement any recommendat   | а     |                      | individual(s) to coordinate and report<br>on any reviews carried out by external  |         | No    |   |  |
| implement any recommendations<br>made as a result of reviewsimplement any recommendations<br>made as a review any recommendations   |       | 1070                 | maintaining a schedule of review dates  |         | No    |   |  |
| Image: segister is populated with risks identified from reviews       Image: segister is populated with risks identified from reviews       Image: segister is populated with risks identified from reviews       Image: segister is populated with risks identified from reviews       Image: segister is populated with risks identified from reviews       Image: segister is populated with risks identified from reviews       Image: segister is populated with risks identified from reviews       Image: segister is populated with risks identified from reviews       Image: segister is populated with risks identified from reviews       Image: segister is populated with risks identified from reviews       Image: segister is populated with risks identified from reviews       Image: segister is populated with risks identified from reviews       Image: segister is populated with risks identified from reviews       Image: segister is populated with risks identified from reviews       Image: segister is populated with risks identified from reviews       Image: segister is populated with risks identified from reviews       Image: segister is populated with risks identified from reviews       Image: segister is populated with risks identified from reviews       Image: segister is populated with risks identified from reviews       Image: segister is populated with risks identified from reviews       Image: segister is populated with risks identified from reviews       Image: segister is populated with risks identified from reviews       Image: segister is populated with risks identified from reviews       Image: segister is populated with risks identified from reviews       Image: segister is populated with risks identified from reviews       Image: segister is populated with risks   | b     | 1072                 |   |         |       |   |  |
| above. Jan 2010   |       | 1073                 | maintaining action plans to<br>implement any recommendations<br>made as a result of reviews   |         | No    | Jan 2010  |  |
| Compliant No Compliant  | C     | 1073<br>1074         | maintaining action plans to<br>implement any recommendations<br>made as a result of reviewsensuring that the organisation-wide<br>risk register is populated with risks<br>identified from reviews                                      |         | No    | Jan 2010<br>GOV/004 in place goes out of date in<br>Jan 2010  |  |
|   | c     | 1073<br>1074<br>1078 | maintaining action plans to<br>implement any recommendations<br>made as a result of reviewsensuring that the organisation-wide<br>risk register is populated with risks<br>identified from reviewsmonitoring compliance with all of the |         | No    | Jan 2010<br>GOV/004 in place goes out of date in<br>Jan 2010<br>GOV/004 in place goes out of date in  |  |

| 1.1.8 |        | The organisation has approved<br>documentation which describes the<br>process for managing the risks  |   |           |     |   |       |  |
|-------|--------|---|---|-----------|-----|---|-------|--|
|       |        | associated with clinical records in all media.  |   |           |     |   |       |  |
|       |        | As a minimum, the approved<br>documentation must include a<br>description of the:   |   |           |     |   |       |  |
| а     | 1081   | duties  |   |           | Yes | COR/022 has now been updated and<br>approved at IGC Nov'09  |       |  |
| b     | 1082   | legal obligations that apply to records   |   |           | Yes | COR/022 has now been updated and<br>approved at IGC Nov'09  |       |  |
| с     | 1083   | process for tracking records  |   |           | Yes | COR/022 has now been updated and<br>approved at IGC Nov'09  |       |  |
| d     | 1084   | process for creating records  |   |           | Yes | COR/022 has now been updated and<br>approved at IGC Nov'09  |       |  |
| е     | 1085   | process for retrieving records  |   |           | Yes | COR/022 has now been updated and  |       |  |
| f     |        | process for retaining and disposing   |   |           | Yes | approved at IGC Nov'09<br>COR/022 has now been updated and  |       |  |
| g     | 1088   | of records<br>process for monitoring compliance with  |   |           | Yes | approved at IGC Nov'09<br>COR/022 has now been updated and  |       |  |
|       |        | all of the above.   |   | Compliant | Yes | approved at IGC Nov'09<br>Compliant   |       |  |
|       |        |   |   | •         |     | · · · ·   |       |  |
| 1.1.9 |        | The organisation has approved<br>documentation which describes the<br>process for ensuring that all clinical  |   |           |     |   |       |  |
|       |        | staff (temporary and permanent) are<br>registered with the appropriate<br>professional body.  |   |           |     |   |       |  |
|       |        | As a minimum, the approved<br>documentation must include a<br>description of the:   |   |           |     |   |       |  |
| а     |        | duties, both on initial appointment and<br>ongoing thereafter   |   |           | No  | PER/004, PER/019, PER/021,<br><b>PER/022</b> , may impact on this area and<br>need review. Key policy out of date in<br>Feb 2009. PER/004 ood Oct 09. |       |  |
| b     |        | process for ensuring registration<br>checks are made directly with the<br>relevant professional body, in<br>accordance with their<br>recommendations, in respect of all<br>permanent clinical staff both on<br>initial appointment and ongoing<br>thereafter  |   |           | No  | PER/004, PER/019, PER/021,<br><b>PER/022</b> , may impact on this area and<br>need review. Key policy out of date in<br>Feb 2009. PER/004 ood Oct 09. |       |  |
| С     | 1093.1 | process for monitoring/receiving<br>assurance that registration checks<br>are being carried out by all external<br>agencies (e.g. NHS Professionals,<br>recruitment agencies, etc.) used by<br>the organisation in respect of all<br>temporary clinical staff |   |           | No  | PER/004, PER/019, PER/021,<br><b>PER/022</b> , may impact on this area and<br>need review. Key policy out of date in<br>Feb 2009. PER/004 ood Oct 09. |       |  |
| d     |        | process in place for following up those<br>permanent clinical staff who fail to<br>satisfy the validation of registration<br>process  |   |           | No  | PER/004, PER/019, PER/021,<br>PER/022, may impact on this area and<br>need review. Key policy out of date in<br>Feb 2009. PER/004 ood Oct 09.         |       |  |
| e     |        | process for monitoring compliance with<br>all of the above.   |   |           | No  | PER/004, PER/019, PER/021,<br>PER/022, may impact on this area and<br>need review. Key policy out of date in<br>Feb 2009. PER/004 ood Oct 09.         |       |  |
| I     |        |   | 1 | I         | 1   | 1   | 1 1 1 |  |
|       |        |   |   | Compliant | Ne  | Compliant   |       |  |

| 1.1.10 |      | The organisation has approved<br>documentation which describes the<br>process for ensuring that all<br>appropriate employment checks are<br>undertaken for all staff (temporary and<br>permanent).                                      |                     |                                |              |                 |           |  |   |                     |  |
|--------|------|---|---------------------|--------------------------------|--------------|-----------------|-----------|--|---|---------------------|--|
|        |      | As a minimum, the approved<br>documentation must include a<br>description of the:   |                     |                                |              |                 |           |  |   |                     |  |
| а      | 1101 | duties  |                     |                                |              |                 | No        | PER/004, PER/006, PER/019,<br>PER/021, <b>PER/022</b> , PER/036 may<br>impact on this area and need review.<br>PER/022 & PER/006 ood Feb<br>2009.PER/004 ood Oct 09. |   |                     |  |
| b      | 1102 | types of check required   |                     |                                |              |                 | No        | PER/004, PER/006, PER/019,<br>PER/021, <b>PER/022</b> , PER/036 may<br>impact on this area and need review.<br>PER/022 & PER/006 ood Feb<br>2009.PER/004 ood Oct 09. |   |                     |  |
| С      | 1103 | checking procedures   |                     |                                |              |                 | No        | PER/004, PER/006, PER/019,<br>PER/021, <b>PER/022</b> , PER/036 may<br>impact on this area and need review.<br>PER/022 & PER/006 ood Feb<br>2009.PER/004 ood Oct 09. |   |                     |  |
| d      |      | process for following up those who fail<br>to satisfy the checking arrangements   |                     |                                |              |                 | No        | PER/004, PER/006, PER/019,<br>PER/021, <b>PER/022</b> , PER/036 may<br>impact on this area and need review.<br>PER/022 & PER/006 ood Feb<br>2009.PER/004 ood Oct 09. |   |                     |  |
| e      |      | process for monitoring/receiving<br>assurance that checks are being<br>carried out by all external agencies<br>(e.g. NHS Professionals, recruitment<br>agencies, etc.) used by the<br>organisation in respect of all temporary<br>staff |                     |                                |              |                 | No        | PER/004, PER/006, PER/019,<br>PER/021, <b>PER/022</b> , PER/036 may<br>impact on this area and need review.<br>PER/022 & PER/006 ood Feb<br>2009.PER/004 ood Oct 09. |   |                     |  |
| f      |      | process for monitoring compliance with all of the above.  |                     |                                |              |                 | No        | PER/004, PER/006, PER/019,<br>PER/021, <b>PER/022</b> , PER/036 may<br>impact on this area and need review.<br>PER/022 & PER/006 ood Feb<br>2009.PER/004 ood Oct 09. |   |                     |  |
|        |      |   |                     |                                |              | Compliant       | No        | Compliant  |   |                     |  |
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|        |      |   | The following summa | ry will be populated automatic | ally from in | formation ent   | tered on  | the worksheet.   |   |                     |  |
|        |      |   |                     |                                |              | 4.4.4           |           |  |   |                     |  |
|        |      |   |                     |                                |              | 1.1.1<br>1.1.2  | No<br>Yes |  | 0 |                     |  |
|        |      |   |                     |                                |              | 1.1.2           | No        |  | 0 |                     |  |
|        |      |   |                     |                                |              | 1.1.4           | 0         |  | 0 |                     |  |
|        |      |   |                     |                                |              | 1.1.5<br>1.1.6  | No<br>No  |  | 0 |                     |  |
|        |      |   |                     |                                |              | 1.1.7           | No        |  | 0 |                     |  |
|        |      |   |                     |                                |              | 1.1.8           | Yes       |  | 0 |                     |  |
|        |      |   |                     |                                |              | 1.1.9<br>1.1.10 | No<br>No  |  | 0 | All Claudende T-t-  |  |
|        |      |   |                     |                                |              | Total           | 2         |  | 0 | All Standards Total |  |
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| Actions required to achieve compliance   | Person/<br>Committee<br>responsible | Target Date | Associated<br>Cost |      |  |  |  |      |
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|  |                                     |             |                    |      |  |  |  |      |
| Possibly joining COR/010 and COR/011, drafts on T drive at   | BS/SM/M-J                           | Mar'10      |                    | <br> |  |  |  | <br> |
| T:\shared\Portsmouth City PCT\PCT<br>Policies\Draft Policies\0910<br>IncidentPolicies  |                                     |             |                    |      |  |  |  |      |
| Possibly joining COR/010 and<br>COR/011, drafts on T drive at<br>T:\shared\Portsmouth City PCT\PCT<br>Policies\Draft Policies\0910<br>IncidentPolicies | BS/SM/M-J                           | Mar'10      |                    |      |  |  |  |      |
| Possibly joining COR/010 and<br>COR/011, drafts on T drive at<br>T:\shared\Portsmouth City PCT\PCT<br>Policies\Draft Policies\0910<br>IncidentPolicies | BS/SM/M-J                           | Mar'10      |                    |      |  |  |  |      |
| Possibly joining COR/010 and<br>COR/011, drafts on T drive at<br>T:\shared\Portsmouth City PCT\PCT<br>Policies\Draft Policies\0910<br>IncidentPolicies | BS/SM/M-J                           | Mar'10      |                    |      |  |  |  |      |
| Possibly joining COR/010 and<br>COR/011, drafts on T drive at<br>T:\shared\Portsmouth City PCT\PCT<br>Policies\Draft Policies\0910<br>IncidentPolicies | BS/SM/M-J                           | Mar'10      |                    |      |  |  |  |      |
| Possibly joining COR/010 and<br>COR/011, drafts on T drive at<br>T:\shared\Portsmouth City PCT\PCT<br>Policies\Draft Policies\0910<br>IncidentPolicies | BS/SM/M-J                           | Mar'10      |                    |      |  |  |  |      |
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| 08/09 Not currently in strategy or TOR  |  |  |  |  |  |  | 1. Martin and |
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| 08/09 Need clearer description of reporting to and from Audit Comm and Board. |  |  |  |  |  |  |   |
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| 08/09 Need clearer description of monitoring.                                 |  |  |  |  |  |  |   |
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| COR/012 needs review to ensure cross-<br>referencing to risk management  | F.Regan | Jan'10 IGC                |      |       |  |            |  |  |
| policies and correct information in<br>TNA. Needs to detail Proactive    |         |                           |      |       |  |            |  |  |
| workplace risk assessment.   |         |                           |      |       |  |            |  |  |
|  |         |                           |      |       |  |            |  |  |
| COR/012 needs review to ensure cross-                                    | F.Regan | Jan'10 IGC                |      |       |  |            |  |  |
| referencing to risk management policies and correct information in       |         |                           |      |       |  |            |  |  |
| TNA. Needs to detail Proactive workplace risk assessment.                |         |                           |      |       |  |            |  |  |
| COR/045 could benefit from clarity regarding the top level review of DSE |         | ? Not ood<br>until Aug'12 |      |       |  |            |  |  |
| assessments and whether this is<br>reported in the H&S Annual report.    |         |                           |      |       |  |            |  |  |
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| COR/012 needs review to ensure cross-<br>referencing to risk management  | F.Regan | Jan'10 IGC                |      |       |  |            |  |  |
| policies and correct information in TNA. Needs to detail Proactive       |         |                           |      |       |  |            |  |  |
| workplace risk assessment.   |         |                           |      |       |  |            |  |  |
|  |         |                           |      |       |  |            |  |  |
| COR/012 needs review to ensure cross-                                    | F.Regan | Jan'10 IGC                | <br> |       |  |            |  |  |
| referencing to risk management<br>policies and correct information in    |         |                           |      |       |  |            |  |  |
| TNA. Needs to detail Proactive workplace risk assessment.                |         |                           |      |       |  |            |  |  |
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| GOV/004 needs to be replaced with policy reflecting Provider arrangements and approved.       | SM | Jan'10 |  |  |  |  |  |  |
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| GOV/004 needs to be replaced with policy reflecting Provider arrangements and approved.       | SM | Jan'10 |  |  |  |  |  |  |
| GOV/004 needs to be replaced with<br>policy reflecting Provider arrangements<br>and approved. | SM | Jan'10 |  |  |  |  |  |  |
| GOV/004 needs to be replaced with policy reflecting Provider arrangements and approved.       |    | Jan'10 |  |  |  |  |  |  |
| GOV/004 needs to be replaced with policy reflecting Provider arrangements and approved.       | SM | Jan'10 |  |  |  |  |  |  |
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| 08/09 Improved detail and cross-<br>referencing between policies needed |      |      |      |   |  |  |  |  |       |
| against all criteria.   |      |      |      |   |  |  |  |  |       |
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Cell: B1 Comment: Admin Use Only

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Cell: L1 Comment: Assessor Use Only

Cell: M1 Comment: Assessor Use Only

Cell: N1 Comment: Assessor Use Only

Cell: H106 Comment: Risk management strategy

Cell: H107 Comment: Policy on procedural documents

Cell: H108 Comment: Risk management committee(s)

Cell: H109 Comment: Risk awareness training for senior management

Cell: H110 Comment: Risk management process

Cell: H111 Comment: Risk register

Cell: H112 Comment: Responding to external recommendations specific to the organisation

Cell: H113 Comment: Clinical records management

Cell: H114 Comment: Professional clinical registration

Cell: H115 Comment: Employment checks

| oerlink/name | Document version name<br>no. and approved and<br>review date | Initials of contact name<br>for document | Compliant?<br>(Organisation) | Reference |  |
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| Criterion number | Index | Criterion and minimum requirements   | Paper or Electronic copy<br>Name of approved document | Electronic file hyperlink/name | Document version name,<br>no. and approved and<br>review date | Initials of contact name<br>for document | Compliant?<br>(Organisation) | Reference | Organisation's comments  | Compliant? (Assessor) | Comment in Report | Assessor's comments | Proposed Future Change | Rationale |
|------------------|-------|--|---|--------------------------------|---|--|------------------------------|-----------|--|-----------------------|-------------------|---------------------|------------------------|-----------|
| 121              | 2010  | The organisation has approved  |   |                                |   |  |                              |           |  |                       |                   |                     |                        |           |
|                  |       | documentation which describes the<br>corporate induction arrangements for<br>all new permanent staff.                              |   |                                |   |  |                              |           |  |                       |                   |                     |                        |           |
|                  |       | As a minimum, the approved<br>documentation must include a<br>description of the:  |   |                                |   |  |                              |           |  |                       |                   |                     |                        |           |
|                  |       | duties   |   |                                |   |  | No                           |           | PER/026 out of date, PER/037                                   |                       |                   |                     |                        |           |
| b                |       | minimum content of the corporate induction programme(s)  |   |                                |   |  | No                           |           | PER/026 out of date, PER/037                                   |                       |                   |                     |                        |           |
| С                | 2013  | process for ensuring that all new<br>permanent staff are booked onto<br>corporate induction  |   |                                |   |  | No                           |           | PER/026 out of date, PER/037                                   |                       |                   |                     |                        |           |
| d                | 2014  | process for checking that all new<br>permanent staff complete corporate<br>induction   |   |                                |   |  | No                           |           | PER/026 out of date, PER/037                                   |                       |                   |                     |                        |           |
| e                | 2015  | process for following up those who<br>fail to attend corporate induction   |   |                                |   |  | No                           |           | PER/026 out of date, PER/037                                   |                       |                   |                     |                        |           |
| f                | 2018  | process for monitoring compliance with   |   |                                |   |  | No                           |           | PER/026 out of date, PER/037                                   |                       |                   |                     |                        |           |
|                  |       | all of the above.  |   |                                |   | Compliant                                | - No                         |           | Compliant  |                       |                   |                     |                        |           |
|                  |       |  |   |                                |   | Compliant                                |                              |           | Compilant  |                       |                   |                     |                        |           |
| 1.2.2            | 2020  | The organisation has approved<br>documentation which describes the<br>local induction arrangements for all<br>new permanent staff. |   |                                |   |  |                              |           |  |                       |                   |                     |                        |           |
|                  |       | As a minimum, the approved<br>documentation must include a<br>description of the:  |   |                                |   |  |                              |           |  |                       |                   |                     |                        |           |
| а                | 2021  | duties   |   |                                |   |  | No                           |           | PER/026 out of date, PER/037                                   |                       | Π                 |                     |                        |           |
| b                |       | minimum content of local induction programme(s)  |   |                                |   |  | No                           |           | PER/026 out of date, PER/037                                   |                       |                   |                     |                        |           |
| с                | 2023  | process for checking that all new<br>permanent staff complete local<br>induction   |   |                                |   |  | No                           |           | PER/026 out of date, PER/037                                   |                       |                   |                     |                        |           |
| d                |       | process for following up those who<br>fail to complete local induction   |   |                                |   |  | No                           |           | PER/026 out of date, PER/037                                   |                       |                   |                     |                        |           |
| е                | 2028  | process for monitoring compliance with all of the above.   |   |                                |   |  | No                           |           | PER/026 out of date, PER/037                                   |                       |                   |                     |                        |           |
|                  |       |  |   |                                |   | Compliant                                | t No                         |           | Compliant  |                       |                   |                     |                        |           |
| 1.2.3            | 2030  | The organisation has approved  |   |                                |   |  |                              |           |  |                       |                   |                     |                        |           |
|                  |       | documentation which describes the<br>local induction arrangements for all<br>temporary staff.                                      |   |                                |   |  |                              |           |  |                       |                   |                     |                        |           |
|                  |       | As a minimum, the approved<br>documentation must include a<br>description of the:  |   |                                |   |  |                              |           |  |                       |                   |                     |                        |           |
|                  |       | duties   |   |                                |   |  | No                           |           | PER/004, PER/019, <b>PER/026</b> out of date, PER/037, PER/039 |                       |                   |                     |                        |           |
| b                |       | minimum content of local induction programme(s)  |   |                                |   |  | No                           |           | PER/004, PER/019, <b>PER/026</b> out of date, PER/037, PER/039 |                       |                   |                     |                        |           |

| С     |      | process for checking that all<br>temporary staff complete local<br>induction   | No           | PER/004, PER/019, <b>PER/026</b> out of date, PER/037, PER/039 |  |
|-------|------|--|--------------|--|--|
| d     |      | process for following up those who       fail to complete local induction  | No           | PER/004, PER/019, <b>PER/026</b> out of date, PER/037, PER/039 |  |
| е     | 2038 | process for monitoring compliance with<br>all of the above.  | No           | PER/004, PER/019, <b>PER/026</b> out of date, PER/037, PER/039 |  |
|       |      |  | Compliant No | Compliant  |  |
| 121   | 2040 | The organisation has approved  |              |  |  |
| 1.2.4 |      | documentation which describes the<br>process for ensuring that the<br>organisation undertakes the<br>appropriate regulatory checks via the<br>NHSLA Family Health Services Appeal<br>Unit on all primary care performers<br>(temporary and permanent). |              |  |  |
|       |      | As a minimum, the approved<br>documentation must include a<br>description of the:  |              |  |  |
| а     |      | duties   | No           | ???? PER/004?  |  |
| b     |      | Process for ensuring checks are made   | No           | ???? PER/004?  |  |
| С     | 2043 | process for following up those who fail<br>to satisfy the checking arrangements  | No           | ???? PER/004?  |  |
| d     | 2044 | procedure for notifying the NHSLA<br>Family Health Service Appeal Unit in<br>the event of concern  | No           | ???? PER/004?  |  |
| е     |      | procedure for notification within the health community   | No           | ???? PER/004?  |  |
| f     | 2048 | process for monitoring compliance with<br>all of the above.  | No           | ???? PER/004?  |  |
|       |      |  | Compliant Nø | Compliant  |  |
| 1.2.5 | 2050 | The organisation has approved<br>documentation which describes the<br>process for ensuring a systematic<br>approach to risk management training<br>for all permanent staff.  |              |  |  |
|       |      | As a minimum, the approved<br>documentation must include a<br>description of the process for:  |              |  |  |
| а     |      | developing a training needs analysis<br>which reflects the TNA Minimum Data<br>Set   | Yes          | PER/037 and updated TNA  |  |
| b     | 2052 | developing action plan(s) to deliver the training identified within the training needs analysis  | Yes          | PER/037 and updated TNA  |  |
| С     | 2053 | developing a training prospectus to<br>reflect the training needs analysis   | Yes          | PER/037 and updated TNA  |  |
| d     | 2054 | checking that all permanent staff  | Yes          | PER/037 and updated TNA  |  |
|       |      | complete the relevant training<br>programmes in accordance with the<br>training needs analysis   |              |  |  |
|       | 2055 | programmes in accordance with the  | Yes          | PER/037 and updated TNA  |  |
|       | 2055 | programmes in accordance with the training needs analysis  | Yes          | PER/037 and updated TNA  |  |
|       | 2055 | programmes in accordance with the<br>training needs analysis<br>following up those who fail to<br>attend relevant training programmes  |              |  |  |

| 1.2.6 2060 The organisation has undertaken a                               | <u> </u>   |           |     |                          |  |   |
|--|------------|-----------|-----|--------------------------|--|---|
| training needs analysis to identify the                                    |            |           |     |                          |  |   |
| risk management training   |            |           |     |                          |  |   |
| requirements for all permanent staff                                       |            |           |     |                          |  |   |
| and documented the results.  |            |           |     |                          |  |   |
| As a minimum, the approved documentation must include:                     |            |           |     |                          |  |   |
| a 2061 a list of topics defined as risk                                    |            |           | Yes | PER/037 and updated TNA  |  |   |
| management training by the   |            |           |     |                          |  |   |
| organisation (MUST include all those                                       |            |           |     |                          |  |   |
| referred to in the NHSLA standards   |            |           |     |                          |  |   |
| TNA Minimum Data Set)  |            |           |     |                          |  |   |
| b 2062 evidence that the organisation has                                  |            |           | Yes | PER/037 and updated TNA  |  |   |
| identified which staff groups are  |            |           |     |                          |  |   |
| required to attend each type of training                                   | او         |           |     |                          |  |   |
|  | <u> </u>   | <br>      |     |                          |  |   |
| c 2063 evidence that the organisation has                                  |            |           | Yes | PER/037 and updated TNA  |  |   |
| identified the frequency of updates<br>required for each type of training. |            |           |     |                          |  |   |
|  |            | Compliant | Yes | Compliant                |  |   |
|  | + + +      | Sompliant | 100 | Compliant                |  |   |
| <b>1.2.7</b> 2070 The organisation has approved                            | <u>+ +</u> |           |     |                          |  |   |
| documentation which describes the  |            |           |     |                          |  |   |
| process for ensuring that all  |            |           |     |                          |  |   |
| permanent staff are trained to safely                                      |            |           |     |                          |  |   |
| use diagnostic and therapeutic   |            |           |     |                          |  |   |
| equipment appropriate to their role.                                       |            | _         |     |                          |  |   |
| As a minimum, the approved   |            |           |     |                          |  |   |
| documentation must include a description of the:                           |            |           |     |                          |  |   |
| a 2071 duties  | +++        | <br>-     | No  | COR/009 ood Jan 2010     |  | - |
|  |            |           |     |                          |  |   |
|  |            |           |     |                          |  |   |
|  |            |           |     |                          |  |   |
| b 2072 inventory (or links to an inventory) of                             |            |           | No  | COR/009 ood Jan 2010     |  |   |
| diagnostic and therapeutic equipment                                       |            |           |     |                          |  |   |
| used within the organisation   |            |           |     |                          |  |   |
| 2073 process for identifying which   | + + + -    | <br>      | No  | COR/009 ood Jan 2010     |  |   |
| c 2073 process for identifying which<br>permanent staff are authorised to  |            |           |     | COR/009 000 Jan 2010     |  |   |
| use the equipment identified on the  |            |           |     |                          |  |   |
| inventory  |            |           |     |                          |  |   |
| d 2074 process for determining the training                                |            |           | No  | COR/009 ood Jan 2010     |  |   |
| required to use the equipment  |            |           |     |                          |  |   |
| identified on the inventory and the  |            |           |     |                          |  |   |
| frequency of updates required  |            |           |     |                          |  |   |
|  |            |           |     |                          |  |   |
| e 2075 process for ensuring that the                                       |            |           | No  | COR/009 ood Jan 2010     |  |   |
| identified training needs of all   |            |           |     |                          |  |   |
| permanent staff are met  |            |           | Ne  |                          |  |   |
| f 2078 process for monitoring compliance with all of the above.            | ή          |           | No  | COR/009 ood Jan 2010     |  |   |
|  |            | Compliant | No  | Compliant                |  |   |
|  | + +        | Compliant |     | Compliant                |  |   |
| <b>1.2.8</b> 2080 The organisation has approved                            |            |           |     |                          |  |   |
| documentation which describes the  |            |           |     |                          |  |   |
| process for ensuring the delivery of                                       |            |           |     |                          |  |   |
| effective hand hygiene training for all                                    |            |           |     |                          |  |   |
| relevant permanent staff groups.   |            |           |     |                          |  |   |
| As a minimum, the approved   |            |           |     |                          |  |   |
| documentation must include a description of the:                           |            |           |     |                          |  |   |
| a 2081 duties  | ++         |           | Yes | INC/003                  |  |   |
|  |            |           |     |                          |  |   |
| b 2082 process for checking that all                                       |            |           | Yes | INC/003, PER/037 and TNA |  |   |
| relevant permanent staff groups, as  |            |           |     |                          |  |   |
| identified in the training needs   |            |           |     |                          |  |   |
| analysis, complete hand hygiene  |            |           |     |                          |  |   |
| training   |            |           |     |                          |  |   |
|  |            |           |     |                          |  |   |

| С           | 2083                                 | process for following up those who  |      | Yes            | INC/003, PER/037 and TNA   |  |
|-------------|--------------------------------------|---|------|----------------|--|--|
|             |                                      | fail to attend hand hygiene training  |      |                |  |  |
|             |                                      |   |      |                |  |  |
| d           | 2088                                 | process for monitoring compliance with  |      | Yes            | INC/003  |  |
|             |                                      | all of the above.   |      |                |  |  |
|             |                                      | +   |      | Compliant Yes  | Compliant  |  |
| 129         | 2090                                 | The organisation has approved   |      |                |  |  |
| 1.2.0       |                                      | documentation which describes the   |      |                |  |  |
|             |                                      | process for ensuring the delivery of  |      |                |  |  |
|             |                                      | effective moving and handling training  |      |                |  |  |
|             |                                      | to all permanent staff.<br>As a minimum, the approved   |      |                |  |  |
|             |                                      | documentation must include a  |      |                |  |  |
|             |                                      | description of the:   |      |                |  |  |
| а           | 2091                                 | duties  |      | Yes            | COR/042  |  |
|             |                                      |   |      |                |  |  |
| b           | 2092                                 | process for checking that all   | <br> | Yes            | COR/042, PER/037 and TNA   |  |
|             | 2002                                 | permanent staff, as identified in the   |      |                |  |  |
|             |                                      | training needs analysis, complete   |      |                |  |  |
|             |                                      | relevant moving and handling  |      |                |  |  |
|             |                                      | training  |      |                |  |  |
| с           |                                      | process for following up those who  |      | Yes            | COR/042, PER/037 and TNA   |  |
|             |                                      | fail to attend relevant moving and handling training  |      |                |  |  |
| d           | 2098                                 | process for monitoring compliance with  |      | Yes            | COR/042  |  |
|             |                                      | all of the above.   |      |                |  |  |
|             |                                      |   |      |                |  |  |
|             |                                      |   |      | Compliant Yes  | Compliant  |  |
| 1 2 10      | 2100                                 | The organisation has approved   |      |                |  |  |
| 1.2.10      | 12100                                |   |      |                |  |  |
|             |                                      |   |      |                |  |  |
|             |                                      | documentation which describes the process for ensuring that all staff   |      |                |  |  |
|             |                                      | documentation which describes the process for ensuring that all staff involved in traumatic/stressful   |      |                |  |  |
|             |                                      | documentation which describes the<br>process for ensuring that all staff<br>involved in traumatic/stressful<br>incidents, complaints or claims are  |      |                |  |  |
|             |                                      | documentation which describes the<br>process for ensuring that all staff<br>involved in traumatic/stressful<br>incidents, complaints or claims are<br>adequately supported.   |      |                |  |  |
|             |                                      | documentation which describes the<br>process for ensuring that all staff<br>involved in traumatic/stressful<br>incidents, complaints or claims are  |      |                |  |  |
|             |                                      | documentation which describes the<br>process for ensuring that all staff<br>involved in traumatic/stressful<br>incidents, complaints or claims are<br>adequately supported.As a minimum, the approved<br>documentation must include a<br>description of the:  |      |                |  |  |
|             |                                      | documentation which describes the<br>process for ensuring that all staff<br>involved in traumatic/stressful<br>incidents, complaints or claims are<br>adequately supported.<br>As a minimum, the approved<br>documentation must include a   |      | No             | 3.8.1 COR/011 ood Jan 2010, no   |  |
|             |                                      | documentation which describes the<br>process for ensuring that all staff<br>involved in traumatic/stressful<br>incidents, complaints or claims are<br>adequately supported.As a minimum, the approved<br>documentation must include a<br>description of the:  |      | No             | 3.8.1 COR/011 ood Jan 2010, no<br>actual staff support policy  |  |
|             |                                      | documentation which describes the<br>process for ensuring that all staff<br>involved in traumatic/stressful<br>incidents, complaints or claims are<br>adequately supported.As a minimum, the approved<br>documentation must include a<br>description of the:  |      | No             |  |  |
|             |                                      | documentation which describes the<br>process for ensuring that all staff<br>involved in traumatic/stressful<br>incidents, complaints or claims are<br>  |      | No             | actual staff support policy  |  |
| а           | 2101                                 | documentation which describes the<br>process for ensuring that all staff<br>involved in traumatic/stressful<br>incidents, complaints or claims are<br>adequately supported.As a minimum, the approved<br>documentation must include a<br>description of the:dutiesimmediate support offered to staff  |      | No No          | actual staff support policy<br>3.8.1 COR/011, no actual staff  |  |
| а           | 2101                                 | documentation which describes the<br>process for ensuring that all staff<br>involved in traumatic/stressful<br>incidents, complaints or claims are<br>  |      |                | actual staff support policy  |  |
| а           | 2101                                 | documentation which describes the<br>process for ensuring that all staff<br>involved in traumatic/stressful<br>incidents, complaints or claims are<br>adequately supported.As a minimum, the approved<br>documentation must include a<br>description of the:dutiesimmediate support offered to staff  |      |                | actual staff support policy<br>3.8.1 COR/011, no actual staff  |  |
| а           | 2101                                 | documentation which describes the<br>process for ensuring that all staff<br>involved in traumatic/stressful<br>incidents, complaints or claims are<br>  |      |                | actual staff support policy<br>3.8.1 COR/011, no actual staff  |  |
| a           | 2101                                 | documentation which describes the<br>process for ensuring that all staff<br>involved in traumatic/stressful<br>incidents, complaints or claims are<br>  |      |                | actual staff support policy<br>3.8.1 COR/011, no actual staff<br>support policy<br>3.8.1 COR/011, no actual staff  |  |
| a           | 2101                                 | documentation which describes the<br>process for ensuring that all staff<br>involved in traumatic/stressful<br>incidents, complaints or claims are<br>adequately supported.As a minimum, the approved<br>documentation must include a<br>description of the:dutiesimmediate support offered to staff<br>(internally and, if necessary,<br>externally)ongoing support offered to staff<br>(internally and, if necessary,<br>   |      | No             | actual staff support policy<br>3.8.1 COR/011, no actual staff<br>support policy  |  |
| a           | 2101                                 | documentation which describes the<br>process for ensuring that all staff<br>involved in traumatic/stressful<br>incidents, complaints or claims are<br>adequately supported.As a minimum, the approved<br>documentation must include a<br>description of the:dutiesimmediate support offered to staff<br>  |      | No             | actual staff support policy<br>3.8.1 COR/011, no actual staff<br>support policy<br>3.8.1 COR/011, no actual staff  |  |
| a           | 2101                                 | documentation which describes the<br>process for ensuring that all staff<br>involved in traumatic/stressful<br>incidents, complaints or claims are<br>adequately supported.As a minimum, the approved<br>documentation must include a<br>description of the:dutiesimmediate support offered to staff<br>(internally and, if necessary,<br>externally)ongoing support offered to staff<br>(internally and, if necessary,<br>   |      | No             | actual staff support policy<br>3.8.1 COR/011, no actual staff<br>support policy<br>3.8.1 COR/011, no actual staff  |  |
| a<br>b<br>c | 2101                                 | documentation which describes the<br>process for ensuring that all staff<br>involved in traumatic/stressful<br>incidents, complaints or claims are<br>adequately supported.As a minimum, the approved<br>documentation must include a<br>description of the:dutiesdutiesimmediate support offered to staff<br>(internally and, if necessary,<br>externally)ongoing support offered to staff<br>(internally and, if necessary,<br>externally)advice available to staff in the event of   |      | No             | actual staff support policy         3.8.1 COR/011, no actual staff         support policy         3.8.1 COR/011, no actual staff         support policy         3.8.1 COR/011, no actual staff         support policy         3.8.1 COR/011, no actual staff         support policy         3.8.1 COR/011, no actual staff   |  |
| a<br>b<br>c | 2101                                 | documentation which describes the<br>process for ensuring that all staff<br>involved in traumatic/stressful<br>incidents, complaints or claims are<br>adequately supported.As a minimum, the approved<br>documentation must include a<br>description of the:dutiesdutiesimmediate support offered to staff<br>  |      | No<br>No       | actual staff support policy<br>3.8.1 COR/011, no actual staff<br>support policy<br>3.8.1 COR/011, no actual staff<br>support policy  |  |
| a<br>b<br>c | 2101                                 | documentation which describes the<br>process for ensuring that all staff<br>involved in traumatic/stressful<br>incidents, complaints or claims are<br>adequately supported.As a minimum, the approved<br>documentation must include a<br>description of the:dutiesimmediate support offered to staff<br>(internally and, if necessary,<br>externally)ongoing support offered to staff<br>(internally and, if necessary,<br>externally)advice available to staff in the event of<br>their being called as a witness<br>(internally and, if necessary,<br>externally)   |      | No<br>No       | actual staff support policy         3.8.1 COR/011, no actual staff         support policy         3.8.1 COR/011, no actual staff         support policy         3.8.1 COR/011, no actual staff         support policy         3.8.1 COR/011, no actual staff         support policy         3.8.1 COR/011, no actual staff   |  |
| a<br>b<br>c | 2101                                 | documentation which describes the<br>process for ensuring that all staff<br>involved in traumatic/stressful<br>incidents, complaints or claims are<br>adequately supported.As a minimum, the approved<br>documentation must include a<br>description of the:dutiesdutiesimmediate support offered to staff<br>(internally and, if necessary,<br>externally)ongoing support offered to staff<br>(internally and, if necessary,<br>   |      | No<br>No       | actual staff support policy         3.8.1 COR/011, no actual staff         support policy         3.8.1 COR/011, no actual staff         support policy         3.8.1 COR/011, no actual staff         support policy         3.8.1 COR/011, no actual staff         support policy         3.8.1 COR/011, no actual staff   |  |
| a<br>b<br>c | 2101<br>2102<br>2103<br>2104         | documentation which describes the<br>process for ensuring that all staff<br>involved in traumatic/stressful<br>incidents, complaints or claims are<br>adequately supported.As a minimum, the approved<br>documentation must include a<br>description of the:dutiesimmediate support offered to staff<br>(internally and, if necessary,<br>externally)ongoing support offered to staff<br>(internally and, if necessary,<br>externally)advice available to staff in the event of<br>their being called as a witness<br>(internally and, if necessary,<br>externally)   |      | No<br>No       | actual staff support policy         3.8.1 COR/011, no actual staff         3.8.1 COR/011, no actual staff         3.8.1 COR/011, no actual staff |  |
| a<br>b<br>c | 2101<br>2102<br>2103<br>2104<br>2104 | documentation which describes the<br>process for ensuring that all staff<br>involved in traumatic/stressful<br>incidents, complaints or claims are<br>adequately supported.As a minimum, the approved<br>documentation must include a<br>description of the:dutiesdutiesimmediate support offered to staff<br>(internally and, if necessary,<br>externally)ongoing support offered to staff<br>(internally and, if necessary,<br>externally)advice available to staff in the event of<br>their being called as a witness<br>(internally and, if necessary,<br>externally)advice available to staff in the event of<br>their being called as a witness<br>(internally and, if necessary,<br>externally)action for managers or individuals<br>to take if the staff member is  |      | No<br>No<br>No | actual staff support policy         3.8.1 COR/011, no actual staff         support policy         3.8.1 COR/011, no actual staff         support policy         3.8.1 COR/011, no actual staff         support policy         3.8.1 COR/011, no actual staff         support policy  |  |
| a<br>b<br>c | 2101<br>2102<br>2103<br>2104<br>2104 | documentation which describes the<br>process for ensuring that all staff<br>involved in traumatic/stressful<br>incidents, complaints or claims are<br>adequately supported.As a minimum, the approved<br>documentation must include a<br>description of the:dutiesdutiesexternally and, if necessary,<br>externally)ongoing support offered to staff<br>(internally and, if necessary,<br>externally)advice available to staff in the event of<br>their being called as a witness<br>(internally and, if necessary,<br>externally)advice available to staff in the event of<br>their being called as a witness<br>(internally and, if necessary,<br>externally)action for managers or individuals<br>to take if the staff member is<br>experiencing difficulties associated |      | No<br>No<br>No | actual staff support policy         3.8.1 COR/011, no actual staff         3.8.1 COR/011, no actual staff         3.8.1 COR/011, no actual staff |  |
| a<br>b<br>c | 2101<br>2102<br>2103<br>2104<br>2104 | documentation which describes the<br>process for ensuring that all staff<br>involved in traumatic/stressful<br>incidents, complaints or claims are<br>adequately supported.As a minimum, the approved<br>documentation must include a<br>description of the:dutiesdutiesimmediate support offered to staff<br>(internally and, if necessary,<br>externally)ongoing support offered to staff<br>(internally and, if necessary,<br>externally)advice available to staff in the event of<br>their being called as a witness<br>(internally and, if necessary,<br>externally)advice available to staff in the event of<br>their being called as a witness<br>(internally and, if necessary,<br>externally)action for managers or individuals<br>to take if the staff member is  |      | No<br>No<br>No | actual staff support policy         3.8.1 COR/011, no actual staff         3.8.1 COR/011, no actual staff         3.8.1 COR/011, no actual staff |  |

| f 2108 process for monitoring compliance with all of the above. |  |               | No        |             | 3.8.1 COR/011, no actual staff support policy |   |                     |
|---|--|---------------|-----------|-------------|---|---|---------------------|
|   |  | Compliant     | No        |             | Compliant                                     |   |                     |
|   |  |               |           |             |   |   |                     |
|   |  |               |           |             |   | l |                     |
| The following sumn  | ary will be populated automatically from i | nformation er | ntered or | n the works | heet.   |   |                     |
|   |  |               |           |             |   |   |                     |
|   |  | 1.2.1         | No        |             |   | 0 |                     |
|   |  | 1.2.2         | No        |             |   | 0 |                     |
|   |  | 1.2.3         | No        |             |   | 0 |                     |
|   |  | 1.2.4         | No        |             |   | 0 |                     |
|   |  | 1.2.5         | No        |             |   | 0 |                     |
|   |  | 1.2.6         | Yes       |             |   | 0 |                     |
|   |  | 1.2.7         | No        |             |   | 0 |                     |
|   |  | 1.2.8         | Yes       |             |   | 0 |                     |
|   |  | 1.2.9         | Yes       |             |   | 0 |                     |
|   |  | 1.2.10        | No        |             |   | 0 | All Standards Total |
|   |  | Total         | 3         |             |   | 0 | 0                   |

| Actions required to achieve originates       Teget Lase       Associated Cool       Image: Cool <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th>   |  |           |             |   |  |  |  |  |  |
|---|--|-----------|-------------|---|--|--|--|--|--|
| responsibilities       Image: Content of Iocal induction in policy.       Image: Content of Iocal induction content of Iocal induction checkling return of all local induction checklists including a monthly exception report       Image: Content of Iocal induction content of Iocal induction checklists including a monthly exception report       Image: Content of Iocal induction content of Iocal induction checklists including a monthly exception report       Image: Content of Iocal induction checklists including a monthly exception report       Image: Content of Iocal induction checklists including a monthly exception report       Image: Content of Iocal induction checklists including a monthly exception report       Image: Content of Iocal induction checklists including a monthly exception report       Image: Content of Iocal induction content       Image: Content of Iocal induction checklists including a monthly exception report       Image: Content of Iocal induction content                          | Actions required to achieve<br>compliance  | Committee | Target Date |   |  |  |  |  |  |
| responsibilities       Image: Content of Iocal induction in policy.       Image: Content of Iocal induction content of Iocal induction checkling return of all local induction checklists including a monthly exception report       Image: Content of Iocal induction content of Iocal induction checklists including a monthly exception report       Image: Content of Iocal induction content of Iocal induction checklists including a monthly exception report       Image: Content of Iocal induction checklists including a monthly exception report       Image: Content of Iocal induction checklists including a monthly exception report       Image: Content of Iocal induction checklists including a monthly exception report       Image: Content of Iocal induction checklists including a monthly exception report       Image: Content of Iocal induction content       Image: Content of Iocal induction checklists including a monthly exception report       Image: Content of Iocal induction content                          |  |           |             | 1 |  |  |  |  |  |
| responsibilities       Image: Content of Iocal induction in policy.       Image: Content of Iocal induction content of Iocal induction checkling return of all local induction checklists including a monthly exception report       Image: Content of Iocal induction content of Iocal induction checklists including a monthly exception report       Image: Content of Iocal induction content of Iocal induction checklists including a monthly exception report       Image: Content of Iocal induction checklists including a monthly exception report       Image: Content of Iocal induction checklists including a monthly exception report       Image: Content of Iocal induction checklists including a monthly exception report       Image: Content of Iocal induction checklists including a monthly exception report       Image: Content of Iocal induction content       Image: Content of Iocal induction checklists including a monthly exception report       Image: Content of Iocal induction content                          |  |           |             |   |  |  |  |  |  |
| responsibilities       Image: Content of Iocal induction in policy.       Image: Content of Iocal induction content of Iocal induction checkling return of all local induction checklists including a monthly exception report       Image: Content of Iocal induction content of Iocal induction checklists including a monthly exception report       Image: Content of Iocal induction content of Iocal induction checklists including a monthly exception report       Image: Content of Iocal induction checklists including a monthly exception report       Image: Content of Iocal induction checklists including a monthly exception report       Image: Content of Iocal induction checklists including a monthly exception report       Image: Content of Iocal induction content       Image: Content of Iocal                            |  |           |             |   |  |  |  |  |  |
| responsibilities       Image: Content of Iocal induction in policy.       Image: Content of Iocal induction content of Iocal induction checkling return of all local induction checklists including a monthly exception report       Image: Content of Iocal induction content of Iocal induction checklists including a monthly exception report       Image: Content of Iocal induction content of Iocal induction checklists including a monthly exception report       Image: Content of Iocal induction checklists including a monthly exception report       Image: Content of Iocal induction checklists including a monthly exception report       Image: Content of Iocal induction checklists including a monthly exception report       Image: Content of Iocal induction content       Image: Content of Iocal                            |  |           |             |   |  |  |  |  |  |
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| 08/09 Detail content of local induction<br>in policy.       Image: Content of local induction<br>checking return of all local induction content   |  |           |             |   |  |  |  |  |  |
| checking return of all local induction       amonthly         ckecking return of all local induction       checklists including a monthly         08/09 Review arrangements for       checklists including a monthly         checklists including a monthly       exception report         08/09 Provide clarity on monitoring       arrangements   | 08/09 Detail content of local induction  |           |             |   |  |  |  |  |  |
| checking return of all local induction   checklists including a monthly   exception report   08/09 Provide clarity on monitoring   arrangements   | checking return of all local induction<br>checklists including a monthly<br>exception report |           |             |   |  |  |  |  |  |
| arrangements       Image: Constraint of the policies, clarify duties for PER/019       Image: Constraint of the policies, clarify duties for PER/019       Image: Constraint of the policies, clarify duties for PER/019       Image: Constraint of the policies, clarify duties for PER/019       Image: Constraint of the policies, clarify duties for PER/019       Image: Constraint of the policies, clarify duties for PER/019       Image: Constraint of the policies, clarify duties for PER/019       Image: Constraint of the policies, clarify duties for PER/019       Image: Constraint of the policies, clarify duties for PER/019       Image: Constraint of the policies, clarify duties for PER/019       Image: Constraint of the policies, clarify duties for PER/019       Image: Constraint of the policies, clarify duties for PER/019       Image: Constraint of the policies, clarify duties for PER/019       Image: Constraint of the policies, clarify duties for PER/019       Image: Constraint of the policies, clarify duties for PER/019       Image: Constraint of the policies, clarify duties for PER/019       Image: Constraint of the policies, clarify duties for PER/019       Image: Constraint of the policies, clarify duties for PER/019       Image: Constraint of the policies, clarify duties for PER/019       Image: Constraint of the policies, clarify duties for PER/019       Image: Constraint of the policies, clarify duties for PER/019       Image: Constraint of the policies, clarify duties for PER/019       Image: Constraint of the policies, clarify duties for PER/019       Image: Constraint of the policies, clarify duties for PER/019       Image: Constraint of the policies, clarify duties for PER/019       Image: Constraint of the policies, clarify duties for PER/019< | checking return of all local induction<br>checklists including a monthly                     |           |             |   |  |  |  |  |  |
| other policies, clarify duties for       PER/019         08/09 Detail local induction content       Image: Clarify duties for   | 08/09 Provide clarity on monitoring  |           |             |   |  |  |  |  |  |
| other policies, clarify duties for       PER/019         08/09 Detail local induction content       Image: Clarify duties for   |  |           |             |   |  |  |  |  |  |
| other policies, clarify duties for       PER/019         08/09 Detail local induction content       Image: Clarify duties for   |  |           |             |   |  |  |  |  |  |
| other policies, clarify duties for       PER/019         08/09 Detail local induction content       Image: Clarify duties for   |  |           |             |   |  |  |  |  |  |
| other policies, clarify duties for       PER/019         08/09 Detail local induction content       Image: Clarify duties for   |  |           |             |   |  |  |  |  |  |
|   | other policies, clarify duties for   |           |             |   |  |  |  |  |  |
|   |  |           |             |   |  |  |  |  |  |

| 08/09 Clarify monitoring compliance<br>arrangements         |    |                  |   |   |       |   |   |   |   |   |
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| 08/09 Investigate this to understand requirements.          |    |                  |   |   |       |   |   |   |   |   |
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|   |    |                  |   |   |       |   |   |   |   |   |
| TNA is currently being<br>separated.Needs to cross ref Risk | AA | ?? Ood<br>Mar'12 |   |   |       |   |   |   |   |   |
| Man & H&S Policies<br>TNA is currently being separated.     | AA | ?? Ood           |   |   |       |   |   |   |   |   |
|   |    | Mar'12           |   |   |       |   |   |   |   |   |
| Training calendar may need clear<br>Prov/Comm split         | AA | ?? Ood<br>Mar'12 |   |   |       |   |   |   |   |   |
| Managers/staff responsibility under<br>PER/037, clarify?    | AA | ?? Ood<br>Mar'12 |   |   |       |   |   |   |   |   |
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| Ensure monitoring is auditable.                             | AA | ?? Ood<br>Mar'12 |   |   |       |   |   |   |   |   |
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| TNA is currently being   | AA          | ?? Ood |  |  |                               |  |      |   |
| separated.Needs to cross ref Risk<br>Man & H&S Policies            |             | Mar'12 |  |  |                               |  |      |   |
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| COR/009 needs to be updated looking at suitable arrangements for   | BS/MT/SM/JH | Feb'10 |  |  |                               |  |      |   |
| local inventories and a central record.<br>Needs to be reapproved. |             |        |  |  |                               |  |      |   |
|  |             |        |  |  |                               |  |      |   |
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| 08/09 Clearer detail required in policy                            |             |        |  |  |                               |  |      |   |
| 08/09 Clearer detail required in policy                            |             |        |  |  |                               |  |      |   |
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| 08/09 Clearer detail required in policy  |           |                  |  |  |  |  |  |
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| 08/09 Clearer detail required in policy  |           |                  |  |  |  |  |  |
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| COR/042 need to fornalise the<br>'generic' M&H assessments for wards<br>etc.   | BS        | ?? Ood<br>Jan'12 |  |  |  |  |  |
| COR/042 need to fornalise the<br>'generic' M&H assessments for wards<br>etc.   |           | ?? Ood<br>Jan'12 |  |  |  |  |  |
| COR/042 need to fornalise the<br>'generic' M&H assessments for wards<br>etc.   |           | ?? Ood<br>Jan'12 |  |  |  |  |  |
| COR/042 need to fornalise the<br>'generic' M&H assessments for wards<br>etc.   |           | ?? Ood<br>Jan'12 |  |  |  |  |  |
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|  |           |                  |  |  |  |  |  |
| Possibly joining COR/010 and<br>COR/011, drafts on T drive at<br>T:\shared\Portsmouth City PCT\PCT<br>Policies\Draft Policies\0910<br>IncidentPolicies | BS/SM/M-J | Dec'09           |  |  |  |  |  |
| Possibly joining COR/010 and<br>COR/011, drafts on T drive at<br>T:\shared\Portsmouth City PCT\PCT<br>Policies\Draft Policies\0910<br>IncidentPolicies | BS/SM/M-J | Dec'09           |  |  |  |  |  |
| Possibly joining COR/010 and<br>COR/011, drafts on T drive at<br>T:\shared\Portsmouth City PCT\PCT<br>Policies\Draft Policies\0910<br>IncidentPolicies | BS/SM/M-J | Dec'09           |  |  |  |  |  |
| Possibly joining COR/010 and<br>COR/011, drafts on T drive at<br>T:\shared\Portsmouth City PCT\PCT<br>Policies\Draft Policies\0910<br>IncidentPolicies | BS/SM/M-J | Dec'09           |  |  |  |  |  |
| Possibly joining COR/010 and<br>COR/011, drafts on T drive at<br>T:\shared\Portsmouth City PCT\PCT<br>Policies\Draft Policies\0910<br>IncidentPolicies | BS/SM/M-J | Dec'09           |  |  |  |  |  |

| Possibly joining COR/010 and<br>COR/011, drafts on T drive at<br>T:\shared\Portsmouth City PCT\PCT<br>Policies\Draft Policies\0910<br>IncidentPolicies | BS/SM/M-J | Dec'09 |  |   |  |   |  |   |
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Cell: B1 Comment: Admin Use Only

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

Cell: L1 Comment: Assessor Use Only

Cell: M1 Comment: Assessor Use Only

Cell: N1 Comment: Assessor Use Only

Cell: H98 Comment: Corporate induction

Cell: H99 Comment: Local induction of permanent staff

Cell: H100 Comment: Local induction of temporary staff

Cell: H101 Comment: Fitness to practice

Cell: H102 Comment: Risk management training

Cell: H103 Comment: Training needs analysis

Cell: H104 Comment: Medical devices training

Cell: H105 Comment: Hand hygiene training

Cell: H106 Comment: Moving & handling training

Cell: H107

Comment: Supporting staff involved in an incident, complaint or claim

| x       Criterion and minimum requirements       0       Description       Name of approved document       Electronic file hyperlink/name       Description       Reference       Organisation's comments       Y       H       Assessor's comments  | Image: Proposed Future Change       Rationale         Image: Proposed Future Change       Rationale         Image: Proposed Future Change       Image: Proposed Future Change         Image: Proposed Future Change       Image: Proposed Future Change |
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| documentation which describes the process for managing the risks associated with the physical security of premises and other assets.       documentation which describes the proved documentation must include a description of the:       As a minimum, the approved documentation must include a description of the:       No       COR/025 cod Jan 2010       documentation must include a description of the:         a       3011       duties       duties       No       COR/025 cod Jan 2010, no lockdown risk profile for each organisational site or other specific building/area       No       COR/025 cod Jan 2010, no lockdown policy       documentation and a sets         c       3013       requirement to undertake a lockdown regaring the physical security of premises and assets       No       COR/025 cod Jan 2010, no lockdown policy       documentation and site or other specific building/area         d       3013       requirement to undertake a lockdown regaring the physical security of premises and assets       No       COR/025 cod Jan 2010       documentation and security of premises and assets  |   |
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| a       risk profile for each organisational site or other specific building/area       a       a       b <td></td>  |   |
| Image: since in the specific building/areaImage: specific building/areaIma  |   |
| appropriate risk assessments<br>regarding the physical security of<br>premises and assets       appropriate risk assessments         d       3014         arrangements for the organisational<br>overview of the risk assessments  |   |
| overview of the risk assessments   |   |
| premises and assets  |   |
| e       3018       process for monitoring compliance with all of the above.       all of the above.       No       No       COR/025 ood Jan 2011, no       Image: No       <   |   |
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| 1.3.2       3020       The organisation has approved documentation which describes the process for managing the risks associated with sickness absences.       Image: Constant of the process for managing the risks associated with sickness absences.       Image: Constant of the process for managing the risks associated with sickness absences.       Image: Constant of the process for managing the risks associated with sickness absences.       Image: Constant of the process for managing the risks associated with sickness absences.       Image: Constant of the process for managing the risks associated with sickness absences.       Image: Constant of the process for managing the risks associated with sickness absences.       Image: Constant of the process for managing the risks associated with sickness absences.       Image: Constant of the process for managing the risks associated with sickness absences.       Image: Constant of the process for managing the risks associated with sickness absences.       Image: Constant of the process for managing the risks associated with sickness absences.       Image: Constant of the process for managing the risks associated with sickness absences.       Image: Constant of the process for managing the risks associated with sickness absences.       Image: Constant of the process for managing the risks associated with sickness absences.       Image: Constant of the process for managing the risks associated with sickness absences.       Image: Constant of the process for managing the risks associated with sickness absences.       Image: Constant of the process for managing the risks associated with sickness absences.       Image: Constant of the process for managing the risks associated with sickness absences.       Image: Constant of the process for managing the risks associa  |   |
| As a minimum, the approved       As a minimum, the approved       Image: Comparison of the comparison of th  |   |
| a 3021 duties No PER/009 ood, PER/027 0 0  |   |
| b 302 process for maintaining contact with absent employees contac |   |
| c 3023 planning and facilitating return to work plans PER/009 ood, PER/027   |   |
| d       3024 planning and undertaking workplace controls or adjustments       planning and undertaking workplace       No       No       PER/009 ood, PER/027       Image: Control or adjustment set of the set of t  |   |
| e 3025 process for analysing sickness absence data   |   |
| f       3026       arrangements for the organisational overview of sickness absence       No       No       PER/009 ood, PER/027       Image: No       I   |   |
| g 3028 process for monitoring compliance with all of the above.  |   |
| Compliant Compliant Compliant  |   |
|  |   |

| 1.3.3 | 3030 | The organisation has approved  |                                       |   |           |       |      |                          |      |
|-------|------|--|---------------------------------------|---|-----------|-------|------|--------------------------|------|
|       |      | documentation which describes the  |                                       |   |           |       |      |                          |      |
|       |      | process for managing the risks   |                                       |   |           |       |      |                          |      |
|       |      | associated with safeguarding adults.   |                                       |   |           |       |      |                          |      |
|       |      | As a minimum, the approved   |                                       |   |           |       |      |                          |      |
|       |      | documentation must include a   |                                       |   |           |       |      |                          |      |
|       |      | description of the:  |                                       |   |           |       |      |                          |      |
| а     |      | duties   |                                       |   |           | Yes   |      | COR/033                  |      |
|       |      | local arrangements for managing  |                                       |   |           | Yes   |      | COR/033                  |      |
| 2     |      | the risks associated with  |                                       |   |           |       |      |                          |      |
|       |      |  |                                       |   |           |       |      |                          |      |
|       |      | safeguarding adults  | <br>/                                 |   |           | Vee   |      |                          | <br> |
| С     |      | organisation's expectations in relation  |                                       |   |           | Yes   |      | COR/033, PER/037 and TNA |      |
|       |      | to staff training, as identified in the  |                                       |   |           |       |      |                          |      |
|       |      | training needs analysis  | <br>                                  |   |           | Maria |      | 00.0/000                 | <br> |
| d     |      | process for monitoring compliance with   |                                       |   |           | Yes   |      | COR/033                  |      |
|       |      | all of the above.  |                                       |   |           |       |      |                          |      |
|       |      |  |                                       |   | Compliant | Yes   |      | Compliant                |      |
|       |      |  |                                       |   |           | ***** |      |                          |      |
| 1.3.4 |      | The organisation has approved  |                                       |   |           |       |      |                          |      |
|       |      | documentation which describes the  |                                       |   |           |       |      |                          |      |
|       |      | process for managing the risks   |                                       |   |           |       |      |                          |      |
|       |      | associated with moving and handling.   |                                       |   |           |       |      |                          |      |
|       |      |  |                                       |   |           |       |      |                          |      |
|       |      | As a minimum, the approved   |                                       |   |           |       |      |                          |      |
|       |      | documentation must include a   |                                       |   |           |       |      |                          |      |
|       |      | description of the:  |                                       |   |           |       |      |                          |      |
| а     |      | duties   |                                       |   |           | Yes   |      | COR/042                  |      |
| -     |      |  |                                       |   |           |       |      |                          |      |
|       |      |  |                                       |   |           |       |      |                          |      |
| b     | 3042 | techniques to be used in the moving  |                                       |   |           | Yes   |      | COR/042                  |      |
| 2     |      | and handling of patients and objects,  |                                       |   |           |       |      |                          |      |
|       |      | including the use of appropriate   |                                       |   |           |       |      |                          |      |
|       |      | equipment  |                                       |   |           |       |      |                          |      |
| с     |      | arrangements for access to   |                                       |   | + +       | Yes   |      | COR/042                  |      |
| C     |      | appropriate specialist advice  |                                       |   |           | 165   | l l` |                          |      |
|       |      | appropriate specialist advice  |                                       |   |           |       |      |                          |      |
|       |      |  |                                       |   |           |       |      |                          |      |
|       |      |  |                                       |   |           |       |      |                          |      |
| 4     | 2044 |  |                                       |   |           | Yes   |      | COR/042                  | <br> |
| d     |      | requirement to undertake   |                                       |   |           | res   |      | COR/042                  |      |
|       |      | appropriate risk assessments for the   |                                       |   |           |       |      |                          |      |
|       |      | moving and handling of patients  |                                       |   |           |       |      |                          |      |
|       |      | and objects  |                                       |   |           |       |      |                          |      |
| е     | 3045 | arrangements for the organisational  |                                       |   |           | Yes   |      | COR/042                  |      |
|       |      | overview of the risk assessments for   |                                       |   |           |       |      |                          |      |
|       |      | the moving and handling of patients  |                                       |   |           |       |      |                          |      |
|       |      | and objects  |                                       |   |           |       |      |                          |      |
|       |      |  |                                       |   |           |       |      |                          |      |
| f     | 3048 | process for monitoring compliance with   | 1 1                                   | 1 | 1 1       | Yes   |      | COR/042                  |      |
|       |      | all of the above.  |                                       |   |           |       | l l  |                          |      |
|       |      |  |                                       |   |           |       |      |                          |      |
| ļ     |      |  |                                       |   | Compliant | Yes   |      | Compliant                |      |
|       |      |  |                                       |   | Sompliant | 100   |      | Compliant                |      |
| 125   | 3050 | The organisation has approved  |                                       |   |           |       |      |                          |      |
| 1.3.3 |      | documentation which describes the  |                                       |   |           |       |      |                          |      |
|       |      | A TELEVISION OF A DECEMPTING AND A DECEMPT |                                       |   |           |       |      |                          |      |
|       |      | process for managing the risks<br>associated with slips, trips and falls   |                                       |   |           |       |      |                          |      |
|       |      | involving patients, staff and others.  |                                       |   |           |       |      |                          |      |
|       |      |  |                                       |   |           |       |      |                          |      |
|       |      | As a minimum, the approved   |                                       |   |           |       |      |                          |      |
|       |      | documentation must include a   |                                       |   |           |       |      |                          |      |
|       |      | description of the:  |                                       |   |           |       |      |                          |      |
| а     | 3051 | duties   |                                       |   |           | No    |      | COR/043 ood Jan 2010     |      |
|       |      |  |                                       |   |           |       |      |                          |      |
|       |      |  |                                       |   |           |       |      |                          |      |
| b     |      | requirement to undertake   |                                       |   |           | No    |      | COR/043 ood Jan 2010     |      |
|       |      | appropriate risk assessments for the   |                                       |   |           |       |      |                          |      |
|       |      | management of slips, trips and falls   |                                       |   |           |       |      |                          |      |
|       |      | involving patients (including falls  |                                       |   |           |       |      |                          |      |
|       |      | from height)   |                                       |   |           |       |      |                          |      |
|       | 1    |  | · · · · · · · · · · · · · · · · · · · | 1 | 1         | . 1   |      |                          |      |

| С     |      | requirement to undertake<br>appropriate risk assessments for the<br>management of slips, trips and falls<br>involving staff and others (including<br>falls from height)                  |  | No           | C  | OR/043 ood Jan 2010                    |  |  |
|-------|------|--|--|--------------|----|--|--|--|
| d     |      | organisation's expectations in relation<br>to staff training, as identified in the<br>training needs analysis  |  | No           |    | OR/043 ood Jan 2010, PER/037<br>nd TNA |  |  |
| e     |      | process for raising awareness about<br>preventing and reducing the number<br>of slips, trips and falls involving<br>patients, staff and others   |  | No           | C  | OR/043 ood Jan 2010                    |  |  |
| f     |      | process for monitoring compliance with all of the above.   |  | No           |    | OR/043 ood Jan 2010                    |  |  |
|       |      |  |  | Compliant No |    | Compliant                              |  |  |
| 1.3.6 |      | The organisation has approved<br>documentation which describes the<br>process for managing the risks<br>associated with inoculation incidents.   |  |              |    |  |  |  |
|       |      | As a minimum, the approved<br>documentation must include a<br>description of the:  |  |              |    |  |  |  |
| а     |      | duties   |  | No           | C  | OR/041                                 |  |  |
| b     |      | reporting arrangements in relation to inoculation incidents  |  | No           | c  | OR/041                                 |  |  |
| с     | 3063 | process for the management of an<br>inoculation incident (including<br>prophylaxis)  |  | Yes          | C  | OR/041                                 |  |  |
| d     | 3065 | organisation's requirements in relation<br>to staff training, as identified in the<br>training needs analysis  |  | Yes          | C  | OR/041, PER/037 and TNA                |  |  |
| е     | 3068 | process for monitoring compliance with all of the above.   |  | No           | C  | OR/041                                 |  |  |
|       |      |  |  | Compliant No |    | Compliant                              |  |  |
|       |      |  |  |              |    |  |  |  |
| 1.3.7 |      | The organisation has approved<br>documentation which describes the<br>process for managing the risks<br>associated with the maintenance of<br>reusable medical devices and<br>equipment. |  |              |    |  |  |  |
|       |      | As a minimum, the approved<br>documentation must include a<br>description of the:  |  |              |    |  |  |  |
| а     | -    | duties   |  | Yes          | IN | IC/009 & COR/009                       |  |  |
| b     |      | requirement to have a systematic<br>inventory of all reusable medical<br>devices and equipment used within the<br>organisation   |  | Yes          |    | IC/009 & COR/009                       |  |  |
| С     | 3073 | process for ensuring that all<br>reusable medical devices and<br>equipment are properly maintained<br>and repaired   |  | Yes          |    | C/009 & COR/009                        |  |  |
| d     | 3074 | process for checking that calibration of<br>all reusable medical devices are<br>completed within the specified time<br>frames  |  | Yes          |    | IC/009 & COR/009                       |  |  |
| е     |      | process for monitoring compliance with all of the above.   |  | Yes          | IN | IC/009 & COR/009                       |  |  |
|       |      |  |  |              |    |  |  |  |

|        |  | Compliant | Yes        | Compliant                |  |
|--------|--|-----------|------------|--------------------------|--|
| 1.3.8  | 3080 The organisation has approved<br>documentation which describes the<br>process for managing the risks<br>associated with the harassment and/or<br>bullying of staff.                     |           |            |                          |  |
|        | As a minimum, the approved<br>documentation must include a<br>description of the:  |           | Vac        | PER/010                  |  |
| b      | 3081       duties         3082       statement by the organisation that<br>harassment and/or bullying are not<br>acceptable  |           | Yes<br>Yes | PER/010                  |  |
|        | 3083 process for raising concerns about harassment and/or bullying   |           | Yes        | PER/010                  |  |
|        | 3084       process to be followed once a concern has been raised   |           | Yes        | PER/010                  |  |
|        | 3085 organisation's requirements in relation<br>to staff training, as identified in the<br>training needs analysis   |           | Yes        | PER/010, PER/037 and TNA |  |
| f      | 3088 process for monitoring compliance with all of the above.  |           | Yes        | PER/010                  |  |
|        |  | Compliant | Yes        | Compliant                |  |
| 1.3.9  | 3090 The organisation has approved<br>documentation which describes the<br>process for managing the risks<br>associated with the prevention and<br>management of violence and<br>aggression. |           |            |                          |  |
|        | As a minimum, the approved<br>documentation must include a<br>description of the:  |           |            |                          |  |
|        | 3091 duties  |           | Yes        | PER/010                  |  |
| b      | 3092 requirement to undertake<br>appropriate risk assessments for the<br>prevention and management of<br>violence and aggression   |           | Yes        | PER/010                  |  |
| с      | <sup>3093</sup> arrangements for ensuring the safety of lone workers   |           | Yes        | PER/010                  |  |
|        | 3094 organisation's expectations in relation<br>to staff training, as identified in the<br>training needs analysis   |           | Yes        | PER/010, PER/037 and TNA |  |
| е      | 3098 process for monitoring compliance with all of the above.  |           | Yes        | PER/010                  |  |
|        |  | Compliant | Yes        | Compliant                |  |
| 1.3.10 | 3100 The organisation has approved<br>documentation which describes the<br>process for managing the risks<br>associated with work-related stress.  |           |            |                          |  |
|        | As a minimum, the approved<br>documentation must include a<br>description of the:  |           |            |                          |  |
|        | 3111 duties  |           | Yes        | PER/027 and PER/009 ood  |  |
|        | 3112 process for accessing information on the management of work-related stress  |           | Yes        | PER/027 and PER/009 ood  |  |
|        | <sup>3113</sup> process for identifying workplace<br>stressors   |           | Yes        | PER/027 and PER/009 ood  |  |
| d      | 3114 requirement to undertake<br>appropriate risk assessments for the<br>prevention and management of<br>work-related stress   |           | Yes        | PER/027 and PER/009 ood  |  |
| е      | 3118 process for monitoring compliance with all of the above.  |           | Yes        | PER/027 and PER/009 ood  |  |
|        |  | Compliant | Yes        | Compliant                |  |
|        |  |           |            |                          |  |

## NHSLA Risk Management Standards for Primary Care Trusts Evidence Template 1.3.

| The following s | ummary will be populated automatically from information en | tered on | the worksheet. |   |                     |
|-----------------|--|----------|----------------|---|---------------------|
|                 |  |          |                |   |                     |
|                 | 1.3.1  | No       |                | 0 |                     |
|                 | 1.3.2  | No       |                | 0 |                     |
|                 | 1.3.3  | Yes      |                | 0 |                     |
|                 | 1.3.4  | Yes      |                | 0 |                     |
|                 | 1.3.5  | No       |                | 0 |                     |
|                 | 1.3.6  | No       |                | 0 |                     |
|                 | 1.3.7  | Yes      |                | 0 |                     |
|                 | 1.3.8  | Yes      |                | 0 |                     |
|                 | 1.3.9  | Yes      |                | 0 |                     |
|                 | 1.3.10   | Yes      |                | 0 | All Standards Total |
|                 | Total  | 6        |                | 0 | 0                   |

| Actions required to achieve compliance       Pageori       rarget Date       Associated       Image Date       Image Date <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th>  |   |           |             |  |  |  |  |  |
|---|---|-----------|-------------|--|--|--|--|--|
| TCS split, cross referencing of other policies, clarification of how we are supporting staff to improve. Needs to be reapproved.       Image: split cross referencing of other policies, clarification about the TCS split, cross referencing of other policies, clarification about the TCS split, cross referencing of other policies, clarification about the SZ       SZ Mar'10         COR/025 needs clarification about the TCS split, cross referencing of other policies, clarification about the SZ       Mar'10         COR/025 needs clarification about the TCS split, cross referencing of other policies, clarification about the TCS split, cross referencing of other policies, clarification about the TCS split, cross referencing of other policies, clarification about the SZ       Mar'10         COR/025 needs clarification about the TCS split, cross referencing of other policies, clarification of how we are supporting staff to improve. Needs to be reapproved.       SZ       Mar'10         COR/025 needs clarification about the TCS split, cross referencing of other policies, clarification of how we are supporting staff to improve. Needs to be reapproved.       SZ       Mar'10         COR/025 needs clarification about the TCS split, cross referencing of other policies, clarification of how we are supporting staff to improve. Needs to be reapproved.       SZ       Mar'10         COR/025 needs clarification about the TCS split, cross referencing of other policies, clarification of how we are supporting staff to improve. Needs to be the policies, clarification of how we are supporting staff to improve. Needs to be the policies, clarification of how we are supporting staff to improve. Needs to be term of thet policies, clarification of how we are supporting sta   | Actions required to achieve compliance  | Committee | Target Date |  |  |  |  |  |
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| TCS split, cross referencing of other policies, clarification of how we are supporting staff to improve. Needs to be reapproved.       Image: split cross referencing of other policies, clarification about the TCS split, cross referencing of other policies, clarification about the TCS split, cross referencing of other policies, clarification about the SZ       Mar'10         COR/025 needs clarification about the TCS split, cross referencing of other policies, clarification about the TCS split, cross referencing of other policies, clarification about the TCS split, cross referencing of other policies, clarification about the SZ       Mar'10         COR/025 needs clarification about the TCS split, cross referencing of other policies, clarification of how we are supporting staff to improve. Needs to be reapproved.       SZ       Mar'10         COR/025 needs clarification about the TCS split, cross referencing of other policies, clarification of how we are supporting staff to improve. Needs to be reapproved.       SZ       Mar'10         COR/025 needs clarification about the TCS split, cross referencing of other policies, clarification of how we are supporting staff to improve. Needs to be reapproved.       SZ       Mar'10         COR/025 needs clarification about the TCS split, cross referencing of other policies, clarification of how we are supporting staff to improve. Needs to be reapproved.       SZ       Mar'10         COR/025 needs clarification about the TCS split, cross referencing of other policies, clarification of how we are supporting staff to improve. Needs to be the policies, clarification of how we are supporting staff to improve. Needs to be the policies, clarification of how we are suporting staff to improve. Needs to   |   |           |             |  |  |  |  |  |
| drafted.       Image: Select sel                              | TCS split, cross referencing of other policies, clarification of how we are supporting staff to improve. Needs to | SZ        | Mar'10      |  |  |  |  |  |
| TCS split, cross referencing of other         policies, clarification of how we are         supporting staff to improve. Needs to         be reapproved.         COR/025 needs clarification about the         TCS split, cross referencing of other         policies, clarification of how we are         supporting staff to improve. Needs to         be reapproved.         COR/025 needs clarification about the         TCS split, cross referencing of other         policies, clarification of how we are         supporting staff to improve. Needs to         be reapproved.         COR/025 needs clarification about the         TCS split, cross referencing of other         policies, clarification about the         TCS split, cross referencing of other         policies, clarification about the         TCS split, cross referencing of other         policies, clarification of how we are         supporting staff to improve. Needs to  |   | SZ/JB     | ??          |  |  |  |  |  |
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| COR/042 need to fornalise the<br>'generic' M&H assessments for wards<br>etc. | BS | ?? Ood<br>Jan'12 |  |   |  |                         |  |                   |
| COR/042 need to fornalise the<br>'generic' M&H assessments for wards<br>etc. | BS | ?? Ood<br>Jan'12 |  |   |  |                         |  |                   |
| 08/09 Improved detail  | BS | ?? Ood<br>Jan'12 |  |   |  |                         |  |                   |
| COR/042 need to fornalise the<br>'generic' M&H assessments for wards<br>etc. |    | Jan 12           |  |   |  |                         |  |                   |
| COR/042 need to fornalise the<br>'generic' M&H assessments for wards<br>etc. | BS | ?? Ood<br>Jan'12 |  |   |  |                         |  |                   |
| 08/09 Improved detail  | BS | ?? Ood           |  |   |  |                         |  |                   |
| COR/042 need to fornalise the<br>'generic' M&H assessments for wards<br>etc. |    | Jan'12           |  |   |  |                         |  |                   |
| COR/042 need to fornalise the  | BS | ?? Ood<br>Jan'12 |  |   |  |                         |  |                   |
| 'generic' M&H assessments for wards<br>etc.                                  |    |                  |  |   |  |                         |  |                   |
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| 08/09 Improved clarity   | BS | Jan'10           |  |   |  |                         |  | -                 |
| COR/043 needs to be reapproved<br>08/09 Improved clarity                     | BS | Jan'10           |  |   |  |                         |  |                   |
| COR/043 needs to be reapproved   |    |                  |  |   |  |                         |  |                   |
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| 08/09 Improved clarity  | BS          | Jan'10               |      |    |      |      |      |   |
| COR/043 needs to be reapproved  |             |                      |      |    |      |      |      |   |
|   |             |                      |      |    |      |      |      |   |
|   |             |                      |      |    |      |      |      |   |
| 08/09 Improved clarity  | BS          | Jan'10               |      |    |      |      |      |   |
| COR/043 needs to be reapproved -  |             |                      |      |    |      |      |      |   |
| need to check with M&H Advisor on                                       |             |                      |      |    |      |      |      |   |
| training requirements   |             |                      |      |    |      |      |      |   |
| 08/09 Improved clarity - particluarly for this criterion                | BS          | Jan'10               |      |    |      |      |      |   |
|   |             |                      |      |    |      |      |      |   |
| COR/043 needs to be reapproved  | BS          | Jan'10               | <br> |    |      |      |      |   |
| 08/09 Improved clarity  | B2          | Jan 10               |      |    |      |      |      |   |
| COR/043 needs to be reapproved  |             |                      |      |    |      |      |      |   |
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| COR/041 roles and responsibilities                                      | FR/DW       | ?in date to          |      |    |      |      |      |   |
| should be clarified<br>COR/041 extra detail needed on non-              | FR/DW       | Jan12<br>2in date to | <br> |    |      |      |      |   |
| medical incident reporting  |             | ?in date to<br>Jan12 |      |    |      |      |      |   |
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| Clarity needed  | FR/DW       | ?in date to          |      |    |      |      |      |   |
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| COR/009 needs to be updated looking                                     | BS/MT/SM/JH | Feb'10               |      |    |      |      |      |   |
| at suitable arrangements for local<br>inventories and a central record. |             |                      |      |    |      |      |      |   |
| Needs to be reapproved.   |             |                      |      |    |      |      |      |   |
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## NHSLA Risk Management Standards for Primary Care Trusts Evidence Template 1.3.

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Cell: B1 Comment: Admin Use Only

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

Cell: L1 Comment: Assessor Use Only

Cell: M1 Comment: Assessor Use Only

Cell: N1 Comment: Assessor Use Only

Cell: H100 Comment: Secure environment

Cell: H101 Comment: Sickness absence

Cell: H102 Comment: Safeguarding adults

Cell: H103 Comment: Moving & handling

Cell: H104 Comment: Slips, trips & falls

Cell: H105 Comment: Inoculation incidents

Cell: H106 Comment: Maintenance of medical devices & equipment

Cell: H107 Comment: Harassment & bullying

Cell: H108 Comment: Violence & aggression

Cell: H109 Comment: Stress

| Criterion number | Index  | Criterion and minimum requirements  | Paper or Electronic copy<br>Name of abbronde go | cument Electronic file hyperlink/name | Document version name,<br>no. and approved and<br>review date | Initials of contact name<br>for document | Compliant?<br>(Organisation) | Reference | Organisation's comments                                | Compliant? (Assessor) | Comment in Report | Assessor's comments | Proposed Future Change | Rationale |
|------------------|--------|---|---|---------------------------------------|---|--|------------------------------|-----------|--|-----------------------|-------------------|---------------------|------------------------|-----------|
| 1.4.1            |        | The organisation has approved<br>documentation which describes the<br>process for managing the risks<br>associated with the identification of all<br>patients.          |   |                                       |   |  |                              |           |  |                       |                   |                     |                        |           |
|                  |        | As a minimum, the approved<br>documentation must include a<br>description of the:   |   |                                       |   |  |                              |           |  |                       |                   |                     |                        |           |
| а                | 4010.1 | definition of all patients groups   |   |                                       |   |  | No                           |           | CLN/018 ood Jan 2010                                   |                       | $\square$         |                     |                        |           |
| b                |        | process for identifying all patients  |   |                                       |   |  | No                           |           | CLN/018 ood Jan 2010                                   |                       |                   |                     |                        |           |
| с                |        | process for ongoing checks<br>throughout the patient care episode   |   |                                       |   |  | No                           |           | CLN/018 ood Jan 2010                                   |                       |                   |                     |                        |           |
| d                | 4013   | procedure to be followed in cases<br>where patient misidentification<br>occurs  |   |                                       |   |  | No                           |           | CLN/018 ood Jan 2010                                   |                       |                   |                     |                        |           |
| е                | 4018   | process for monitoring compliance with all of the above.  |   |                                       |   |  | No                           |           | CLN/018 ood Jan 2010                                   |                       |                   |                     |                        |           |
|                  |        |   |   |                                       |   | Compliant                                | No                           |           | Compliant  |                       |                   |                     |                        |           |
| 1.1.0            | 4000   |   |   |                                       |   |  |                              |           |  |                       |                   |                     |                        |           |
| 1.4.2            |        | The organisation has approved<br>documentation which describes the<br>process for developing patient<br>information associated with care,<br>treatments and procedures. |   |                                       |   |  |                              |           |  |                       |                   |                     |                        |           |
|                  |        | As a minimum, the approved<br>documentation must include a<br>description of the:   |   |                                       |   |  |                              |           |  |                       |                   |                     |                        |           |
| а                |        | process for the development of patient information  |   |                                       |   |  | No                           |           | COR/040 ood Jan 2010                                   |                       |                   |                     |                        |           |
| b                |        | list of the essential content to be<br>included in leaflets or other media<br>i.e. risks, benefits and alternatives,<br>where appropriate                               |   |                                       |   |  | No                           |           | COR/040 ood Jan 2010                                   |                       |                   |                     |                        |           |
| с                |        | reviewing process, including review date  |   |                                       |   |  | No                           |           | COR/040 ood Jan 2010                                   |                       |                   |                     |                        |           |
| d                | 4025   | archiving arrangements  |   |                                       |   |  | No                           |           | COR/040 ood Jan 2010                                   |                       |                   |                     |                        |           |
| е                |        | process for monitoring compliance<br>with all of the above.   |   |                                       |   |  | No                           |           | COR/040 ood Jan 2010                                   |                       |                   |                     |                        |           |
|                  |        |   |   |                                       |   | Compliant                                | No                           |           | Compliant  |                       |                   |                     |                        |           |
|                  |        |   |   |                                       |   |  |                              |           |  |                       |                   |                     |                        |           |
| 1.4.3            |        | The organisation has approved<br>documentation which describes the<br>process for managing the risks<br>associated with consent.  |   |                                       |   |  |                              |           |  |                       |                   |                     |                        |           |
|                  |        | As a minimum, the approved<br>documentation must include a<br>description of the:   |   |                                       |   |  |                              |           |  |                       |                   |                     |                        |           |
| а                |        | process for obtaining consent   |   |                                       |   |  | Yes                          |           | CLN/002 approved at Provider<br>Committee October 2009 |                       |                   |                     |                        |           |
|                  |        | process for recording consent   | <del>   </del>                                  |                                       |   |  | Yes                          |           | CLN/002 approved at Provider                           | +                     | + +               |                     | +                      | <u> </u>  |

| с      | 4033 | process for identifying staff who are                                     |   | <u>г</u>  | Yes | CLN/002 approved at Provider  |   |
|--------|------|---|---|-----------|-----|---|---|
|        |      | not capable of performing the   |   |           |     | Committee October 2009  |   |
|        |      | procedure but are authorised to   |   |           |     |   |   |
|        |      | obtain consent for that procedure   |   |           |     |   |   |
| d      | 4034 | generic training on the consent   |   |           | Yes | CLN/002 approved at Provider  |   |
|        | 4005 | process   |   |           | Nia | Committee October 2009  |   |
| е      | 4035 | process for the delivery of<br>procedure specific training on             |   |           | No  | CLN/002 approved at Provider<br>Committee October 2009, staff who   |   |
|        |      | consent, for staff to whom the  |   |           |     | didn't take up training need to   |   |
|        |      | consent process is delegated and  |   |           |     | demonstrate compliance  |   |
|        |      | who are not capable of performing the procedure                           |   |           |     |   |   |
| f      | 4038 | process for monitoring compliance   |   |           | No  | CLN/002 approved at Provider  |   |
|        |      | with all of the above.  |   |           |     | Committee October 2009, might just  |   |
|        |      |   |   |           |     | need minor update for clarity.  |   |
|        |      |   |   | Compliant | NO  | Compliant   |   |
| 1.4.4  | 4040 | The organisation has approved   |   |           |     |   |   |
|        |      | documentation which describes the   |   | L I       |     |   |   |
|        |      | process for managing the risks<br>associated with the quality of clinical |   | L I       |     |   |   |
|        |      | records in all media.   |   | L I       |     |   |   |
|        |      | As a minimum, the approved  |   |           |     |   |   |
|        |      | documentation must include a description of the:                          |   |           |     |   |   |
| а      |      | duties  |   |           | Yes | COR/022 has now been updated and |   |
|        |      |   |   |           |     | approved at IGC Nov'09  |   |
| b      | 4042 | criteria against which the clinical records must be audited for all       |   |           | Yes | COR/022 has now been updated and approved at IGC Nov'09   |   |
|        |      | healthcare professionals  |   |           |     |   |   |
| с      | 4043 | frequency of audit of clinical records                                    |   |           | Yes | COR/022 has now been updated and  |   |
| d      | 4044 | format for all audit reports i.e.   |   |           | Yes | approved at IGC Nov'09     COR/022 has now been updated and   |   |
| d      | 4044 | methodology, conclusions, action  |   |           | 165 | approved at IGC Nov'09  |   |
|        |      | plans, etc.   |   |           |     |   |   |
| е      | 4045 | arrangements for the review of  |   |           | Yes | COR/022 has now been updated and approved at IGC Nov'09   |   |
| f      | 4048 | action plans process for monitoring compliance                            |   |           | Yes | COR/022 has now been updated and  |   |
|        |      | with all of the above.  |   |           |     | approved at IGC Nov'09  |   |
|        |      |   |   | Compliant | Yes | Compliant   |   |
| 4.4.5  | 4050 | The ergeniegtion has entroved   |   |           |     |   | _ |
| 1.4.5  | 4050 | The organisation has approved documentation which describes the           |   | I I       |     |   |   |
|        |      | process for managing the risks  |   | L I       |     |   |   |
|        |      | associated with the transfer of patients.                                 |   | L I       |     |   |   |
|        |      | As a minimum, the approved  |   |           |     |   |   |
|        |      | documentation must include a  |   |           |     |   |   |
| а      | 4051 | description of the:<br>duties   |   |           | Yes | CLN/020   |   |
| a<br>b |      | transfer requirements which are   |   |           | Yes | CLN/020   |   |
|        |      | specific to each patient group  |   |           |     |   |   |
| с      | 4053 | documentation to accompany the  |   |           | Yes | CLN/020   |   |
| d      | 4054 | patient when being transferred<br>process for transfer out of hours       |   |           | Yes | CLN/020   |   |
| e      |      | process for monitoring compliance   | + |           | Yes | CLN/020   |   |
|        |      | with all of the above.  |   |           |     |   |   |
|        |      |   |   | Compliant | Yes | Compliant   |   |
| 1.4.6  | 4060 | The organisation has approved   |   |           |     |   |   |
|        |      | documentation which describes the   |   |           |     |   |   |
|        |      | process for managing the risks<br>associated with medicines in all care   |   |           |     |   |   |
|        |      | environments.   |   |           |     |   |   |
|        |      | As a minimum, the approved  |   |           |     |   |   |
|        |      | documentation must include a description of the:                          |   |           |     |   |   |
|        |      |   |   |           |     |   |   |

| а        |        | process for prescribing medicines in all care environments  |   |          | No    | CLN/011(ood Jun 2010), CLN/016 & CLN/017               |   |  |  |
|----------|--------|---|---|----------|-------|--|---|--|--|
| b        | 4061.1 | process for ensuring the accuracy<br>of all prescription charts   |   |          | No    | CLN/011(ood Jun 2010), CLN/016 &<br>CLN/017            |   |  |  |
| с        |        | process for the administration of   |   |          | No    | CLN/011(ood Jun 2010), CLN/016 &                       |   |  |  |
| d        |        | medication in all care environments process for patient self administration   |   |          | No    | CLN/017<br>CLN/011(ood Jun 2010), CLN/016 &<br>CLN/017 |   |  |  |
| е        | 4064   | procedure for the safe disposal of  |   |          | No    | CLN/017<br>CLN/011(ood Jun 2010), CLN/016 &<br>CLN/017 |   |  |  |
| f        | 4065   | controlled drugs<br>training requirements for all staff, as   |   |          | No    | CLN/017<br>CLN/011(ood Jun 2010), CLN/016 &            |   |  |  |
|          |        | identified in the training needs<br>analysis  |   |          |       | CLN/017, PER/037 and TNA                               |   |  |  |
| g        | 4068   | process for monitoring compliance<br>with all of the above.   |   |          | No    | CLN/011(ood Jun 2010), CLN/016 &<br>CLN/017            |   |  |  |
|          |        |   |   | Complian | t No  | Compliant  |   |  |  |
|          |        |   |   |          |       |  |   |  |  |
| 1.4.7    |        | The organisation has approved<br>documentation which describes the<br>process for managing the risks<br>associated with the blood transfusion<br>process. |   |          |       |  |   |  |  |
|          |        | As a minimum, the approved documentation must include a   |   |          |       |  |   |  |  |
| a        |        | description of the:<br>duties   |   |          |       | Not Applicable   |   |  |  |
| b        | 4072   | process for the request of blood<br>samples for pre-transfusion<br>compatibility testing  |   |          |       |  |   |  |  |
| с        | 4073   | process for the administration of   |   |          |       |  |   |  |  |
| d        | 4074   | blood and blood products<br>care of patient(s) receiving  |   |          |       |  |   |  |  |
| е        |        | transfusion<br>training requirements of all staff, as   |   |          |       |  |   |  |  |
|          |        | identified in the training needs<br>analysis  |   |          |       |  |   |  |  |
| f        |        | requirements for the competency<br>assessment of all staff involved in the<br>blood transfusion process   |   |          |       |  |   |  |  |
| g        | 4078   | process for monitoring compliance<br>with all of the above.   |   |          |       |  |   |  |  |
|          |        |   |   | Complian | t Yes | Compliant  |   |  |  |
|          | 4000   |   | - |          |       |  |   |  |  |
| 1.4.8    |        | The organisation has approved<br>documentation which describes the<br>process for managing the risks<br>associated with resuscitation.                    |   |          |       |  |   |  |  |
|          |        | As a minimum, the approved<br>documentation must include a<br>description of the:   |   |          |       |  |   |  |  |
| а        | 4081   | duties  |   |          | No    | CLN/006 ood Jun 2009                                   |   |  |  |
| b        |        | early warning systems in place for<br>the recognition of patients at risk of<br>cardio-respiratory arrest   |   |          | No    | CLN/006 ood Jun 2009                                   |   |  |  |
| с        |        | post-resuscitation care   |   |          | No    | CLN/006 ood Jun 2009                                   |   |  |  |
| d        | 4084   | do not attempt resuscitation orders<br>(DNAR)   |   |          | No    | CLN/006 ood Jun 2009                                   |   |  |  |
| е        |        | process for ensuring the continual<br>availability of resuscitation equipment   |   |          | No    | CLN/006 ood Jun 2009                                   |   |  |  |
| f        |        | training requirements for all staff, as<br>identified in the training needs<br>analysis   |   |          | No    | CLN/006 ood Jun 2009, PER/037 and TNA                  |   |  |  |
| g        | 4088   | process for monitoring compliance<br>with all of the above.   |   |          | No    | CLN/006 ood Jun 2009                                   |   |  |  |
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| Actions required to achieve  | Person/                  |             | Associated |      |      |  |
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| Need to check on remedial action & AER process                         | SM                       | Feb'10      |            |      |      |  |
| Monitoring needs tightening up.  | SM                       | Feb'10      |            |      |      |  |
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| COR/040 needs to be checked for  | D.Barker                 | Mar'10      |            | <br> |      |  |
| compliance, reviewed and reapproved<br>COR/040 needs to be checked for | D.Barker                 | Mar'10      |            | <br> |      |  |
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| COR/040 needs to be checked for  | D.Barker                 | Mar'10      |            |      |      |  |
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| COR/040 needs to be checked for compliance, reviewed and reapproved    | D.Barker                 | Mar'10      |            |      | <br> |  |
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| CLN/002 needs to have minor                                     | SM/JC | Mar'10 |             |      |      |      |      |   |
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| amendment to Training/Monitoring to reflect this.               |       |        |             |      |      |      |      |   |
| renect this.  |       |        |             |      |      |      |      |   |
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| CLN/002 needs to have minor amendment to Training/Monitoring to | SM/JC | Mar'10 |             |      |      |      |      |   |
| reflect this.   |       |        |             |      |      |      |      |   |
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| leed dates to be rolled forward at ommittee | SM/AS | Jan'10 |   |      |           |      |   |       |
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| 08/09 Need to detail or cross reference                                     | DW/JC | Jan'10 |  |   |      |      |   |          |   |  |
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| to all core clinical care protocols.<br>Should refer to the Health Act 2006 |       |        |  |   |      |      |   |          |   |  |
| (revised Jan 2008).   |       |        |  |   |      |      |   |          |   |  |
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| Needs disseminating   | SL    | Jan'10 |  |   |      | <br> |   |          |   |  |
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|   |       |        |  |   |      |      |   |          |   |  |
|   |       |        | <b>NA 18. 18. 18. 18. 18. 19. 19. 19. 19. 19. 19. 19. 19. 19. 19</b> | 915-514-914-914-914-914-914-914-914-914-914-9 |      |      |   |          |   |  |
|   | i     | 1      | 1  | 1   | **** |      | i | <br>**** | i |  |

Cell: B1 Comment: Admin Use Only

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

Cell: L1 Comment: Assessor Use Only

Cell: M1 Comment: Assessor Use Only

Cell: N1 Comment: Assessor Use Only

Cell: H104 Comment: Patient identification

Cell: H105 Comment: Patient information

Cell: H106 Comment: Consent

Cell: H107 Comment: Clinical record-keeping standards

Cell: H108 Comment: Transfer of patients

Cell: H109 Comment: Medicines management

Cell: H110 Comment: Blood transfusion

Cell: H111 Comment: Resuscitation

Cell: H112 Comment: Infection control

Cell: H113 Comment: Diagnostic testing and screening procedures

| Criterion number | Index | Criterion and minimum requirements  | Paper or Electronic copy | Name of approved document | Electronic file hyperlink/name | Document version name,<br>no. and approved and<br>review date | Initials of contact name<br>for document | Compliant?<br>(Organisation) | Reference | Organisation's comments                       | Compliant? (Assessor) | Comment in Report | Assessor's comments | Proposed Future Change | Rationale |
|------------------|-------|---|--------------------------|---------------------------|--------------------------------|---|--|------------------------------|-----------|---|-----------------------|-------------------|---------------------|------------------------|-----------|
| 1.5.1            | 5010  | The organisation has approved<br>documentation which describes the<br>process for managing the risks<br>associated with the reporting of all  |                          |                           |                                |   |  |                              |           |   |                       |                   |                     |                        |           |
|                  |       | internally and externally reportable<br>incidents.<br>As a minimum, the approved  |                          |                           |                                |   |  |                              |           |   |                       |                   |                     |                        |           |
|                  |       | documentation must include a description of the:  |                          |                           |                                |   |  |                              |           |   |                       |                   |                     |                        |           |
| а                | 5011  | duties  |                          |                           |                                |   |  | No                           |           | COR/010 ood Dec 2009                          |                       |                   |                     |                        |           |
| b                |       | process for reporting all<br>incidents/near misses, involving<br>staff, patients and others   |                          |                           |                                |   |  | No                           |           | COR/010 ood Dec 2009                          |                       |                   |                     |                        |           |
| с                |       | process for reporting to external<br>agencies   |                          |                           |                                |   |  | No                           |           | COR/010 ood Dec 2009                          |                       |                   |                     |                        |           |
| d                | 5014  | reference to the processes for staff to<br>raise concerns e.g. whistle<br>blowing/open disclosure   |                          |                           |                                |   |  | No                           |           | COR/010 ood Dec 2009, PER/012<br>OOD Jun 2009 |                       |                   |                     |                        |           |
| e                | 5018  | process for monitoring compliance with all of the above.  |                          |                           |                                |   |  | No                           |           | COR/010 ood Dec 2009                          |                       |                   |                     |                        |           |
|                  |       |   |                          |                           |                                |   | Compliant                                | No                           |           | Compliant                                     |                       |                   |                     |                        |           |
| 150              | 5020  | The organisation has approved   |                          |                           |                                |   | •  |                              |           |   |                       |                   |                     |                        |           |
| 1.0.2            | 0020  | documentation which describes the<br>process for ensuring that patients,<br>their relatives and carers have suitable<br>and accessible information about, and<br>clear access to, procedures to raise<br>concerns informally. |                          |                           |                                |   |  |                              |           |   |                       |                   |                     |                        |           |
|                  |       | As a minimum, the approved<br>documentation must include a<br>description of the:   |                          |                           |                                |   |  |                              |           |   |                       |                   |                     |                        |           |
|                  |       | duties<br>process for raising concerns  |                          |                           |                                |   |  | No<br>No                     |           | COR/001 ood Mar 09<br>COR/001 ood Mar 09      |                       |                   |                     |                        |           |
| , a di digen     |       | (informal complaints/Patient Advice<br>and Liaison Services)  |                          |                           |                                |   |  |                              |           |   |                       |                   |                     |                        |           |
| с                | 5023  | process for ensuring that patients,<br>relatives and their carers are not<br>treated differently as a result of raising<br>a concern  |                          |                           |                                |   |  | No                           |           | COR/001 ood Mar 09                            |                       |                   |                     |                        |           |
| d                |       | process by which the organisation<br>aims to make changes as a result of<br>concerns being raised   |                          |                           |                                |   |  | No                           |           | COR/001 ood Mar 09                            |                       |                   |                     |                        |           |

| е     |      | process for monitoring compliance with                                   |           | No    | COR/001 ood Mar 09          |   |   |      |
|-------|------|--|-----------|-------|-----------------------------|---|---|------|
|       |      | all of the above.  |           |       |                             |   |   |      |
|       |      |  | Compliant | No    | Compliant                   |   |   |      |
|       |      |  |           |       |                             |   |   |      |
| 1.5.3 |      | The organisation has approved  |           |       |                             |   |   |      |
|       |      | documentation which describes the  |           |       |                             |   |   |      |
|       |      | process for ensuring that patients,                                      |           |       |                             |   |   |      |
|       |      | their relatives and carers have suitable                                 |           |       |                             |   |   |      |
|       |      | and accessible information about, and                                    |           |       |                             |   |   |      |
|       |      | clear access to, procedures to register                                  |           |       |                             |   |   |      |
|       |      | formal complaints.   |           |       |                             |   |   |      |
|       |      |  |           |       |                             |   |   |      |
|       |      | As a minimum, the approved   |           |       |                             |   |   |      |
|       |      | documentation must include a   |           |       |                             |   |   |      |
|       |      | description of the:  |           | N.    |                             |   |   |      |
|       |      | duties   |           | No    | COR/001 ood Mar 09          |   |   | <br> |
| b     | 5032 | complaints management process,   |           | No    | COR/001 ood Mar 09          |   |   |      |
|       |      | which includes internal and external                                     |           |       |                             |   |   |      |
|       |      | communication, and collaboration   |           |       |                             |   |   |      |
|       |      | with other organisations when  |           |       |                             |   |   |      |
| press | E000 | necessary  |           | N les |                             |   |   | <br> |
| с     | 5033 | procedure to ensure that patients,<br>relatives and their carers are not |           | No    | COR/001 ood Mar 09          |   |   |      |
|       |      | treated differently as a result of a                                     |           |       |                             |   |   |      |
|       |      | complaint  |           |       |                             |   |   |      |
| 4     |      | process by which the organisation  |           | No    | COR/001 ood Mar 09          |   |   | _    |
| u     |      | aims to make changes as a result of                                      |           |       |                             |   |   |      |
|       |      | formal complaints  |           |       |                             |   |   |      |
|       |      |  |           |       |                             |   |   |      |
| е     | 5038 | process for monitoring compliance with                                   |           | No    | COR/001 ood Mar 09          |   |   | _    |
| C     |      | all of the above.  |           |       |                             |   |   |      |
|       |      |  | Compliant | No    | Compliant                   |   |   |      |
|       |      |  | Compliant |       | compliant                   |   |   |      |
| 154   | 5040 | The organisation has approved  |           |       |                             |   |   |      |
|       |      | documentation which describes the  |           |       |                             |   |   |      |
|       |      | process for managing all claims in                                       |           |       |                             |   |   |      |
|       |      | accordance with NHSLA requirements.                                      |           |       |                             |   |   |      |
|       |      |  |           |       |                             |   |   |      |
|       |      | As a minimum, the approved   |           |       |                             |   |   |      |
|       |      | documentation must include a   |           |       |                             |   |   |      |
|       |      | description of the:  |           |       |                             |   |   |      |
| а     | 5041 | duties   |           | Yes   | COR/023 may need update for |   |   |      |
|       |      |  |           |       | changes to org              |   |   |      |
| -     | 5040 |  |           | Vez   |                             |   |   | <br> |
| b     |      | NHSLA schemes relevant to the  |           | Yes   | COR/023 may need update for |   |   |      |
|       |      | organisation (i.e. CNST, LTPS and PES)                                   |           |       | changes to org              |   |   |      |
| с     | 5043 | action to be taken, including  |           | No    | COR/023 may need update for |   |   |      |
| Ŭ     | 0010 | timescales   |           |       | changes to org              |   |   |      |
| d     | 5044 | communication with relevant  |           | Yes   | COR/023 may need update for |   |   |      |
| u     |      | stakeholders   |           | 103   | changes to org              |   |   |      |
| е     |      | process for monitoring compliance with                                   |           | Yes   | COR/023 may need update for |   |   |      |
| C     |      | all of the above.  |           | 103   | changes to org              |   |   |      |
|       |      |  | Compliant | No    | Compliant                   |   |   |      |
|       |      |  | Compliant | 140   | Compliant                   |   |   |      |
| 1.5.5 | 5050 | The organisation has approved  |           |       |                             |   | l |      |
|       |      | documentation which describes the  |           |       |                             |   |   |      |
|       |      | process for investigating all incidents,                                 |           |       |                             |   |   |      |
|       |      | complaints and claims.   |           |       |                             |   |   |      |
|       |      | As a minimum, the approved   |           |       |                             |   |   |      |
|       |      | documentation must include a   |           |       |                             |   |   |      |
|       |      | description of the:  |           |       |                             |   |   |      |
| а     | 5051 | duties   |           | No    | COR/011 ood Jan 2010        |   |   |      |
|       |      |  |           |       |                             |   |   |      |
|       |      |  |           |       |                             |   |   |      |
|       |      |  |           |       |                             |   | 1 |      |
|       |      |  |           | l I   |                             | I |   | · ·  |
|       |      |  |           |       |                             |   |   |      |

| b     |      | organisation's expectations in relation<br>to staff training, as identified in the<br>training needs analysis   |     | No        | COR/011 ood Jan 2010 |   |  |  |
|-------|------|---|-----|-----------|----------------------|---|--|--|
| с     |      | different levels of investigation<br>appropriate to the severity of the<br>event(s)   |     | No        | COR/011 ood Jan 2010 |   |  |  |
| d     | 2    | process for involving and<br>communicating with internal and<br>external stakeholders to share safety<br>lessons  |     | No        | COR/011 ood Jan 2010 |   |  |  |
| e     |      | process for following up relevant action plans  |     | No        | COR/011 ood Jan 2010 |   |  |  |
| f     |      | process for monitoring compliance with all of the above.  |     | No        | COR/011 ood Jan 2010 |   |  |  |
|       |      |   | Com | oliant No | Compliant            | : |  |  |
|       |      |   |     |           | -                    |   |  |  |
| 1.5.6 |      | The organisation has approved<br>documentation which describes the<br>process for ensuring a systematic<br>approach to the aggregation of<br>incidents, complaints and claims on an<br>ongoing basis. |     |           |                      |   |  |  |
|       |      | As a minimum, the approved<br>documentation must include a<br>description of the:   |     |           |                      |   |  |  |
| а     | 5061 | duties  |     | No        | COR/011 ood Jan 2010 |   |  |  |
| b     |      | coordinated approach to the aggregation of incidents, complaints and claims   |     | No        | COR/011 ood Jan 2010 |   |  |  |
| С     | 8    | frequency with which an aggregated<br>analysis of incidents, complaints and<br>claims is to be completed  |     | No        | COR/011 ood Jan 2010 |   |  |  |
| d     | 8    | minimum content required within<br>the analysis report, including<br>qualitative and quantitative analysis  |     | No        | COR/011 ood Jan 2010 |   |  |  |
| e     |      | process for communicating this<br>information to relevant individuals or<br>groups  |     | No        | COR/011 ood Jan 2010 |   |  |  |
| f     | 5068 | process for monitoring compliance with all of the above.  |     | No        | COR/011 ood Jan 2010 |   |  |  |
|       |      |   |     |           |                      |   |  |  |
|       |      |   |     | oliant No | Compliant            |   |  |  |

| 12.5       507       Recognitization the spectrum<br>become by procession in package<br>processing procession in package<br>procession in package<br>p |                  |  |  |           |    |                                |  |  |
|---|------------------|--|--|-----------|----|--------------------------------|--|--|
| Image: Second  | <b>1.5.7</b> 507 | documentation which describes the<br>process for encouraging learning and<br>promoting improvements in practice,<br>based on individual and aggregated   |  |           |    |                                |  |  |
| description affinite         description affinite         description affinite         description affinite         description affinite         description         description <thdescription< th="">         description         descrip</thdescription<>  |                  | As a minimum, the approved   |  |           |    |                                |  |  |
| Image: Another the field and argonization of agenization of ageni   |                  | description of the:  |  |           |    | 005/011                        |  |  |
| a stores for page-relation is approved       and a store store within the argument of the store store for the store store for the store store for the store st  | a 50,            | ensures both local and organisational learning from incidents, complaints  |  |           | No | COR/011 ood Jan 2010           |  |  |
| ensures that issues kent from origination if culture and practice or implementing site multi a clamp and if culture and practice or implementing site multi changes contraining ensures or implementing ensures or implement ensures or implementing   | b 507            | from incidents, complaints and claims  |  |           | No | COR/011 ood Jan 2010           |  |  |
| a       Strate  | c 507            | ensures that lessons learnt from<br>analysis result in a change in   |  |           | No | COR/011 ood Jan 2010           |  |  |
| all of the above.       al  | d 507            |  |  |           | No | COR/011 ood Jan 2010           |  |  |
| a       a       b   | e 507            | 78 process for monitoring compliance with all of the above.  |  |           | No | COR/011 ood Jan 2010           |  |  |
| documentation which describes the<br>practice as defined in all NCE<br>guidance (where appropriate), is taken<br>in the context of the<br>dincet services provided by the<br>organisation.abaaaaa4As a minimum, the approved<br>documentation must include a<br>description of the:<br>organisation.Aaaa  |                  |  |  | Compliant | No | Compliant                      |  |  |
| Image: set of the process for ensuring that agreed best practice as defined in all NCE guidance (where appropriate), is taken in the context of the dinical services provided by the organisation.Image: set of the dinical services provided by the organisation.Image: set of the dinical services provided by the organisation.Image: set of the dinical services provided by the organisation.Image: set of the dinical services provided by the organisation.Image: set of the dinical services provided by the organisation.Image: set of the dinical services provided by the organisation.Image: set of the dinical services provided by the organisation.Image: set of the dinical services provided by the organisation.Image: set of the dinical services provided by the organisation.Image: set of the dinical services provided by the organisation.Image: set of the dinical services provided by the organisation.Image: set of the dinical services provided by the organisation.Image: set of the dinical services provided by the organisation.Image: set of the dinical services provided by the organisation.Image: set of the dinical services provided by the organisation.Image: set of the dinical services provided by the organisation.Image: set of the dinical services provided by the organisation dinical services provided by the dinical services proves provided d   |                  |  |  |           |    |                                |  |  |
| documentation must include a description of the:       documentation must include a description description description on to inplement NICE recommend   | <b>1.5.8</b> 508 | documentation which describes the<br>process for ensuring that agreed best<br>practice as defined in all NICE<br>guidance (where appropriate), is taken<br>into account in the context of the<br>clinical services provided by the |  |           |    |                                |  |  |
| istages of the process       istages of the process for identifying relevant<br>documents       istages of the process for onlucting an<br>organisational gap analysis       istages of the process for conducting an<br>organisational gap analysis       istages of the process for occumenting any<br>decision       istages of the process for occumenting any<br>decision       istages of the process for occumenting any decision<br>not to implement NICE<br>recommendations       istages of the process for occumenting any decision<br>not to implement NICE<br>recommendations       istages of the process for monitoring compliance with<br>all of the above.       istages of the process for monitoring compliance with<br>all of the above.       istages of the process for monitoring compliance with<br>all of the above.       istages of the process for document clinical<br>Audit & Effectiveness Strategy       istages of the process for monitoring compliance with<br>all of the above.       istages of the process for monitoring compliance with<br>all of the above.       istages of the process for document clinical<br>Audit & Effectiveness Strategy       istages of the process for additional papers   |                  | documentation must include a description of the:   |  |           |    |                                |  |  |
| documents       documents       documents       addit & Effectiveness Strategy       addit & Effectiveness Strategy         c       508 process for cisseminating relevant documents       addit & Effectiveness Strategy  |                  | stages of the process  |  |           |    | Audit & Effectiveness Strategy |  |  |
| documents       documents       documents       Audit & Effectiveness Strategy       Image: Constration of the constrating of the constration of the constrate of the constrat   |                  | documents  |  |           |    | Audit & Effectiveness Strategy |  |  |
| Image: constant of the above.organisational gap analysisimage: constant of the above.image: constant of   |                  | documents  |  |           |    | Audit & Effectiveness Strategy |  |  |
| recommendations are acted upon<br>throughout the organisationmethodmethodmethodmethodMethodMethodMethodMethodMethodf5086<br>process for documenting any decision<br>not to implement NICE<br>recommendationsmethodMethodMethodPartially covered by current Clinical<br>Audit & Effectiveness StrategymethodMeth   |                  | organisational gap analysis  |  |           |    | Audit & Effectiveness Strategy |  |  |
| not to implement NICE<br>recommendationsnot to implement NICE<br>recommendationsAudit & Effectiveness StrategyImage: Comparison of the strategyg508process for monitoring compliance with<br>all of the above.Image: Comparison of the strategyImage: Comparison of the strategyImage: Comparison of the strategyImage: Comparison of the strategyImage: Comparison of the strategy   |                  | recommendations are acted upon throughout the organisation   |  |           |    | Audit & Effectiveness Strategy |  |  |
| all of the above. Audit & Effectiveness Strategy  |                  | not to implement NICE recommendations  |  |           |    | Audit & Effectiveness Strategy |  |  |
| Compliant Compliant   | g 508            |  |  |           |    | Audit & Effectiveness Strategy |  |  |
|   |                  |  |  | Compliant | No | Compliant                      |  |  |

| 1.5.9 5090 The organisation has approved                |                                    |   |                        |   |
|---|------------------------------------|---|------------------------|---|
| documentation which describes the                       |                                    |   |                        |   |
| process for ensuring that agreed best                   |                                    |   |                        |   |
| practice, as defined in nationally                      |                                    |   |                        |   |
| agreed guidance, the National Service                   |                                    |   |                        |   |
| Frameworks, National Confidential                       |                                    |   |                        |   |
| Enquiries and other High Level                          |                                    |   |                        |   |
| Enquiries that make recommendations                     |                                    |   |                        |   |
| for patient safety, is taken into account               |                                    |   |                        |   |
| in the context of the clinical services                 |                                    |   |                        |   |
| provided by the organisation.                           |                                    |   |                        |   |
|   |                                    |   |                        |   |
| As a minimum, the approved                              |                                    |   |                        |   |
| documentation must include a description of the:        |                                    |   |                        |   |
|   |                                    |   | Na                     | Destielly express hy express Clinical                                   |
| a 5091 duties   |                                    |   | No                     | Partially covered by current Clinical<br>Audit & Effectiveness Strategy |
| b 5092 process for identifying relevant                 |                                    |   | No                     | Partially covered by current Clinical                                   |
| documents   |                                    |   |                        | Audit & Effectiveness Strategy  |
| c 5093 process for disseminating relevant               |                                    |   | No                     | Partially covered by current Clinical                                   |
| documents   |                                    |   |                        | Audit & Effectiveness Strategy  |
| d 5094 process for conducting an                        |                                    |   | No                     | Partially covered by current Clinical                                   |
| organisational gap analysis                             |                                    |   |                        | Audit & Effectiveness Strategy  |
| e 5095 process for ensuring that                        |                                    |   | No                     | Partially covered by current Clinical                                   |
| recommendations are acted upon                          |                                    |   |                        | Audit & Effectiveness Strategy  |
| throughout the organisation                             |                                    |   |                        |   |
| f 5098 process for monitoring compliance with           |                                    |   | No                     | Partially covered by current Clinical                                   |
| all of the above.                                       |                                    |   |                        | Audit & Effectiveness Strategy  |
|   |                                    | Compliant                                 | No                     | Compliant   |
|   |                                    |   |                        |   |
| 1.5.10 5100 The organisation has approved               |                                    |   |                        |   |
| documentation which describes the                       |                                    |   |                        |   |
| process for ensuring that all                           |                                    |   |                        |   |
| communication is open, honest and                       |                                    |   |                        |   |
| occurs as soon as possible following                    |                                    |   |                        |   |
| an incident, complaint or claim.                        |                                    |   |                        |   |
|   |                                    |   |                        |   |
| As a minimum, the approved documentation must include a |                                    |   |                        |   |
| description of the:                                     |                                    |   |                        |   |
| a 5101 process for encouraging open                     |                                    |   | No                     | COR/032 ood Dec 2009  |
| communication between healthcare                        |                                    |   |                        |   |
| organisations, healthcare teams,                        |                                    |   |                        |   |
| staff and patients and/or their carers                  |                                    |   |                        |   |
| stan and patients and/or their barers                   |                                    |   |                        |   |
| b 5102 process for acknowledging,                       |                                    |   | No                     | COR/032 ood Dec 2009  |
| apologising and explaining when                         |                                    |   |                        |   |
| things go wrong   |                                    |   |                        |   |
| c 5103 requirements for truthfulness,                   |                                    |   | No                     | COR/032 ood Dec 2009  |
| timeliness and clarity of                               |                                    |   |                        |   |
| communication   |                                    |   |                        |   |
| d 5104 provision of additional support as               |                                    |   | No                     | COR/032 ood Dec 2009  |
| required  |                                    |   |                        |   |
| e 5105 requirements for documenting all                 |                                    |   | No                     | COR/032 ood Dec 2009  |
| communication   |                                    |   |                        |   |
| f 5108 process for monitoring compliance with           |                                    |   | No                     | COR/032 ood Dec 2009  |
| all of the above.                                       |                                    |   | 1000000000000000000000 |   |
|   |                                    | Compliant                                 | No                     | Compliant   |
|   |                                    |   |                        |   |
|   |                                    |   |                        |   |
|   | I ne tollowing summary will be por | pulated automatically from information en | terea on t             |   |
|   |                                    | 1.5.1                                     | No                     |   |
|   |                                    | 1.5.1                                     | No                     |   |
|   |                                    | 1.5.2                                     | No                     |   |
|   |                                    | 1.5.3                                     | No                     |   |
|   |                                    | 1.5.5                                     | No                     |   |
|   |                                    | 1.5.6                                     | No                     |   |
|   |                                    | 1.5.7                                     | No                     |   |
|   |                                    | 1.5.8                                     | No                     |   |
|   |                                    | 1.5.0                                     | 00001001000000         |   |

## NHSLA Risk Management Standards for Primary Care Trusts Evidence Template 1.5.

| 1.5.9  | No | 0 |                     |  |
|--------|----|---|---------------------|--|
| 1.5.10 | No | 0 | All Standards Total |  |
| Total  | 0  | 0 | 0                   |  |

| Actions required to achieve<br>compliance  | Person/<br>Committee<br>responsible | Target Date | Associated<br>Cost |  |  |  |  |  |
|--|-------------------------------------|-------------|--------------------|--|--|--|--|--|
|  |                                     |             |                    |  |  |  |  |  |
|  |                                     |             |                    |  |  |  |  |  |
| Possibly joining COR/010 and<br>COR/011, drafts on T drive at<br>T:\shared\Portsmouth City PCT\PCT<br>Policies\Draft Policies\0910<br>IncidentPolicies | BS/SM/M-J                           | Mar'10      |                    |  |  |  |  |  |
| Possibly joining COR/010 and<br>COR/011, drafts on T drive at<br>T:\shared\Portsmouth City PCT\PCT<br>Policies\Draft Policies\0910<br>IncidentPolicies | BS/SM/M-J                           | Mar'10      |                    |  |  |  |  |  |
| Possibly joining COR/010 and<br>COR/011, drafts on T drive at<br>T:\shared\Portsmouth City PCT\PCT<br>Policies\Draft Policies\0910<br>IncidentPolicies | BS/SM/M-J                           | Mar'10      |                    |  |  |  |  |  |
| Possibly joining COR/010 and<br>COR/011, drafts on T drive at<br>T:\shared\Portsmouth City PCT\PCT<br>Policies\Draft Policies\0910<br>IncidentPolicies | BS/SM/M-J                           | Mar'10      |                    |  |  |  |  |  |
| Possibly joining COR/010 and<br>COR/011, drafts on T drive at<br>T:\shared\Portsmouth City PCT\PCT<br>Policies\Draft Policies\0910<br>IncidentPolicies | BS/SM/M-J                           | Mar'10      |                    |  |  |  |  |  |
|  |                                     |             |                    |  |  |  |  |  |
|  |                                     |             |                    |  |  |  |  |  |
|  |                                     |             |                    |  |  |  |  |  |
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| COR/023 needs to detail how it will   |           |        |  |  |  |  | <br> |
| work with other organisations and who takes the lead.                                 |           |        |  |  |  |  |      |
| COR/023 needs to list the schemes of insurance and cross-reference 'Being             |           |        |  |  |  |  |      |
| Open'.<br>COR/023 timescales need stating   |           |        |  |  |  |  | <br> |
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| Possibly joining COR/010 and COR/011, drafts on T drive at                            | BS/SM/M-J | Mar'10 |  |  |  |  |      |
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## NHSLA Risk Management Standards for Primary Care Trusts Evidence Template

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Cell: H102 Comment: Incident reporting

Cell: H103 Comment: Raising concerns

Cell: H104 Comment: Complaints

Cell: H105 Comment: Claims

Cell: H106 Comment: Investigations

Cell: H107 Comment: Analysis

Cell: H108 Comment: Improvement

Cell: H109 Comment: Best practice - NICE

Cell: H110 Comment: Best practice - NSFs, NCEs & High Level Enquiries

Cell: H111 Comment: Being open

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| Criterion number | Index  | Criterion and minimum requirements   | Electronic file hyperlink/name | Document version name,<br>no. and approved and<br>review dates | Initials of contact name<br>for document | Compliant?<br>(Organisation) | Reference | Organisation's comments | Compliant? (Assessor) | Comment for report? | Assessor's comments | Proposed Future Change | Rationale |
|------------------|--------|--|--------------------------------|--|--|------------------------------|-----------|-------------------------|-----------------------|---------------------|---------------------|------------------------|-----------|
|                  |        |  |                                |  |  |                              |           |                         |                       |                     |                     |                        |           |
| 2.1.1            |        | The organisation can demonstrate<br>implementation of the approved<br>organisation-wide risk management<br>strategy.   |                                |  |  |                              |           |                         |                       |                     |                     |                        |           |
|                  |        | The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:                      |                                |  |  |                              |           |                         |                       |                     |                     |                        |           |
| Level 1          | 1013   | the management of risk locally, which reflects the organisation-wide risk management strategy.   |                                |  |  |                              |           |                         |                       |                     |                     |                        |           |
|                  |        |  |                                |  | Compliant                                |                              |           | Compliant               |                       |                     |                     |                        |           |
|                  |        |  |                                |  |  |                              |           |                         |                       |                     |                     |                        |           |
| 2.1.2            |        | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for developing organisation-<br>wide procedural documents.                    |                                |  |  |                              |           |                         |                       |                     |                     |                        |           |
|                  |        | The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the:                                     |                                |  |  |                              |           |                         |                       |                     |                     |                        |           |
| Level 1          | 1024   | ratification process   |                                |  |  |                              |           |                         |                       |                     |                     |                        |           |
| Level 1          | 1026   | control of documents, including  |                                |  |  |                              |           |                         |                       |                     |                     |                        |           |
|                  |        | archiving arrangements.  |                                |  | Comuliant                                |                              |           | O                       |                       |                     |                     |                        |           |
|                  |        |  |                                |  | Compliant                                |                              |           | Compliant               |                       |                     |                     |                        |           |
| 2.1.3            | 1030   | The organisation can demonstrate that  |                                |  |  |                              |           |                         |                       |                     |                     |                        |           |
|                  |        | the high level committee(s) with<br>overarching responsibility for risk is<br>performing as described in the<br>approved terms of reference.   |                                |  |  |                              |           |                         |                       |                     |                     |                        |           |
|                  |        | The organisation can demonstrate<br>compliance with the objectives set out<br>within the terms of reference described<br>at Level 1, in relation to the:   |                                |  |  |                              |           |                         |                       |                     |                     |                        |           |
| Level 1          | 1032.1 | reporting arrangements to the board  |                                |  |  |                              |           |                         |                       |                     |                     |                        |           |
| Level 1          |        | reporting arrangements into the high   |                                |  |  |                              |           |                         |                       | $\uparrow \uparrow$ |                     |                        |           |
|                  |        | level committee(s).  |                                |  | 0  |                              |           |                         |                       |                     |                     |                        |           |
|                  |        |  |                                |  | Compliant                                |                              |           | Compliant               |                       |                     |                     |                        |           |
| 044              | 1044   | The organisation can demonstrate   |                                |  |  |                              |           |                         |                       |                     |                     |                        |           |
| 2.1.4            |        | implementation of the approved<br>documentation which describes the<br>process for delivering risk<br>management awareness training for all<br>board members, executives and senior<br>managers. |                                |  |  |                              |           |                         |                       |                     |                     |                        |           |
|                  |        | The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:                      |                                |  |  |                              |           |                         |                       |                     |                     |                        |           |
| Level 1          |        | ensuring that all board members and<br>senior managers receive relevant risk<br>management awareness training  |                                |  |  |                              |           |                         |                       |                     |                     |                        |           |

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| Level 1 | 1044                | following up non-attendance.  |   |      |           |      |  |
|         |                     |   |   | <br> | Compliant | 1    |  |
|         | 1051                |   |   |      |           |      |  |
| 2.1.5   | 1051                | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>organisation-wide systematic risk<br>management process.   |   |      |           |      |  |
|         | 1052                | The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:   |   |      |           |      |  |
| Level 1 |                     | assessing <b>strategic risks</b><br>ensuring a continual, systematic  |   |      |           |      |  |
| Level 1 | 1000                | approach to all risk assessments is followed throughout the organisation  |   |      |           |      |  |
|         |                     |   |   |      | Compliant |      |  |
|         |                     |   |   |      |           |      |  |
| 2.1.6   | 1061                | The organisation-wide risk register is<br>populated from a diverse range of<br>sources  |   |      |           |      |  |
|         |                     | The organisation can demonstrate that<br>the approved organisation-wide risk<br>register described at Level 1, is<br>populated with significant risks from<br>the following sources:  |   |      |           |      |  |
| Level 1 | 1062                | incident reports  |   |      |           |      |  |
| Level 1 | 100. 740. 105.02 20 | risk assessments  |   |      |           |      |  |
| Level 1 | 1062                | significant risks from directorate risk registers.  |   |      |           |      |  |
|         |                     |   |   |      | Compliant |      |  |
|         |                     |   |   |      |           |      |  |
| 2.1.7   | 1070                | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for responding to the<br>recommendations and requirements<br>arising from external agency visits,<br>inspections and accreditations specific<br>to the organisation. |   |      |           |      |  |
|         |                     | The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:   |   |      |           |      |  |
| Level 1 | 1073                | maintaining action plans to implement<br>any recommendations made as a<br>result of reviews.  |   |      |           |      |  |
|         |                     |   |   |      | Compliant |      |  |
|         |                     |   |   |      |           |      |  |
| 2.1.8   | 1080                | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with clinical records in all<br>media.  |   |      |           |      |  |
| Lough 4 | 1092                | The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:   |   |      |           |      |  |
| Level 1 | 1083<br>1086        | tracking records<br>retaining and disposing of records.   |   |      |           |      |  |
| 01011   | 1000                | retaining and disposing of records.   |   |      |           |      |  |
| Level 1 |                     |   | İ |      | Compliant |      |  |

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| 2.1.9   | 1090 | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for ensuring that all clinical<br>staff (temporary and permanent) are<br>registered with the appropriate<br>professional body. |   |            |                       |               |            |                |           |              |           |
|---------|------|---|---|------------|-----------------------|---------------|------------|----------------|-----------|--------------|-----------|
|         |      | The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:   |   |            |                       |               |            |                |           |              |           |
| Level 1 | 1092 | ensuring <b>ongoing</b> registration checks<br>are made directly with the relevant<br>professional body, in accordance with<br>their recommendations, in respect of<br>all permanent clinical staff.  |   |            |                       |               |            |                |           |              |           |
|         |      |   |   |            |                       |               |            | Compliant      |           |              |           |
| 0 4 40  | 1100 | The ergenization can domonstrate  |   |            |                       |               |            |                |           |              |           |
| 2.1.10  | 1100 | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for ensuring that all<br>appropriate employment checks are<br>undertaken for all staff (temporary and<br>permanent).           |   |            |                       |               |            |                |           |              |           |
|         |      | The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the:  |   |            |                       |               |            |                |           |              |           |
| Level 1 | 1102 | types of check required.  |   |            |                       |               |            |                |           |              |           |
|         |      | The assessor will select two elements<br>of the Employment Checks Minimum<br>Data Set at random to assess the<br>organisation's compliance with the<br>above minimum requirement.   |   |            |                       |               |            |                |           |              |           |
|         |      |   |   |            |                       |               |            | Compliant      |           |              |           |
|         |      |   |   |            |                       |               |            |                |           |              |           |
|         |      | I   | I | The follow | ing summary will be p | opulated auto | omatically | from informati | ion enter | ed on the wo | orksheet. |
|         |      |   |   |            |                       |               |            | 244            | 0         |              |           |
|         |      |   |   |            |                       |               |            | 2.1.1<br>2.1.2 | 0         |              |           |
|         |      |   |   |            |                       |               |            | 2.1.2          | 0         |              |           |
|         |      |   |   |            |                       |               |            | 2.1.4          | 0         |              |           |
|         |      |   |   |            |                       |               |            | 2.1.5          | 0         |              |           |
|         |      |   |   |            |                       |               |            | 2.1.6<br>2.1.7 | 0         |              |           |
|         |      |   |   |            |                       |               |            | 2.1.7          | 0         |              |           |
|         |      |   |   |            |                       |               |            | 2.1.9          | 0         |              |           |
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Cell: H66 Comment: Risk management strategy

Cell: H67 Comment: Policy on procedural documents

Cell: H68 Comment: Risk management committee(s)

Cell: H69 Comment: Risk awareness training for senior management

Cell: H70 Comment: Risk management process

Cell: H71 Comment: Risk register

Cell: H72 Comment: Responding to external recommendations specific to the organisation

Cell: H73 Comment: Clinical records management

Cell: H74 Comment: Professional clinical registration

Cell: H75 Comment: Employment checks

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| 2.  | 2 |    |     |

| Criterion number | Index | Criterion and minimum requirements  | Daper or Electronic copy       Document submitter | d Electronic file hyperlink/name | Document version name,<br>no. and approved and<br>review dates | Initials of contact name<br>for document | Compliant?<br>(Organisation) | Reference | Organisation's commer | Compliant? (Assessor) | Comment in Report | Assessor's comments | Proposed Future Change Rational |
|------------------|-------|---|---|----------------------------------|--|--|------------------------------|-----------|-----------------------|-----------------------|-------------------|---------------------|---------------------------------|
| 2.2.1            |       | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>corporate induction arrangements for<br>all new permanent staff.   |   |                                  |  |  |                              |           |                       |                       |                   |                     |                                 |
|                  |       | The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:   |   |                                  |  |  |                              |           |                       |                       |                   |                     |                                 |
| Level 1          |       | checking that all new permanent staff complete corporate induction  |   |                                  |  |  |                              |           |                       |                       |                   |                     |                                 |
| Level 1          | 2015  | following up those who fail to attend corporate induction.  |   |                                  |  |  |                              |           | -                     |                       |                   |                     |                                 |
|                  |       |   |   |                                  |  | Compliant                                |                              |           | Compli                | ant                   |                   |                     |                                 |
| 2.2.2            |       | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>local induction arrangements for all<br>new permanent staff.   |   |                                  |  |  |                              |           |                       |                       |                   |                     |                                 |
|                  |       | The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:   |   |                                  |  |  |                              |           |                       |                       |                   |                     |                                 |
| Level 1          |       | checking that all new permanent staff<br>complete local induction   |   |                                  |  |  |                              |           |                       |                       |                   |                     |                                 |
| Level 1          | 2024  | following up those who fail to complete local induction.  |   |                                  |  |  |                              |           |                       |                       |                   |                     |                                 |
|                  |       |   |   |                                  |  | Compliant                                |                              |           | Compli                | ant                   |                   |                     |                                 |
| 2.2.3            |       | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>local induction arrangements for all<br>temporary staff.   |   |                                  |  |  |                              |           |                       |                       |                   |                     |                                 |
|                  |       | The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:   |   |                                  |  |  |                              |           |                       |                       |                   |                     |                                 |
| Levern           |       | checking that all temporary staff<br>complete local induction   |   |                                  |  |  |                              |           |                       |                       |                   |                     |                                 |
| Level 1          | 2034  | following up those who fail to complete local induction.  |   |                                  |  | Compliant                                |                              |           | Compli                | ant                   |                   |                     |                                 |
|                  |       |   |   |                                  |  | Compliant                                |                              |           | Compli                | a111                  |                   |                     |                                 |
| 2.2.4            |       | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for ensuring that the<br>organisation undertakes the<br>appropriate regulatory checks via the<br>NHSLA Family Health Service Appeal<br>Unit on all primary care performers<br>(temporary and permanent). |   |                                  |  |  |                              |           |                       |                       |                   |                     |                                 |

|                   | The organisation can demonstrate  |   |   |           |      |           |     |   |  |
|-------------------|---|---|---|-----------|------|-----------|-----|---|--|
|                   | compliance with the objectives set out  |   |   |           |      |           |     |   |  |
|                   | within the approved documentation   |   |   |           |      |           |     |   |  |
|                   | described at Level 1, in relation to the:   |   |   |           |      |           |     |   |  |
| Level 1 2042      | process for ensuring checks are made  |   |   |           |      |           |     |   |  |
|                   | procedure for notifying the NHSLA   |   | _ |           |      |           |     |   |  |
| Level 1           | Family Health Service Appeal Unit in  |   |   |           |      |           |     |   |  |
|                   | the event of concern.   |   |   | -         |      |           |     |   |  |
|                   |   |   |   | Compliant |      | Compliant |     |   |  |
| <b>2.2.5</b> 2050 | The organisation can demonstrate  |   |   |           |      |           |     |   |  |
|                   | implementation of the approved  |   |   |           |      |           |     |   |  |
|                   | documentation which describes the   |   |   |           |      |           |     |   |  |
|                   | process for ensuring a systematic   |   |   |           |      |           |     |   |  |
|                   | approach to risk management training  |   |   |           |      |           |     |   |  |
|                   | for all permanent staff.  |   |   |           |      |           |     |   |  |
|                   | The organisation can demonstrate compliance with the objectives set out   |   |   |           |      |           |     | The assessor will record below the                                      |  |
|                   | within the approved documentation   |   |   |           |      |           |     | two elements of risk management   |  |
|                   | described at Level 1, in relation to the  |   |   |           |      |           |     | training selected at random to test<br>the implementation of the bullet |  |
|                   | process for:  |   |   |           |      |           |     | points:   |  |
| 2057              | 7 i   | İ | i |           |      |           | i i |   |  |
| 2057              |   |   |   |           |      |           | Li  |   |  |
| 2054              | checking that all permanent staff   |   |   |           |      |           |     |   |  |
| Level 1           | complete the relevant training  |   |   |           |      |           |     |   |  |
|                   | programmes in accordance with the   |   |   |           |      |           |     |   |  |
| 2055              | training needs analysis<br>following up those who fail to attend  |   | _ |           | <br> |           |     |   |  |
| Level 1           | relevant training programmes.   |   |   |           |      |           |     |   |  |
|                   | The assessor will select two elements   |   |   |           |      |           |     |   |  |
|                   | of risk management training from the TNA Minimum Data Set at random to  |   |   |           |      |           |     |   |  |
|                   | assess the organisation's compliance  |   |   |           |      |           |     |   |  |
|                   | with the above minimum requirements.  |   |   |           |      |           |     |   |  |
|                   |   |   |   |           |      |           |     |   |  |
|                   |   |   |   | Compliant |      | Compliant |     |   |  |
|                   |   |   |   |           |      |           |     |   |  |
| 2.2.6 2060        | The organisation can demonstrate the provision of the risk management   |   |   |           |      |           |     |   |  |
|                   | training required by all permanent staff  |   |   |           |      |           |     |   |  |
|                   | as identified in the training needs   |   |   |           |      |           |     |   |  |
|                   | analysis at Level 1.  |   |   |           |      |           |     |   |  |
|                   | The organisation can demonstrate the  |   |   |           |      |           |     |   |  |
|                   | provision of the risk management  |   |   |           |      |           |     |   |  |
|                   | training required by all permanent staff  |   |   |           |      |           |     |   |  |
|                   | as identified in the training needs analysis at Level 1 by:   |   |   |           |      |           |     |   |  |
| 2064              | producing an annual training  |   |   |           |      |           |     |   |  |
| Level 1           | prospectus which reflects the training  |   |   |           |      |           |     |   |  |
|                   | needs analysis.   |   |   |           |      |           |     |   |  |
|                   |   |   |   | Compliant |      | Compliant |     |   |  |
|                   |   |   |   |           |      |           |     |   |  |
| <b>2.2.7</b> 2070 | The organisation can demonstrate  |   |   |           |      |           |     |   |  |
|                   | implementation of the approved documentation which describes the  |   |   |           |      |           |     |   |  |
|                   | process for ensuring that all   |   |   |           |      |           |     |   |  |
|                   | permanent staff are trained to safely   |   |   |           |      |           |     |   |  |
|                   | use diagnostic and therapeutic  |   |   |           |      |           |     |   |  |
|                   | equipment appropriate to their role.  |   |   |           |      |           |     |   |  |
|                   | The organisation can demonstrate  |   |   |           |      |           |     |   |  |
|                   | a second lines as writtle the such is attract and such  |   |   |           |      |           |     |   |  |
|                   | compliance with the objectives set out  |   |   |           |      |           |     |   |  |
|                   | within the approved documentation   |   |   |           |      |           |     |   |  |
|                   | within the approved documentation described at Level 1, in relation to the  |   |   |           |      |           |     |   |  |
| 2073              | within the approved documentation<br>described at Level 1, in relation to the<br>process for:   |   |   |           |      |           |     |   |  |
|                   | within the approved documentation<br>described at Level 1, in relation to the<br>process for:<br>dentifying which permanent staff are |   |   |           |      |           |     |   |  |
| 2073<br>Level 1   | within the approved documentation<br>described at Level 1, in relation to the<br>process for:   |   |   |           |      |           |     |   |  |

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| 12000         Result of to its instruct of all on some instruction of an analysis an analysis of an anananananalysis of an analysis of an  |                    | use the equipment identified on the inventory and the frequency of  |  |           |           |  |  |
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| Image: set of the second se   |                    |   |  | Compliant | Compliant |  |  |
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| amplificate with the deprode figuration and approde figuration with app   | <b>2.2.8</b> 2080  | implementation of the approved<br>documentation which describes the<br>process for ensuring the delivery of<br>effective hand hygiene training to all   |  |           |           |  |  |
| $ \begin{array}{c c c c c c c } \mbox{complex} & set for yous, as defined in the set only only the set only the se$  |                    | compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:   |  |           |           |  |  |
| Linker       Index hygines training.       Image: selection of the selection   | Level 1            | staff groups, as identified in the<br>training needs analysis, complete<br>hand hygiene training  |  |           |           |  |  |
| 2.9       Soft The organisation and demonstrate<br>membershallshow of the approved<br>documentation which describes the<br>effective storemetation<br>to all permanents of the approved<br>documentation which describes the<br>effective storemetation<br>to all permanents of the approved<br>documentation which describes the<br>effective storemetation<br>describes at user.       Image: Compliant<br>of the approved documentation<br>describes at user.       Image: Compliant<br>of the approved documentation<br>documentation which describes the<br>process for statung that all staff<br>endowed in transactions the approved<br>documentation which describes the<br>process for statung the all staff<br>endowed in transactions the approved<br>describes at user.       Image: Compliant<br>of the approved documentation<br>describes at user.       Image: Compliantin approved<br>documentation which describes the  | Level 1 2083       |   |  |           |           |  |  |
| implementation with exproved       implementation with exceptions and using training the delivery of enciptions with exceptions and using training the delivery of enciptions with exceptions and using training the delivery of enciptions with exceptions and using training the delivery of enciptions with exceptions and using training the delivery of enciptions with exceptions and using training the delivery of enciptions with exceptions and using training the delivery of enciptions with exceptions and using training the delivery of enciptions with exceptions and using training the delivery of enciptions with exceptions and using training the delivery of enciptions with exceptions and using training the delivery of enciptions with exceptions and using training the delivery of enciptions with exceptions and using training   |                    |   |  | Compliant | Compliant |  |  |
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| a compliance with the objective set out with the approved forcementation of the approved forcementation with the approved forcementation the approved forcementation and examples is an approved force of the set out with the atter of the set out with the approved force of the set out with the approved force of the set out with the approved force of the set out with the approved force of the set out with the approved force of the set out with the approved force of the set out with the approved force of the set out with the approved force of the set out with the approved force of the set out with the approved force of the set out with the approve   | 2.2.9 2090         | implementation of the approved<br>documentation which describes the<br>process for ensuring the delivery of<br>effective moving and handling training<br>to all permanent staff.                              |  |           |           |  |  |
| Level       identified in the training needs analysis, complete relevant moving and handling training.       Image: Some set analysis and the training needs analysis analysis and the training training.       Image: Some set analysis   |                    | compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:   |  |           |           |  |  |
| Level 1       relevant moving and handling training.       Image: second   | Level 1            | identified in the training needs<br>analysis, complete relevant moving<br>and handling training   |  |           |           |  |  |
| 2.2.10       2100       The organisation can demonstrate implementation of the approved documentation which describes the process for ensuring that all staff involved in traumatic/stressful incidents, complaints or claims are adequately supported.       Image: Complaints or claims are adequately support of fored to staff (internally and, if necessary, externally)       Image: Complaints or claims are adecuately or claims are adecuately with the event.       Image: Complaints or claims are adecuately or claims are adecuately or claims are adecuately or claims are adecuately or claims   |                    |   |  |           |           |  |  |
| implementation of the approved<br>documentation which describes the<br>process for ensuing that all staff<br>involved in traumatic/stressful<br>inoidents, complaints or claims are<br>adequately supported.       Ime organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the:       Ime organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the:       Ime organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the:       Ime organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the:       Ime organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the:       Immediate support offered to staff<br>(internally and, if necessary,<br>externally)       Immediate support offered to staff<br>(internally and if necessary,<br>externally)       Immediate support offered to staff<br>(internally and if necessary,<br>externally)       Immediate support offered to staff<br>(internally and if necessary,<br>ex   |                    |   |  | Compliant | Compliant |  |  |
| Level 1       compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:       l  | <b>2.2.10</b> 2100 | implementation of the approved<br>documentation which describes the<br>process for ensuring that all staff<br>involved in traumatic/stressful<br>incidents, complaints or claims are<br>adequately supported. |  |           |           |  |  |
| Level 1       (internally and, if necessary, externally)       (internally and, if necessary)       (internally and, if necessary) </td <td></td> <td>compliance with the objectives set out within the approved documentation</td> <td></td> <td></td> <td></td> <td></td> <td></td>   |                    | compliance with the objectives set out within the approved documentation  |  |           |           |  |  |
| Level 1 take if the staff member is experiencing difficulties associated with the event.  | Level 1            | (internally and, if necessary, externally)  |  |           |           |  |  |
| Compliant     Compliant   |                    | take if the staff member is experiencing difficulties associated  |  |           |           |  |  |
|   |                    |   |  | Compliant | Compliant |  |  |
|   |                    |   |  |           |           |  |  |

## NHSLA Risk Management Standards for Primary Care Trusts Evidence Template 2.2.

|   | The following summary will be populated automatically from information entered on the worksheet. |    |   |  |   |                     |  |  |  |  |  |
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|   | 2.2.2  | 2  | 0 |  | 0 |                     |  |  |  |  |  |
|   | 2.2.3  | 3  | 0 |  | 0 |                     |  |  |  |  |  |
|   | 2.2.4  | 4  | 0 |  | 0 |                     |  |  |  |  |  |
|   | 2.2.5  | 5  | 0 |  | 0 |                     |  |  |  |  |  |
|   | 2.2.6  | 6  | 0 |  | 0 |                     |  |  |  |  |  |
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|   | 2.2.8  | 8  | 0 |  | 0 |                     |  |  |  |  |  |
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| Actions required to achieve<br>compliance | Person/<br>Committee<br>responsible | Target Date | Associated<br>Cost |  |  |  |  |  |
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## NHSLA Risk Management Standards for Primary Care Trusts Evidence Template 2.2.

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## NHSLA Risk Management Standards for Primary Care Trusts Evidence Template 2.2.

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Cell: L1 Comment: Assessor Use Only

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Cell: N1 Comment: Assessor Use Only

Cell: H69 Comment: Corporate induction

Cell: H70 Comment: Local induction of permanent staff

Cell: H71 Comment: Local induction of temporary staff

Cell: H72 Comment: Fitness to practice

Cell: H73 Comment: Risk management training

Cell: H74 Comment: Training needs analysis

Cell: H75 Comment: Medical devices training

Cell: H76 Comment: Hand hygiene training

Cell: H77 Comment: Moving & handling training

Cell: H78

Comment: Supporting staff involved in an incident, complaint or claim

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| Criterion number | Index | Criterion and minimum requirements  | Electronic file hyperlink/name | Document version name,<br>no. and approved and<br>review dates | Initials of contact name<br>for document | Compliant?<br>(Organisation) | Reference | Organisation's comments | Compliant? (Assessor) | Comment in Report<br>Assessor's comments | Proposed Future Change | Rationale | Actions required to achieve<br>compliance |
|------------------|-------|---|--------------------------------|--|--|------------------------------|-----------|-------------------------|-----------------------|--|------------------------|-----------|---|
| 2.3.1            | 3010  | The organisation can demonstrate  |                                |  |  |                              |           |                         |                       |  |                        |           |   |
| 2.0.1            |       | implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the physical security of<br>premises and other assets.   |                                |  |  |                              |           |                         |                       |  |                        |           |   |
|                  |       | The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the:                      |                                |  |  |                              |           |                         |                       |  |                        |           |   |
| Level 1          |       | requirement to undertake appropriate<br>risk assessments regarding the<br>physical security of premises and<br>assets   |                                |  |  |                              |           |                         |                       |  |                        |           |   |
| Level 1          |       | arrangements for the organisational<br>overview of the risk assessments<br>regarding the physical security of<br>premises and assets.   |                                |  |  |                              |           |                         |                       |  |                        |           |   |
|                  |       |   |                                |  | Compliant                                |                              |           | Compliant               |                       |  |                        |           |   |
| 2.3.2            |       | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with sickness absences.   |                                |  |  |                              |           |                         |                       |  |                        |           |   |
|                  |       | The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the:                      |                                |  |  |                              |           |                         |                       |  |                        |           |   |
| Level 1          |       | process for analysing sickness<br>absence data  |                                |  |  |                              |           |                         |                       |  |                        |           |   |
| Level 1          |       | arrangements for the organisational overview of sickness absence.   |                                |  |  |                              |           |                         |                       |  |                        |           |   |
|                  |       |   |                                |  | Compliant                                |                              |           | Compliant               |                       |  |                        |           |   |
| 2.3.3            |       | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with safeguarding adults. |                                |  |  |                              |           |                         |                       |  |                        |           |   |
|                  |       | The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the:                      |                                |  |  |                              |           |                         |                       |  |                        |           |   |
| Level 1          |       | local arrangements for managing the risks associated with safeguarding adults.  |                                |  | Compliant                                |                              |           | Compliant               |                       |  |                        |           |   |
|                  |       |   |                                |  | Compliant                                |                              |           | Compliant               |                       |  |                        |           |   |
| 2.3.4            |       | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with moving and handling. |                                |  |  |                              |           |                         |                       |  |                        |           |   |

|                  |                | The organisation can demonstrate  |  |     |                               |           |  |  |     |
|------------------|----------------|---|--|-----|-------------------------------|-----------|--|--|-----|
|                  |                | compliance with the objectives set out  |  |     |                               |           |  |  |     |
|                  |                | within the approved documentation   |  |     |                               |           |  |  |     |
|                  |                | described at Level 1, in relation to the:   |  |     |                               |           |  |  |     |
|                  |                |   |  |     |                               |           |  |  |     |
|                  |                | requirement to undertake appropriate  |  |     |                               |           |  |  |     |
| Level 1          |                | risk assessments for the moving and   |  |     |                               |           |  |  |     |
|                  |                | handling of patients and objects  |  |     |                               |           |  |  |     |
|                  | 3045           | arrangements for the organisational   |  |     |                               |           |  |  |     |
|                  |                | overview of the risk assessments for  |  |     |                               |           |  |  |     |
| Level 1          |                | the moving and handling of patients   |  |     |                               |           |  |  |     |
|                  |                | and objects.  |  |     |                               |           |  |  |     |
|                  |                |   |  |     | Compliant                     | Compliant |  |  |     |
|                  |                |   |  |     |                               |           |  |  |     |
| 2.3.5            | 3050           | The organisation can demonstrate  |  |     |                               |           |  |  |     |
|                  |                | implementation of the approved  |  |     |                               |           |  |  |     |
|                  |                | documentation which describes the   |  |     |                               |           |  |  |     |
|                  |                | process for managing the risks  |  |     |                               |           |  |  |     |
|                  |                | associated with slips, trips and falls  |  |     |                               |           |  |  |     |
|                  |                | involving patients, staff and others.   |  |     |                               |           |  |  |     |
|                  |                | The organisation can demonstrate  |  |     |                               |           |  |  |     |
|                  |                | compliance with the objectives set out within the approved documentation  |  |     |                               |           |  |  |     |
|                  |                | described at Level 1, in relation to the:   |  |     |                               |           |  |  |     |
|                  |                |   |  |     |                               |           |  |  |     |
|                  | 3052           | requirement to undertake appropriate  |  |     |                               |           |  |  |     |
|                  |                | risk assessments for the management   |  |     |                               |           |  |  |     |
| Level 1          |                | of slips, trips and falls involving   |  |     |                               |           |  |  |     |
| 5                |                | patients (including falls from height)  |  |     |                               |           |  |  |     |
|                  |                |   |  |     |                               |           |  |  |     |
|                  |                | requirement to undertake appropriate  |  |     |                               |           |  |  |     |
|                  |                | risk assessments for the management   |  |     |                               |           |  |  |     |
| Level 1          |                | of slips, trips and falls involving staff   |  |     |                               |           |  |  |     |
|                  |                | and others (including falls from<br>height).  |  |     |                               |           |  |  |     |
|                  |                |   |  | I I |                               |           |  |  | 1 1 |
|                  |                |   |  |     | Compliant                     | Compliant |  |  |     |
|                  |                |   |  |     | Compliant                     | Compliant |  |  |     |
| 236              | 3060           |   |  |     | Compliant                     | Compliant |  |  |     |
| 2.3.6            | 3060           | The organisation can demonstrate  |  |     | Compliant                     | Compliant |  |  |     |
| 2.3.6            |                |   |  |     | Compliant                     | Compliant |  |  |     |
| 2.3.6            |                | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks   |  |     | Compliant                     | Compliant |  |  |     |
| 2.3.6            |                | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the   |  |     | Compliant                     | Compliant |  |  |     |
| 2.3.6            |                | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with inoculation incidents.   |  |     | Compliant                     | Compliant |  |  |     |
| 2.3.6            |                | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with inoculation incidents.   |  |     | Compliant /                   | Compliant |  |  |     |
| 2.3.6            |                | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with inoculation incidents.<br>The organisation can demonstrate<br>compliance with the objectives set out   |  |     | Compliant                     | Compliant |  |  |     |
| 2.3.6            |                | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with inoculation incidents.<br>The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation  |  |     | Compliant Compliant           | Compliant |  |  |     |
| 2.3.6            |                | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with inoculation incidents.<br>The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the  |  |     | Compliant Compliant           | Compliant |  |  |     |
| 2.3.6            |                | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with inoculation incidents.<br>The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:  |  |     | Compliant Compliant           | Compliant |  |  |     |
| 2.3.6            |                | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with inoculation incidents.<br>The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:<br>the management of an inoculation  |  |     | Compliant Compliant           | Compliant |  |  |     |
|                  |                | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with inoculation incidents.<br>The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:  |  |     |                               |           |  |  |     |
|                  |                | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with inoculation incidents.<br>The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:<br>the management of an inoculation  |  |     | Compliant Compliant Compliant | Compliant |  |  |     |
| Level 1          | 3063           | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with inoculation incidents.<br>The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:<br>the management of an inoculation  |  |     |                               |           |  |  |     |
| Level 1          | 3063<br>3070   | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with inoculation incidents.The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:the management of an inoculation<br>incident (including prophylaxis).The organisation can demonstrate<br>group of the approved  |  |     |                               |           |  |  |     |
| Level 1          | 3063           | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with inoculation incidents.The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:the management of an inoculation<br>incident (including prophylaxis).The organisation can demonstrate<br>group to the approved<br>documentation   |  |     |                               |           |  |  |     |
| Level 1          | 3063           | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with inoculation incidents.The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:the management of an inoculation<br>incident (including prophylaxis).The organisation can demonstrate<br>process for:the management of the approved<br>documentation<br>incident (including prophylaxis).   |  |     |                               |           |  |  |     |
| Level 1          | 3063           | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with inoculation incidents.The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:the management of an inoculation<br>incident (including prophylaxis).The organisation can demonstrate<br>process for:The organisation can demonstrate<br>process for:The management of an inoculation<br>incident (including prophylaxis).The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the maintenance of   |  |     |                               |           |  |  |     |
| Level 1          | 3063           | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with inoculation incidents.The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:the management of an inoculation<br>incident (including prophylaxis).The organisation can demonstrate<br>grocess for:The organisation can demonstrate<br>process for:The organisation can demonstrate<br>process for:The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the maintenance of<br>reusable medical devices and  |  |     |                               |           |  |  |     |
| Level 1          | 3063           | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with inoculation incidents.The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:the management of an inoculation<br>incident (including prophylaxis).The organisation can demonstrate<br>grocess for:The organisation can demonstrate<br>process for:The organisation can demonstrate<br>incident (including prophylaxis).The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the maintenance of<br>reusable medical devices and<br>equipment.   |  |     |                               |           |  |  |     |
| Level 1          | 3063           | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with inoculation incidents.The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:The management of an inoculation<br>incident (including prophylaxis).The organisation can demonstrate<br>implementation of the approved<br>documentation<br>incident (including prophylaxis).The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the maintenance of<br>reusable medical devices and<br>equipment.The organisation can demonstrate  |  |     |                               |           |  |  |     |
| Level 1          | 3063           | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with inoculation incidents.The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:The management of an inoculation<br>incident (including prophylaxis).The organisation can demonstrate<br>implementation of the approved<br>documentation<br>incident (including prophylaxis).The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the maintenance of<br>reusable medical devices and<br>equipment.The organisation can demonstrate<br>compliance with the objectives set out  |  |     |                               |           |  |  |     |
| Level 1          | 3063           | Image: |  |     |                               |           |  |  |     |
| Level 1          | 3063           | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with inoculation incidents.The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:The management of an inoculation<br>incident (including prophylaxis).The organisation can demonstrate<br>implementation of the approved<br>documentation<br>incident (including prophylaxis).The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the maintenance of<br>reusable medical devices and<br>equipment.The organisation can demonstrate<br>compliance with the objectives set out  |  |     |                               |           |  |  |     |
| Level 1          | 3063           | Image: Constraint of the approved documentation which describes the process for managing the risks associated with inoculation incidents.The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process for:The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process for:The organisation can demonstrate incident (including prophylaxis).The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks associated with the maintenance of reusable medical devices and equipment.The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process for:   |  |     |                               |           |  |  |     |
| Level 1          | 3063 3070 3073 | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with inoculation incidents.The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:The organisation can demonstrate<br>incident (including prophylaxis).The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the maintenance of<br>reusable medical devices and<br>equipment.The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:Example the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:Ensuring that all reusable medical<br>devices and equipment are properly   |  |     |                               |           |  |  |     |
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| Level 1<br>2.3.7 | 3063 3070 3073 | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with inoculation incidents.The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>  |  |     |                               |           |  |  |     |
| Level 1<br>2.3.7 | 3063 3070 3073 | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>   |  |     | Compliant                     | Compliant |  |  |     |

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| 2.3.10         0         All Standards Total  | Level 1  | 3100<br>3113<br>3114 | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with work-related stress.The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the:process for identifying workplace<br>stressorsrequirement to undertake appropriate<br>risk assessments for the prevention<br>and management of work-related | The following sum | nmary will be populated autor | Compliant           2.3.1           2.3.2           2.3.3           2.3.4           2.3.5           2.3.7  | 0       0          | Compliant |  |  |  |
|   | Level 1  | 3100<br>3113<br>3114 | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with work-related stress.The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the:process for identifying workplace<br>stressorsrequirement to undertake appropriate<br>risk assessments for the prevention<br>and management of work-related | The following sum | nmary will be populated autor | Compliant           Compliant           natically from information er           2.3.1           2.3.2           2.3.3           2.3.4           2.3.5           2.3.6           2.3.7           2.3.8                                  | 0       0          | Compliant |  |  |  |
|   | Level 1  | 3100<br>3113<br>3114 | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with work-related stress.The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the:process for identifying workplace<br>stressorsrequirement to undertake appropriate<br>risk assessments for the prevention<br>and management of work-related | The following sum | nmary will be populated autor | Compliant         Compliant         Compliant         Matically from information er         2.3.1         2.3.2         2.3.3         2.3.4         2.3.5         2.3.6         2.3.7         2.3.8         2.3.9                      | Image: state of the state | Compliant |  |  |  |
|   | Level 1  | 3100<br>3113<br>3114 | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with work-related stress.The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the:process for identifying workplace<br>stressorsrequirement to undertake appropriate<br>risk assessments for the prevention<br>and management of work-related | The following sum | nmary will be populated autor | Compliant           Compliant           natically from information er           2.3.1           2.3.2           2.3.3           2.3.4           2.3.5           2.3.6           2.3.7           2.3.8           2.3.9           2.3.10 | 0       0          | Compliant |  |  |  |

| Person/<br>Committee<br>responsible | Target Date | Associated<br>Cost |  |      |  |  |  |  |
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Cell: L1 Comment: Assessor Use Only

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Cell: N1 Comment: Assessor Use Only

Cell: H63 Comment: Secure environment

Cell: H64 Comment: Sickness absence

Cell: H65 Comment: Safeguarding adults

Cell: H66 Comment: Moving & handling

Cell: H67 Comment: Slips, trips & falls

Cell: H68 Comment: Inoculation incidents

Cell: H69 Comment: Maintenance of medical devices & equipment

Cell: H70 Comment: Harassment & bullying

Cell: H71 Comment: Violence & aggression

Cell: H72 Comment: Stress

| Criterion number   | Index | Criterion and minimum requirements  | Paper or Electronic copy | Document submitted | Electronic file hyperlink/name | Document version name,<br>no. and approved and<br>review dates | Initials of contact name<br>for document | Compliant?<br>(Organisation) | Reference | Organisation's comments | Compliant? (Assessor) | Comment in Report | Assessor's comments | Proposed Future Change | Rationale |
|--------------------|-------|---|--------------------------|--------------------|--------------------------------|--|--|------------------------------|-----------|-------------------------|-----------------------|-------------------|---------------------|------------------------|-----------|
| 2.4.1              |       | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the identification of<br>inpatients.<br>The organisation can demonstrate   |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
|                    |       | compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the:  |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
| Level 1<br>Level 1 | 4013  | process for identifying <b>in</b> patients<br>procedure to be followed in cases<br>where patient misidentification occurs.  |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
|                    |       |   |                          |                    |                                |  | Compliant                                |                              |           | Compliant               |                       |                   |                     |                        |           |
| 2.4.2              |       | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for developing patient<br>information associated with care,<br>treatments and procedures.  |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
|                    |       | The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the:  |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
| Level 1            |       | list of the essential content to be<br>included in leaflets or other media i.e.<br>risks, benefits and alternatives, where<br>appropriate   |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
| Level 1            | 4025  | archiving arrangements.   |                          |                    |                                |  | Compliant                                |                              |           | Compliant               |                       |                   |                     |                        |           |
| 2.4.3              |       | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with consent.<br>The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the: |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
| Level 1            |       | process for identifying staff who are<br>not capable of performing the<br>procedure but are authorised to obtain<br>consent for that procedure  |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
| Level 1            |       | process for the delivery of procedure<br>specific training on consent, for staff to<br>whom the consent process is<br>delegated and who are not capable of<br>performing the procedure.   |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
|                    |       |   |                          |                    |                                |  | Compliant                                |                              |           | Compliant               |                       |                   |                     |                        |           |

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| 2.4.4               | 4040   | The organisation can demonstrate  |      |        |           |      |  |
|                     |        | implementation of the approved  |      |        |           |      |  |
|                     |        | documentation which describes the   |      |        |           |      |  |
|                     |        | process for managing the risks  |      |        |           |      |  |
|                     |        | associated with the quality of clinical<br>records in all media.            |      |        |           |      |  |
|                     |        | The organisation can demonstrate  |      |        |           |      |  |
|                     |        | compliance with the objectives set out                                      |      |        |           |      |  |
|                     |        | within the approved documentation   |      |        |           |      |  |
|                     |        | described at Level 1, in relation to:                                       |      |        |           |      |  |
|                     | 10.11  |   |      |        |           |      |  |
| Loren Ld            | 4044   | format for all audit reports i.e.   |      |        |           |      |  |
| Level 1             |        | methodology, conclusions, action<br>plans, etc.                             |      |        |           |      |  |
|                     | 4045   | arrangements for the review of action                                       |      |        |           |      |  |
| Level 1             |        | plans.  |      |        |           |      |  |
|                     |        |   |      |        | Compliant |      |  |
|                     | 10.50  |   |      |        |           |      |  |
| 2.4.5               | 4050   | The organisation can demonstrate<br>implementation of the approved          |      |        |           |      |  |
|                     |        | documentation which describes the   |      |        |           |      |  |
|                     |        | process for managing the risks  |      |        |           |      |  |
|                     |        | associated with the transfer of   |      |        |           |      |  |
|                     |        | patients.   |      |        |           |      |  |
|                     |        | The organisation can demonstrate  |      |        |           |      |  |
|                     |        | compliance with the objectives set out within the approved documentation    |      |        |           |      |  |
|                     |        | described at Level 1, in relation to the:                                   |      |        |           |      |  |
|                     |        |   |      |        |           |      |  |
|                     |        |   |      |        |           |      |  |
|                     | 4052   | transfer requirements which are   |      |        |           |      |  |
| Level 1             | 4052   | specific to each patient group  |      |        |           |      |  |
| Level 1             | 4053   | documentation to accompany the  |      |        |           |      |  |
|                     |        | patient when being transferred.   |      |        |           |      |  |
|                     |        | The assessor will select two patient groups at random to assess the         |      |        |           |      |  |
|                     |        | organisation's compliance with the  |      |        |           |      |  |
|                     |        | above minimum requirements.   |      |        |           |      |  |
|                     |        |   |      |        | Compliant |      |  |
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| 2.4.6               | 4060   | The organisation can demonstrate  |      |        |           |      |  |
|                     |        | implementation of the approved<br>documentation which describes the         |      |        |           |      |  |
|                     |        | process for managing the risks  |      |        |           |      |  |
|                     |        | associated with medicines in all care                                       |      |        |           |      |  |
|                     |        | environments.   |      |        |           |      |  |
|                     |        | The organisation can demonstrate  |      |        |           |      |  |
|                     |        | compliance with the objectives set out                                      |      |        |           |      |  |
|                     |        | within the approved documentation described at Level 1, in relation to the: |      |        |           |      |  |
|                     |        |   |      |        |           |      |  |
| W. Landaura         | 4061.1 | process for ensuring the accuracy of  |      |        |           |      |  |
| Level 1             |        | all prescription charts.  |      |        |           |      |  |
|                     |        |   |      |        | Compliant |      |  |
| <b>a</b> <i>t</i> = | 4070   |   |      |        |           |      |  |
| 2.4.7               | 4070   | The organisation can demonstrate  |      |        |           |      |  |
|                     |        | implementation of the approved<br>documentation which describes the         |      |        |           |      |  |
|                     |        | process for managing the risks  |      |        |           |      |  |
|                     |        | associated with the blood transfusion                                       |      |        |           |      |  |
|                     |        | process.  |      |        |           |      |  |
|                     |        | The organisation can demonstrate  |      |        |           |      |  |
|                     |        | compliance with the objectives set out                                      |      |        |           |      |  |
|                     |        | within the approved documentation described at Level 1, in relation to the: |      |        |           |      |  |
|                     |        |   |      |        |           |      |  |
| Level 1             | 4073   | process for the administration of blood                                     |      |        |           |      |  |
|                     |        | and blood products  |      |        |           |      |  |
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|           |         | The assessor will select two patient groups at random to assess the |  |
|           |         | organisation's compliance with the above minimum requirements.      |  |
|           |         | above minimum requirements.   |  |
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| Level 1 | 4074          | care of patient(s) receiving transfusion.                                   |          |             |  |             |                |           |              |           |
|---------|---------------|---|----------|-------------|--|-------------|----------------|-----------|--------------|-----------|
|         |               |   |          |             |  |             | Compliant      |           |              |           |
|         |               |   |          |             |  |             | Compliant      |           |              |           |
| 2.4.8   | 4080          | The organisation can demonstrate  |          |             |  |             |                |           |              |           |
| 2.4.0   | +000          | implementation of the approved  |          |             |  |             |                |           |              |           |
|         |               | documentation which describes the   |          |             |  |             |                |           |              |           |
|         |               | process for managing the risks  |          |             |  |             |                |           |              |           |
|         |               | associated with resuscitation.  |          |             |  |             |                |           |              |           |
|         |               | The organisation can demonstrate  |          |             |  |             |                |           |              |           |
|         |               | compliance with the objectives set out                                      |          |             |  |             |                |           |              |           |
|         |               | within the approved documentation described at Level 1, in relation to the: |          |             |  |             |                |           |              |           |
|         |               |   |          |             |  |             |                |           |              |           |
|         | 4082          | early warning systems in place for the                                      | -        |             |  |             |                |           |              |           |
| Level 1 |               | recognition of patients at risk of cardio-                                  |          |             |  |             |                |           |              |           |
|         |               | respiratory arrest  |          |             |  |             |                |           |              |           |
| Level 1 | 4084          | do not attempt resuscitation orders   |          |             |  |             |                |           |              |           |
| Levert  |               | (DNAR).   |          |             |  |             |                |           |              |           |
|         |               |   |          |             |  |             | Compliant      |           |              |           |
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| 2.4.9   | 4090          | The organisation can demonstrate implementation of the approved             |          |             |  |             |                |           |              |           |
|         |               | documentation which describes the   |          |             |  |             |                |           |              |           |
|         |               | process for managing the risks  |          |             |  |             |                |           |              |           |
|         |               | associated with infection prevention  |          |             |  |             |                |           |              |           |
|         |               | and control.  |          |             |  |             |                |           |              |           |
|         |               | The organisation can demonstrate  |          |             |  |             |                |           |              |           |
|         |               | compliance with the objectives set out                                      |          |             |  |             |                |           |              |           |
|         |               | within the approved documentation described at Level 1, in relation to the: |          |             |  |             |                |           |              |           |
|         |               |   |          |             |  |             |                |           |              |           |
|         | 4092          | infection control assurance framework.                                      |          |             |  |             |                |           |              |           |
| Level 1 |               |   |          |             |  |             |                |           |              |           |
|         |               |   |          |             |  |             | Compliant      |           |              |           |
|         |               |   |          |             |  |             |                |           |              |           |
| 2.4.10  | 4100          | The organisation can demonstrate  |          |             |  |             |                |           |              |           |
|         |               | implementation of the approved  |          |             |  |             |                |           |              |           |
|         |               | documentation which describes the organisation-wide process for             |          |             |  |             |                |           |              |           |
|         |               | developing local policies to manage   |          |             |  |             |                |           |              |           |
|         |               | the risks associated with the process                                       |          |             |  |             |                |           |              |           |
|         |               | of clinical diagnostic tests and  |          |             |  |             |                |           |              |           |
|         |               | screening procedures.   |          |             |  |             |                |           |              |           |
|         |               | The organisation can demonstrate  |          |             |  |             |                |           |              |           |
|         |               | compliance with the objectives set out                                      |          |             |  |             |                |           |              |           |
|         |               | within the approved documentation described at Level 1, in relation to the  |          |             |  |             |                |           |              |           |
|         |               | process for:  |          |             |  |             |                |           |              |           |
|         | 4102          | taking action on test and screening   |          |             |  |             |                |           |              |           |
| Level 1 | ji se sesse a | results   |          |             |  |             |                |           |              |           |
| Level 1 | 4104          | the communication of clinical test and                                      |          |             |  |             |                |           |              |           |
| LOVOIT  |               | screening results.  |          |             |  |             |                |           |              |           |
|         |               |   |          |             |  |             | Compliant      |           |              |           |
|         |               |   |          |             |  |             |                |           |              |           |
|         |               |   | <u> </u> | The followi | ng summary will be populated aut       | tomatically | from informat  | ion enter | ed on the wo | orksheet. |
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|         |               |   |          |             |  |             | 2.4.1          | 0         |              |           |
|         |               |   |          |             |  |             | 2.4.2          | 0         |              |           |
|         |               |   |          |             |  |             | 2.4.3          | 0         |              |           |
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| Actions required to achieve<br>compliance | Person/<br>Committee<br>responsible | Target Date | Associated<br>Cost |  |  |  |  |  |  |
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Cell: N1 Comment: Assessor Use Only

Cell: H67 Comment: Patient identification

Cell: H68 Comment: Patient information

Cell: H69 Comment: Consent

Cell: H70 Comment: Clinical record-keeping standards

Cell: H71 Comment: Transfer of patients

Cell: H72 Comment: Medicines management

Cell: H73 Comment: Blood transfusion

Cell: H74 Comment: Resuscitation

Cell: H75 Comment: Infection control

Cell: H76 Comment: Diagnostic testing and screening procedures

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| Criterion number | Index | Criterion and minimum requirements   | Paper or Electronic copy | Document submitted | Electronic file hyperlink/name | Document version name,<br>no. and approved and<br>review dates | Initials of contact name<br>for document | Compliant?<br>(Organisation) | Reference | Organisation's comments | Compliant? (Assessor) | Comment in Report | Assessor's comments | Proposed Future Change | Rationale |
|------------------|-------|--|--------------------------|--------------------|--------------------------------|--|--|------------------------------|-----------|-------------------------|-----------------------|-------------------|---------------------|------------------------|-----------|
| 2.5.1            |       | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the reporting of all<br>internally and externally reportable<br>incidents.  |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
|                  |       | The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for reporting:  |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
| Level 1          |       | all incidents/near misses, involving<br>staff, patients and others   |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
| Level 1          |       | to external agencies.  |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
|                  |       |  |                          |                    |                                |  | Compliant                                |                              |           | Compliant               |                       |                   |                     |                        |           |
| 2.5.2            |       | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for ensuring that patients,<br>their relatives and carers have suitable<br>and accessible information about, and<br>clear access to, procedures to raise<br>concerns informally.  |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
|                  |       | The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process:  |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
| Level 1          |       | for raising concerns (informal<br>complaints/PALS)   |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
| Level 1          |       | by which the organisation aims to make changes as a result of concerns   |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
| Leveri           |       | being raised.  |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
|                  |       |  |                          |                    |                                |  | Compliant                                |                              |           | Compliant               |                       |                   |                     |                        |           |
| 2.5.3            |       | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for ensuring that patients,<br>their relatives and carers have suitable<br>and accessible information about, and<br>clear access to, procedures to register<br>formal complaints. |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
|                  |       | The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the:   |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
| Level 1          |       | complaints management process,<br>which includes internal and external<br>communication, and collaboration with<br>other organisations when necessary  |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |

|                   |   |           | 1 |           |   |           | <br>1 | · · · · · |  |
|-------------------|---|-----------|---|-----------|---|-----------|-------|-----------|--|
|                   | 4 process by which the organisation   |           |   |           |   |           |       |           |  |
| Level 1           | aims to make changes as a result of   |           |   |           |   |           |       |           |  |
|                   | formal complaints.  |           |   |           |   |           |       |           |  |
|                   |   |           |   | Compliant |   | Compliant |       |           |  |
| 254 504           | O The ergenization can domonstrate  |           |   |           |   |           |       |           |  |
| 2.5.4 5040        | 0 The organisation can demonstrate<br>implementation of the approved        |           |   |           |   |           |       |           |  |
|                   | documentation which describes the   |           |   |           |   |           |       |           |  |
|                   | process for managing all claims in  |           |   |           |   |           |       |           |  |
|                   | accordance with NHSLA requirements.   |           |   |           |   |           |       |           |  |
|                   |   |           |   |           |   |           |       |           |  |
|                   | The organisation can demonstrate  |           |   |           |   |           |       |           |  |
|                   | compliance with the objectives set out                                      |           |   |           |   |           |       |           |  |
|                   | within the approved documentation   |           |   |           |   |           |       |           |  |
|                   | described at Level 1, in relation to the:                                   |           |   |           |   |           |       |           |  |
| 504               | 3 action to be taken, including   |           |   |           |   |           |       |           |  |
| Level 1           | timescales  |           |   |           |   |           |       |           |  |
| 504               | 4 communication with relevant   |           |   |           |   |           | <br>1 |           |  |
| Level 1           | stakeholders.   |           |   |           |   |           |       |           |  |
|                   |   |           |   | Compliant |   | Compliant |       |           |  |
|                   |   |           |   |           |   | •         |       |           |  |
| 2.5.5 5050        | 0 The organisation can demonstrate  |           |   |           |   |           |       |           |  |
|                   | implementation of the approved  |           |   |           |   |           |       |           |  |
|                   | documentation which describes the   |           |   |           |   |           |       |           |  |
|                   | process for investigating all incidents,<br>complaints and claims.          |           |   |           |   |           |       |           |  |
|                   | The organisation can demonstrate  |           |   |           |   |           |       |           |  |
|                   | compliance with the objectives set out                                      |           |   |           |   |           |       |           |  |
|                   | within the approved documentation   |           |   |           |   |           |       |           |  |
|                   | described at Level 1, in relation to the:                                   |           |   |           |   |           |       |           |  |
|                   |   |           |   |           |   |           |       |           |  |
| 505               | 3 different levels of investigation   |           |   |           |   |           |       |           |  |
| Level 1           | appropriate to the severity of the  |           |   |           |   |           |       |           |  |
|                   | event(s)  |           |   |           |   |           |       |           |  |
| Level 1           | 5 process for following up relevant action                                  |           |   |           |   |           |       |           |  |
|                   | plans.  |           |   |           |   |           |       |           |  |
|                   |   |           |   | Compliant |   | Compliant |       |           |  |
| 2.5.6 5060        | 0 The organisation can demonstrate  |           |   |           |   |           |       |           |  |
| 2.5.6             | implementation of the approved  |           |   |           |   |           |       |           |  |
|                   | documentation which describes the   |           |   |           |   |           |       |           |  |
|                   | process for ensuring a systematic   |           |   |           |   |           |       |           |  |
|                   | approach to the aggregation of  |           |   |           |   |           |       |           |  |
|                   | incidents, complaints and claims on an                                      |           |   |           |   |           |       |           |  |
|                   | ongoing basis.  |           |   |           |   |           |       |           |  |
|                   | The organisation can demonstrate  |           |   |           |   |           |       |           |  |
|                   | compliance with the objectives set out                                      |           |   |           |   |           |       |           |  |
|                   | within the approved documentation described at Level 1, in relation to the: |           |   |           |   |           |       |           |  |
|                   |   |           |   |           |   |           |       |           |  |
| 506               | 2 coordinated approach to the   |           |   |           |   |           |       |           |  |
| Level 1           | aggregation of incidents, complaints  |           |   |           |   |           |       |           |  |
|                   | and claims  |           |   |           |   |           |       |           |  |
| 5064              | 4 minimum content required within the                                       |           |   |           |   |           |       |           |  |
| Level 1           | analysis report, including qualitative                                      |           |   |           |   |           |       |           |  |
|                   | and quantitative analysis.  |           |   |           |   |           |       |           |  |
|                   |   |           |   | Compliant | 3 | Compliant |       |           |  |
|                   |   |           |   |           |   |           |       |           |  |
| <b>2.5.7</b> 5070 | 0 The organisation can demonstrate  |           |   |           |   |           |       |           |  |
|                   | implementation of the approved<br>documentation which describes the         |           |   |           |   |           |       |           |  |
|                   | process for encouraging learning and  |           |   |           |   |           |       |           |  |
|                   | promoting improvements in practice,   |           |   |           |   |           |       |           |  |
|                   | based on individual and aggregated  |           |   |           |   |           |       |           |  |
|                   | analysis of incidents, complaints and                                       |           |   |           |   |           |       |           |  |
|                   | claims.   |           |   |           |   |           |       |           |  |
|                   |   | · · · · · |   | • • •     |   |           |       |           |  |

|                    | The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process by which the organisation<br>ensures:   |  |           |           |   |  |
|--------------------|--|--|-----------|-----------|---|--|
| Level 1 5074       | the implementation of risk reduction measures.   |  |           |           |   |  |
|                    |  |  | Compliant | Compliant |   |  |
| 0 5 0 5080         | The organization can domonatrate   |  |           |           |   |  |
| <b>2.5.8</b> 5080  | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for ensuring that agreed best<br>practice as defined in all NICE<br>guidance is taken into account in the<br>context of the clinical services provided<br>by the organisation.  |  |           |           |   |  |
|                    | The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:  |  |           |           | The assessor will select two clinical<br>guidelines from the list to assess the<br>organisation's compliance with the<br>above minimum requirement. |  |
| 5085               | ensuring that recommendations are acted upon throughout the organisation.  |  |           |           |   |  |
|                    | The assessor will select two clinical<br>guidelines from the list to assess the<br>organisation's compliance with the<br>above minimum requirement.  |  |           |           |   |  |
|                    |  |  | Compliant | Compliant |   |  |
| <b>2.5.9</b> 5090  | The organisation can demonstrate<br>implementation of the approved<br>documentation which describes the<br>process for ensuring that agreed best<br>practice, as defined in nationally<br>agreed guidance, the National Service<br>Frameworks, National Confidential<br>Enquiries and other High Level<br>Enquiries that make recommendations<br>for patient safety, is taken into account<br>in the context of the clinical services<br>provided by the organisation. |  |           |           |   |  |
|                    | The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:  |  |           |           |   |  |
| Level 1 5095       | ensuring that recommendations are acted upon throughout the organisation.  |  |           |           |   |  |
|                    |  |  | Compliant | Compliant |   |  |
| <b>2.5.10</b> 5100 | The organisation can demonstrate   |  |           |           |   |  |
|                    | implementation of the approved<br>documentation which describes the<br>process for ensuring that all<br>communication is open, honest and<br>occurs as soon as possible following<br>an incident, complaint or claim.  |  |           |           |   |  |
|                    | The organisation can demonstrate<br>compliance with the objectives set out<br>within the approved documentation<br>described at Level 1, in relation to the:   |  |           |           |   |  |

| Level 1 |  | process for encouraging open<br>communication between healthcare<br>organisations, healthcare teams, staff<br>and patients and/or their carers |  |  |     |        |   |  |  |           |   |  |                     |  |  |
|---------|--|--|--|--|-----|--------|---|--|--|-----------|---|--|---------------------|--|--|
| Level 1 |  | requirements for documenting all communication.  |  |  |     |        |   |  |  |           |   |  |                     |  |  |
|         |  |  |  |  | Com | pliant |   |  |  | Compliant |   |  |                     |  |  |
|         |  |  |  |  |     |        |   |  |  |           |   |  |                     |  |  |
|         |  |  |  |  |     |        |   |  |  |           |   |  |                     |  |  |
|         | The following summary will be populated automatically from information entered on the worksheet. |  |  |  |     |        |   |  |  |           |   |  |                     |  |  |
|         |  |  |  |  |     | - 4    | - |  |  |           |   |  |                     |  |  |
|         |  |  |  |  |     | 5.1    | 0 |  |  |           | 0 |  |                     |  |  |
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|         |  |  |  |  | 2.  | 5.4    | 0 |  |  |           | 0 |  |                     |  |  |
|         |  |  |  |  | 2.  | 5.5    | 0 |  |  |           | 0 |  |                     |  |  |
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| *****   |  |  |  |  | 2.  | 5.8    | 0 |  |  |           | 0 |  |                     |  |  |
|         |  |  |  |  | 2.  | 5.9    | 0 |  |  |           | 0 |  |                     |  |  |
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| Actions required to achieve<br>compliance | Person/<br>Committee<br>responsible | Target Date | Associated<br>Cost |  |  |  |  |
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## NHSLA Risk Management Standards for Primary Care Trusts Evidence Template 2.5.

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Cell: B1 Comment: Admin Use Only

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Cell: L1 Comment: Assessor Use Only

Cell: M1 Comment: Assessor Use Only

Cell: N1 Comment: Assessor Use Only

Cell: H66 Comment: Incident reporting

Cell: H67 Comment: Raising concerns

Cell: H68 Comment: Complaints

Cell: H69 Comment: Claims

Cell: H70 Comment: Investigations

Cell: H71 Comment: Analysis

Cell: H72 Comment: Improvement

Cell: H73 Comment: Best practice - NICE

Cell: H74 Comment: Best practice - NSFs, NCEs & High Level Enquiries

Cell: H75 Comment: Being open

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| and<br>bit         Criterion and minimum requestation<br>and monosities have<br>been processed in place to monitor<br>complexes with the approved<br>information and demonstrate has<br>an expression of a locally, whom<br>effects the organisation can demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved information and demonstrate has<br>approved informatin approved information and dem |                  |       |  |               |                    |                                |  |  |                              |           |               |
|--|------------------|-------|--|---------------|--------------------|--------------------------------|--|--|------------------------------|-----------|---------------|
| Image: Section of the section of the constraint of the section o  | Criterion number | Index | Criterion and minimum requirements   | or Electronic | Document submitted | Electronic file hyperlink/name | Document version name,<br>no. and approved and<br>review dates | Initials of contact name<br>for document | Compliant?<br>(Organisation) | Reference | Organisation' |
| is is monitoring compliance with the minimum requirements on tandem within the approved documentation described at Level 1, in relation to the process for.     Image: Image   | 3.1.1            | 1010  | there are processes in place to monitor<br>compliance with the approved<br>organisation-wide risk management   |               |                    |                                |  |  |                              |           |               |
| Level 1       reflects the organisation-wide risk management strategy.         1010       Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been must be evidence that recommendations and action plans have been must be evidence that recommendations and action plans have been must be evidence that recommendations and action plans have been must be evidence that recommendations and action plans have been must be evidence that the approved occurrents to which describes the process for place to monitor compliance with the approved documents.       Compliant         3.1.2       1020       The organisation can demonstrate that the re are processes in place to monitor compliance with the approved documents.       Image: the plant to the the plant to  |                  |       | it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the  |               |                    |                                |  |  |                              |           |               |
| addiciencies, there must be evidence<br>that recommendations and action<br>plans have been developed and<br>changes implemented accordingly.       Compliant         3.1.2       1020       The organisation can demonstrate that<br>there are processes in plane to monitor<br>compliants with the approved<br>documentation which describes the<br>process for developing organisation-<br>wide procedural documents.       Image: Compliant with the approved<br>documents.         Image: Compliant with the approved<br>documentation which describes the<br>minimum requirements contained<br>with the approved documentation<br>described at Level 1, in relation to the:       Image: Compliant with the<br>minimum requirements.         Image: Control of documents, including<br>arching arengements.       Image: Control of documents, including<br>arching arengements.       Image: Compliant with<br>the recommendations and action<br>plans have been developed and<br>deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and<br>changes implemented accordingly.       Image: Compliant with<br>the performance of the high level<br>committee(s) with everating<br>responsibility or rise.         3.1.3       1030       The organisation can demonstrate that<br>there are processes in place to monitor<br>the performance of the high level<br>committee(s) with everation<br>described at Level 1, in relation to the.         Level 1       1024       The organisation can demonstrate that<br>there are processes in place to monitor<br>the performance of the high here<br>committee(s) with everation<br>described at Level 1, in relation to the.         Level 1       1022.       The organisation can demonstrate that<br>there are proceed documentation<br>descrintee(s) with everation<br>the performance of the high here  | Level 1          | 1013  | reflects the organisation-wide risk  |               |                    |                                |  |  |                              |           |               |
| 3.1.2       1020       The organisation can demonstrate that<br>there are processes in place to monitor<br>compliance with the approved<br>documentation which describes the<br>process for developing organisation-<br>wide procedural documents.         Image: the organisation can demonstrate that<br>is is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the:         Level 1       1024         Table comments.       Image: the organisation content of<br>minimum requirements.         1028       ratification process<br>control of documents, including<br>archiving arrangements.         1029       Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and<br>changes implemented accordingly.         3.1.3       1030       The organisation can demonstrate that<br>it fiere are processes in place to monitor<br>the performance of the high level<br>committee(s) with overarching<br>responsibility for risk.         The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the<br>level 1   |                  | 1019  | deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and   |               |                    |                                |  |  |                              |           |               |
| Image: Instruction which the approved documentation which describes the process for developing organisation-wide procedural documents.       Image: Ima   |                  |       |  |               |                    |                                |  | Compliant                                |                              |           |               |
| Image: Instruction which the approved documentation which describes the process for developing organisation-wide procedural documents.       Image: Ima   | 210              | 1020  | The organisation can demonstrate that  |               |                    |                                |  |  |                              |           |               |
| It is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:       Image: the minimum requirements contained within the approved documents, including archiving arrangements.         Level 1       1024       ratification process       Image: the minimum requirements contained within the approved documents, including archiving arrangements.       Image: the minimum requirements contained within the approved documents, including archiving arrangements in the high tevel         1029       Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.       Image: the monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:         3.1.3       1030       The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:       Image: the minimum requirements to the board the minimum requirements in the high tevel         Level 1       1032.1       reporting arrangements to the board tevel       Image: tere tere tere tere tere tere tere te   |                  |       | there are processes in place to monitor<br>compliance with the approved<br>documentation which describes the<br>process for developing organisation-     |               |                    |                                |  |  |                              |           |               |
| Level 1       1026       control of documents, including archiving arrangements.         1029       Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.       Compliant         3.1.3       1030       The organisation can demonstrate that there are processes in place to monitor the performance of the high level committee(s) with overarching responsibility for risk.       Compliant         The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:       Image: second se  |                  |       | it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation  |               |                    |                                |  |  |                              |           |               |
| Level1       archiving arrangements.       Image: constraint of the second of t  | Level 1          |       |  |               |                    |                                |  |  |                              |           |               |
| 1029       Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.       Compliant         3.1.3       1030       The organisation can demonstrate that there are processes in place to monitor the performance of the high level committee(s) with overarching responsibility for risk.       Image: Compliant of the compliant of the performance of the high level committee(s) with overarching responsibility for risk.         Image: Compliant of the approved documentation described at Level 1, in relation to the:       Image: Compliant of the compliant of the compliant of the performance of the high level committee (s) with the approved documentation described at Level 1, in relation to the:         Level 1       1032       reporting arrangements to the board level 1         Level 1       1035       reporting arrangements into the high   | Level 1          | 1026  | -  |               |                    |                                |  |  |                              |           |               |
| 3.1.3       1030       The organisation can demonstrate that there are processes in place to monitor the performance of the high level committee(s) with overarching responsibility for risk.         Image: the second secon  |                  | 1029  | Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and          |               |                    |                                |  |  |                              |           |               |
| Level 1       1032.1       reporting arrangements to the board         Lovel 1       1035       reporting arrangements into the high   |                  |       |  |               |                    |                                |  | Compliant                                |                              |           |               |
| Level 1       1032.1       reporting arrangements to the board         Lovel 1       1035       reporting arrangements into the high   | 312              | 1030  | The organisation can demonstrate that  |               |                    |                                |  |  |                              |           |               |
| Level 11032.1reporting arrangements to the boardImage: Compute section of the secti  | 5.1.5            |       | there are processes in place to monitor<br>the performance of the high level<br>committee(s) with overarching<br>responsibility for risk.                |               |                    |                                |  |  |                              |           |               |
| 1035 reporting arrangements into the high  |                  |       | it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the: |               |                    |                                |  |  |                              |           |               |
|  | Level 1          |       |  |               |                    |                                |  |  |                              |           |               |
|  | Level 1          | 1035  |  |               |                    |                                |  |  |                              |           |               |

| on's comments | Compliant? (Assessor) | Comment in Report | Assessor's comments | Proposed Future Change | Rationale |
|---------------|-----------------------|-------------------|---------------------|------------------------|-----------|
|               |                       |                   |                     |                        |           |
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| Compliant     |                       |                   |                     |                        |           |
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| Compliant     |                       |                   |                     |                        |           |
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|                | 1039  | Where the monitoring has identified  |     |               |  |           |   |   |   |   |
|----------------|-------|--|-----|---------------|--|-----------|---|---|---|---|
|                |       | deficiencies, there must be evidence   |     |               |  |           |   |   |   |   |
|                |       | that recommendations and action  |     |               |  |           |   |   |   |   |
|                |       | plans have been developed and  |     |               |  |           |   |   |   |   |
|                |       | changes implemented accordingly.   |     |               |  |           |   |   |   |   |
|                |       |  |     | Compliant     |  | Compliant |   |   |   |   |
|                |       |  |     | <br>          |  |           |   |   |   |   |
| 3.1.4          | 1040  | The organisation can demonstrate that  |     |               |  |           |   |   |   |   |
|                |       | there are processes in place to monitor  |     |               |  |           |   |   |   |   |
|                |       | compliance with the approved   |     |               |  |           |   |   |   |   |
|                |       | documentation which describes the  |     |               |  |           |   |   |   |   |
|                |       | process for delivering risk  |     |               |  |           |   |   |   |   |
|                |       | management awareness training for  |     |               |  |           |   |   |   |   |
|                |       | board members, executives and senior   |     |               |  |           |   |   |   |   |
|                |       | managers.  |     |               |  |           |   |   |   |   |
|                |       | The organisation can demonstrate that  |     |               |  |           |   |   |   |   |
|                |       | it is monitoring compliance with the   |     |               |  |           |   |   |   |   |
|                |       | minimum requirements contained   |     |               |  |           |   |   |   |   |
|                |       | within the approved documentation  |     |               |  |           |   |   |   |   |
|                |       | described at Level 1, in relation to the   |     |               |  |           |   |   |   |   |
|                |       | process for:   |     |               |  |           |   |   |   |   |
|                |       | ensuring that all board members and  |     |               |  |           |   |   |   |   |
| Level 1        |       | senior managers receive relevant risk  |     |               |  |           |   |   |   |   |
|                |       | management awareness training  |     |               |  |           |   |   |   |   |
|                | 10.11 |  | +   | <br>          |  |           |   |   |   | ļ |
| Level 1        |       | following up non-attendance.   | +   |               |  |           | + |   |   |   |
|                |       | Where the monitoring has identified deficiencies, there must be evidence                                 |     |               |  |           |   |   |   |   |
|                |       | that recommendations and action  |     |               |  |           |   |   |   |   |
|                |       | plans have been developed and  |     |               |  |           |   |   |   |   |
|                |       | changes implemented accordingly.   |     |               |  |           |   |   |   |   |
|                |       |  |     | <br>Compliant |  | Compliant |   |   |   |   |
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| 3.1.5          | 1050  | The organisation can demonstrate that  |     |               |  |           |   |   |   |   |
| NO. 11 DOURDON |       | there are processes in place to monitor  |     |               |  |           |   |   |   |   |
|                |       | compliance with the approved   |     |               |  |           |   |   |   |   |
|                |       | documentation which describes the  |     |               |  |           |   |   |   |   |
|                |       | organisation-wide systematic risk  |     |               |  |           |   |   |   |   |
|                |       | management process.  |     |               |  |           |   |   |   |   |
|                |       |  |     |               |  |           |   |   |   |   |
|                |       | The organisation can demonstrate that  |     |               |  |           |   |   |   |   |
|                |       | it is monitoring compliance with the   |     |               |  |           |   |   |   |   |
|                |       | minimum requirements contained   |     |               |  |           |   |   |   |   |
|                |       | within the approved documentation  |     |               |  |           |   |   |   |   |
|                |       | described at Level 1, in relation to the   |     |               |  |           |   |   |   |   |
| Louis I d      |       | process for:   |     |               |  |           |   |   |   |   |
| Level 1        |       | assessing <u>strategic risks</u><br>ensuring a continual, systematic                                     | +   |               |  |           | + |   |   | + |
| Level 1        |       | approach to all risk assessments is  |     |               |  |           |   |   |   |   |
|                |       | followed throughout the organisation.  |     |               |  |           |   |   |   |   |
|                |       | Where the monitoring has identified  | + + |               |  |           |   | 1 |   |   |
|                |       | deficiencies, there must be evidence   |     |               |  |           |   |   |   |   |
|                |       | that recommendations and action  |     |               |  |           |   |   |   |   |
|                |       | plans have been developed and  |     |               |  |           |   |   |   |   |
|                |       | changes implemented accordingly.   |     |               |  |           |   |   |   |   |
|                |       |  |     | Compliant     |  | Compliant |   |   |   |   |
|                |       |  |     |               |  |           |   |   |   |   |
| 3.1.6          |       | The organisation can demonstrate that  |     | <u> </u>      |  |           |   |   |   |   |
|                |       | the organisation-wide risk register is a   |     |               |  |           |   |   |   |   |
|                |       | dynamic document.  |     |               |  |           |   |   |   |   |
|                |       | The organisation can demonstrate that  |     |               |  |           |   |   |   |   |
| Level 1        |       | it is monitoring the approved  |     |               |  |           |   |   |   |   |
|                |       | organisation-wide risk register.   |     |               |  |           |   |   |   |   |
|                |       | Where the monitoring has identified  |     |               |  |           |   |   |   |   |
|                |       |  |     |               |  |           |   |   | 1 |   |
|                |       | deficiencies, there must be evidence   |     |               |  |           |   |   |   |   |
|                |       | deficiencies, there must be evidence<br>that recommendations and action                                  |     |               |  |           |   |   |   |   |
|                |       | deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and |     |               |  |           |   |   |   |   |
|                |       | deficiencies, there must be evidence<br>that recommendations and action                                  |     | 0             |  |           |   |   |   |   |
|                |       | deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and |     | Compliant     |  | Compliant |   |   |   |   |

| 3.1.7              | The organisation can demonstrate that<br>there are processes in place to monitor<br>compliance with the approved<br>documentation which describes the<br>process for responding to the<br>recommendations and requirements<br>arising from external agency visits,<br>inspections and accreditations specific<br>to the organisation.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained |  |           |  |           |  |  |
|--------------------|--|--|-----------|--|-----------|--|--|
|                    | within the approved documentation<br>described at Level 1, in relation to the<br>process for:<br>maintaining action plans to implement   |  |           |  |           |  |  |
| Level 1            | any recommendations made as a result of reviews.<br>Where the monitoring has identified  |  |           |  |           |  |  |
|                    | that recommendations and action<br>plans have been developed and<br>changes implemented accordingly.   |  |           |  |           |  |  |
|                    |  |  | Compliant |  | Compliant |  |  |
| 3.1.8              | The organisation can demonstrate that<br>there are processes in place to monitor<br>compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with clinical records in all<br>media.   |  |           |  |           |  |  |
|                    | The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:   |  |           |  |           |  |  |
| Level 1<br>Level 1 | tracking records retaining and disposing of records.   |  |           |  |           |  |  |
|                    | Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and<br>changes implemented accordingly.  |  | Compliant |  | Compliant |  |  |
|                    |  |  | Compliant |  | Compliant |  |  |
| 3.1.9              | The organisation can demonstrate that<br>there are processes in place to monitor<br>compliance with the approved<br>documentation which describes the<br>process for ensuring that all clinical<br>staff (temporary and permanent) are<br>registered with the appropriate<br>professional body.  |  |           |  |           |  |  |
|                    | The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:   |  |           |  |           |  |  |
| Level 1            | ensuring registration checks are made<br>directly with the relevant professional<br>body, in accordance with their<br>recommendations in respect of all<br>permanent clinical staff both on initial<br>appointment and ongoing thereafter  |  |           |  |           |  |  |

| ·           |   |  |                                  |             |                      |             |                                       |      |
|-------------|---|--|----------------------------------|-------------|----------------------|-------------|---------------------------------------|------|
| 1093        | .1 monitoring/receiving assurance that    |  |                                  |             |                      |             |                                       |      |
|             | registration checks are being carried     |  |                                  |             |                      |             |                                       |      |
|             | out by all external agencies (e.g. NHS    |  |                                  |             |                      |             |                                       |      |
| Level 1     | Professionals, recruitment agencies,      |  |                                  |             |                      |             |                                       |      |
|             | etc.) used by the organisation in         |  |                                  |             |                      |             |                                       |      |
|             | respect of all temporary clinical staff.  |  |                                  |             |                      |             |                                       |      |
|             | respect of an temporary clinical stan.    |  |                                  |             |                      |             |                                       |      |
|             |   |  |                                  |             |                      |             |                                       |      |
| 109ទ        | 9 Where the monitoring has identified     |  |                                  |             |                      |             |                                       |      |
|             | deficiencies, there must be evidence      |  |                                  |             |                      |             |                                       |      |
|             | that recommendations and action           |  |                                  |             |                      |             |                                       |      |
|             | plans have been developed and             |  |                                  |             |                      |             |                                       |      |
|             | changes implemented accordingly.          |  |                                  |             |                      |             |                                       |      |
|             |   |  | Complian                         | t l         | Compliant            |             |                                       |      |
|             |   |  | eempilai                         |             |                      |             |                                       |      |
| 3.1.10 1100 | The organisation can demonstrate that     |  |                                  |             |                      |             |                                       | 1    |
|             | there are processes in place to monitor   |  |                                  |             |                      |             |                                       |      |
|             | compliance with the approved              |  |                                  |             |                      |             |                                       |      |
|             | documentation which describes the         |  |                                  |             |                      |             |                                       |      |
|             |   |  |                                  |             |                      |             |                                       |      |
|             | process for ensuring that all             |  |                                  |             |                      |             |                                       |      |
|             | appropriate employment checks are         |  |                                  |             |                      |             |                                       |      |
|             | undertaken for all staff (temporary and   |  |                                  |             |                      |             |                                       |      |
|             | permanent).                               |  |                                  |             |                      |             |                                       |      |
|             | The organisation can demonstrate that     |  |                                  |             |                      |             | The assessor will select two elements |      |
|             | it is monitoring compliance with the      |  |                                  |             |                      |             | of the Employment Checks Minimum      |      |
|             | minimum requirements contained            |  |                                  |             |                      |             | Data Set at random to assess the      |      |
|             | within the approved documentation         |  |                                  |             |                      |             | organisation's compliance with the    |      |
|             | described at Level 1, in relation to the: |  |                                  |             |                      |             | above minimum requirement.            |      |
|             |   |  |                                  |             |                      |             |                                       |      |
|             |   |  |                                  |             |                      |             |                                       |      |
| 1107        | 1 1                                       |  |                                  |             |                      |             |                                       |      |
| 1107        |   |  |                                  |             |                      |             |                                       |      |
|             | 2 types of check required.                |  |                                  |             |                      |             |                                       |      |
| 1109        | 9 Where the monitoring has identified     |  |                                  |             |                      |             |                                       |      |
|             | deficiencies, there must be evidence      |  |                                  |             |                      |             |                                       |      |
|             | that recommendations and action           |  |                                  |             |                      |             |                                       |      |
|             | plans have been developed and             |  |                                  |             |                      |             |                                       |      |
|             | changes implemented accordingly.          |  |                                  |             |                      |             |                                       |      |
|             | 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.                |  |                                  |             |                      |             |                                       |      |
|             | above minimum requirement.                |  |                                  |             |                      |             |                                       |      |
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|             |   |  |                                  |             |                      |             |                                       |      |
|             |   | The following summary will be populated au | tomatically from inform          | ation enter | ed on the worksheet. |             |                                       |      |
|             |   |  |                                  | I           |                      |             |                                       |      |
|             |   |  | 3.1.1                            | 0           |                      | 0           |                                       |      |
|             |   |  | 3.1.2                            | 0           |                      | 0           |                                       |      |
|             |   |  | 3.1.3                            | 0           |                      | 0           |                                       |      |
|             |   |  | 3.1.4                            |             |                      | 0           |                                       |      |
|             |   |  | 3.1.4                            | 0           |                      |             |                                       |      |
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|             |   |  | 3.1.6                            | 0           |                      | 0           |                                       | <br> |
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|             |   |  | 3.1.6                            |             |                      |             |                                       |      |
|             |   |  | 3.1.6<br>3.1.7                   | 0           |                      | 0           |                                       |      |
|             |   |  | 3.1.6<br>3.1.7<br>3.1.8<br>3.1.9 | 0<br>0<br>0 |                      | 0<br>0<br>0 | All Standards Total                   |      |
|             |   |  | 3.1.6<br>3.1.7<br>3.1.8          | 0           |                      | 0           | All Standards Total                   |      |

| Actions required to achieve<br>compliance<br>Person/<br>Committee<br>responsible | Target Date <sup>/</sup> | Associated<br>Cost |  |  |  |  |  |
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Cell: N1 Comment: Assessor Use Only

Cell: H74 Comment: Risk management strategy

Cell: H75 Comment: Policy on procedural documents

Cell: H76 Comment: Risk management committee(s)

Cell: H77 Comment: Risk awareness training for senior management

Cell: H78 Comment: Risk management process

Cell: H79 Comment: Risk register

Cell: H80 Comment: Responding to external recommendations specific to the organisation

Cell: H81 Comment: Clinical records management

Cell: H82 Comment: Professional clinical registration

Cell: H83 Comment: Employment checks

| Criterion number | Index | Criterion and minimum requirements  | Paper or Electronic copy | Document submitted | Electronic file hyperlink/name | Document version name,<br>no. and approved and<br>review dates | Initials of contact name<br>for document | Compliant?<br>(Organisation) | Reference | Organisation's comments | Compliant? (Assessor) | Comment in Report | Assessor's comments | Proposed Future Change Rationale |
|------------------|-------|---|--------------------------|--------------------|--------------------------------|--|--|------------------------------|-----------|-------------------------|-----------------------|-------------------|---------------------|----------------------------------|
| 3.2.1            |       | The organisation can demonstrate that<br>there are processes in place to monitor<br>compliance with the approved<br>documentation which describes the<br>corporate induction arrangements for<br>all new permanent staff.                                 |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                                  |
|                  |       | The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:<br>checking that all new permanent staff |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                                  |
| Level 1          |       | complete corporate induction<br>following up those who fail to attend   |                          |                    |                                |  |  |                              |           |                         |                       | $\left  \right $  |                     |                                  |
| Lever1           |       | corporate induction.<br>Where the monitoring has identified   |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                                  |
|                  |       | deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and<br>changes implemented accordingly.  |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                                  |
|                  |       |   |                          |                    |                                |  | Compliant                                |                              |           | Compliant               |                       |                   |                     |                                  |
| 3.2.2            |       | The organisation can demonstrate that<br>there are processes in place to monitor<br>compliance with the approved<br>documentation which describes the<br>local induction arrangements for all<br>new permanent staff.                                     |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                                  |
|                  |       | The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:  |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                                  |
| Level 1          |       | checking that all new permanent staff<br>complete local induction   |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                                  |
| Level 1          |       | following up those who fail to complete local induction.  |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                                  |
|                  |       | Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and<br>changes implemented accordingly.   |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                                  |
|                  |       |   |                          |                    |                                |  | Compliant                                |                              |           | Compliant               |                       |                   |                     |                                  |
| 3.2.3            |       | The organisation can demonstrate that<br>there are processes in place to monitor<br>compliance with the approved<br>documentation which describes the<br>local induction arrangements for all<br>temporary staff.   |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                                  |
|                  |       | The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:  |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                                  |

| Level 1 |      | checking that all temporary staff         |      |   |           |  |           |                                       |  |
|---------|------|---|------|---|-----------|--|-----------|---------------------------------------|--|
| 6       |      | complete local induction                  |      |   |           |  |           |                                       |  |
| Level 1 |      | following up those who fail to complete   |      |   |           |  |           |                                       |  |
|         |      | local induction.                          |      |   |           |  |           |                                       |  |
|         |      | Where the monitoring has identified       |      |   |           |  |           |                                       |  |
|         |      | deficiencies, there must be evidence      |      |   |           |  |           |                                       |  |
|         | · ·  | that recommendations and action           |      |   |           |  |           |                                       |  |
|         |      | plans have been developed and             |      |   |           |  |           |                                       |  |
|         |      | changes implemented accordingly.          |      |   |           |  |           |                                       |  |
|         |      |   |      |   | Compliant |  | Compliant |                                       |  |
|         |      |   |      |   |           |  |           |                                       |  |
| 3.2.4   | 2040 | The organisation can demonstrate that     |      |   |           |  |           |                                       |  |
|         |      | there are processes in place to monitor   |      |   |           |  |           |                                       |  |
|         |      | compliance with the approved              |      |   |           |  |           |                                       |  |
|         |      | documentation which describes the         |      |   |           |  |           |                                       |  |
|         |      | process for ensuring that the             |      |   |           |  |           |                                       |  |
|         |      | organisation undertakes the               |      |   |           |  |           |                                       |  |
|         |      | appropriate regulatory checks via the     |      |   |           |  |           |                                       |  |
|         |      | NHSLA Family Health Service Appeal        |      |   |           |  |           |                                       |  |
|         |      | Unit on all primary care performers       |      |   |           |  |           |                                       |  |
|         |      | (temporary and permanent).                |      |   |           |  |           |                                       |  |
|         |      |   |      |   |           |  |           |                                       |  |
|         |      | The organisation can demonstrate that     |      |   |           |  |           |                                       |  |
|         |      | it is monitoring compliance with the      |      |   |           |  |           |                                       |  |
|         |      | minimum requirements contained            |      |   |           |  |           |                                       |  |
|         |      | within the approved documentation         |      |   |           |  |           |                                       |  |
|         |      | described at Level 1, in relation to the: |      |   |           |  |           |                                       |  |
|         |      |   |      |   |           |  |           |                                       |  |
|         | 2042 | process for ensuring checks are made      |      | _ |           |  |           |                                       |  |
| Level 1 |      |   |      |   |           |  |           |                                       |  |
|         | 2044 | procedure for notifying the NHSLA         |      |   |           |  |           |                                       |  |
| Level 1 |      | Family Health Service Appeal Unit in      |      |   |           |  |           |                                       |  |
|         |      | the event of concern.                     |      |   |           |  |           |                                       |  |
|         | 2049 | Where the monitoring has identified       |      |   |           |  |           |                                       |  |
|         |      | deficiencies, there must be evidence      |      |   |           |  |           |                                       |  |
|         |      | that recommendations and action           |      |   |           |  |           |                                       |  |
|         |      | plans have been developed and             |      |   |           |  |           |                                       |  |
|         |      | changes implemented accordingly.          |      |   |           |  |           |                                       |  |
|         |      |   |      |   | Compliant |  | Compliant |                                       |  |
|         |      |   |      |   |           |  |           |                                       |  |
| 3.2.5   | 2050 | The organisation can demonstrate that     |      |   |           |  |           |                                       |  |
|         |      | there are processes in place to monitor   |      |   |           |  |           |                                       |  |
|         |      | compliance with the approved              |      |   |           |  |           |                                       |  |
|         |      | documentation which describes the         |      |   |           |  |           |                                       |  |
|         |      | process for ensuring a systematic         |      |   |           |  |           |                                       |  |
|         |      | approach to risk management training      |      |   |           |  |           |                                       |  |
|         |      | for all permanent staff.                  |      |   |           |  |           |                                       |  |
|         |      |   |      |   |           |  |           |                                       |  |
|         |      | The organisation can demonstrate that     |      |   |           |  |           | The assessor will select two elements |  |
|         |      | it is monitoring compliance with the      |      |   |           |  |           | of risk management training from the  |  |
|         |      | minimum requirements contained            |      |   |           |  |           | TNA Minimum Data Set at random to     |  |
|         |      | within the approved documentation         |      |   |           |  |           | assess the organisation's compliance  |  |
|         |      | described at Level 1, in relation to the  |      |   |           |  |           | with the above minimum requirements.  |  |
|         |      | process for:                              |      |   |           |  |           |                                       |  |
|         | 2057 |   |      |   |           |  |           |                                       |  |
|         | 2057 |   |      |   |           |  |           |                                       |  |
|         |      | checking that all permanent staff         |      |   |           |  |           |                                       |  |
|         |      | complete the relevant training            |      |   |           |  |           |                                       |  |
| Level 1 |      | programmes in accordance with the         |      |   |           |  |           |                                       |  |
|         | · ·  | training needs analysis                   |      |   |           |  |           |                                       |  |
|         |      | following up those who fail to attend     | <br> |   |           |  |           |                                       |  |
| Level 1 |      | relevant training programmes.             |      |   |           |  |           |                                       |  |
|         |      | Where the monitoring has identified       |      |   | + +       |  |           |                                       |  |
|         |      | deficiencies, there must be evidence      |      |   |           |  |           |                                       |  |
| 1       |      | that recommendations and action           |      |   |           |  |           |                                       |  |
| 1       |      | plans have been developed and             |      |   |           |  |           |                                       |  |
|         |      | changes implemented accordingly.          |      |   |           |  |           |                                       |  |
|         | 1 I  | J   |      | 1 |           |  |           | <br>L                                 |  |

|             |      | The assessor will select two elements     |  |          |   |           |  |          |
|-------------|------|---|--|----------|---|-----------|--|----------|
|             |      | of risk management training from the      |  |          |   |           |  |          |
|             |      | TNA Minimum Data Set at random to         |  |          |   |           |  |          |
|             |      | assess the organisation's compliance      |  |          |   |           |  |          |
|             |      | with the above minimum requirements.      |  |          |   |           |  |          |
|             |      |   |  |          |   |           |  |          |
|             |      |   |  | Complian | + | Compliant |  |          |
|             |      |   |  | eemphan  |   | Compliant |  |          |
| 3.2.6       | 2060 | The organisation can demonstrate that     |  |          |   |           |  |          |
| 5.2.0       | 2000 | there are processes in place to monitor   |  |          |   |           |  |          |
|             |      | the risk management training needs        |  |          |   |           |  |          |
|             |      | analysis identified at Level 1 for all    |  |          |   |           |  |          |
|             |      | permanent staff.                          |  |          |   |           |  |          |
|             |      | The organisation can demonstrate the      |  |          |   |           |  |          |
|             |      | risk management training needs            |  |          |   |           |  |          |
|             |      | analysis for all permanent staff by:      |  |          |   |           |  |          |
|             |      | producing an annual training report       |  |          |   |           |  |          |
| Level 1     | 2000 | covering all the topics identified within |  |          |   |           |  |          |
| Leveri      |      | the TNA Minimum Data Set.                 |  |          |   |           |  |          |
| <b> </b>    |      | Where the monitoring has identified       |  |          |   |           |  | +        |
| 1           | 2009 | deficiencies, there must be evidence      |  |          |   |           |  |          |
| 1           |      | that recommendations and action           |  |          |   |           |  |          |
|             |      | plans have been developed and             |  |          |   |           |  |          |
|             |      | changes implemented accordingly.          |  |          |   |           |  |          |
|             |      |   |  | Complian |   | Compliant |  |          |
|             |      |   |  | Complian |   | Compliant |  |          |
| 3 2 7       | 2070 | The organisation can demonstrate that     |  |          |   |           |  |          |
| 5.2.7       | 2070 | there are processes in place to monitor   |  |          |   |           |  |          |
|             |      | compliance with the approved              |  |          |   |           |  |          |
|             |      | documentation which describes the         |  |          |   |           |  |          |
|             |      | process for ensuring that all             |  |          |   |           |  |          |
|             |      | permanent staff are trained to safely     |  |          |   |           |  |          |
|             |      | use diagnostic and therapeutic            |  |          |   |           |  |          |
|             |      | equipment appropriate to their role.      |  |          |   |           |  |          |
|             |      |   |  |          |   |           |  |          |
|             |      | The organisation can demonstrate that     |  |          |   |           |  |          |
|             |      | it is monitoring compliance with the      |  |          |   |           |  |          |
|             |      | minimum requirements contained            |  |          |   |           |  |          |
|             |      | within the approved documentation         |  |          |   |           |  |          |
|             |      | described at Level 1, in relation to the  |  |          |   |           |  |          |
|             |      | process for:                              |  |          |   |           |  |          |
|             | 2073 | identifying which permanent staff are     |  |          |   |           |  |          |
| Level 1     |      | authorised to use the equipment           |  |          |   |           |  |          |
|             |      | identified on the inventory               |  |          |   |           |  |          |
|             |      | determining the training required to      |  |          |   |           |  | <u> </u> |
| _           |      | use the equipment identified on the       |  |          |   |           |  |          |
| Level 1     |      | inventory and the frequency of            |  |          |   |           |  |          |
|             |      | updates required                          |  |          |   |           |  |          |
|             | 2075 | ensuring that the identified training     |  |          |   |           |  |          |
| Level 1     |      | needs of all permanent staff are met.     |  |          |   |           |  |          |
| · · · · · · |      |   |  |          |   |           |  |          |
|             | 2079 | Where the monitoring has identified       |  |          |   |           |  |          |
| 1           |      | deficiencies, there must be evidence      |  |          |   |           |  |          |
| 1           |      | that recommendations and action           |  |          |   |           |  |          |
| 1           |      | plans have been developed and             |  |          |   |           |  |          |
|             |      | changes implemented accordingly.          |  |          |   |           |  |          |
|             |      |   |  | Complian | t | Compliant |  |          |
|             |      |   |  |          |   |           |  |          |
| 3.2.8       | 2080 | The organisation can demonstrate that     |  |          |   |           |  |          |
| 1           |      | there are processes in place to monitor   |  |          |   |           |  |          |
| 1           |      | compliance with the approved              |  |          |   |           |  |          |
| 1           |      | documentation which describes the         |  |          |   |           |  |          |
|             |      | process for ensuring the delivery of      |  |          |   |           |  |          |
| 1           |      | effective hand hygiene training to all    |  |          |   |           |  |          |
| 1           |      | relevant permanent staff groups.          |  |          |   |           |  |          |
| 1           |      |   |  |          |   |           |  |          |

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| 2102 immediate support offered to staff I I I I I I I I I I I I I I I I I I  |
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| externally)  |
| 2105 action for managers or individuals to   |
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| 2109       Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | Compliant  |            |               | Compliant |   |                     |  |
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## NHSLA Risk Management Standards for Primary Care Trusts Evidence Template 3.2.

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

Cell: L1 Comment: Assessor Use Only

Cell: M1 Comment: Assessor Use Only

Cell: N1 Comment: Assessor Use Only

Cell: H79 Comment: Corporate induction

Cell: H80 Comment: Local induction of permanent staff

Cell: H81 Comment: Local induction of temporary staff

Cell: H82 Comment: Fitness to practice

Cell: H83 Comment: Risk management training

Cell: H84 Comment: Training needs analysis

Cell: H85 Comment: Medical devices training

Cell: H86 Comment: Hand hygiene training

Cell: H87 Comment: Moving & handling training

Cell: H88 Comment: Supporting staff involved in an incident, complaint or claim

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| Criterion number | Index | Criterion and minimum requirements  | Paper or Electronic copy | Electronic file hyperlink/name | Document version name,<br>no. and approved and<br>review dates | Initials of contact name<br>for document | Compliant?<br>(Organisation) | Reference | Organisation's comments | Compliant? (Assessor) | Comment in Report | Assessor's comments | Proposed Future Change | Rationale | Actions required to achieve<br>compliance |
|------------------|-------|---|--------------------------|--------------------------------|--|--|------------------------------|-----------|-------------------------|-----------------------|-------------------|---------------------|------------------------|-----------|---|
| 3.3.1            | 3010  | The organisation can demonstrate that<br>there are processes in place to monitor<br>compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the physical security of<br>premises and other assets. |                          |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |   |
|                  |       | The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the:   |                          |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |   |
| Level 1          | 3013  | requirement to undertake appropriate<br>risk assessments regarding the<br>physical security of premises and<br>assets   |                          |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |   |
| Level 1          | 3014  | arrangements for the organisational<br>overview of the risk assessments<br>regarding the physical security of<br>premises and assets.   |                          |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |   |
|                  | 3019  | Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and<br>changes implemented accordingly.   |                          |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |   |
|                  |       |   |                          |                                |  | Compliant                                |                              |           | Compliant               |                       |                   |                     |                        |           |   |
| 3.3.2            | 3020  | The organisation can demonstrate that<br>there are processes in place to monitor<br>compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with sickness absences.                                     |                          |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |   |
|                  |       | The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the:   |                          |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |   |
| Level 1          | 3025  | process for analysing sickness<br>absence data  |                          |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |   |
| Level 1          |       | arrangements for the organisational overview of sickness absence.   |                          |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |   |
|                  | 3029  | Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and<br>changes implemented accordingly.   |                          |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |   |
|                  |       |   |                          |                                |  | Compliant                                |                              |           | Compliant               |                       |                   |                     |                        |           |   |
| 3.3.3            | 3030  | The organisation can demonstrate that<br>there are processes in place to monitor<br>compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with safeguarding adults.                                   |                          |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |   |

|         |      | The organisation can demonstrate that  |      |           |           |  |  |  |  |
|---------|------|--|------|-----------|-----------|--|--|--|--|
|         |      | it is monitoring compliance with the   |      |           |           |  |  |  |  |
|         |      | minimum requirements contained   |      |           |           |  |  |  |  |
|         |      | within the approved documentation  |      |           |           |  |  |  |  |
|         |      | described at Level 1, in relation to the:                                      |      |           |           |  |  |  |  |
|         |      |  |      |           |           |  |  |  |  |
|         |      | local arrangements for managing the  |      |           |           |  |  |  |  |
| Level 1 |      | risks associated with safeguarding   |      |           |           |  |  |  |  |
|         |      | adults.  |      |           |           |  |  |  |  |
|         |      | Where the monitoring has identified  |      |           |           |  |  |  |  |
|         |      | deficiencies, there must be evidence<br>that recommendations and action        |      |           |           |  |  |  |  |
|         |      | plans have been developed and  |      |           |           |  |  |  |  |
|         |      | changes implemented accordingly.   |      |           |           |  |  |  |  |
|         |      | 5,   |      | Compliant | Compliant |  |  |  |  |
|         |      |  |      | Compliant | Compliant |  |  |  |  |
| 3.3.4   | 1    | The organisation can demonstrate that  |      |           |           |  |  |  |  |
| 5.5.4   |      | there are processes in place to monitor  |      |           |           |  |  |  |  |
|         |      | compliance with the approved   |      |           |           |  |  |  |  |
|         |      | documentation which describes the  |      |           |           |  |  |  |  |
|         |      | process for managing the risks   |      |           |           |  |  |  |  |
| 1       |      | associated with moving and handling.   |      |           |           |  |  |  |  |
|         |      |  |      |           |           |  |  |  |  |
|         |      | The organisation can demonstrate that  |      |           |           |  |  |  |  |
|         |      | it is monitoring compliance with the   |      |           |           |  |  |  |  |
|         |      | minimum requirements contained   |      |           |           |  |  |  |  |
|         |      | within the approved documentation<br>described at Level 1, in relation to the: |      |           |           |  |  |  |  |
|         |      |  |      |           |           |  |  |  |  |
|         |      | requirement to undertake appropriate   |      |           |           |  |  |  |  |
|         |      | rick assessments for the moving and  |      |           |           |  |  |  |  |
| Level 1 |      | handling of patients and objects   |      |           |           |  |  |  |  |
|         |      |  |      |           |           |  |  |  |  |
|         |      | arrangements for the organisational  |      |           |           |  |  |  |  |
| Lovel 1 | 3045 | overview of the risk assessments for<br>the moving and handling of patients    |      |           |           |  |  |  |  |
| Leveri  |      | 9  |      |           |           |  |  |  |  |
|         |      | and objects.   | <br> |           |           |  |  |  |  |
|         |      | Where the monitoring has identified  |      |           |           |  |  |  |  |
|         |      | deficiencies, there must be evidence<br>that recommendations and action        |      |           |           |  |  |  |  |
|         |      | plans have been developed and  |      |           |           |  |  |  |  |
|         |      | changes implemented accordingly.   |      |           |           |  |  |  |  |
|         |      |  |      | Compliant | Compliant |  |  |  |  |
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| 3.3.5   |      | The organisation can demonstrate that  |      |           |           |  |  |  |  |
|         |      | there are processes in place to monitor  |      |           |           |  |  |  |  |
| 1       |      | compliance with the approved   |      |           |           |  |  |  |  |
|         |      | documentation which describes the  |      |           |           |  |  |  |  |
|         |      | process for managing the risks   |      |           |           |  |  |  |  |
| 1       |      | associated with slips, trips and falls   |      |           |           |  |  |  |  |
| 1       |      | involving patients, staff and others.  |      |           |           |  |  |  |  |
|         |      | The organization can demonstrate that  |      |           |           |  |  |  |  |
|         |      | The organisation can demonstrate that it is monitoring compliance with the     |      |           |           |  |  |  |  |
|         |      | minimum requirements contained   |      |           |           |  |  |  |  |
|         |      | within the approved documentation  |      |           |           |  |  |  |  |
|         |      | described at Level 1, in relation to the:                                      |      |           |           |  |  |  |  |
|         |      |  |      |           |           |  |  |  |  |
|         |      | requirement to undertake appropriate   |      |           |           |  |  |  |  |
|         |      | risk assessments for the management  |      |           |           |  |  |  |  |
| Level 1 | 3052 | of slips, trips and falls involving  |      |           |           |  |  |  |  |
|         |      | patients (including falls from height)   |      |           |           |  |  |  |  |
|         |      |  |      |           |           |  |  |  |  |
|         |      | requirement to undertake appropriate risk assessments for the management       |      |           |           |  |  |  |  |
|         |      | of slips, trips and falls involving staff                                      |      |           |           |  |  |  |  |
|         | 3033 | and others (including falls from   |      |           |           |  |  |  |  |
| 1       |      | height).   |      |           |           |  |  |  |  |
|         |      |  |      |           |           |  |  |  |  |

|         | 3059 | Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and<br>changes implemented accordingly.   |  |          |   |           |  |  |  |
|---------|------|---|--|----------|---|-----------|--|--|--|
|         |      |   |  | Complian | t | Compliant |  |  |  |
|         |      |   |  |          |   |           |  |  |  |
| 3.3.6   | 3060 | The organisation can demonstrate that<br>there are processes in place to monitor<br>compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with inoculation incidents.   |  |          |   |           |  |  |  |
|         |      | The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:  |  |          |   |           |  |  |  |
| Level 1 |      | the management of an inoculation<br>incident (including prophylaxis).   |  |          |   |           |  |  |  |
|         | 3069 | Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and<br>changes implemented accordingly.   |  |          |   |           |  |  |  |
|         |      |   |  | Complian | t | Compliant |  |  |  |
| 3.3.7   |      | The organisation can demonstrate that<br>there are processes in place to monitor<br>compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the maintenance of<br>reusable medical devices and<br>equipment. |  |          |   |           |  |  |  |
|         |      | The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:  |  |          |   |           |  |  |  |
| Level 1 | 3073 | ensuring that all reusable medical devices and equipment are properly maintained and repaired.  |  |          |   |           |  |  |  |
|         | 3079 | Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and<br>changes implemented accordingly.   |  |          |   |           |  |  |  |
|         |      |   |  | Complian |   | Compliant |  |  |  |
| 3.3.8   | 3080 | The organisation can demonstrate that<br>there are processes in place to monitor<br>compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the harassment and/or<br>bullying of staff.                      |  |          |   |           |  |  |  |
|         |      | The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the<br>process:  |  |          |   |           |  |  |  |
| Level 1 | 3083 | for raising concerns about harassment<br>and/or bullying  |  |          |   |           |  |  |  |
| Level 1 |      | to be followed once a concern has been raised.  |  |          |   |           |  |  |  |

| $ \left  \begin{array}{c c c c c } \hline \\ \hline \\ \hline \\ \hline \\ \hline \\ \hline \\ \hline \\ \hline \\ \hline \\ \hline $  |              |   |                   |                                   |                     |            |                   |           |   |   |      |  |
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| 3.10       The organisation can demonstrate that<br>there are processes in place to monitor<br>compliants with the approved<br>100       Compliants with the approved<br>process or managing the risks of<br>associated with work-release that<br>it is monitoring compliance with the<br>minit the approved documents that<br>it is monitoring compliance with the<br>minit the approved documents that<br>it is monitoring compliance with the<br>minit the approved documents that<br>it is monitoring compliance with the<br>minit the approved documents that<br>it is monitoring compliance with the<br>minit the approved documents that<br>it is monitoring compliance with the<br>minit the approved documents that<br>it is monitoring compliance with the<br>minit the approved documents that<br>it is monitoring compliance with the<br>minit the approved documents that<br>it is monitoring compliance with the<br>minit the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with the approved document<br>with t  |              |   |                   |                                   | Com                 | oliant     |                   | Compliant |   |   |      |  |
| associated with rear are processes on place to monitor operations with describes the process for managing the fields associated with work-related stress.       associated with work-relat  |              |   |                   |                                   |                     | •          |                   | •         |   |   |      |  |
| 310       compliance with the approved decumentation which describes in process for managing the risks associated with origination and emonistrate that it is monitoning compliance with the approved documentation which related stress.       Image: Compliance with the approved documentation which related stress.       Image: Compliance with the approved documentation which related stress.       Image: Compliance with the approved documentation which related stress.       Image: Compliance with the approved documentation which related stress.       Image: Compliance with the approved documentation which related stress.       Image: Compliance with the approved documentation which related stress.       Image: Compliance with the approved documentation which related stress.       Image: Compliance with the approved documentation which related stress.       Image: Compliance with the approved documentation which related stress.       Image: Compliance with the approved documentation which related stress.       Image: Compliance with the approved documentation which related stress.       Image: Compliance with the approved documentation which related stress.       Image: Compliance with the approved documentation which related stress.       Image: Compliance with the approved related stress.       Image: Compliance with the approved related stress.       Image: Compliance with the approved related stress.       Image: Compliance with the approved related stress.       Image: Compliance with the approved related stress.       Image: Compliance with the approved related stress.       Image: Compliance with the approved related stress.       Image: Compliance with the approved related stress.       Image: Compliance with the approved related stress.       Image: Compliance with   |              |   |                   |                                   |                     |            |                   |           |   |   |      |  |
| 3100       documentation which describes the process for managing the risks associated with work-related stress.       Image: monitoring constrained management scontained minimum requirements contained minimum related minimum   |              |   |                   |                                   |                     |            |                   |           |   |   |      |  |
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| $ \begin{array}{ c c c c c } \hline 10^{13} & $ $ $ $ $ $ $ $ $ $ $ $ $ $ $ $ $ $ $  |              | process for identifying workplace         |                   |                                   |                     |            |                   |           |   |   |      |  |
| 114       is assessments for the prevention and management of work-related stress.       1 <td>Level 1 3113</td> <td>stressors</td> <td></td> <td></td> <td>ļ</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>   | Level 1 3113 | stressors                                 |                   |                                   | ļ                   |            |                   |           |   |   |      |  |
| 1114       and management of work-related stress.       <  |              |   |                   |                                   |                     |            |                   |           |   |   |      |  |
| and and generated stress.       and and generated stress.       and and generated stress.       and and generated stress.       and and generated stress.       and and generated stress.       and and generated stress.       and and generated stress.       and and generated stress.       and and generated stress.       and generet.       and generated stress. </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>  |              |   |                   |                                   |                     |            |                   |           |   |   |      |  |
| Where the monitoring has identified deficiencies, there must be evidence 3119       Where the monitoring has identified deficiencies, there must be evidence 3119       Image: State Stat  |              | and management of work related            |                   |                                   |                     |            |                   |           |   |   |      |  |
| 3119       deficiencies, there must be evidence that recommendations and action plans have been devidence dation anges implemented accordingly.       Image:  |              |   |                   |                                   | <u> </u>            |            |                   |           |   |   |      |  |
| 319       that recommendations and action plans have been developed and changes implemented accordingly.       Image: molecular plans have been developed and changes implemented accordingly.       Image: molecular plans have been developed and changes implemented accordingly.       Image: molecular plans have been developed and changes implemented accordingly.       Image: molecular plans have been developed and changes implemented accordingly.       Image: molecular plans have been developed and changes implemented accordingly.       Image: molecular plans have been developed and changes implemented accordingly.       Image: molecular plans have been developed and changes implemented accordingly.       Image: molecular plans have been developed and changes implemented accordingly.       Image: molecular plans have been developed and changes implemented accordingly.       Image: molecular plans have been developed and changes implemented accordingly.       Image: molecular plans have been developed and changes implemented accordingly.       Image: molecular plans have been developed and changes implemented molecular plans have been developed and changes implemented accordingly.       Image: molecular plans have been developed and changes implemented molecular plans have been developed and changes implemented molecular plans have been developed accordingly.       Image: molecular plans have been developed and changes implemented molecular plans have been developed accordingly.       Image: molecular plans have been developed accordingly.       Image: molecular plans have been developed accordingly.       Image: molecular plans have been developed accordingly.       Image: molecular plans have been developed accordingly.       Image: molecular plans have been developed accordingly.       Image: mo   |              |   |                   |                                   |                     |            |                   |           |   |   |      |  |
| plans have been developed and changes implemented accordingly.       implemented accor   |              |   |                   |                                   |                     |            |                   |           |   |   |      |  |
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## NHSLA Risk Management Standards for Primary Care Trusts Evidence Template 3.3.

| 3.3.8  | 0 | 0 |                     |
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| 3.3.9  | 0 | 0 |                     |
| 3.3.10 | 0 | 0 | All Standards Total |
| Total  | 0 | 0 | 0                   |

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Cell: N1 Comment: Assessor Use Only

Cell: H73 Comment: Secure environment

Cell: H74 Comment: Sickness absence

Cell: H75 Comment: Safeguarding adults

Cell: H76 Comment: Moving & handling

Cell: H77 Comment: Slips, trips & falls

Cell: H78 Comment: Inoculation incidents

Cell: H79 Comment: Maintenance of medical devices & equipment

Cell: H80 Comment: Harassment & bullying

Cell: H81 Comment: Violence & aggression

Cell: H82 Comment: Stress

| Criterion number | Index | Criterion and minimum requirements   | Paper or Electronic copy | Document submitted | Electronic file hyperlink/name | Document version<br>name, no. and approved<br>and review dates | Initials of contact name<br>for document | Compliant?<br>(Organisation) | Reference | Organisation's comments | Compliant? (Assessor) | Comment in Report | Assessor's comments | Proposed Future Change | Rationale |
|------------------|-------|--|--------------------------|--------------------|--------------------------------|--|--|------------------------------|-----------|-------------------------|-----------------------|-------------------|---------------------|------------------------|-----------|
| 3.4.1            |       | The organisation can demonstrate that<br>there are processes in place to monitor<br>compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the identification of<br>inpatients.<br>The organisation can demonstrate that |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
|                  |       | it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the:   |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
| Level 1          |       | process for identifying <b>in</b> patients<br>procedure to be followed in cases  |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
| Level 1          |       | where patient misidentification occurs.  |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
|                  |       | Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and<br>changes implemented accordingly.  |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
|                  |       |  |                          |                    |                                |  | Compliant                                |                              |           | Compliant               |                       |                   |                     |                        |           |
| 3.4.2            |       | The organisation can demonstrate that<br>there are processes in place to monitor<br>compliance with the approved<br>documentation which describes the<br>process for developing patient<br>information associated with care,<br>treatments and procedure.                                |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
|                  |       | The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the:  |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
| Level 1          |       | list of the essential content to be<br>included in leaflets or other media i.e.<br>risks, benefits and alternatives, where<br>appropriate  |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
| Level 1          | 4029  | archiving arrangements.<br>Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and<br>changes implemented accordingly.   |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
|                  |       |  |                          |                    |                                |  | Compliant                                |                              |           | Compliant               |                       |                   |                     |                        |           |
| 3.4.3            |       | The organisation can demonstrate that<br>there are processes in place to monitor<br>compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with consent.  |                          |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |

|         |              | The organisation can demonstrate that                                       |     |  |   |           |  |           |   |                                      |   |
|---------|--------------|---|-----|--|---|-----------|--|-----------|---|--------------------------------------|---|
|         |              | it is monitoring compliance with the  |     |  |   |           |  |           |   |                                      |   |
|         |              | minimum requirements contained  |     |  |   |           |  |           |   |                                      |   |
|         |              | within the approved documentation   |     |  |   |           |  |           |   |                                      |   |
|         |              | described at Level 1, in relation to the:                                   |     |  |   |           |  |           |   |                                      |   |
|         |              |   |     |  |   |           |  |           |   |                                      |   |
|         | 4033         | process for identifying staff who are                                       |     |  |   |           |  |           |   |                                      |   |
| Level 1 |              | not capable of performing the   |     |  |   |           |  |           |   |                                      |   |
| LOVOIT  |              | procedure but are authorised to obtain                                      |     |  |   |           |  |           |   |                                      |   |
|         |              | consent for that procedure  |     |  |   |           |  |           |   |                                      |   |
|         | 4035         | process for the delivery of procedure                                       |     |  |   |           |  |           |   |                                      |   |
|         |              | specific training on consent, for staff to                                  |     |  |   |           |  |           |   |                                      |   |
| Level 1 |              | whom the consent process is delegated and who are not capable of            |     |  |   |           |  |           |   |                                      |   |
|         |              | performing the procedure.   |     |  |   |           |  |           |   |                                      |   |
|         | 4039         | Where the monitoring has identified   | + + |  |   |           |  |           |   |                                      |   |
|         |              | deficiencies, there must be evidence  |     |  |   |           |  |           |   |                                      |   |
|         |              | that recommendations and action   |     |  |   |           |  |           |   |                                      |   |
|         |              | plans have been developed and   |     |  |   |           |  |           |   |                                      |   |
|         |              | changes implemented accordingly.  |     |  |   |           |  |           |   |                                      |   |
|         |              |   |     |  |   | Compliant |  | Compliant |   |                                      |   |
|         |              |   |     |  |   |           |  |           |   |                                      |   |
| 3.4.4   | 4040         | The organisation can demonstrate that                                       | 1 1 |  | Í |           |  |           |   |                                      |   |
|         |              | there are processes in place to monitor                                     |     |  |   |           |  |           |   |                                      |   |
|         |              | compliance with the approved  |     |  |   |           |  |           |   |                                      |   |
|         |              | documentation which describes the   |     |  |   |           |  |           |   |                                      |   |
|         |              | process for managing the risks  |     |  |   |           |  |           |   |                                      |   |
|         |              | associated with the quality of clinical records in all media.               |     |  |   |           |  |           |   |                                      |   |
|         |              |   |     |  |   |           |  |           |   |                                      |   |
|         |              | The organisation can demonstrate that                                       |     |  |   |           |  |           |   |                                      |   |
|         |              | it is monitoring compliance with the minimum requirements contained         |     |  |   |           |  |           |   |                                      |   |
|         |              | within the approved documentation   |     |  |   |           |  |           |   |                                      |   |
|         |              | described at Level 1, in relation to the:                                   |     |  |   |           |  |           |   |                                      |   |
|         |              |   |     |  |   |           |  |           |   |                                      |   |
|         | 4044         | format for all audit reports i.e.   |     |  |   |           |  |           |   |                                      |   |
| Level 1 | 1            | methodology, conclusions, action  |     |  |   |           |  |           |   |                                      |   |
|         |              | plans, etc.   |     |  |   |           |  |           |   |                                      |   |
| Level 1 | 4045         | arrangements for the review of action                                       |     |  |   |           |  |           |   |                                      |   |
|         |              | plans.  |     |  |   |           |  |           |   |                                      |   |
|         | 4049         | Where the monitoring has identified   |     |  |   |           |  |           |   |                                      |   |
|         |              | deficiencies, there must be evidence that recommendations and action        |     |  |   |           |  |           |   |                                      |   |
|         |              | plans have been developed and   |     |  |   |           |  |           |   |                                      |   |
|         |              | changes implemented accordingly.  |     |  |   |           |  |           |   |                                      |   |
|         |              |   |     |  |   | Compliant |  | Compliant |   |                                      |   |
|         |              |   |     |  |   | Compliant |  | Compliant |   |                                      |   |
| 3.4.5   | 4050         | The organisation can demonstrate that                                       |     |  |   |           |  | I         |   |                                      |   |
| 0.4.0   |              | there are processes in place to monitor                                     |     |  |   |           |  |           |   |                                      |   |
|         |              | compliance with the approved  |     |  |   |           |  |           |   |                                      |   |
|         |              | documentation which describes the   |     |  |   |           |  |           |   |                                      |   |
|         |              | process for managing the risks  |     |  |   |           |  |           |   |                                      |   |
|         |              | associated with the transfer of   |     |  |   |           |  |           |   |                                      |   |
|         |              | patients.   |     |  |   |           |  |           |   |                                      |   |
|         |              | The organisation can demonstrate that                                       |     |  |   |           |  |           |   | The assessor will select two patient |   |
|         |              | it is monitoring compliance with the  |     |  |   |           |  |           |   | groups at random to assess the       |   |
|         |              | minimum requirements contained  |     |  |   |           |  |           |   | organisation's compliance with the   |   |
|         |              | within the approved documentation described at Level 1, in relation to the: |     |  |   |           |  |           |   | above minimum requirements.          |   |
|         |              |   |     |  |   |           |  |           |   |                                      |   |
|         | 4057         |   |     |  |   |           |  |           |   |                                      |   |
|         | 4057<br>4057 |   |     |  |   |           |  |           |   |                                      |   |
|         |              | transfer requirements which are   |     |  |   |           |  |           |   |                                      |   |
| Level 1 |              | specific to each patient group  |     |  |   |           |  |           |   |                                      |   |
|         | 4053         | documentation to accompany the  | 1 1 |  | 1 |           |  |           | + |                                      | + |
| Level 1 |              | patient when being transferred.   |     |  |   |           |  |           |   |                                      |   |
|         |              |   |     |  |   |           |  | •         |   |                                      |   |

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|---|--|--|--|----------|-----------|--|--|
|   |  | Where the monitoring has identified  |  |          |           |  |  |
|   |  | deficiencies, there must be evidence   |  |          |           |  |  |
|   |  | that recommendations and action  |  |          |           |  |  |
|   |  | plans have been developed and  |  |          |           |  |  |
|   |  | changes implemented accordingly.   |  |          |           |  |  |
|   |  | The assessor will select two patient   |  |          |           |  |  |
|   |  | groups at random to assess the   |  |          |           |  |  |
|   |  | organisation's compliance with the   |  |          |           |  |  |
|   |  | above minimum requirements.  |  |          |           |  |  |
|   |  |  |  |          |           |  |  |
|   |  |  |  | Complian | Compliant |  |  |
|   | 1000   |  |  |          |           |  |  |
| 3.4.6 4   |  | The organisation can demonstrate that  |  |          |           |  |  |
|   |  | there are processes in place to monitor  |  |          |           |  |  |
|   |  | compliance with the approved   |  |          |           |  |  |
|   |  | documentation which describes the  |  |          |           |  |  |
|   |  | process for managing the risks   |  |          |           |  |  |
|   |  | associated with medicines in all care  |  |          |           |  |  |
|   |  | environments.  |  |          |           |  |  |
|   |  | The organisation can demonstrate that  |  |          |           |  |  |
|   |  | it is monitoring compliance with the   |  |          |           |  |  |
|   |  | minimum requirements contained   |  |          |           |  |  |
|   |  | within the approved documentation  |  |          |           |  |  |
|   | 4  | described at Level 1, in relation to the:  |  |          |           |  |  |
|   |  |  |  |          |           |  |  |
| 40  | 061.1  | process for ensuring the accuracy of   |  |          |           |  |  |
| Level 1   |  | all prescription charts.   |  |          |           |  |  |
| 4   | 4069   | Where the monitoring has identified  |  |          |           |  |  |
|   |  | deficiencies, there must be evidence   |  |          |           |  |  |
|   |  | that recommendations and action  |  |          |           |  |  |
|   |  | plans have been developed and  |  |          |           |  |  |
|   |  | changes implemented accordingly.   |  |          |           |  |  |
|   |  |  |  | Complian | Compliant |  |  |
|   |  |  |  | Compilan | oompilant |  |  |
|   | 4070   | The organisation can demonstrate that  |  |          |           |  |  |
| 347 4   |  |  |  |          |           |  |  |
| 3.4.7 4   | 1  | there are processes in place to monitor l  |  |          |           |  |  |
| 3.4.7 4   |  | there are processes in place to monitor<br>compliance with the approved  |  |          |           |  |  |
| 3.4.7 4   | 3  | compliance with the approved   |  |          |           |  |  |
| 3.4.7 4   |  | compliance with the approved<br>documentation which describes the  |  |          |           |  |  |
| 3.4.7 4   | 1  | compliance with the approved<br>documentation which describes the<br>process for managing the risks  |  |          |           |  |  |
| 3.4.7 4   |  | compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the blood transfusion   |  |          |           |  |  |
| 3.4.7 4   |  | compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the blood transfusion<br>process.   |  |          |           |  |  |
| 3.4.7 4   |  | compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the blood transfusion<br>process.<br>The organisation can demonstrate that  |  |          |           |  |  |
| 3.4.7 4   | <br> <br> <br> <br> <br> <br>                | compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the blood transfusion<br>process.<br>The organisation can demonstrate that<br>it is monitoring compliance with the  |  |          |           |  |  |
| 3.4.7 4   | <br> <br> <br> <br> <br> <br> <br>           | compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the blood transfusion<br>process.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained  |  |          |           |  |  |
| 3.4.7 4   |  | compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the blood transfusion<br>process.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation   |  |          |           |  |  |
| 3.4.7 4   |  | compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the blood transfusion<br>process.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained  |  |          |           |  |  |
|   |  | compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the blood transfusion<br>process.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the:  |  |          |           |  |  |
|   | 4073   | compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the blood transfusion<br>process.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the:<br>process for the administration of blood   |  |          |           |  |  |
| Level 1   | 4073   | compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the blood transfusion<br>process.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the:<br>process for the administration of blood<br>and blood products   |  |          |           |  |  |
| Level 1 4   | 4073   | compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the blood transfusion<br>process.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the:<br>process for the administration of blood   |  |          |           |  |  |
| Level 1 44<br>Level 1 44  | 4073   | compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the blood transfusion<br>process.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the:<br>process for the administration of blood<br>and blood products<br>care of patient(s) receiving transfusion.  |  |          |           |  |  |
| Level 1 44<br>Level 1 44  | 4073<br>4074<br>4079                         | compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the blood transfusion<br>process.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the:<br>process for the administration of blood<br>and blood products<br>care of patient(s) receiving transfusion.<br>Where the monitoring has identified   |  |          |           |  |  |
| Level 1 44<br>Level 1 44  | 4073<br>4074<br>4079                         | compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the blood transfusion<br>process.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the:<br>process for the administration of blood<br>and blood products<br>care of patient(s) receiving transfusion.<br>Where the monitoring has identified<br>deficiencies, there must be evidence   |  |          |           |  |  |
| Level 1 44<br>Level 1 44  | 4073<br>4074<br>4079                         | compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the blood transfusion<br>process.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the:<br>process for the administration of blood<br>and blood products<br>care of patient(s) receiving transfusion.<br>Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action  |  |          |           |  |  |
| Level 1 44<br>Level 1 44  | 4073<br>4074<br>4079                         | compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the blood transfusion<br>process.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the:<br>process for the administration of blood<br>and blood products<br>care of patient(s) receiving transfusion.<br>Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and   |  |          |           |  |  |
| Level 1 44<br>Level 1 44  | 4073<br>4074<br>4079                         | compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the blood transfusion<br>process.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the:<br>process for the administration of blood<br>and blood products<br>care of patient(s) receiving transfusion.<br>Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action  |  |          |           |  |  |
| Level 1 44<br>Level 1 44  | 4073<br>4074<br>4079                         | compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the blood transfusion<br>process.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the:<br>process for the administration of blood<br>and blood products<br>care of patient(s) receiving transfusion.<br>Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and   |  | Complian | Compliant |  |  |
| Level 1 44<br>Level 1 44  | 4073<br>4074<br>4079                         | compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the blood transfusion<br>process.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the:<br>process for the administration of blood<br>and blood products<br>care of patient(s) receiving transfusion.<br>Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and   |  | Complian | Compliant |  |  |
| Level 1         4           Level 1         4           Level 1         4           4         4           1         4           1         4 | 4073<br>4074<br>4079                         | compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the blood transfusion<br>process.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the:<br>process for the administration of blood<br>and blood products<br>care of patient(s) receiving transfusion.<br>Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and<br>changes implemented accordingly.   |  | Complian | Compliant |  |  |
| Level 1         4           Level 1         4           Level 1         4           4         4           1         4           1         4 | 4073<br>4074<br>4079<br>4079                 | compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the blood transfusion<br>process.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the:<br>process for the administration of blood<br>and blood products<br>care of patient(s) receiving transfusion.<br>Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and<br>changes implemented accordingly.   |  | Complian | Compliant |  |  |
| Level 1         4           Level 1         4           Level 1         4           4         4           1         4           1         4 | 4073<br>4074<br>4079<br>4080                 | compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the blood transfusion<br>process.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the:<br>process for the administration of blood<br>and blood products<br>care of patient(s) receiving transfusion.<br>Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and<br>changes implemented accordingly.   |  | Complian | Compliant |  |  |
| Level 1         4           Level 1         4           Level 1         4           4         4           1         4           1         4 | 4073<br>4074<br>4079<br>4080                 | compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the blood transfusion<br>process.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the:<br>process for the administration of blood<br>and blood products<br>care of patient(s) receiving transfusion.<br>Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and<br>changes implemented accordingly.<br>The organisation can demonstrate that<br>there are processes in place to monitor<br>compliance with the approved   |  | Complian | Compliant |  |  |
| Level 1         4           Level 1         4           Level 1         4           4         4           1         4           1         4 | 4073<br>4074<br>4079<br>4080                 | compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the blood transfusion<br>process.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the:<br>process for the administration of blood<br>and blood products<br>care of patient(s) receiving transfusion.<br>Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and<br>changes implemented accordingly.<br>The organisation can demonstrate that<br>there are processes in place to monitor<br>compliance with the approved<br>documentation which describes the  |  | Complian | Compliant |  |  |
| Level 1         4           Level 1         4           Level 1         4           4         4           1         4           1         4 | 4073<br>4074<br>4079<br>4080                 | compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the blood transfusion<br>process.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the:<br>process for the administration of blood<br>and blood products<br>care of patient(s) receiving transfusion.<br>Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and<br>changes implemented accordingly.<br>The organisation can demonstrate that<br>there are processes in place to monitor<br>compliance with the approved<br>documentation which describes the<br>process for managing the risks  |  | Complian | Compliant |  |  |
| Level 1 44<br>Level 1 44<br>Level 1 44  | 4073<br>4074<br>4079<br>4080                 | compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the blood transfusion<br>process.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the:<br>process for the administration of blood<br>and blood products<br>care of patient(s) receiving transfusion.<br>Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and<br>changes implemented accordingly.<br>The organisation can demonstrate that<br>there are processes in place to monitor<br>compliance with the approved<br>documentation which describes the  |  | Complian | Compliant |  |  |
| Level 1 44<br>Level 1 44<br>Level 1 44  | 4073<br>4074<br>4079<br>4080                 | compliance with the approved         documentation which describes the         process for managing the risks         associated with the blood transfusion         process.         The organisation can demonstrate that         it is monitoring compliance with the         minimum requirements contained         within the approved documentation         described at Level 1, in relation to the:         process for the administration of blood         and blood products         care of patient(s) receiving transfusion.         Where the monitoring has identified         deficiencies, there must be evidence         that recommendations and action         plans have been developed and         changes implemented accordingly.         The organisation can demonstrate that         there are processes in place to monitor         compliance with the approved         documentation which describes the         process for managing the risks         associated with resuscitation. |  | Complian | Compliant |  |  |
| Level 1 44<br>Level 1 44<br>Level 1 44  | 4073 4074 4079 4079 4080 7                   | compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the blood transfusion<br>process.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the:<br>process for the administration of blood<br>and blood products<br>care of patient(s) receiving transfusion.<br>Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and<br>changes implemented accordingly.<br>The organisation can demonstrate that<br>there are processes in place to monitor<br>compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with resuscitation.  |  | Complian | Compliant |  |  |
| Level 1 44<br>Level 1 44<br>Level 1 44  | 4073 4074 4079 4080                          | compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the blood transfusion<br>process.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the:<br>process for the administration of blood<br>and blood products<br>care of patient(s) receiving transfusion.<br>Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and<br>changes implemented accordingly.<br>The organisation can demonstrate that<br>there are processes in place to monitor<br>compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with resuscitation.  |  | Complian | Compliant |  |  |
| Level 1 44<br>Level 1 44<br>Level 1 44  | 4073 4074 4079 4080                          | compliance with the approved         documentation which describes the         process for managing the risks         associated with the blood transfusion         process.         The organisation can demonstrate that         it is monitoring compliance with the         minimum requirements contained         within the approved documentation         described at Level 1, in relation to the:         process for the administration of blood         and blood products         care of patient(s) receiving transfusion.         Where the monitoring has identified         deficiencies, there must be evidence         that recommendations and action         plans have been developed and         changes implemented accordingly.         The organisation can demonstrate that         there are processes in place to monitor         compliance with the approved         documentation which describes the         process for managing the risks         associated with resuscitation. |  | Complian | Compliant |  |  |
| Level 1 44<br>Level 1 44<br>Level 1 44  | 4073 4074 4079 4079 4079 4079 4079 4079 4079 | compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the blood transfusion<br>process.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the:<br>process for the administration of blood<br>and blood products<br>care of patient(s) receiving transfusion.<br>Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and<br>changes implemented accordingly.<br>The organisation can demonstrate that<br>there are processes in place to monitor<br>compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with resuscitation.  |  | Complian | Compliant |  |  |
| Level 1 44<br>Level 1 44<br>Level 1 44  | 4073 4074 4079 4079 4079 4079 4079 4079 4079 | compliance with the approved         documentation which describes the         process for managing the risks         associated with the blood transfusion         process.         The organisation can demonstrate that         it is monitoring compliance with the         minimum requirements contained         within the approved documentation         described at Level 1, in relation to the:         process for the administration of blood         and blood products         care of patient(s) receiving transfusion.         Where the monitoring has identified         deficiencies, there must be evidence         that recommendations and action         plans have been developed and         changes implemented accordingly.         The organisation can demonstrate that         there are processes in place to monitor         compliance with the approved         documentation which describes the         process for managing the risks         associated with resuscitation. |  | Complian | Compliant |  |  |

|         | 4082 | early warning systems in place for the                                   |       |                                      |                   |                |            |             |  |   |      |  |
|---------|------|--|-------|--------------------------------------|-------------------|----------------|------------|-------------|--|---|------|--|
| Level 1 |      | recognition of patients at risk of cardio-                               |       |                                      |                   |                |            |             |  |   |      |  |
|         |      | respiratory arrest   |       |                                      |                   |                |            |             |  |   |      |  |
| Level 1 |      | do not attempt resuscitation orders                                      |       |                                      |                   |                |            |             |  |   |      |  |
|         |      | (DNAR).  |       |                                      |                   |                |            |             |  |   |      |  |
|         |      | Where the monitoring has identified deficiencies, there must be evidence |       |                                      |                   |                |            |             |  |   |      |  |
|         |      | that recommendations and action  |       |                                      |                   |                |            |             |  |   |      |  |
|         | 1    | plans have been developed and  |       |                                      |                   |                |            |             |  |   |      |  |
|         |      | changes implemented accordingly.   |       |                                      |                   |                |            |             |  |   |      |  |
|         |      |  |       |                                      |                   | Compliant      |            |             | Compliant  |   |      |  |
|         |      |  |       |                                      |                   |                |            |             |  |   |      |  |
| 3.4.9   |      | The organisation can demonstrate that                                    |       |                                      |                   |                |            |             |  |   |      |  |
|         |      | there are processes in place to monitor                                  |       |                                      |                   |                |            |             |  |   |      |  |
|         |      | compliance with the approved documentation which describes the           |       |                                      |                   |                |            |             |  |   |      |  |
|         | 1    | process for managing the risks   |       |                                      |                   |                |            |             |  |   |      |  |
|         |      | associated with infection prevention                                     |       |                                      |                   |                |            |             |  |   |      |  |
|         |      | and control.   |       |                                      |                   |                |            |             |  |   |      |  |
|         |      | The organisation can demonstrate that                                    |       |                                      |                   |                |            |             |  |   |      |  |
|         |      | it is monitoring compliance with the                                     |       |                                      |                   |                |            |             |  |   |      |  |
|         |      | minimum requirements contained within the approved documentation         |       |                                      |                   |                |            |             |  |   |      |  |
|         |      | described at Level 1, in relation to the:                                |       |                                      |                   |                |            |             |  |   |      |  |
|         |      |  |       |                                      |                   |                |            |             |  |   |      |  |
| Level 1 | 4092 | infection control assurance framework.                                   |       |                                      |                   |                |            |             |  |   |      |  |
|         | 4000 |  |       |                                      |                   |                |            |             |  |   | <br> |  |
|         |      | Where the monitoring has identified deficiencies, there must be evidence |       |                                      |                   |                |            |             |  |   |      |  |
|         |      | that recommendations and action  |       |                                      |                   |                |            |             |  |   |      |  |
|         |      | plans have been developed and  |       |                                      |                   |                |            |             |  |   |      |  |
|         |      | changes implemented accordingly.   |       |                                      |                   |                |            |             |  |   |      |  |
|         |      |  |       |                                      |                   | Compliant      |            |             | Compliant  |   |      |  |
|         |      |  |       |                                      |                   |                |            |             |  |   |      |  |
| 3.4.10  | 4100 | The organisation can demonstrate that                                    |       |                                      |                   |                |            |             |  |   |      |  |
|         |      | there are processes in place to monitor compliance with the approved     |       |                                      |                   |                |            |             |  |   |      |  |
|         |      | documentation which describes the  |       |                                      |                   |                |            |             |  |   |      |  |
|         |      | organisation-wide process for  |       |                                      |                   |                |            |             |  |   |      |  |
|         |      | developing local policies to manage                                      |       |                                      |                   |                |            |             |  |   |      |  |
|         |      | the risks associated with the process                                    |       |                                      |                   |                |            |             |  |   |      |  |
|         |      | of clinical diagnostic test and<br>screening procedures.                 |       |                                      |                   |                |            |             |  |   |      |  |
|         |      | The organisation can demonstrate that                                    |       |                                      |                   |                |            |             |  |   |      |  |
|         |      | it is monitoring compliance with the                                     |       |                                      |                   |                |            |             |  |   |      |  |
|         |      | minimum requirements contained   |       |                                      |                   |                |            |             |  |   |      |  |
|         |      | within the approved documentation  |       |                                      |                   |                |            |             |  |   |      |  |
|         |      | described at Level 1, in relation to the process for:                    |       |                                      |                   |                |            |             |  |   |      |  |
|         |      | • • •  |       |                                      |                   |                |            |             |  |   |      |  |
| Level 1 | 4102 | taking action on test and screening results                              |       |                                      |                   |                |            |             |  |   |      |  |
|         | 4104 | the communication of clinical tests and                                  |       |                                      |                   |                |            |             |  |   |      |  |
| Level 1 |      | screening results.   |       |                                      |                   |                |            |             |  |   |      |  |
|         | 4109 | Where the monitoring has identified                                      |       |                                      |                   |                |            |             |  |   |      |  |
|         |      | deficiencies, there must be evidence                                     |       |                                      |                   |                |            |             |  |   |      |  |
|         |      | that recommendations and action plans have been developed and            |       |                                      |                   |                |            |             |  |   |      |  |
|         |      | changes implemented accordingly.   |       |                                      |                   |                |            |             |  |   |      |  |
|         |      |  |       |                                      |                   | Compliant      |            |             | Compliant  |   |      |  |
|         |      |  |       |                                      |                   |                |            |             | oomphant   |   |      |  |
|         |      |  |       |                                      |                   |                |            |             |  |   |      |  |
|         |      | · · · · · · · · · · · · · · · · · · ·                                    | The f | ollowing summary will be populated a | automatically fro | om informatio  | on entered | on the work | sheet.   | 1 |      |  |
|         |      |  |       |                                      |                   | 244            |            |             |  | - |      |  |
|         |      |  |       |                                      |                   | 3.4.1          | 0          |             |  | 0 |      |  |
|         |      |  |       |                                      |                   | 3.4.2<br>3.4.3 | 0          |             |  | 0 |      |  |
|         |      |  |       |                                      |                   | 3.4.3          | 0          |             |  | 0 |      |  |
|         |      |  |       |                                      |                   | 3.4.5          | 0          |             |  | 0 |      |  |
|         |      |  |       |                                      |                   | 3.4.6          | 0          |             | ด้หลังและและและประกับเรื่องต้องต่องและประกับเรื่องต้องต่องเราะสามรับเราะหรือเป็นเราะสามรับเรื่องต้องและประ | 0 |      |  |
|         |      |  |       |                                      |                   | 3.4.7          | 0          |             |  | 0 |      |  |
|         | :    | ۶  |       | 8                                    | 3                 |                |            |             |  |   |      |  |

## NHSLA Risk Management Standards for Primary Care Trusts Evidence Template 3.4.

| 3.4.8  | 0 | 0 |                  |      |  |
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| 3.4.9  | 0 | 0 |                  |      |  |
| 3.4.10 | 0 | 0 | All Standards To | otal |  |
| Total  | 0 | 0 | 0                |      |  |

| Actions required to achieve<br>compliance | Person/<br>Committee<br>responsible | Target Date | Associated<br>Cost |  |  |  |  |  |
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## NHSLA Risk Management Standards for Primary Care Trusts Evidence Template

3.4.

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

Cell: L1 Comment: Assessor Use Only

Cell: M1 Comment: Assessor Use Only

Cell: N1 Comment: Assessor Use Only

Cell: H77 Comment: Patient identification

Cell: H78 Comment: Patient information

Cell: H79 Comment: Consent

Cell: H80 Comment: Clinical record-keeping standards

Cell: H81 Comment: Transfer of patients

Cell: H82 Comment: Medicines management

Cell: H83 Comment: Blood transfusion

Cell: H84 Comment: Resuscitation

Cell: H85 Comment: Infection control

Cell: H86 Comment: Diagnostic testing and screening procedures

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| 3.  | 5 |   |    |   |

| Criterion number | Index | Criterion and minimum requirements  | Paper or El | Document submitted | Electronic file hyperlink/name | Document version name,<br>no. and approved and<br>review dates | Initials of contact name<br>for document | Compliant?<br>(Organisation) | Reference | Organisation's comments | Compliant? (Assessor) | Comment in Report | Assessor's comments | Proposed Future Change | Rationale |
|------------------|-------|---|-------------|--------------------|--------------------------------|--|--|------------------------------|-----------|-------------------------|-----------------------|-------------------|---------------------|------------------------|-----------|
| 3.5.1            |       | The organisation can demonstrate that<br>there are processes in place to monitor<br>compliance with the approved<br>documentation which describes the<br>process for managing the risks<br>associated with the reporting of all<br>internally and externally reportable<br>incidents.   |             |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
|                  |       | The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for reporting:  |             |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
| Level 1          |       | all incidents/near misses, involving<br>staff, patients and others  |             |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
|                  | 5013  | to external agencies.   |             |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
|                  |       | Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and<br>changes implemented accordingly.   |             |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
|                  |       | changes implemented accordingly.  |             |                    |                                |  | Compliant                                |                              |           | Compliant               |                       |                   |                     |                        |           |
|                  |       |   |             |                    |                                |  | oomphant                                 |                              |           | Compliant               |                       |                   |                     |                        |           |
| 3.5.2            |       | The organisation can demonstrate that<br>there are processes in place to monitor<br>compliance with the approved<br>documentation which describes the<br>process for ensuring that patients,<br>their relatives and carers have suitable<br>and accessible information about, and<br>clear access to, procedures to raise<br>concerns informally. |             |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
|                  |       | The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the<br>process:  |             |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
| Level 1          |       | for raising concerns (informal<br>complaints/PALS)  |             |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
| Level 1          | 5024  | by which the organisation aims to<br>make changes as a result of concerns<br>being raised.  |             |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
|                  |       | Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and<br>changes implemented accordingly.   |             |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |
|                  |       |   |             |                    |                                |  | Compliant                                |                              |           | Compliant               |                       |                   |                     |                        |           |
|                  |       |   |             |                    |                                |  |  |                              |           |                         |                       |                   |                     |                        |           |

| 3.5.3       5030       The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for ensuring that patients, their relatives and carers have suitable and accessible information about, and clear access to, procedures to register formal compliants.       Image: Compliance with the approved documentation can demonstrate that their relatives and carers have suitable and accessible information about, and clear access to, procedures to register formal compliance.       Image: Compliance with the approved documentation can demonstrate that it is monitoring compliance with the minimum requirements contained       Image: Compliance with the approved documentation can demonstrate that it is monitoring compliance with the minimum requirements contained       Image: Compliance with the approved documentation can demonstrate that it is monitoring compliance with the minimum requirements contained       Image: Compliance with the approved documentation can demonstrate that it is monitoring compliance with the minimum requirements contained       Image: Compliance with the minimum requirements contained  |  |
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| within the approved documentation   |  |
| described at Level 1, in relation to the:   |  |
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| 5032 complaints management process,   |  |
| which includes internal and external  |  |
| Level 1 communication, and collaboration with   |  |
| other organisations when necessary  |  |
|   |  |
| 5034 process by which the organisation     Image: Constraint of the organisation </td <td></td>   |  |
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| Level 1 aims to make changes as a result of   |  |
| formal complaints.  |  |
| 5039 Where the monitoring has identified  |  |
| deficiencies, there must be evidence  |  |
| that recommendations and action   |  |
| plans have been developed and   |  |
| changes implemented accordingly.  |  |
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| documentation which describes the   |  |
| process for managing all claims in  |  |
| accordance with NHSLA requirements.   |  |
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| and       box       contrained approach to aggregation<br>of indicatis, compliants and claims       i       contrained approach to aggregation<br>of indicatis, compliants and claims       i       contrained approach to aggregation<br>of indicatis, compliants and claims       i       contrained approach to aggregation<br>of indicatis, compliants and claims       i       contrained approach to aggregation<br>of indicatis, compliants and claims       i       contrained approach to aggregation<br>of indicatis, compliants and claims       i       contrained approach to aggregation<br>of indicatis, compliants and claims       i       contrained approach to aggregation<br>of indicatis, compliants and action<br>that accommendations ith the approach<br>compliance with the approach<br>action<br>accompliance with the approach<br>down accompliants and<br>dame.       compliant accommendation<br>that accommendation that action<br>that accommendation with the approach<br>down accompliants and<br>dame.       compliant accommendation<br>that accommendation with the approach<br>down accompliants and<br>dame.       compliant accommendation<br>that accommendation with the approach<br>down accommendation with the approach<br>down accommendation accommendation<br>that accommendation accommendation<br>that accommendation accommendation<br>accommendation accommendation<br>accommendation accommendation<br>accommendation accommendation<br>accommendation ac  |  |      |   |    |       |   |               |  |   |   |
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| Lend       Set       Immuno monther required within the analysis report, including qualitative analysis report, including report, including qualitative analysis rep  | Level 1  |      |   |    |       |   |               |  |   |   |
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| and quantative analysis. $a$ <   |  |      |   |    |       |   |               |  |   |   |
| 900       More the monitoring has identified deficiencias, there must be evidence in the average implemented accordingly.       Image: multiple  | Level 1  |      |   |    |       |   |               |  |   |   |
| a       deficiencies, three must be endenced and claims and action plans have been developed and claims.       a   |  |      |   |    |       |   |               |  |   |   |
| i intercommendations and action planes have been developed and changes implemented accordingly. i<   |  | 5069 | Where the monitoring has identified       |    |       |   |               |  |   |   |
| i intercommendations and action planes have been developed and changes implemented accordingly. i<   |  |      | deficiencies, there must be evidence      |    |       |   |               |  |   |   |
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| k       there are processes in place to monitor<br>documentation which describes the<br>process for encouraging learning and<br>process for encouraging learning and<br>process for encouraging learning and<br>parsies of individual and aggregated<br>analysis of individual and a |  |      |   |    |       | Compliant                                     | Compliant     |  |   |   |
| k       there are processes in place to monitor<br>documentation which describes the<br>process for encouraging learning and<br>process for encouraging learning and<br>process for encouraging learning and<br>parsies of individual and aggregated<br>analysis of individual and a |  |      |   |    |       |   |               |  |   |   |
| k       there are processes in place to monitor<br>documentation which describes the<br>process for encouraging learning and<br>process for encouraging learning and<br>process for encouraging learning and<br>parsies of individual and aggregated<br>analysis of individual and a | 3.5.7  | 5070 | The organisation can demonstrate that     |    |       |   |               |  |   |   |
| b       compliance with the approved documentation which describes the process for encouraging learning and promoting improvements in practice, based on individual and aggregated analysis of incidents, compliants and calimis.       Image: Compliance with the approved documentation describes the process for encouraging learning and promoting improvements in practice, based on individual and aggregated analysis of incidents, compliants and calimis.       Image: Compliance with the approved documentation describes the process by which the approved documentation described at Level 1, in relation to the process by which the organisation encouraging learning and encouraging learning and encouraging learning and encouraging learning and encouraging learning and encouraging learning and encouraging learning and promoting has identified and encouraging learning and encouraging learning and promoting has identified encouraging learning and encouraging learnin   |  |      |   |    |       |   |               |  |   |   |
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| k       process for encouraging learning and promoting improvements in practice, based on individual and aggregated analysis of incidents, complaints and claims.       k  |  |      |   |    |       |   |               |  |   |   |
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| a described at Level 1, in relation to the<br>process by which the organisation<br>ensures:a level 1a  |  |      | within the approved documentation         |    |       |   |               |  |   |   |
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| instrumentation        |  |      |   |    |       |   |               |  |   |   |
| Level       5074       the implementation of risk reduction measures.       Image: Construction of risk reduction of   |  |      |   |    |       |   |               |  |   |   |
| Level 1       measures.  |  |      |   |    |       |   |               |  |   |   |
| 5079       Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and<br>changes implemented accordingly.       Image: Control of the contr  | Level 1  |      |   |    |       |   |               |  |   |   |
| deficiencies, there must be evidence       that recommendations and action       Image: mplemented accordingly.   |  |      |   |    |       |   |               |  |   |   |
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| plans have been developed and changes implemented accordingly.   |  |      |   |    |       |   |               |  |   |   |
| changes implemented accordingly.   |  |      |   |    |       |   |               |  |   |   |
|  |  |      |   |    |       |   |               |  |   |   |
| Image: Compliant     Compliant     Compliant   |  |      | changes implemented accordingly.          |    |       |   |               |  |   |   |
|  |  |      |   |    |       | Compliant                                     | Compliant     |  |   |   |
|  | I I  |      |   |    | <br>1 |   | - singulation |  | 1 | 1 |
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| 3.5.8   | 5080 | The organisation can demonstrate that   |     |   |           |   |   |           |   |  |  |
|---------|------|---|-----|---|-----------|---|---|-----------|---|--|--|
|         |      | there are processes in place to monitor   |     |   |           |   |   |           |   |  |  |
|         |      | compliance with the approved  |     |   |           |   |   |           |   |  |  |
|         |      | documentation which describes the   |     |   |           |   |   |           |   |  |  |
|         |      |   |     |   |           |   |   |           |   |  |  |
|         |      | process for ensuring that agreed best   |     |   |           |   |   |           |   |  |  |
|         |      | practice as defined in all NICE   |     |   |           |   |   |           |   |  |  |
|         |      | guidance is taken into account in the   |     |   |           |   |   |           |   |  |  |
|         |      | context of the clinical services provided   |     |   |           |   |   |           |   |  |  |
|         |      | by the organisation.  |     |   |           |   |   |           |   |  |  |
|         |      | y the eigenleaten.  |     |   |           |   |   |           |   |  |  |
|         |      |   |     |   |           |   |   |           |   |  |  |
|         |      | The organisation can demonstrate that   |     |   |           |   |   |           |   | The assessor will select two clinical  |  |
|         |      | it is monitoring compliance with the  |     |   |           |   |   |           |   | guidelines from the list to assess the |  |
|         |      | minimum requirements contained  |     |   |           |   |   |           |   | organisation's compliance with the     |  |
|         |      | within the approved documentation   |     |   |           |   |   |           |   | above minimum requirement.             |  |
|         |      | described at Level 1, in relation to the  |     |   |           |   |   |           |   |  |  |
|         |      |   |     |   |           |   |   |           |   |  |  |
|         |      | process for:  |     |   |           |   |   |           |   |  |  |
| / I     | 5087 |   |     |   |           | 1 | Î |           | 1 |  |  |
| i i     | 5087 |   | i i |   |           | i | i |           | i |  |  |
|         |      | oncuring that recommendations are   |     |   |           |   |   |           |   |  |  |
|         |      | ensuring that recommendations are   |     |   |           |   |   |           |   |  |  |
| Level 1 |      | acted upon throughout the   |     |   |           |   |   |           |   |  |  |
|         |      | organisation.   |     |   |           |   |   |           |   |  |  |
|         | 5089 | Where the monitoring has identified   |     |   |           |   |   |           |   |  |  |
|         |      | deficiencies, there must be evidence  |     |   |           |   |   |           |   |  |  |
|         |      | that recommendations and action   |     |   |           |   |   |           |   |  |  |
|         |      | plans have been developed and   |     |   |           |   |   |           |   |  |  |
|         |      |   |     |   |           |   |   |           |   |  |  |
|         |      | changes implemented accordingly.  |     |   |           |   |   |           |   |  |  |
|         |      | The assessor will select two clinical   |     |   |           |   |   |           |   |  |  |
|         |      | guidelines from the list to assess the  |     |   |           |   |   |           |   |  |  |
|         |      | organisation's compliance with the  |     |   |           |   |   |           |   |  |  |
|         |      | above minimum requirement.  |     |   |           |   |   |           |   |  |  |
|         |      |   |     |   | Compliant |   |   | Compliant |   |  |  |
|         |      |   |     |   | Compliant |   |   | Compliant |   |  |  |
|         |      |   |     |   |           |   |   |           |   |  |  |
| 3.5.9   | 5090 | The organisation can demonstrate that   |     |   |           |   |   |           |   |  |  |
|         |      | there are processes in place to monitor   |     |   |           |   |   |           |   |  |  |
|         |      | compliance with the approved  |     |   |           |   |   |           |   |  |  |
|         |      | documentation which describes the   |     |   |           |   |   |           |   |  |  |
|         |      | process for ensuring that agreed best   |     |   |           |   |   |           |   |  |  |
|         |      | practice, as defined in nationally  |     |   |           |   |   |           |   |  |  |
|         |      |   |     |   |           |   |   |           |   |  |  |
|         |      | agreed guidance, the National Service   |     |   |           |   |   |           |   |  |  |
|         |      | Frameworks, National Confidential   |     |   |           |   |   |           |   |  |  |
|         |      | Enquiries and other High Level  |     |   |           |   |   |           |   |  |  |
|         |      | Enquiries that make recommendations   |     |   |           |   |   |           |   |  |  |
|         |      | for patient safety, is taken into account   |     | 1 |           |   |   |           |   |  |  |
|         |      |   |     |   |           |   |   |           |   |  |  |
|         | . I  | in the context of the clinical services   |     |   |           |   |   |           |   |  |  |
|         |      | in the context of the clinical services   |     |   |           |   |   |           |   |  |  |
|         |      | in the context of the clinical services provided by the organisation.   |     |   |           |   |   |           |   |  |  |
|         |      |   |     |   |           |   |   |           |   |  |  |
|         |      | provided by the organisation.   |     |   |           |   |   |           |   |  |  |
|         |      | provided by the organisation.<br>The organisation can demonstrate that  |     |   |           |   |   |           |   |  |  |
|         |      | provided by the organisation.<br>The organisation can demonstrate that<br>it is monitoring compliance with the  |     |   |           |   |   |           |   |  |  |
|         |      | provided by the organisation.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained  |     |   |           |   |   |           |   |  |  |
|         |      | provided by the organisation.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation   |     |   |           |   |   |           |   |  |  |
|         |      | provided by the organisation.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the   |     |   |           |   |   |           |   |  |  |
|         |      | provided by the organisation.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation   |     |   |           |   |   |           |   |  |  |
|         |      | provided by the organisation.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:   |     |   |           |   |   |           |   |  |  |
|         | 5095 | provided by the organisation.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:<br>ensuring that recommendations are  |     |   |           |   |   |           |   |  |  |
| Level 1 | 5095 | The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:<br>ensuring that recommendations are<br>acted upon throughout the  |     |   |           |   |   |           |   |  |  |
| Level 1 | 5095 | provided by the organisation.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:<br>ensuring that recommendations are<br>acted upon throughout the<br>organisation.  |     |   |           |   |   |           |   |  |  |
| Level 1 | 5095 | provided by the organisation.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:<br>ensuring that recommendations are<br>acted upon throughout the<br>organisation.<br>Where the monitoring has identified   |     |   |           |   |   |           |   |  |  |
| Level 1 | 5095 | The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:<br>ensuring that recommendations are<br>acted upon throughout the<br>organisation.<br>Where the monitoring has identified<br>deficiencies, there must be evidence  |     |   |           |   |   |           |   |  |  |
| Level 1 | 5095 | provided by the organisation.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:<br>ensuring that recommendations are<br>acted upon throughout the<br>organisation.<br>Where the monitoring has identified   |     |   |           |   |   |           |   |  |  |
| Level 1 | 5095 | provided by the organisation.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:<br>ensuring that recommendations are<br>acted upon throughout the<br>organisation.<br>Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action                                  |     |   |           |   |   |           |   |  |  |
| Level 1 | 5095 | provided by the organisation.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:<br>ensuring that recommendations are<br>acted upon throughout the<br>organisation.<br>Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and |     |   |           |   |   |           |   |  |  |
| Level 1 | 5095 | provided by the organisation.<br>The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:<br>ensuring that recommendations are<br>acted upon throughout the<br>organisation.<br>Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action                                  |     |   |           |   |   |           |   |  |  |
| Level 1 | 5095 | The organisation can demonstrate that<br>it is monitoring compliance with the<br>minimum requirements contained<br>within the approved documentation<br>described at Level 1, in relation to the<br>process for:<br>ensuring that recommendations are<br>acted upon throughout the<br>organisation.<br>Where the monitoring has identified<br>deficiencies, there must be evidence<br>that recommendations and action<br>plans have been developed and                                  |     |   | Compliant |   |   | Compliant |   |  |  |

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| 3.5.10  |        | he organisation can demonstrate that                           |            |                                 |             |                |            |              |   |   |                     |
|         |        | nere are processes in place to monitor                         |            |                                 |             |                |            |              |   |   |                     |
|         | cc     | ompliance with the approved                                    |            |                                 |             |                |            |              |   |   |                     |
|         |        | ocumentation which describes the                               |            |                                 |             |                |            |              |   |   |                     |
|         | pr     | rocess for ensuring that all                                   |            |                                 |             |                |            |              |   |   |                     |
|         |        | ommunication is open, honest and                               |            |                                 |             |                |            |              |   |   |                     |
|         | 0      | ccurs as soon as possible following                            |            |                                 |             |                |            |              |   |   |                     |
|         | ar     | n incident, complaint or claim.                                |            |                                 |             |                |            |              |   |   |                     |
|         | a      |  |            |                                 |             |                |            |              |   |   |                     |
|         |        | he organisation can demonstrate that                           |            |                                 |             |                |            |              |   |   |                     |
|         |        | is monitoring compliance with the                              |            |                                 |             |                |            |              |   |   |                     |
|         |        | ninimum requirements contained                                 |            |                                 |             |                |            |              |   |   |                     |
|         |        | <i>i</i> thin the approved documentation                       |            |                                 |             |                |            |              |   |   |                     |
|         |        |  |            |                                 |             |                |            |              |   |   |                     |
|         | ae     | escribed at Level 1, in relation to the:                       |            |                                 |             |                |            |              |   |   |                     |
|         | 5404   |  |            |                                 |             |                |            |              |   |   |                     |
|         | Siuipr | rocess for encouraging open<br>ommunication between healthcare |            |                                 |             |                |            |              |   |   |                     |
| Level 1 |        |  |            |                                 |             |                |            |              |   |   |                     |
|         | or     | rganisations, healthcare teams, staff                          |            |                                 |             |                |            |              |   |   |                     |
|         |        | nd patients and/or their carers                                |            |                                 |             |                |            |              |   |   |                     |
| Level 1 |        | equirements for documenting all                                |            |                                 |             |                |            |              |   |   |                     |
|         |        | ommunication.  |            |                                 |             |                |            |              |   |   |                     |
| 2       |        | Vhere the monitoring has identified                            |            |                                 |             |                |            |              |   |   |                     |
|         | de     | eficiencies, there must be evidence                            |            |                                 |             |                |            |              |   |   |                     |
|         | th     | nat recommendations and action                                 |            |                                 |             |                |            |              |   |   |                     |
|         | pl     | lans have been developed and                                   |            |                                 |             |                |            |              |   |   |                     |
|         |        | hanges implemented accordingly.                                |            |                                 |             |                |            |              |   |   |                     |
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|         |        |  | The follow | ing summary will be populated a | utomaticall | y from informa | ation ente | red on the w | orksheet.                               | 1 |                     |
|         |        |  |            |                                 |             | 3.5.1          | 0          |              |   | 0 |                     |
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|         |        |  |            |                                 |             | 3.5.7          | 0          |              |   | 0 |                     |
|         |        |  |            |                                 |             | 3.5.8          | 0          |              |   | 0 |                     |
|         |        |  |            |                                 |             | 3.5.9          | 0          |              |   | 0 |                     |
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|         |        |  |            |                                 |             | Total          | 0          |              |   | 0 | 0                   |
|         |        |  |            |                                 |             |                |            |              |   |   |                     |

| Actions required to achieve<br>compliance<br>Person/<br>Committee<br>responsible | Target Date | Associated<br>Cost |  |  |  |  |
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Cell: L1 Comment: Assessor Use Only

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Cell: H76 Comment: Incident reporting

Cell: H77 Comment: Raising concerns

Cell: H78 Comment: Complaints

Cell: H79 Comment: Claims

Cell: H80 Comment: Investigations

Cell: H81 Comment: Analysis

Cell: H82 Comment: Improvement

Cell: H83 Comment: Best practice - NICE

Cell: H84 Comment: Best practice - NSFs, NCEs & High Level Enquiries

Cell: H85 Comment: Being open