NHSLA Risk Management Standards for Primary Care Trusts Evidence Template Summary

Organisation Name:		Southampton City PCT	г								
NHSLA Membership Number:	P163										
NHS or Foundation trust	NHS		Evidence Template								
			for use with								
Day 1 of Assessment:	24 March 2010	NHSLA Risk Ma	anagement Standards for Pr	imary Care Trusts							
Day 2 of Assessment:	25 March 2010		2009/10 version								
Existing CNST/NHSLA Level:	1										
Level Applied For: Level Achieved:	1	This evidence temp	plate has been produced to a	assist organisations in							
Assigned Assessor:	Karen Lewis		ssessment and is based on th								
Chief Executive:	Bob Deans	In the system of any	Standards.								
email address	bob.deans@scpct.nhs.uk										
Organisation Contact:	Anne Baileff										
designation	Head of Clinical Standards										
email address	anne.baileff@scpct.nhs.uk										
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		Level 1 Summary									
Standard 1	Standard 2	Standard 3	Standard 4	Standard 5	Total						
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1.1.1 Yes Yes 1.1.2 Yes Yes	1.2.1 Yes Yes 1.2.2 Yes Yes	1.3.1 Yes Yes 1.3.2 Yes Yes	1.4.1 Yes Yes 1.4.2 Yes Yes	1.5.1 Yes Yes 1.5.2 Yes Yes							
1.1.3 Yes No.	1.2.3 Yes No.	1.3.3 Yes Yes	1.4.3 Yes No	1.5.3 Yes Yes							
1.1.4 Yes Yes	1.2.4 No Yes	1.3.4 Yes Yes	1.4.4 Yes Yes	1.5.4 Yes Yes							
1.1.5 Yes Yes 1.1.6 Yes Yes	1.2.5 Yes Yes 1.2.6 Yes Yes	1.3.5 Yes Yes 1.3.6 Yes Yes	1.4.5 Yes No. 1.4.6 Yes Yes	1.5.5 Yes Yes 1.5.6 Yes Yes							
1.1.7 Yes Yes	1.2.7 Yes Yes	1.3.7 Yes Yes	1.4.7 Yes Yes	1.5.7 Yes Yes							
1.1.8 Yes Yes	1.2.8 Yes Yes	1.3.8 Yes Yes	1.4.8 Yes No	1.5.8 Yes Yes							
1.1.9 Yes Yes	1.2.9 Yes Yes	1.3.9 Yes Yes	1.4.9 Yes Yes	1.5.9 Yes No.							
1.1.10 Yes Yes Total 10 9	1.2.10 Yes Yes Total 9 9	1.3.10 Yes Yes Total 10 10	1.4.10 Yes Yes Total 10 7	1.5.10 Yes Yes Total 10 9	49 44						
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Summary	

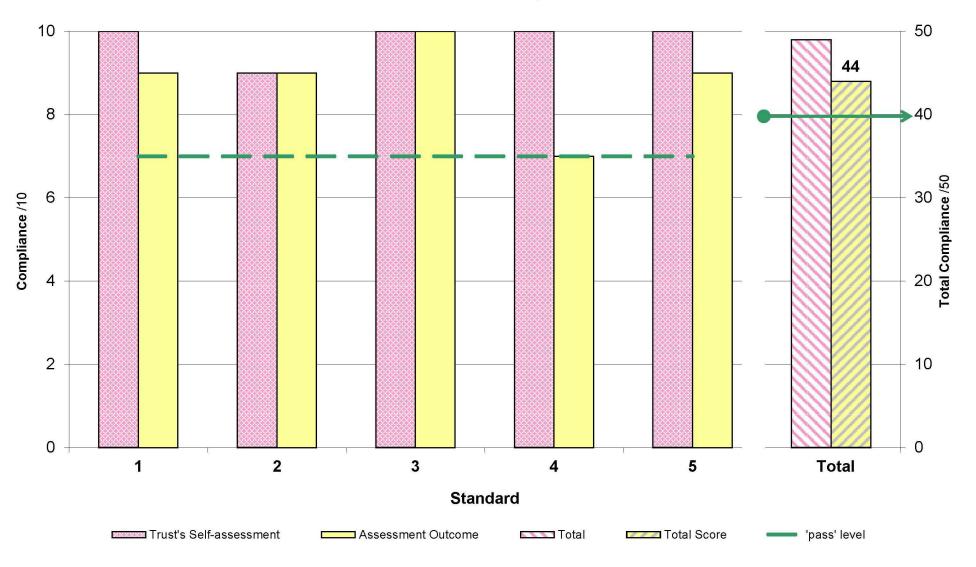
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c	Cell: E1 mment: Your first action should be to select your organisation's name here.
	Related cells will be populated automatically.
C	mment: The navigation facility from the matrix below may function incorrectly until the appropriate assessment level is selected here.
C	mment: Risk management strategy
C	Cell: G20 mment: Corporate induction
C	Cell: L20 mment: Secure environment
c	Cell: Q20 imment: Patient identification
C	Cell: V20 mment: Incident reporting
C	Cell: B21 mment: Policy on procedural documents
c	Cell: G21 mment: Local induction of permanent staff
C	Cell: L21 mment: Sickness absence
C	Cell: Q21 mment: Patient information
c	Cell: V21 mment: Raising concerns
C	Cell: 822 mment: Risk management committee(s)
C	Cell: G22 mment: Local induction of temporary staff
C	Cell: L22 mment: Safeguarding adults
C	Cell: Q22 mment: Consent
C	Cell: V22 mment: Complaints
	Cell: B23 mment: Risk management committee(s)
	Cell: G23 mment: Filness to practice
	Cell: L23 mment: Moving & handling
	Cell: Q23 mment: Clinical record-keeping standards
	Cell: V23
	mment: Claims Cell: 824
	mment: Risk management committee(s) Cell: G24
	mment: Risk management training Cell: L24
C	mment: Slips, trips& falls Cell: Q24
C	mment: Transfer of patients Cell: V24
C	mment: Investigations Cell: B25
C	mment: Risk management committee(s) Cell: G25
C	mment: Training needs analysis Cell: L25
C	mment: Inoculation incidents Cell: Q25
C	cell: V25
C	Cell: B26
c	mment: Responding to external recommendations specific to the organisation
C	Cell: G26 mment: Medical devices training
C	Cell: L26 mment: Maintenance of medical devices & equipment
C	Cell: Q26 mment: Blood transfusion
C	Cell: V26 mment: Improvement
C	Cell: B27 imment: Clinical records management
C	Cell: G27 imment: Hand hygiene training
C	Cell: L27 imment: Harassment & bullying
C	Cell: Q27 imment: Resuscitation
C	Cell: V27 mment: Best practice - NICE
c	Cell: B28 mment: Professional clinical registration
C	Cell: G28 mment: Moving & handling training
C	Cell: L28 mment: Violence & aggression
c	Cell: Q28 mment: Infection control
C	Cell: V28 mment: Best practice - NSFs, NCEs & High Level Enquiries
C	Cell: B29 mment: Employment checks
C	Cell: G29 mment: Supporting staff involved in an incident, complaint or claim
C	Cell: L29 mment: Stress
	Cell: Q29 mment: Diagnostic testing and screening procedures
	Cell: V29

Cell: V29 Comment: Being open

NHSLA Risk Management Standards for Acute Trusts Evidence Template





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

Standard ⇔	1	2	3	4	5
Criterion ↓	Governance	Competent & Capable Workforce	Safe 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	<u>Consent</u>	<u>Complaints</u>
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

1.1.

Criterion number	Index	Criterion and minimum requirements	Paper or Electronic copy	Name of approved document	Electronic file hyperlink/name	Document version name, no. and approved and review date	Initials of contact name for document	Compliant? (Organisation)	Reference	Organisation's comments	Compliant? (Assessor)	Actions required to achieve compliance	Person/ Committee responsible	Target Date	Associated Cost	
1.1.1		There is an organisation-wide risk management strategy which has been approved by the board.		SCH Risk Management Strategy	versionNHSLA FINAL 11 03 10.doc	SCH V1 AD - 03/10 RD - 03/11	JH									
		As a minimum, the approved documentation must include a description of the:														
а		organisational risk management structure detailing all those committees/sub- committees/groups which have some responsibility for risk	E	SCH Risk Management Strategy				Yes	Appendix 2		Yes					
b		process for board or high level committee review of the organisation-wide risk register	E	SCH Risk Management Strategy				Yes	Section 8		Yes					
с		process for the management of risk locally, which reflects the organisation- wide risk management strategy	E	SCH Risk Management Strategy				Yes	Section 6		Yes					
d	1014	duties of the key individual(s) for risk management activities	E	SCH Risk Management Strategy				Yes	Section 5		Yes					
e		authority of all managers with regard to managing risk		SCH Risk Management Strategy					Section 5		Yes					
f		process for monitoring compliance with all of the above.	E	SCH Risk Management Strategy					Section 11		Yes					
							Compliant	Yes		Compliant	Yes					
1.1.2		The organisation has approved documentation which describes the process for developing organisation-wide procedural documents.	E	Policy on policies		SCPCT/Polic y/CS/06/V8 AD - 10/2009 RD - 10/2010	RC									
		As a minimum, the approved documentation must include a description of the following requirements:														
а		style and format		Policy on policies					section 3		Yes					
b		an explanation of any terms used in documents developed		Policy on policies					section 2		Yes					
с		consultation process		Policy on policies					section 4.5		Yes					
d	1024	ratification process	E	Policy on policies					section 4.6 appendix 5		Yes					
е	1025	review arrangements	E	Policy on policies				Yes	section 4.8		Yes					
f		control of documents, including archiving arrangements		Policy on policies					section 4.9		Yes					
g		associated documents		Policy on policies					section 9		Yes					
h		supporting references		Policy on policies					section 9		Yes					
ļ		the process for monitoring compliance with all of the above.		Policy on policies					section 7		Yes					
							Compliant	Yes		Compliant	Yes					

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1.1.3		The organisation has approved terms of reference for the high level committee(s) with overarching responsibility for risk.		Integrated Governance & Performance Committee TOR	Integrated Governance & Performance Committee TOR V7 20090902 FINAL.DOC	V7 A - July 2009 R - July 2010	RC							
		As a minimum, the terms of reference must include a description of the:												
а		duties		Integrated Governance & Performance Committee TOR				Yes	page 1 - main		Yes			
									responsibil ities					
b	1032.1	reporting arrangements to the board		Integrated Governance & Performance Committee TOR				Yes	page 6 - reporting		Yes			
с	1033	membership, including nominated deputy where appropriate		Integrated Governance & Performance Committee TOR					page 5 - membershi p	I I	Yes			
d	1034	required frequency of attendance by members		Integrated Governance & Performance Committee TOR				Yes	page 6 - frequency		No			
e	1035	reporting arrangements into the high level committee(s)		Integrated Governance & Performance Committee TOR				Yes	page 6 - reporting		Yes			
f	1036	requirements for a quorum		Integrated Governance & Performance Committee TOR				Yes	page 6 - Quorom		Yes			
g	1037	frequency of meetings		Integrated Governance & Performance Committee TOR				Yes	page 6 - frequency	1 1	Yes			
h		process for monitoring compliance with all of the above.	E						page 6 - TORs reviewed annually		Yes			
							Compliant	Yes		Compliant	No			
1.1.4		The organisation has approved documentation which describes the process for delivering risk management awareness training for all board members, executives and senior managers.		Induction & Mandatory Training Policy	Induction and Mandatory Training Policy.doc	SCPCT/POLI CY/LD/02 - Version 3.0 A - 04/2009 R - 04/2010	CC							
		As a minimum, the approved documentation must include a description of the process for:												
а		ensuring that all board members, and senior managers receive relevant risk management awareness training	E	SCH Risk Management Strategy	SCH Risk Management Strategy versionNHSLA FINAL 11 03 10.doc	SCH V1 AD - 03/10 RD - 03/11	JH	Yes	9.3 and TNA		Yes			
b		recording attendance		Induction & Mandatory Training Policy				Yes	4.4 and 5.4		Yes	88		
С	1044	following up non-attendance		Learning & Development Policy	NHSLA-LD Policy.doc	SCPCT/POLI CY/LD/01 - Version 2.0 A - sep 05 R - April 10	СС	Yes			Yes			
		monitoring compliance with all of the above.	E	Induction & Mandatory Training				Yes	section 7		Yes			
d	1048	information and an or the above.		Policy			Compliant			Compliant				

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f	1068	residual risk rating.					Yes	BAF -	Ye				
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						Compliant	Yes		Compliant Ye	25			
1.1.7	1070	The organisation has approved	E Policy for the Management of	policy for the	SCPCT/Polic								
1.1.7		documentation which describes the process	External Agency Visits,	managementofexternalagencyvisitsin spections_	y/SCH/CS/0								
		for preparing and responding to the recommendations and requirements arising	Inspections and Accreditations	andaccreditationsfinalratified 0310.d	in an on								
		from external agency visits, inspections and accreditations specific to the organisation.		<u>oc</u>	2010 R - March								
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		As a minimum, the approved documentation must include a description of the process for:											
а	1071	nominating/appointing a suitable individual(s) to coordinate and report on any	E Policy for the Management of External Agency Visits,				Yes	section 3.1	Ye	es			
		reviews carried out by external agencies	Inspections and Accreditations										
b	1072	maintaining a schedule of review dates	E Policy for the Management of External Agency Visits,				Yes	section 4.5	Ye	es			
с	1073	maintaining action plans to implement	Inspections and AccreditationsEPolicy for the Management of				Yes	section 4.5	Ye	es			
-		any recommendations made as a result of reviews	External Agency Visits, Inspections and Accreditations										
d	1074	ensuring that the organisation-wide risk register is populated with risks identified	E Policy for the Management of External Agency Visits,				Yes	section 4.5	Ye	es			
		from reviews	Inspections and Accreditations										
е	1078	monitoring compliance with all of the above.	E Policy for the Management of External Agency Visits,				Yes	section 7	Ye	es			
			Inspections and Accreditations				Yes		Ye				
						Compliant	100		Compliant				
1.1.8		The organisation has approved	STANDARDS OF CLINICAL										
		documentation which describes the process for managing the risks associated with	RECORDS POLICY										
		clinical records in all media.											
		As a minimum, the approved documentation											
		must include a description of the:											
а	1081	duties	E STANDARDS OF CLINICAL RECORDS POLICY				Yes	section 4	Ye	es			
b	1082	legal obligations that apply to records	E STANDARDS OF CLINICAL RECORDS POLICY				Yes	4.5, 4.1.5, 12.6	Ye	es			
с	1083	process for tracking records	E STANDARDS OF CLINICAL RECORDS POLICY				Yes	section 9	Ye	es			
d	1084	process for creating records	E STANDARDS OF CLINICAL				Yes	section 5	Ye	es			
е	1085	process for retrieving records	RECORDS POLICY E STANDARDS OF CLINICAL				Yes	section 4.8	Ye	es			
f	1086	process for retaining and disposing of	RECORDS POLICY E STANDARDS OF CLINICAL				Yes	4.5 and	Ye	es			
•		records	RECORDS POLICY					4.6					ļ

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enament clinical staff work for lot satisfy the valication of registration procedure including procedure			in respect of an temperary enniour stan											
ermann clinical staff work fail to satisfy the validation or registration process including procedure	d	1094	process in place for following up those	E Professional staff registration				Yes	4,5 and 6		Yes			
e 1088 process for monitoring compliance with all of the above. E Processional staff registration checking procedure Image: Compliant (he above. Yes section 7 Yes Yes Section 7 Yes Yes Yes Section 7 Yes Yes Section 7 <td></td> <td></td> <td>permanent clinical staff who fail to satisfy</td> <td>checking procedure</td> <td></td>			permanent clinical staff who fail to satisfy	checking procedure										
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bdocumentation which describes the process for ensuing that all appropriate employment checks are undertaken for all staff (temporary and permanent).isecures secures check are undertaken for all staffisecures check are undertaken for all staffisecures 	1.1.10	1100	The organisation has approved	E Recruitment and Selection Policy	23 Recruitment and Selection v3.doc	SCPCT	LB							
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a 1101 duties E Recruitment and Selection Policy C Yes section 4 Yes Yes <td></td>														
b 1102 types of check required E Recruitment and Selection Policy Yes 7.1.3 Yes 7.1.3			must include a description of the:											
	а	1101	duties	E Recruitment and Selection Policy	1			Yes	section 4		Yes			_
		1102	types of check required	E Recruitment and Selection Policy	· · · · · · · · · · · · · · · · · · ·			Vec	713		Yes		 	
c 1103 checking procedures E Recruitment and Selection Policy Yes 7.1.3 Yes	0	1102	types of check required					1 CS	7.1.5		105			
	с	1103	checking procedures	E Recruitment and Selection Policy	n			Yes	7.1.3		Yes			
					1							L		

d	1104	process for following up those who fail to	E	Managers Actions when	3 Managers Action in CRB Checks v	SCPCT/		Yes	8.3		Yes	
		satisfy the checking arrangements		undertaking CRB checks	4.doc	Management						
				-		Guide/						
						Human						
						Resource						
						003 v 4						
						A - march						
						2010						
						D - March						
						2012						
	1105		┝═╴	Dreference of staff registration	A Professional Desistration sheaking			Vaa	Annandin		Vee	
е		process for monitoring/receiving assurance			4 Professional Registration checking procedures v4 (2).doc	Management	LB	res	Appendix		Yes	
		that checks are being carried out by all		checking procedure	procedures v4 (2).doc	Guide/			В			
		external agencies (e.g. NHS Professionals,				Human						
		recruitment agencies, etc.) used by the				Resource						
		organisation in respect of all temporary staff				003						
						A - March						
						2010						
						R - March						
						2012						
f	1108	process for monitoring compliance with all of		Recruitment and Selection Policy				Yes	section 8		Yes	
		the above.										
								Yes		a	Yes	
							Compliant			Compliant		
	9999											
	.il	Th	ne fo	llowing summary will be populated a	utomatically from information entered	d on the worksh	neet.				1	
							1.1.1	Yes			Yes Yes	
							1.1.2	Yes			Yes	
							1.1.3	Yes			No	
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							1.1.6	Yes			Yes	
							1.1.7	Yes			Yes	
							1.1.8	Yes			Yes	
							1.1.9	Yes			Yes	
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Cell: L1 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

End End Criterion and minimum requirements Image: Second and minimum requirement	Actions required to achieve compliance Person/ Committee responsible Target Date Associated Cost
documentation which describes the Policy Policy.doc CY/LD/02 -	
documentation which describes the Policy Policy.doc CY/LD/02 -	
corporate induction arrangements for all new permanent staff. Version 3.0 A - 04/2009 R - 04/2010 Version 3.0 A - 04/2009	
As a minimum, the approved documentation must include a description of the:	
a 2011 duties E Induction & Mandatory Training Yes section 4 Yes	
b 2012 minimum content of the corporate induction E Induction & Mandatory Training Policy Yes 5.3, page 24,25	
c 2013 process for ensuring that all new permanent staff are booked onto corporate induction E Induction & Mandatory Training Policy Yes 5.4 Yes	
d 2014 process for checking that all new permanent staff complete corporate induction E Induction & Mandatory Training Policy Yes 5.4.2 Yes 5.4.2 Yes	
e 2015 process for following up those who fail to attend corporate induction A mandatory Training Policy Yes 5.4.2, 5.7	
f 2018 process for monitoring compliance with all of the above. E Induction & Mandatory Training Policy Yes Section 7 Yes	
Compliant Yes Compliant Yes	
1.2.2 2020 The organisation has approved E Induction & Mandatory Training Induction and Mandatory Training SCPCT/POLI CC Image: CC = CC	
documentation which describes the local induction arrangements for all new permanent staff.	
As a minimum, the approved documentation must include a description of the:	
a 2021 duties E Induction & Mandatory Training Policy Francisco Fr	
b 2022 minimum content of local induction programme(s) E Induction & Mandatory Training Policy Yes	
c 2023 process for checking that all new permanent staff complete local induction E Induction & Mandatory Training Y 5.1.6 Yes	
d 2024 process for following up those who fail to complete local induction E Induction & Mandatory Training Yes 5.1.6 Yes 5.1.6 Yes Yes	
e 2028 process for monitoring compliance with all of the above. E Induction & Mandatory Training Yes section 7 Yes	
Inclusion Inclusion Image: Second s	
1.2.3 2030 The organisation has approved E Induction & Mandatory Training Induction and Mandatory Training SCPCT/POLI CC Image: CC = CC	
documentation which describes the local induction arrangements for all temporary staff. Policy Policy.doc CY/LD/02 - Version 3.0 A - 04/2009 Version 3.0	
R - 04/2010	
As a minimum, the approved documentation must include a description of the: Image: Control of the control of t	

b		minimum content of local induction programme(s)	E Induction & Mandatory Training Policy					5.1.1 and appendix a		Yes		
с		process for checking that all temporary staff complete local induction	E Induction & Mandatory Training Policy				Yes	5.1.6		No		
d		process for following up those who fail to complete local induction	E Induction & Mandatory Training Policy				Yes	5.1.6		No		
е	2038	process for monitoring compliance with all of the above.	,				Yes	section 7		Yes		
						Compliant	Yes		Compliant	No		
1.2.4		The organisation has approved documentation which describes the process for ensuring that the organisation undertakes the appropriate regulatory checks via the NHSLA Family Health Services Appeal Unit on all primary care performers (temporary and permanent).	e Medical and Dental HR Recruitment Procedures	MEDICAL HR RECRUITMENT PROCEDURES.doc		LB			document needs to be reformatted to meet current NHSLA standards to include version numbers, monitoring and compliance			
		As a minimum, the approved documentation must include a description of the:										
а	2041	duties	e Medical and Dental HR Recruitment Procedures	MEDICAL HR RECRUITMENT PROCEDURES.doc		LB	Yes	section 12		Yes		
b	2042	process for ensuring checks are made	e Medical and Dental HR Recruitment Procedures	MEDICAL HR RECRUITMENT PROCEDURES.doc		LB	Yes	11 and appendix		Yes		
с		process for following up those who fail to satisfy the checking arrangements	e Medical and Dental HR Recruitment Procedures	MEDICAL HR RECRUITMENT PROCEDURES.doc		LB	Yes	13		Yes		
d		procedure for notifying the NHSLA Family Health Service Appeal Unit in the event of concern	E Managing Performance Policy for Medical and Dental Staff	r <u>17 Managing Performance for</u> <u>Medical and Dental Staff.doc</u>	SCPCT /Policy/ Human Resources 017 A - Dec 05 R - June 10	LB	Yes	7.7.4		Yes		
e		procedure for notification within the health community	E Managing Performance Policy for Medical and Dental Staff	r <u>17 Managing Performance for</u> <u>Medical and Dental Staff.doc</u>	SCPCT /Policy/ Human Resources 017 A - Dec 05 R - June 10	LB	Yes	7.7.4 and appendix 2b		Yes		
f		process for monitoring compliance with all of the above.					No			Yes		
						Compliant	No		Compliant	Yes		
1.2.5	2050	The organisation has approved	E Learning & Development Policy	NHSLA-LD Policy.doc	SCPCT/POL	СС						
		documentation which describes the process for ensuring a systematic approach to risk management training for all permanent staff.			CY/LD/01 - Version 2.0 A - sep 05 R - April 10							
		As a minimum, the approved documentation must include a description of the process for:										
а	2051	developing a training needs analysis which reflects the TNA Minimum Data Set	E Learning & Development Policy				Yes	3.2		Yes		
b		developing action plan(s) to deliver the training identified within the training needs analysis	E Learning & Development Policy				Yes	3.2		Yes		
с		developing a training prospectus to reflect the training needs analysis	E Learning & Development Policy				Yes	3.2		Yes		

d		checking that all permanent staff complete the relevant training programmes in accordance with the training needs analysis	Learning & Development Policy				Yes	4.2		Yes	
е			Learning & Development Policy				Yes	4.2		Yes	
f	2056	coordinating training records	Learning & Development Policy				Yes	4.3		Yes	
g		monitoring compliance with all of the above.	Learning & Development Policy				Yes	7		Yes	
						Compliant	Yes		Compliant	Yes	
1.2.6	2060	The organisation has undertaken a training E needs analysis to identify the risk management training requirements for all permanent staff and documented the results.	Training Needs Analysis (extracted from induction & mandatory training policy)	<u>Training Needs Analysis</u> (11032010).xls	SCPCT/POLI CY/LD/02 - Version 3.0 A - 04/2009 R - 04/2010	cc					
		As a minimum, the approved documentation must include:									
а	2061	a list of topics defined as risk management training by the organisation (MUST include all those referred to in the NHSLA standards TNA Minimum Data Set)	Training Needs Analysis (extracted from induction & mandatory training policy)					column b in spreadshe et		Yes	
b	2062	evidence that the organisation has identified E which staff groups are required to attend each type of training	Training Needs Analysis (extracted from induction & mandatory training policy)					Row 1 in spreadshe et		Yes	
С		evidence that the organisation has identified E the frequency of updates required for each type of training.	Training Needs Analysis (extracted from induction & mandatory training policy)					Column C in spreadshe et		Yes	
						Compliant	Yes		Compliant	Yes	
1.2.7	2070	The organisation has approved E documentation which describes the process for ensuring that all permanent staff are trained to safely use diagnostic and therapeutic equipment appropriate to their role.	E Management of Medical Devices (Equipment)	MDG policy November 2008 V008 NHSLA FINAL.doc	SCPCT / Policy / MDG / 008 a Jan 09 r Mar 11	NM					
		As a minimum, the approved documentation must include a description of the:									
а	2071	duties E	Management of Medical Devices (Equipment)				Yes	5		Yes	
		inventory (or links to an inventory) of E diagnostic and therapeutic equipment used within the organisation	Management of Medical Devices (Equipment)				Yes	12.5		Yes	
С	2073	process for identifying which permanent staff are authorised to use the equipment identified on the inventory	Management of Medical Devices (Equipment)				Yes	12.2		Yes	
d	2074	process for determining the training required to use the equipment identified on the inventory and the frequency of updates required	Management of Medical Devices (Equipment)				Yes	14		Yes	
е		process for ensuring that the identified E training needs of all permanent staff are met	Management of Medical Devices (Equipment)				Yes	14 appendix 15 & 16		Yes	
	0070	process for monitoring compliance with all of E	Management of Medical Devices				Yes	24		Yes	
f		the above.	(Equipment)								
f			(Equipment)			Compliant	Yes		Compliant	Yes	

1.2.8	2080 The organisation has approved	E	Hand hygiene policy	SCPCT Hand Hygiene V005.pdf	SCPCT/Polic	JW							
	documentation which describes the process				y/IC/005								
	for ensuring the delivery of effective hand				A - July 08								
	hygiene training for all relevant permanent				R July 10								
	staff groups.												
	As a minimum, the approved documentation												
	must include a description of the:												
а	2081 duties	E	Hand hygiene policy				Yes	3		Yes			
b	2082 process for checking that all relevant	E	Learning & Development Policy	NHSLA-LD Policy.doc	SCPCT/POLI	CC	Yes	4.2		Yes			
	permanent staff groups, as identified in				CY/LD/01 -								
	the training needs analysis, complete				Version 2.0								
	hand hygiene training				A - sep 05								
					R - April 10							 	
С	²⁰⁸³ process for following up those who fail		Induction & Mandatory Training	Induction and Mandatory Training	SCPCT/POLI	cc	Yes	5.4.2, 5.7		Yes			
	to attend hand hygiene training		Policy	Policy.doc	CY/LD/02 -								
					Version 3.0 A - 04/2009								
					R - 04/2009								
			Llevel burgers and a		IX - 04/2010		Ver	40		Vee		 ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	
d	2088 process for monitoring compliance with all of the above.		Hand hygiene policy				Yes	13		Yes			
						Compliant	Yes		Compliant	Yes			
1.2.9	2090 The organisation has approved	E	Moving and Handling Policy	Moving and Handling policy 6-31 10	SCPCT/Polic	MH							
	documentation which describes the process			07FINAL (2)1 KB.doc	y/ OCH/002								
	for ensuring the delivery of effective moving				V2								
	and handling training to all permanent staff.				A - Oct 07								
					R - Mar 2010								
	As a minimum, the approved documentation												
	must include a description of the:												
	2091 duties	E	Moving and Handling Deligy				Vaa	4		Vac			
a h	2091 duties 2092 process for checking that all permanent	F	Moving and Handling Policy Learning & Development Policy	NHSLA-LD Policy.doc	SCPCT/POLI	СС	Yes Yes	4.2		Yes Yes		 	
	staff, as identified in the training needs				CY/LD/01 -		103	7.2		103			
	analysis, complete relevant moving and				Version 2.0								
	handling training				A - sep 05								
					R - April 10								
с	2093 process for following up those who fail	E	Induction & Mandatory Training	Induction and Mandatory Training	SCPCT/POLI	СС	Yes	5.4.2, 5.7		Yes			
	to attend relevant moving and handling		Policy	Policy.doc	CY/LD/02 -								
	training				Version 3.0								
					A - 04/2009								
					R - 04/2010								
d	2098 process for monitoring compliance with all of	fΕ	Moving and Handling Policy				Yes	14		Yes			
	the above.					1						 	
						Compliant	Yes		Compliant	Yes			
				1		•			-				
1 2 40	2100 The organisation has approved		Incident, Complaints / Concerns,	Incident ComplaintsConcerns	SCPCT/polic	.14							
1.2.10	documentation which describes the process			Investigation Analysis	y/SCHRSK/								
	for ensuring that all staff involved in		· · · · · · · · · · · · · · · · · · ·	Orgainsational Policy SCH V1	004/ v2								
	traumatic/stressful incidents, complaints or			NHSLA Final 10.03.10.doc	A - March 10								
	claims are adequately supported.				R - March 11								
	As a minimum, the approved documentation												
	must include a description of the:												
دني		-	lacident Operation (O				N.			V			
a	2101 duties	E	Incident, Complaints / Concerns,				Yes	section 3		Yes			
			Investigation, Analysis and Organisational Learning Policy										
			Granisational Learning Fullcy										
b	2102 immediate support offered to staff	F	Incident, Complaints / Concerns,				Yes	11.4		Yes		 	
	(internally and, if necessary, externally)		Investigation, Analysis and				103	11.4					
			Organisational Learning Policy										
С	2103 ongoing support offered to staff (internally	E	Incident, Complaints / Concerns,	1		1	Yes	11.5		Yes		 	
	and, if necessary, externally)		Investigation, Analysis and										
			Organisational Learning Policy										
											· · _ · _ · _ · _ · _ · _ ·	 	

d	2104	advice available to staff in the event of their	E Incident, Complaints / Concerns,		Yes	s 11.8	Yes	
		being called as a witness (internally and, if	Investigation, Analysis and					
		necessary, externally)	Organisational Learning Policy					
е	2105	⁵ action for managers or individuals to take	E Incident, Complaints / Concerns,		Yes	s 11.6	Yes	
		if the staff member is experiencing	Investigation, Analysis and					
		difficulties associated with the event	Organisational Learning Policy					
		unifoldities associated with the event						
f	2108	8 process for monitoring compliance with all of	E Incident, Complaints / Concerns,		Yes	s 18	Yes	
1	2100	the above.	Investigation, Analysis and		165		165	
		the above.	Organisational Learning Policy					
			Organisational Learning Policy					
	-							
				Complian	Yes	s Complia	Yes	
	9999	9						
		1	The following summary will be populated automatically from information of the second second second second second	tion entered on the worksheet.				
				1.2.1	Yes	S	Yes	
				1.2.2	Yes	s	Yes	
				1.2.3	Yes	s	Yes Yes No	
				1.2.4	No		Yes	
				1.2.5	Yes	s	Yes	
*****				1.2.6	Yes		Yes	
				1.2.7	Yes		Ves	
				1.2.7	Yes		Vec	
							Yes Yes Yes Yes Yes Yes	
				1.2.9	Yes		res	
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Cell: L1 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

Criterion number	Index		Paper or Electronic copy		Electronic file hyperlink/name	Document version name, no. and approved and review date	Initials of contact name for document	Compliant? (Organisation)	Reference	Organisation's comments	Compliant? (Assessor)
1.3.1		The organisation has approved documentation which describes the process for managing the risks associated with the physical security of premises and other assets.		Security Management Policy	Security Management Policy V1NHSLA Final.doc	SCPCT /Policy/H&S/ V1 A - March 10 R - April 11	MH				
a		As a minimum, the approved documentation must include a description of the: duties		Security Management Policy				Yes	4		Yes
		requirement to undertake a lockdown risk profile for each organisational site or other specific building/area		Security Management Policy				No			No
с		requirement to undertake appropriate risk assessments regarding the physical security of premises and assets	E	Security Management Policy				Yes	4.11		Yes
		overview of the risk assessments regarding the physical security of premises and assets		Security Management Policy				Yes	4.1.2		Yes
e		process for monitoring compliance with all of the above.	E	Security Management Policy			Compliant	Yes Yes	7	Complian	Yes Yes
							Compliant			Complian	τ
1.3.2		The organisation has approved documentation which describes the process for managing the risks associated with sickness absences.		SCPCT /Policy/ Human Resources 016 v3	<u>16 Sickness Absence Policy v 3.doc</u>	SCPCT /Policy/ Human Resources 016 v3 A - May 2007 R - May 2011					
		As a minimum, the approved documentation must include a description of the:									
а	3021	duties	E	SCPCT /Policy/ Human Resources 016 v3				Yes	3		Yes
b		process for maintaining contact with absent employees		SCPCT /Policy/ Human Resources 016 v3				Yes	4.1, Appendix 5, Appendix 8		Yes
C		planning and facilitating return to work plans	E	SCPCT /Policy/ Human Resources 016 v3					14,15.16, Appendix 3, appendix 4, appendix 5		Yes
d		planning and undertaking workplace controls or adjustments		SCPCT /Policy/ Human Resources 016 v3				Yes	15		Yes
		data		SCPCT /Policy/ Human Resources 016 v3					3, , 22, 23.2		Yes
f		arrangements for the organisational overview of sickness absence	E	SCPCT /Policy/ Human Resources 016 v3				Yes	23		Yes

g	3028	process for monitoring compliance with all of the above.	E	SCPCT /Policy/ Human Resources 016 v3
1.3.3	3030	The organisation has approved documentation which describes the process for managing the risks associated with safeguarding adults.	E	ADULT PROTECTION POLICY
		As a minimum, the approved documentation must include a description of the:		
а	3031	duties	E	ADULT PROTECTION POLICY
b		local arrangements for managing the risks associated with safeguarding adults		ADULT PROTECTION POLICY
С		organisation's expectations in relation to staff training, as identified in the training needs analysis		ADULT PROTECTION POLICY
d	3038	process for monitoring compliance with all of the above.	E	ADULT PROTECTION POLICY
	0040			
1.3.4	3040	The organisation has approved documentation which describes the process for managing the risks associated with moving and handling.	E	Moving and Handling Policy
		As a minimum, the approved documentation must include a description of the:		
а		duties	_	Moving and Handling Policy
b	3042	techniques to be used in the moving and handling of patients and objects, including the use of appropriate equipment	E	Moving and Handling Policy
с	3043	arrangements for access to appropriate specialist advice	E	Moving and Handling Policy
d	3044	requirement to undertake appropriate risk assessments for the moving and handling of patients and objects	E	Moving and Handling Policy
e		arrangements for the organisational overview of the risk assessments for the moving and handling of patients and objects	E	Moving and Handling Policy
f	3048	process for monitoring compliance with all of the above.	E	Moving and Handling Policy
1.3.5	3050	The organisation has approved documentation which describes the process for managing the risks associated with slips, trips and falls involving patients, staff and others.	P	Management of Slips, Trips & Falls Policy
		As a minimum, the approved documentation must include a description of the:		
а	3051	duties	Р	Management of Slips, Trips & Falls Policy
b	3052	requirement to undertake appropriate risk assessments for the management of slips, trips and falls involving patients (including falls from height)	Ρ	Management of Slips, Trips & Falls Policy

			Yes	23		Yes
		Compliant	Yes		Compliant	Yes

<u>safeguarding adults policy ratified</u> 2010.doc	SCPCT/Polic y/AP/001 A - Feb 10 R - Sep 10	M				
			Yes	3		Yes
			Yes	3.1, 12.5, 23.3		Yes
			Yes	17		Yes
			Yes	23		Yes
		Compliant	Yes		Compliant	Yes
<u>Moving and Handling policy 6-31 10</u> 07FINAL (2)1 KB.doc	SCPCT/Polic y/ OCH/002 V2 A - Oct 07 R - Mar 2010	MH				
			Yes	4		Yes
			Yes	11		Yes
			Yes	13		Yes
			Yes	5		Yes
			Yes	14		Yes
			Yes	14		Yes
		Compliant	Yes		Compliant	Yes
Management of all and the A T II		MLI				
<u>Management of slips, trips & Falls</u> 016 V2 Final.doc	SCH/Policy/ HS/ 016 V 2 A - Oct 07 R Oct 2011	MH				
			Yes			Yes
			Yes	4.2		Yes

						1					
С	4	requirement to undertake appropriate risk assessments for the management of slips, trips and falls involving staff and others (including falls from height)	P	Management of Slips, Trips & Falls Policy				Yes	4.3		Yes
d		organisation's expectations in relation to staff training, as identified in the training needs analysis	P	Management of Slips, Trips & Falls Policy				Yes	6		Yes
е		process for raising awareness about preventing and reducing the number of slips, trips and falls involving patients, staff and others	P	Management of Slips, Trips & Falls Policy				Yes	1, 4.1, 5.3, 5.4, 6		Yes
f		process for monitoring compliance with all of the above.	P	Management of Slips, Trips & Falls Policy				Yes	7		Yes
							Compliant	Yes		Compliant	t Yes
1.3.6	1	The organisation has approved documentation which describes the process for managing the risks associated with noculation incidents.	E		Management of Inoculation Incidents <u>11 03 10.doc</u>	SCPCT/ Policy/ Occupational Health 007 v4 A - oct 07 R - March	СМ				
		As a minimum, the approved documentation	_	POLICY ON THE MANAGEMENT OF INOCULATION OR CONTAMINATION INCIDENTS (sharps, bites, scratches, or cuts)		2011					
	ľ	must include a description of the:									
а	3061 (duties	E	POLICY ON THE MANAGEMENT OF INOCULATION OR CONTAMINATION INCIDENTS (sharps, bites, scratches, or cuts)				Yes	3		Yes
b		reporting arrangements in relation to noculation incidents	E	POLICY ON THE MANAGEMENT OF INOCULATION OR CONTAMINATION INCIDENTS (sharps, bites, scratches, or cuts)				Yes	Appendix a - 1, Appendix B - 1 - All appendice s		Yes
с	i	process for the management of an noculation incident (including prophylaxis)	E					Yes	Appendix B		Yes
d	3065		Е	POLICY ON THE MANAGEMENT OF INOCULATION OR CONTAMINATION INCIDENTS (sharps, bites, scratches, or cuts)				Yes	Appendix a - 7		Yes
е		process for monitoring compliance with all of the above.	E					Yes	section 9		Yes
				POLICY ON THE MANAGEMENT OF INOCULATION OR CONTAMINATION INCIDENTS (sharps, bites, scratches, or cuts)			Compliant	Yes		Compliant	Yes
							Compnant			Compliant	<u>·</u>
1.3.7	1	The organisation has approved documentation which describes the process for managing the risks associated with the maintenance of reusable medical devices and equipment.	E	Management of Medical Devices (Equipment)	MDG policy November 2008 V008 NHSLA FINAL.doc	SCPCT / Policy / MDG / 008 a Jan 09 r Mar 11	NM				
		As a minimum, the approved documentation must include a description of the:									
а	3071 (duties	E	Management of Medical Devices (Equipment)				Yes	5		Yes
b		requirement to have a systematic inventory of all reusable medical devices and equipment used within the organisation	E	Management of Medical Devices (Equipment)				Yes	2		Yes
с		process for ensuring that all reusable medical devices and equipment are properly maintained and repaired	E	Management of Medical Devices (Equipment)				Yes	10, 11.3, 11.5, 11.8, 24.4		Yes

d		process for checking that calibration of all reusable medical devices are completed within the specified time frames	E	Management of Medical Devices (Equipment)
e		process for monitoring compliance with all of the above.	E	Management of Medical Devices (Equipment)
1.3.8		The organisation has approved documentation which describes the process for managing the risks associated with the harassment and/or bullying of staff.	E	Dignity at Work (Bullying and Harassment) Policy
		As a minimum, the approved documentation must include a description of the:		
а	3081	duties	E	Dignity at Work (Bullying and Harassment) Policy
b		statement by the organisation that harassment and/or bullying are not acceptable	E	Dignity at Work (Bullying and Harassment) Policy
с	1	process for raising concerns about harassment and/or bullying	E	Dignity at Work (Bullying and Harassment) Policy
d	3084	process to be followed once a concern has been raised	E	Grievance Policy
e		organisation's requirements in relation to staff training, as identified in the training needs analysis	E	Dignity at Work (Bullying and Harassment) Policy
f		process for monitoring compliance with all of the above.	E	Dignity at Work (Bullying and Harassment) Policy
1.3.9	1	The organisation has approved documentation which describes the process for managing the risks associated with the prevention and management of violence and aggression.	E	The Prevention and Management of Violence and Aggression Directed at NHS Staff, including Lone Workin
		As a minimum, the approved documentation must include a description of the:		
а	3091	duties	E	The Prevention and Management of Violence and Aggression Directed at NHS Staff, including Lone Workin
b		requirement to undertake appropriate risk assessments for the prevention and management of violence and aggression	E	The Prevention and Management of Violence and Aggression Directed at NHS Staff, including Lone Workin
С	3093	arrangements for ensuring the safety of lone workers	E	The Prevention and Management of Violence and Aggression Directed at NHS Staff, including Lone Workin

				Yes	10, appendix 9 - 2		Yes
				Yes	24		Yes
			Compliant	Yes		Compliant	Yes
	20 Dignity at work Policy v2.doc	SCPCT	LB				
		/Policy/ Human Resources 020 v2 A - Feb 09 R - Feb 2011	LB				
	20 Dignity at work Policy v2.doc			Yes	8		Yes
	20 Dignity at work Policy v2.doc			Yes	1,3. 5.1		Yes
	20 Dignity at work Policy v2.doc			Yes	10		Yes
	Grievance Policy.doc	SCPCT /Policy/ Human Resources 019 A - April 09 R - April 11	LB	Yes	11		Yes
	20 Dignity at work Policy v2.doc			Yes	17		Yes
	20 Dignity at work Policy v2.doc			Yes	15		Yes
			Compliant	Yes		Compliant	Yes
ing	Prevention and management of Violence and aggression directed at NHS staff(inc. Lone working) NHSLA Final 12.03.10.doc	SCPCT / Policy/ Health and Safety 013 v4 A - July 06 R - March 11	AB				
ing				Yes	5		Yes
ing				Yes	4.11		Yes
ing					Throughou t, appendix 5, appendix 6, appendix 7		Yes

d	3094 organisation's expectations in relation to staff training, as identified in the training needs analysis	E	The Prevention and Management of Violence and Aggression Directed at NHS Staff, including Lone Working				Yes	section 6	Yes
e	3098 process for monitoring compliance with all of the above.	E	The Prevention and Management of Violence and Aggression Directed at NHS Staff, including Lone Working				Yes	section 7	Yes
						Compliant	Yes		Compliant Yes
1.3.10	3100 The organisation has approved documentation which describes the process for managing the risks associated with work- related stress.	E	Employee Well-being and Stress Risk Assessment Policy	<u>3 Employee Wellbeing and Stress</u> <u>Risk Assessment v4.doc</u>	SCPCT/Polic y/ Health and Safety 004 A - Nov 07 R - Nov 11	CM			
	As a minimum, the approved documentation must include a description of the:								
а	3111 duties	E	Employee Well-being and Stress Risk Assessment Policy				Yes	6	Yes
b	3112 process for accessing information on the management of work-related stress	E	Employee Well-being and Stress Risk Assessment Policy				Yes	appendix 2	Yes
C	3113 process for identifying workplace stressors	E	Employee Well-being and Stress Risk Assessment Policy					appendix 4, appendix 8, appendix 9	Yes
d	3114 requirement to undertake appropriate risk assessments for the prevention and management of work-related stress	E	Employee Well-being and Stress Risk Assessment Policy					section 7 - appendix 6- 9	Yes
е	3118 process for monitoring compliance with all of the above.	E	Employee Well-being and Stress Risk Assessment Policy				Yes	8	Yes
						Compliant	Yes		Compliant Yes
	9999								
		l	The following summary will be populated automatically from information entered on	the worksheet.					
						1.3.1	Yes		Yes
						1.3.2	Yes		Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes
						1.3.3	Yes		Yes
						1.3.4 1.3.5	Yes Yes		Yes
						1.3.6	Yes		Yes
						1.3.7	Yes		Yes
						1.3.8	Yes		Yes
						1.3.9 1.3.10	Yes Yes		Yes

Actions required to achieve compliance	Person/ Committee responsible	Target Date	Associated Cost					

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Cell: L1 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

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Criterion number	Index	Criterion and minimum requirements	Paper or Electronic copy	Name of approved document	Electronic file hyperlink/name	Document version name, no. and approved and review date	Initials of contact name for document	Compliant? (Organisation)	Reference	Organisation's comments	Compliant? (Assessor)	Actions required to achieve compliance	Person/ Committee responsible	Target Date	Associated Cost
1.4.1		The organisation has approved documentation which describes the process for managing the risks associated with the identification of all patients.			KB amend.DOC	SCPCT/ Policy/RK/01 1 A - Oct 07 R - Oct 2010	JH								
		As a minimum, the approved documentation must include a description of the:													
а		definition of all patients groups		Patient Identification Policy				Yes	5 and 6		Yes				
b				Patient Identification Policy				Yes	5 and 6		Yes				
с		process for ongoing checks throughout the patient care episode	E	Patient Identification Policy				Yes	5.4, 6.5		Yes				
d		procedure to be followed in cases where patient misidentification occurs	E	Patient Identification Policy				Yes	7		Yes				
е	4018	process for monitoring compliance with all of the above.	E	Patient Identification Policy				Yes	9		Yes				
							Compliant	Yes		Compliant	Yes				
1.4.2	4020	The organisation has approved	E	Patient Information Development	Final patient information policy V2	SCPCT/	AM						<u> </u> /		
		documentation which describes the process for developing patient information associated with care, treatments and procedures.			<u>20010310.doc</u>	Policy/C&PR /001 A - Oct 07 R - Oct 2010									
		As a minimum, the approved documentation must include a description of the:													
а		process for the development of patient information	E	Patient Information Development Policy				Yes	6		Yes				
b		list of the essential content to be included in leaflets or other media i.e. risks, benefits and alternatives, where appropriate	E	Patient Information Development Policy				Yes	7		Yes				
с		reviewing process, including review date	E	Patient Information Development Policy				Yes	10		Yes				
d	4025	archiving arrangements	E	Patient Information Development Policy				Yes	10		Yes				
е		process for monitoring compliance with all of the above.	E	Patient Information Development Policy				Yes	18		Yes				
							Compliant	Yes		Compliant	Yes				
1.4.3		The organisation has approved documentation which describes the process for managing the risks associated with consent.			Policyfinalratified0310.doc	SCPCT/Polic y/SCH/CS/00 2/v2 A - Nov 06 R - March 11	AB								
		As a minimum, the approved documentation must include a description of the:													
а	4031	process for obtaining consent	E	Policy for Consent to Examination or Treatment				Yes	4		Yes				

с		process for identifying staff who are not capable of performing the procedure but are authorised to obtain consent for that procedure		Policy for Consent to Examination or Treatment				Yes	ALL OF 5.5		No		
d		-	E	Policy for Consent to Examination or Treatment				Yes	6		Yes		
e		process for the delivery of procedure specific training on consent, for staff to whom the consent process is delegated and who are not capable of performing the procedure	E	Policy for Consent to Examination or Treatment				Yes	5.5.2 AND 6.2		No		
f		process for monitoring compliance with all of the above.	E	Policy for Consent to Examination or Treatment				Yes	7		Yes		
							Compliant	Yes		Compliant	No		
1.4.4		The organisation has approved documentation which describes the process for managing the risks associated with the quality of clinical records in all media.	E	Standards of Clinical Records Policy	20100319 SCPCTPolicyIMT09 StandardsClinicalRecordsPolicy V10.1 SC.doc	SCPCT_Poli cy_IMT09_V1 0 A - March 10 R - March 12							
		As a minimum, the approved documentation must include a description of the:											
а	4041	duties	E	Standards of Clinical Records Policy				Yes	12		Yes		
b		criteria against which the clinical records must be audited for all healthcare professionals	E	Standards of Clinical Records Policy				Yes	15.6		Yes		
с	4043	frequency of audit of clinical records	E	Standards of Clinical Records Policy				Yes	15.1		Yes		
d		format for all audit reports i.e. methodology, conclusions, action plans, etc.		Standards of Clinical Records Policy				Yes	appendix I & J		Yes		
е		arrangements for the review of action plans	E	Standards of Clinical Records Policy				Yes	15.3		Yes		
f		process for monitoring compliance with all of the above.	E	Standards of Clinical Records Policy				Yes	15		Yes		
							Compliant	Yes		Compliant	Yes		
1.4.5		The organisation has approved documentation which describes the process for managing the risks associated with the transfer of patients.		SCPCT//Policy/SCH/N/CH/12 V 3	Admission transfer and discharge policy 22 3 09.doc	SCPCT//Poli cy/SCH/N/C H/12 V 3 A - March 2010 D - March 2011	FB						
		As a minimum, the approved documentation must include a description of the:											
а	4051	duties	E	SCPCT//Policy/SCH/N/CH/12 V 3				Yes	5		Yes		
b		transfer requirements which are specific to each patient group		SCPCT//Policy/SCH/N/CH/12 V 3				Yes	11		No		
С		documentation to accompany the patient when being transferred	E	SCPCT//Policy/SCH/N/CH/12 V 3				Yes	11.2, appendix 11, appendix 12		Yes		
- 1	4054	process for transfer out of hours	E	SCPCT//Policy/SCH/N/CH/12 V 3				Yes	8.1		Yes		
a													
a e		process for monitoring compliance with all of the above.	E	SCPCT//Policy/SCH/N/CH/12 V 3				Yes	17		Yes		

1.4.6		The organisation has approved documentation which describes the process for managing the risks associated with medicines in all care environments.	E	Policy for control, prescribing, supply and admin of medicines	Control,Prescribing,Supply & Admin of Medicines V3.doc	SCPCT/Polic y/PB/03 v3 A - Nov 09 R - Nov 11	СВ						
		As a minimum, the approved documentation must include a description of the:											
а	4061	process for prescribing medicines in all care environments	E	Policy for control, prescribing, supply and admin of medicines	Control,Prescribing,Supply & Admin of Medicines V3.doc	SCPCT/Polic y/PB/03 v3 A - Nov 09 R - Nov 11	СВ	Yes	section 5		Yes		
b	4061.1	process for ensuring the accuracy of all prescription charts	E	Policy for control, prescribing, supply and admin of medicines	Control,Prescribing,Supply & Admin of Medicines V3.doc	SCPCT/Polic y/PB/03 v3 A - Nov 09 R - Nov 11	СВ	Yes	5.1		No		
с	4062	process for the administration of medication in all care environments	E	Policy for control, prescribing, supply and admin of medicines	Control,Prescribing,Supply & Admin of Medicines V3.doc	SCPCT/Polic y/PB/03 v3 A - Nov 09 R - Nov 11	СВ	Yes	section 6		Yes		
d	4063	process for patient self administration	E		Self administration procedure sept 2008 City PCT(2).DOC	SCPCT/Polic y/PB09 A - Sep 08 R 0 Sep 10	СВ	Yes	Entire policy		Yes		
e		procedure for the safe disposal of controlled drugs	E	Policy for control, prescribing, supply and admin of medicines	Control,Prescribing,Supply & Admin of Medicines V3.doc	SCPCT/Polic y/PB/03 v3 A - Nov 09 R - Nov 11	СВ	Yes	section 9		Yes		
f		training requirements for all staff, as identified in the training needs analysis	E	Policy for control, prescribing, supply and admin of medicines	Control,Prescribing,Supply & Admin of Medicines V3.doc	SCPCT/Polic y/PB/03 v3 A - Nov 09 R - Nov 11	СВ	Yes	throughout , Appendix B, appendix c (10) and TNA and L&D policy		Yes		
g		process for monitoring compliance with all of the above.	E	Policy for control, prescribing, supply and admin of medicines	Control,Prescribing,Supply & Admin of Medicines V3.doc	SCPCT/Polic y/PB/03 v3 A - Nov 09 R - Nov 11	СВ	Yes	section 12		Yes		
							Compliant	Yes		Compliant	Yes		
1.4.7		The organisation has approved documentation which describes the process for managing the risks associated with the blood transfusion process.		NA - SCH does not do									
		As a minimum, the approved documentation must include a description of the:											
а		duties									Yes		
b		process for the request of blood samples for pre-transfusion compatibility testing process for the administration of blood									Yes Yes		
d		and blood products care of patient(s) receiving transfusion									Yes		
e		training requirements of all staff, as									Yes		
f		identified in the training needs analysis requirements for the competency									Yes		
		assessment of all staff involved in the blood transfusion process											
g		process for monitoring compliance with all of the above.						N			Yes		
							Compliant	Yes		Compliant	Yes		

1.4.8		The organisation has approved documentation which describes the process for managing the risks associated with		Cardiopulmonary Resuscitation Policy	SCH CPR Policy final.doc	SCPCT/Polic y/SD/01 V3 A - oct 07	IB						
		resuscitation. As a minimum, the approved documentation must include a description of the:				R - Sep 11							
а	4081	duties	E	Cardiopulmonary Resuscitation Policy				Yes	section 5		Yes		
b	4082	early warning systems in place for the recognition of patients at risk of cardio- respiratory arrest	E	Cardiopulmonary Resuscitation Policy				Yes	2.1.7		No		
С		post-resuscitation care		Cardiopulmonary Resuscitation Policy				Yes	S	post-resuscitation care not provided as all patient's transferred by 999 ambulance to acute Trust	No		
d	4084	do not attempt resuscitation orders (DNAR)	E	Cardiopulmonary Resuscitation Policy				Yes	4.2.9		Yes		
е		process for ensuring the continual availability of resuscitation equipment	E	Cardiopulmonary Resuscitation Policy				Yes	4.3.0		Yes		
f		training requirements for all staff, as identified in the training needs analysis	E	Cardiopulmonary Resuscitation Policy				Yes	section 6		Yes		
g	4088	process for monitoring compliance with all of the above.	E	Cardiopulmonary Resuscitation Policy				Yes	section 8		Yes		
							Compliant	Yes		Compliant	No		
	4000			Deline for infantion and online	Infection Drevention and Control		11.47						
1.4.9		The organisation has approved documentation which describes the process for managing the risks associated with infection prevention and control.	E	Policy for infection prevention and control framework for the Trust	Infection Prevention and Control Framework for the Trust V4.pdf	SCPCT/Polic y/IC/010 V4 A - Oct 07 R - Oct 2010	500						
		As a minimum, the approved documentation must include a description of the:											
а	4092	infection control assurance framework	E	Policy for infection prevention and control framework for the Trust				Yes	Appendix 1		Yes		
b		details of, or cross reference to, appropriate core policies	E	Policy for infection prevention and control framework for the Trust				Yes	15 and 16		Yes		
с		information available to patients and the public about the organisation's general processes and arrangements for preventing and controlling healthcare acquired infections		Policy for infection prevention and control framework for the Trust				Yes	12		Yes		
d		training requirements for all staff, as identified in the training needs analysis	E	Policy for infection prevention and control framework for the Trust				Yes	Section 10, Roles section, 3.1.4, TNA, L&D policy		Yes		
e	4098	process for monitoring compliance with all of the above.	E	Policy for infection prevention and control framework for the Trust				Yes	section 13		Yes		
							Compliant	Yes		Compliant	Yes		
	4400					00007.1							
1.4.10		The organisation has 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.		Clinical Diagnostic Testing Policy	Clinical Diagnostic Testing Policy CLS 002.doc	SCPCT / Policy/CLS/ 002 A - Aug 07 R - Mar 11	AB						
		As a minimum, the approved documentation must include a description of the:											

а		procedures for requesting clinical tests and E screening			Yes	4.2	Y	/es		
b		process for taking action on clinical tests E and screening results	Clinical Diagnostic Testing Policy		Yes	4.3	Y	íes 🛛		
с	4103	process for recording the actions taken E	Clinical Diagnostic Testing Policy		Yes	4.4	Y	/es		
d	1	process for the communication of test E and screening results	Clinical Diagnostic Testing Policy		Yes	4.5	Y	/es		
е	4108	process for monitoring compliance with all of E the above.	Clinical Diagnostic Testing Policy		Yes	7	Y	íes 🛛		
				Complia	nt Yes		Compliant Y			
	9999									
		TI	he following summary will be populated a	cally from information entered on the worksheet.	l		. I			
				-						
				1.4.1	Yes		Y	/es		
				1.4.2	Yes			/es		
				1.4.3	Yes		Ν	No		
				1.4.4	Yes		Y	es		
				1.4.5	Yes			No		
				1.4.6	Yes			es		
				1.4.7	Yes			'es		
				1.1.1						
				1.4.8	Yes			No		
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				1.4.8	Yes Yes		Y			

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Cell: L1 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	Criterion and minimum requirements	Name of approved document	Electronic file hyperlink/name	Document version name no. and approved and review date	Initials of contact name fo document	Compliant? (Organisation)	Reference	Organisation's comments	Compliant? (Assessor	Actions required to achieve compliance	Person/ Committee responsible	Target Date	Associated Cost	
1.5.1 5010	D The organisation has approved E documentation which describes the process for managing the risks associated with the reporting of all internally and externally reportable incidents.	ADVERSE INCIDENT REPORTING (AIR) POLICY	SCH Adverse Incident Reporting (AIR) Policy SCH V1 NHSLA Final 10.03.10.doc	SCPCT/polic y/SCHRSK/ 008/ v3 A - March 2010 R - March 2011	JH									
	As a minimum, the approved documentation must include a description of the:													
a 501 ⁷	1 duties E	ADVERSE INCIDENT REPORTING (AIR) POLICY				Yes	4		Yes					
b 5012	 ² process for reporting all incidents/near E misses, involving staff, patients and others 	ADVERSE INCIDENT REPORTING (AIR) POLICY					section 6 and appendix a		Yes					
c 501:	³ process for reporting to external E agencies	ADVERSE INCIDENT REPORTING (AIR) POLICY				Yes	13		Yes					
	4 reference to the processes for staff to raise E concerns e.g. whistle blowing/open disclosure	ADVERSE INCIDENT REPORTING (AIR) POLICY				Yes	5		Yes					
e 501	⁸ process for monitoring compliance with all of E the above.	ADVERSE INCIDENT REPORTING (AIR) POLICY				Yes	section 15		Yes					
					Compliant	Yes		Complian	Yes					
1.5.2 5020	D The organisation has approved E 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 raise concerns informally.	Complaints and Concerns Policy and Procedure for Patients and Staff	SCH Complaints & Concerns Policy Final ratified 0310.doc	SCPCT/Polic y/SCH/CS/00 4 A - March 10 R - March 11	SR									
	As a minimum, the approved documentation must include a description of the:													
a 502 ⁻	1 duties E	Complaints and Concerns Policy and Procedure for Patients and Staff				Yes	9		Yes					
b 5022	 ² process for raising concerns (informal E complaints/Patient Advice and Liaison Services) 	Complaints and Concerns Policy and Procedure for Patients and Staff				Yes	section 12		Yes					
c 5023	3 process for ensuring that patients, relatives E and their carers are not treated differently as a result of raising a concern	Complaints and Concerns Policy and Procedure for Patients and Staff				Yes	Appendix B		Yes					
d 5024	 ⁴ process by which the organisation aims E to make changes as a result of concerns being raised 	Complaints and Concerns Policy and Procedure for Patients and Staff				Yes	section 24		Yes					
e 5028	⁸ process for monitoring compliance with all of E the above.	Complaints and Concerns Policy and Procedure for Patients and Staff				Yes	section 31		Yes					
					Compliant	Yes		Complian	Yes					

a 5031 (b 5032 (c 5033)	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.EAs a minimum, the approved documentation must include a description of the:EdutiesEcomplaints management process, which 	Staff Complaints and Concerns Policy and Procedure for Patients and Staff Complaints and Concerns Policy and Procedure for Patients and Staff Complaints and Concerns Policy and Procedure for Patients and Staff Complaints and Concerns Policy	Final ratified 0310.doc	SCPCT/Polic y/SCH/CS/00 4 A - March 10 R - March 11		Yes	9	formatting of policy needs to be	Yes	
a 5031 (b 5032 (c 5033)	procedures to register formal complaints.As a minimum, the approved documentation must include a description of the:dutiesdutiesEcomplaints management process, which includes internal and external communication, and collaboration with other organisations when necessaryprocedure to ensure that patients, relatives and their carers are not treated differently as	and Procedure for Patients and Staff Complaints and Concerns Policy and Procedure for Patients and Staff Complaints and Concerns Policy		R - March 11		Yes	9	formatting of policy needs to be	Yes	
a 5031 (b 5032 (c 5033)	must include a description of the: E duties E complaints management process, which includes internal and external communication, and collaboration with other organisations when necessary E procedure to ensure that patients, relatives and their carers are not treated differently as E	and Procedure for Patients and Staff Complaints and Concerns Policy and Procedure for Patients and Staff Complaints and Concerns Policy				Yes	9	formatting of policy needs to be	Yes	
b 5032 (i c 5033 (complaints management process, which includes internal and external communication, and collaboration with other organisations when necessaryEprocedure to ensure that patients, relatives and their carers are not treated differently asE	and Procedure for Patients and Staff Complaints and Concerns Policy and Procedure for Patients and Staff Complaints and Concerns Policy				Yes	9	formatting of policy needs to be	Yes	
c 5033	includes internal and external communication, and collaboration with other organisations when necessary procedure to ensure that patients, relatives and their carers are not treated differently as	and Procedure for Patients and Staff Complaints and Concerns Policy						revised.		
	and their carers are not treated differently as					Yes	2		Yes	
d 5034		and Procedure for Patients and Staff				Yes	appendix B		Yes	
	process by which the organisation aims to make changes as a result of formal complaints	Complaints and Concerns Policy and Procedure for Patients and Staff				Yes	section 24		Yes	
	process for monitoring compliance with all of E the above.	Complaints and Concerns Policy and Procedure for Patients and Staff				Yes	section 31		Yes	
					Compliant	Yes		Compliant	Yes	
4 - 4 - 5040										
1	The organisation has approved E documentation which describes the process for managing all claims in accordance with NHSLA requirements.	Claims Management Policy and Procedure	Policyratifiedfinal0310.doc	SCPCT/Polic y/SCH/CS/00 3/V1 A - March 2010 R- March 2011						
	As a minimum, the approved documentation must include a description of the:									
a 5041 (duties E	Claims Management Policy and Procedure				Yes	section 4		Yes	
	NHSLA schemes relevant to the organisation E (i.e. CNST, LTPS and PES)	Procedure				Yes	3.3		Yes	
	action to be taken, including timescales	Claims Management Policy and Procedure				Yes	3.4		Yes	
	communication with relevant E stakeholders	Claims Management Policy and Procedure					1,4, 1.5, section 7		Yes Yes	
	process for monitoring compliance with all of E the above.	Claims Management Policy and Procedure				Yes	Section 7		Yes	
					Compliant			Compliant		
1	The organisation has approved E documentation which describes the process for investigating all incidents, complaints and claims.	Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy	Investigation Analysis Orgainsational Policy SCH V1 NHSLA Final 10.03.10.doc	SCPCT/polic y/SCHRSK/ 004/ v2 a - march 2010 R - march 2011	JH					
	As a minimum, the approved documentation must include a description of the:									
a 5051 (duties E	Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy				Yes	3		Yes	

b		organisation's expectations in relation to staff training, as identified in the training needs analysis		Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy				Yes	section 13		Yes	
С		different levels of investigation appropriate to the severity of the event(s)		Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy				Yes	section 5		Yes	
d		process for involving and communicating with internal and external stakeholders to share safety lessons	E	Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy				Yes	section 14		Yes	
е	5055	process for following up relevant action	E	Incident, Complaints / Concerns, Investigation, Analysis and				Yes	14.7, 18.2, section 18		Yes	
f		process for monitoring compliance with all of	E	Organisational Learning Policy Incident, Complaints / Concerns,				Yes	section 18		Yes	
		the above.		Investigation, Analysis and Organisational Learning Policy								
							Compliant	Yes		Compliant	Yes	
1.5.6		The organisation has approved a documentation which describes the process for ensuring a systematic approach to the aggregation of incidents, complaints and claims on an ongoing basis.		Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy	Incident ComplaintsConcerns Investigation Analysis Orgainsational Policy SCH V1 NHSLA Final 10.03.10.doc	SCPCT/polic y/SCHRSK/ 004/ v2 a - march 2010 R - march 2011	JH					
		As a minimum, the approved documentation must include a description of the:										
а	5061	duties E		Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy				Yes	section 3		Yes	
b	5062	coordinated approach to the aggregation ^E of incidents, complaints and claims		Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy				Yes	section 12		Yes	
с		frequency with which an aggregated analysis of incidents, complaints and claims is to be completed		Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy				Yes	section 12		Yes	
d		minimum content required within the analysis report, including qualitative and quantitative analysis		Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy				Yes	section 12		Yes	
e		process for communicating this information to relevant individuals or groups		Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy				Yes	section 12		Yes	
f		process for monitoring compliance with all of E the above.		Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy				Yes	section 18		Yes	
							Compliant	Yes		Compliant	Yes	
.5.7		The organisation has approved documentation which describes the process for encouraging learning and promoting improvements in practice, based on individual and aggregated analysis of incidents, complaints and claims.		Organisational Learning Policy	Incident ComplaintsConcerns Investigation Analysis Orgainsational Policy SCH V1 NHSLA Final 10.03.10.doc	SCPCT/polic y/SCHRSK/ 004/ v2 a - march 2010 R - march 2011	JH					
		As a minimum, the approved documentation must include a description of the:										

а	5071 process by which the organisation ensures	E Incident, Complaints / Concerns,				Yes	section 14		Yes		
	both local and organisational learning from	Investigation, Analysis and									
	incidents, complaints and claims	Organisational Learning Policy									
b	5072 opportunities for sharing lessons learnt from					Yes	section 14		Yes		
	incidents, complaints and claims across the	Investigation, Analysis and					incl 14.1				
	local health community	Organisational Learning Policy									
с	5073 process by which the organisation ensures	E Incident, Complaints / Concerns,				Yes	section 14 incl 14.10		Yes		
	that lessons learnt from analysis result in a change in organisational culture and	Investigation, Analysis and Organisational Learning Policy					IIICI 14.10				
	practice										
d	5074 process for implementing risk reduction	E Incident, Complaints / Concerns,				Yes	section		Yes		
ŭ	measures	Investigation, Analysis and					3.5, 4.4,		100		
	incusures	Organisational Learning Policy					8.6, 9.2,				
							10.22				
е	5078 process for monitoring compliance with all of	E Incident, Complaints / Concerns,				Yes	section 18		Yes		
	the above.	Investigation, Analysis and									
		Organisational Learning Policy									
					Compliant	Yes		Compliant	Yes		
					Compliant			Compliant			
1.5.8	-		SCH Implementation of national	SCPCT/Polic							
	documentation which describes the process	National Guidance	guidanceratifiedfinal0310.doc	y/SCH/CS/00							
	for ensuring that agreed best practice as			3 A Marah							
	defined in all NICE guidance (where appropriate), is taken into account in the			A - March 2010							
	context of the clinical services provided by			R - March							
	the organisation.			2011							
	As a minimum, the approved documentation								<u> </u>		
	must include a description of the:										
а	5081 duties including leadership for all stages of	E Policy for the Implementation of				Yes	section 4		Yes		
	the process	National Guidance									
b	5082 process for identifying relevant documents	E Policy for the Implementation of				Yes	3.1		Yes		
		National Guidance									
с	5083 process for disseminating relevant	E Policy for the Implementation of				Yes			Yes		
	documents	National Guidance					3.1.6, 4.3,				
							4.4, 4.5				
d	5084 process for conducting an organisational	E Policy for the Implementation of				Yes	appendix 1		Yes		
	gap analysis	National Guidance					and				
							appendix 2				
		- Doliny for the Implementation of				Yes	3.3		Yes		
6	5085 process for ensuring that recommendations are acted upon	E Policy for the Implementation of National Guidance				les	0.0		lies		
	throughout the organisation										
f	5086 process for documenting any decision not to I	E Policy for the Implementation of				Yes	3.3.5		Yes	<u>├</u> ───	
'	implement NICE recommendations	National Guidance				les	0.0.0		lies		
g	5088 process for monitoring compliance with all of I					Yes	section 7		Yes	<u> </u>	
9	the above.	National Guidance									
						Yes			Yes		
1					Compliant			Compliant			
1.5.9	5090 The organisation has approved	E Policy for the Implementation of	SCH Implementation of national	SCPCT/Polic	AB						1
	documentation which describes the process		guidanceratifiedfinal0310.doc	y/SCH/CS/00							
	for ensuring that agreed best practice, as			3							
	defined in nationally agreed guidance, the			A - March							
1	National Service Frameworks, National			2010							
	Confidential Enquiries and other High Level			R - March							
1	Enquiries that make recommendations for patient safety, is taken into account in the			2011							
1	context of the clinical services provided by										
1	the organisation.										
1											
	As a minimum, the approved documentation										
	must include a description of the:										
						1					

а	5091 duties	E Policy for the Implementation of National Guidance				Yes	section 4		Yes	
b	5092 process for identifying relevant documents	E Policy for the Implementation of National Guidance				Yes	3.1		Yes	
с	5093 process for disseminating relevant documents	E Policy for the Implementation of National Guidance				Yes	3.1.2, 3.1.6, 4.3, 4.4, 4.5		Yes	
d	5094 process for conducting an organisational gap analysis	E Policy for the Implementation of National Guidance					appendix 1 and appendix 2		No	
e	recommendations are acted upon throughout the organisation	E Policy for the Implementation of National Guidance				Yes	3.3		Yes	
f	5098 process for monitoring compliance with all of the above.	E Policy for the Implementation of National Guidance					section 7		Yes	
					Compliant	Yes		Compliant	No	
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.		<u>SCH-032 - Being Open PolicyV4</u> <u>NHSLA Final 10 03 10.doc</u>	SCPCT/polic y/SCHRSKP ES/ 032/ v1 A - March 10 R - March 2011						
	As a minimum, the approved documentation must include a description of the:									
а	5101 process for encouraging open communication between healthcare organisations, healthcare teams, staff and patients and/or their carers	E BEING OPEN POLICY				Yes	3.2.5, appendix 1		Yes	
b	5102 process for acknowledging, apologising and explaining when things go wrong	E BEING OPEN POLICY				Yes	3.1.4		Yes	
С	5103 requirements for truthfulness, timeliness and clarity of communication	E BEING OPEN POLICY				Yes	appendix 1 - communic ation		Yes	
d	5104 provision of additional support as required	E BEING OPEN POLICY				Yes	appendix 1 - additional support		Yes	
е	5105 requirements for documenting all communication	E BEING OPEN POLICY				Yes	section 3		Yes	
f	5108 process for monitoring compliance with all of the above.	E BEING OPEN POLICY					section 8		Yes	
					Compliant	Yes		Compliant	Yes	
	9999	The following summary will be populate	d automatically from information en	tered on the wo	orksheet.					
						Yes			Yes	
					1.5.3	Yes Yes			Yes Yes	
					1.5.5	Yes Yes			Yes Yes	
					1.5.7	Yes Yes Yes			Yes Yes Yes	
					1.5.9	Yes Yes			No Yes	
					Total	10			9	

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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, no. and approved and review dates	Initials of contact name for document	Compliant? (Organisation)	Reference	Organisation's comments	Compliant? (Assessor)	Comment for report?	Assessor's comments	Proposed Future Change	Rationale
2.1.1		The organisation can demonstrate implementation of the approved organisation-wide risk management strategy.											
		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	1013	the management of risk locally, which reflects the organisation-wide risk management strategy.											
					Compliant			Compliant					
2.1.2		The organisation can demonstrate implementation of the approved documentation which describes the process for developing organisation- wide procedural documents.											
		The organisation can demonstrate compliance with the objectives set out within the approved documentation 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 overarching responsibility for risk is performing as described in the approved terms of reference.											
		The organisation can demonstrate compliance with the objectives set out within the terms of reference described 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	1		Compliant	2 2 2				
2.1.4	1044	The organisation can demonstrate											
2. 1.4		implementation of the approved documentation which describes the process for delivering risk management awareness training for all board members, executives and senior managers.											
		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		ensuring that all board members and senior managers receive relevant risk management awareness training											

Level 1	1044	following up non-attendance.						
			C	ompliant		Compliant		
2.1.5		The organisation can demonstrate						
		implementation of the approved						
	1	documentation which describes the						
	1	organisation-wide systematic risk						
		management process.						
		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		assessing <b>strategic risks</b>						
	1053	ensuring a continual, systematic						
Level 1	1000	approach to all risk assessments is						
		followed throughout the organisation						
			C	ompliant		Compliant		
						p		
2.1.6	1061	The organisation-wide risk register is				·		
		populated from a diverse range of						
		sources						
		The organisation can demonstrate that						
		the approved organisation-wide risk						
		register described at Level 1, is						
		populated with significant risks from						
		the following sources:						
Level 1		incident reports						
Level 1		risk assessments						
Level 1		significant risks from directorate risk						
		registers.						
			C	ompliant		Compliant		
	1070							
2.1.7		The organisation can demonstrate implementation of the approved						
		documentation which describes the						
	1	process for responding to the						
		recommendations and requirements						
		arising from external agency visits,						
		inspections and accreditations specific						
		to the organisation.						
		The organisation can demonstrate						
		compliance with the objectives set out						
		within the approved documentation						
		described at Level 1, in relation to the						
		process for:						
		maintaining action plans to implement						
Level 1		any recommendations made as a						
		result of reviews.			_	<b>O</b>		
				ompliant		Compliant		
0.1.5	1000							
2.1.8		The organisation can demonstrate						
		implementation of the approved documentation which describes the						
	1	process for managing the risks						
		associated with clinical 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 the						
		process for:						
Level 1		tracking records						
Level 1	1086	retaining and disposing of records.						
			C	ompliant		Compliant		
		1			1	1		

2.1.9	1090	The organisation can demonstrate implementation of the approved documentation which describes the process for ensuring that all clinical staff (temporary and permanent) are registered with the appropriate professional body.									
		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	1092	ensuring <b>ongoing</b> registration checks are made directly with the relevant professional body, in accordance with their recommendations, in respect of all permanent clinical staff.									
								Compliant			
0.4.40	1100	The ergenization can domonstrate									
2.1.10	1100	The organisation can demonstrate implementation of 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 compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:									
Level 1	1102	types of check required.									
		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.									
								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 2.1.2	0		
								2.1.2	0		
								2.1.4	0		
								2.1.5	0		
								2.1.6 2.1.7	0		
								2.1.7	0		
								2.1.9	0		
								2.1.10	0		
								Total	0		

Compliant			
Compliant			
		The assessor will record below the two	
		elements of the emmployment checks	
		min. data set selected at random to	
		test the implementation of the bullet	
		points:	
Compliant			
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		 All Standards Total	
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Actions required to achieve compliance	Person/ Committee responsible	Target Date	Associated Cost					

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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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Criterion number	Index	Criterion and minimum requirements	Paper or Electronic copy	Document submitted	Electronic file hyperlink/name	Document version name, no. and approved and review dates	Initials of contact name for document	Compliant? (Organisation)	Reference	Organisation's comments	Compliant? (Assessor)	Comment in Report	Assessor's comments	Proposed Future Change	Rationale
2.2.1		The organisation can demonstrate implementation of the approved documentation which describes the corporate induction arrangements for all new permanent staff.													
		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		checking that all new permanent staff complete corporate induction													
Level 1	2015	following up those who fail to attend corporate induction.					Comulia								
							Compliant			Compliant					
2.2.2		The organisation can demonstrate implementation of the approved documentation which describes the local induction arrangements for all new permanent staff.													
		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		checking that all new permanent staff complete local induction	Π									Π			
Level 1		following up those who fail to complete local induction.													
							Compliant			Compliant				1	
2.2.3		The organisation can demonstrate implementation of the approved documentation which describes the local induction arrangements for all temporary staff.													
		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		checking that all temporary staff complete local induction													
Level 1	2034	following up those who fail to complete local induction.					Compliant			Compliant					
							compliant			Compliant					
2.2.4		The organisation can demonstrate implementation of 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							
	compliance with the objectives set out							
	within the approved documentation							
	described at Level 1, in relation to the:							
2042	2 process for ensuring checks are made							
Lever1								
	4 procedure for notifying the NHSLA							
#REF!	Family Health Service Appeal Unit in the event of concern.							
				Compliant	 Complian	4		
				Compliant	Compilan			
2.2.5 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					+ +	The assessor will record below the	
	compliance with the objectives set out						two elements of risk management	
	within the approved documentation						training selected at random to test	
	described at Level 1, in relation to the						the implementation of the bullet	
	process for:						points:	
205								
205								
	4 checking that all permanent staff complete the relevant training							
Level 1	programmes in accordance with the							
	training needs analysis							
Level 1 205	5 following up those who fail to attend							
	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	Complian	t		
226 206				Compliant	Complian	t		
<b>2.2.6</b> 2060	D The organisation can demonstrate the			Compliant	Complian	t		
2.2.6 2060				Compliant	Complian	t		
<b>2.2.6</b> 2060	D The organisation can demonstrate the provision of the risk management training required by all permanent staff as identified in the training needs			Compliant	Complian	t		
<b>2.2.6</b> 2060	D 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.			Compliant	Complian	t		
<b>2.2.6</b> 2060	<ul> <li>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.</li> <li>The organisation can demonstrate the</li> </ul>			Compliant	Complian	t		
<b>2.2.6</b> 2060	<ul> <li>D 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.</li> <li>The organisation can demonstrate the provision of the risk management</li> </ul>			Compliant	Complian	t		
<b>2.2.6</b> 2060	<ul> <li>D 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.</li> <li>The organisation can demonstrate the provision of the risk management training required by all permanent staff</li> </ul>			Compliant	Complian	t		
<b>2.2.6</b> 2060	<ul> <li>D 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.</li> <li>The organisation can demonstrate the provision of the risk management</li> </ul>			Compliant	Complian	t		
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Level 1       2064         2.2.7       2070	<ul> <li>D 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.</li> <li>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:</li> <li>4 producing an annual training prospectus which reflects the training needs analysis.</li> <li>D 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.</li> <li>The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process for:</li> </ul>							
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2074	determining the training required to use the equipment identified on the inventory and the frequency of updates required					
2075 Level 1	ensuring that the identified training needs of all permanent staff are met.					
			Compliant	Compliant		
			compliant	Compliant		
<b>2.2.8</b> 2080	The organisation can demonstrate implementation of the approved documentation which describes the process for ensuring the delivery of effective hand hygiene training to all relevant permanent staff groups.					
	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	checking that all relevant permanent staff groups, as identified in the training needs analysis, complete hand hygiene training					
Level 1 2083	following up those who fail to attend hand hygiene training.					
			Compliant	Compliant		
220 2000	The organisation can domonstrate					
<b>2.2.9</b> 2090	The organisation can demonstrate implementation of the approved documentation which describes the process for ensuring the delivery of effective moving and handling training to all permanent staff.					
	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	checking that all permanent staff, as identified in the training needs analysis, complete relevant moving and handling training					
2093 Level 1	following up those who fail to attend relevant moving and handling training.					
			Compliant	Compliant		
<b>2.2.10</b> 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.					
	The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:					
Level 1	immediate support offered to staff (internally and, if necessary, externally)					
2105	action for managers or individuals to take if the staff member is experiencing difficulties associated with the event.					
			Compliant	Compliant		

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

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Actions required to achieve compliance	Person/ Committee responsible	Target Date	Associated Cost						

## 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: 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	Paper or Electronic copy	ent submitted	Electronic file hyperlink/name	Document version name, no. and approved and review dates	Initials of contact name for document	Compliant? (Organisation)	Reference	Organisation's comments	Compliant? (Assessor)	Comment in Report	Assessor's comments	Proposed Future Change	Rationale	Actions required to achieve compliance
2.3.1	3010	The organisation can demonstrate	Veneral													
		implementation of the approved documentation which describes the process for managing the risks associated with the physical security of premises and other assets.														
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:														
Level 1		requirement to undertake appropriate risk assessments regarding the physical security of premises and assets														
Level 1		arrangements for the organisational overview of the risk assessments regarding the physical security of premises and assets.														
							Compliant			Compliant						
2.3.2		The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks associated with sickness absences.														
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:														
Level 1		process for analysing sickness absence data														
Level 1		arrangements for the organisational overview of sickness absence.														
							Compliant			Compliant						
2.3.3		The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks associated with safeguarding adults.														
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:														
Level 1		local arrangements for managing the risks associated with safeguarding adults.														
							Compliant			Compliant						
2.3.4		The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks 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:											
	3044	requirement to undertake appropriate										-	
Level 1		risk assessments for the moving and											
Leveri		handling of patients and objects											
	3045	arrangements for the organisational				-				$\left  \right $			
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Level 1		the moving and handling of patients											
		and objects.				- 1		Oo maliaa	4				
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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:											
		requirement to undertake appropriate											
		risk assessments for the management											
Level 1		of slips, trips and falls involving patients (including falls from height)											
		requirement to undertake appropriate											
		risk assessments for the management											
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2.3.6	3060	The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks associated with inoculation incidents.			Complia	nt		Complian	t				
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Person/ Committee responsible	Target Date	Associated Cost						


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Cell: M1 Comment: Assessor Use Only

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

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2.4.1       4010       The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks associated with the identification of inpatients.       Image: Content of the approved documentation of the approved documentation which describes the process for managing the risks associated with the identification of the approved documentation of the approved documentation of the approved documentation which describes the process for managing the risks associated with the identification of the approved documentation of the approved documentation of the approved documentation which describes the process for managing the risks associated with the identification of the approved documentation of the approved documentation of the approved documentation which describes the process for managing the risks associated with the identification of the approved documentation of the approved documentation of the approved documentation of the approved documentation which describes the process for managing the risks associated with the identification of the approved documentation of the approved	
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compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:	
Level 1       4011       process for identifying inpatients       Image: constraint of the state of the	
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2.4.2       4020       The organisation can demonstrate implementation of the approved documentation which describes the process for developing patient information associated with care, treatments and procedures.       Image: Construction of the approved documents and procedures.       Image: Construction of the approved document at the process for developing patient information associated with care, treatments and procedures.       Image: Construction of the approved documents and procedures.       Image: Construction of the approved document at the process for developing patient information associated with care, treatments and procedures.       Image: Construction of the approved document at the procedures.       Image: Construction of the approved document at the procedures.       Image: Construction of the approved document at the procedures.       Image: Construction of the approved document at the procedures.       Image: Construction of the approved document at the procedures.       Image: Construction of the approved document at the procedures.       Image: Construction of the approved document at the procedures.       Image: Construction of the approved document at the procedures.       Image: Construction of the approved document at the procedures.       Image: Construction of the approved document at the procedures.       Image: Construction of the approved document at the procedures.       Image: Construction of the approved document at the procedures.       Image: Construction of the approved document at the procedures.       Image: Construction of the approved document at the procedures.       Image: Construction of the approved document at the procedures.       Image: Construction of the approved document at the procedures.       Image: Consthe procedures.	
The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:	
Level 1       4023       list of the essential content to be included in leaflets or other media i.e. risks, benefits and alternatives, where appropriate       Ist of the essential content to be       Ist of the essential content to be       Ist of the essential content to be	
Level 1       4025       archiving arrangements.       Image: Compliant of the second secon	
2.4.3 4030 The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks associated with consent.	
The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:	
Level 1       4033 process for identifying staff who are not capable of performing the procedure but are authorised to obtain consent for that procedure       Image: Consent for that p	
4035       process for the delivery of procedure specific training on consent, for staff to whom the consent process is delegated and who are not capable of performing the procedure.       Image: Constant of the delivery of procedure of the delivery of the delivery of procedure of the delivery of procedure of the delivery of procedure of the delivery of the delivery of procedure of the delivery of procedure of the delivery of the delivery of procedure of the delivery of procedure of the delivery of procedure of the delivery of the delivery of procedure of the delivery of the	
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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 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						
Land	4044	format for all audit reports i.e.					
Level 1		methodology, conclusions, action plans, etc.					
	4045	arrangements for the review of action					
Level 1		plans.					
					Compliant		
	10.50						
2.4.5	4050	The organisation can demonstrate 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		
				*****			
2.4.6	4060	The organisation can demonstrate					
		implementation of the approved 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 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					

Compliant			
		The assessor will select two patient groups at random to assess the	
		organisation's compliance with the	
		above minimum requirements.	
Compliant			
Compliant			
Compliant			

Level 1	4074	care of patient(s) receiving transfusion.							
						Compliant			
						Compliant			
2.4.8	4080	The organisation can demonstrate							
2.1.0		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							
Lever		(DNAR).							
						Compliant			
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	4092	Infection control assurance framework.							
						Compliant			
						Compliant			
2.4.10	4100	The organisation can demonstrate							
2.4.10		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:							
Level 1	4102	taking action on test and screening							
		results							
Level 1	4104	the communication of clinical test and							
		screening results.				Compliant			
						Compliant			
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Actions required to achieve compliance	Person/ Committee responsible	Target Date	Associated 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, no. and approved and review dates	Initials of contact name for document	Compliant? (Organisation)	Reference	Organisation's comments	Compliant? (Assessor)	Comment in Report	Assessor's comments	Proposed Future Change	Rationale
2.5.1		The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks associated with the reporting of all internally and externally reportable 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 reporting:													
Level 1		all incidents/near misses, involving staff, patients and others													
Level 1		to external agencies.													
							Compliant			Compliant					
2.5.2		The organisation can demonstrate implementation of 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 raise concerns informally.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process:													
Level 1		for raising concerns (informal complaints/PALS)													
	5024	by which the organisation aims to										$\square$			
Level 1		make changes as a result of concerns being raised.													
							Compliant			Compliant					
2.5.3		The organisation can demonstrate implementation of 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 complaints.													
		The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the:													
Level 1		complaints management process, which includes internal and external communication, and collaboration with other organisations when necessary													

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5064       minimum content required within the analysis report, including qualitative analysis.       Image: seport, including qualitativ	Level 1	aggregation of incidents, complaints						
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documentation which describes the       Image: Comparison of the comparison of t								
promoting improvements in practice, based on individual and aggregated analysis of incidents, complaints and								
based on individual and aggregated analysis of incidents, complaints and								
analysis of incidents, complaints and								

<i></i>							
	The organisation can demonstrate						
	compliance with the objectives set out						
	within the approved documentation described at Level 1, in relation to the						
	process by which the organisation						
5074	ensures:						
Level 1	the implementation of risk reduction measures.						
			Compliant	Compliant			
2 5 0 5000				 			
<b>2.5.8</b> 5080	The organisation can demonstrate implementation of 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.						
	The organisation can demonstrate				The assessor will select two clinical		
	compliance with the objectives set out				guidelines from the list to assess the		
	within the approved documentation				organisation's compliance with the		
	described at Level 1, in relation to the process for:				above minimum requirement.		
	ensuring that recommendations are						
Level 1	acted upon throughout the organisation.						
	The assessor will select two clinical						
	guidelines from the list to assess the						
	organisation's compliance with the						
	above minimum requirement.						
			Compliant	Compliant			
<b>2.5.9</b> 5090	The organisation can demonstrate						
2.3.9 0000	implementation of 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 in the context of the clinical services						
	provided by the organisation.						
	The organisation can demonstrate						
	compliance with the objectives set out						
	within the approved documentation						
	described at Level 1, in relation to the process for:						
5095	ensuring that recommendations are						
Level 1	acted upon throughout the						
	organisation.						
			Compliant	Compliant			
2 5 40 5100	The organisation can demonstrate					[ 	
2.3.10 5100	implementation of the approved						
	documentation which describes the						
	process for ensuring that all						
	communication is open, honest and						
	accurate according to the state of the state		1				
	occurs as soon as possible following						
	occurs as soon as possible following an incident, complaint or claim.						
	an incident, complaint or claim.						
	an incident, complaint or claim. The organisation can demonstrate compliance with the objectives set out						
	an incident, complaint or claim. The organisation can demonstrate compliance with the objectives set out within the approved documentation						
	an incident, complaint or claim. The organisation can demonstrate compliance with the objectives set out						

Level 1		process for encouraging open communication between healthcare organisations, healthcare teams, staff and patients and/or their carers								
Level 1		requirements for documenting all communication.								
					Compliant			Compliant		
	1		The follow	ving summary will be populated a	utomatically from informa	ation ente	red on the w	orksheet.		
					0.5.4	0			-	
					2.5.1	0			0	
					2.5.2	0			0	
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					2.5.8	0			0	
					2.5.9	0			0	
					2.5.10	0			0	All Standards Total
					Total	0			0	44

Actions required to achieve compliance	Person/ Committee responsible	Target Date	Associated Cost				

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## NHSLA Risk Management Standards for Primary Care Trusts Evidence Template 2.5.

Image: Second Secon	

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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 bit         Criterion and minimum requestation and monosities have been processed in place to monitor complexes with the approved information and demonstrate has an expression of a locally, whom effects the organisation can demonstrate has approved information and demonstrate has approved informatin approved information and dem											
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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 compliance with the approved 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 minimum requirements contained within the approved documentation described at Level 1, in relation to the								
addiciencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.       Compliant         3.1.2       1020       The organisation can demonstrate that there are processes in plane to monitor compliants with the approved documentation which describes the process for developing organisation- wide procedural documents.       Image: Compliant with the approved documents.         Image: Compliant with the approved documentation which describes the minimum requirements contained with the approved documentation described at Level 1, in relation to the:       Image: Compliant with the minimum requirements.         Image: Control of documents, including arching arengements.       Image: Control of documents, including arching arengements.       Image: Compliant with the recommendations and action plans have been developed and deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.       Image: Compliant with the performance of the high level committee(s) with everating responsibility or rise.         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 everation described at Level 1, in relation to the.         Level 1       1024       The organisation can demonstrate that there are processes in place to monitor the performance of the high here committee(s) with everation described at Level 1, in relation to the.         Level 1       1022.       The organisation can demonstrate that there are proceed documentation descrintee(s) with everation the performance of the high here	Level 1	1013	reflects the organisation-wide risk								
3.1.2       1020       The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for developing organisation- wide procedural documents.         Image: the organisation can demonstrate that is is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:         Level 1       1024         Table comments.       Image: the organisation content of minimum requirements.         1028       ratification process 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.         3.1.3       1030       The organisation can demonstrate that it fiere are processes in place to monitor the performance of the high level committee(s) with overarching responsibility for risk.         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		1019	deficiencies, there must be evidence that recommendations and action plans have been developed and								
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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								
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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 minimum requirements contained 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 of the	Level 1	1026	-								
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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 the performance of the high level committee(s) with overarching responsibility for risk.								
1035 reporting arrangements into the high			it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:								
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	Level 1	1035									

on's comments	Compliant? (Assessor)	Comment in Report	Assessor's comments	Proposed Future Change	Rationale
Compliant					
Compliant					

	1039	Where the monitoring has identified							
		deficiencies, there must be evidence							
1 '		that recommendations and action							
		plans have been developed and							
		changes implemented accordingly.							
				Compliant		Compliant			
				Compilant		oomphan			
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							
Transfer 1	1011								
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.							
'				Compliant		Compliant			
				Compliant		Compliant			
3.1.5	1050	The organisation can demonstrate that							
0.1.0		there are processes in place to monitor							
		compliance with the approved							
		documentation which describes the							
		organisation-wide systematic risk							
		management process.							
			1						
		The organisation can demonstrate that			 				
		it is monitoring compliance with the							
		it is monitoring compliance with the minimum requirements contained							
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		it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the							
		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	1055	it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process for: assessing <u>strategic risks</u>							
	1055 1053	it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process for: assessing <u>strategic risks</u> ensuring a continual, systematic							
Level 1 Level 1	1055 1053	it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process for: assessing <u>strategic risks</u> ensuring a continual, systematic approach to all risk assessments is							
	1055 1053	it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process for: assessing <u>strategic risks</u> ensuring a continual, systematic approach to all risk assessments is followed throughout the organisation.							
	1055 1053 1059	it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process for: assessing <u>strategic risks</u> ensuring a continual, systematic approach to all risk assessments is followed throughout the organisation. Where the monitoring has identified							
	1055 1053 1059	it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process for: assessing <u>strategic risks</u> ensuring a continual, systematic approach to all risk assessments is followed throughout the organisation. Where the monitoring has identified deficiencies, there must be evidence							
	1055 1053 1059	it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process for: assessing <u>strategic risks</u> ensuring a continual, systematic approach to all risk assessments is followed throughout the organisation. Where the monitoring has identified deficiencies, there must be evidence that recommendations and action							
	1055 1053 1059	it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process for: assessing <u>strategic risks</u> ensuring a continual, systematic approach to all risk assessments is followed throughout the organisation. Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and							
	1055 1053 1059	it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process for: assessing <u>strategic risks</u> ensuring a continual, systematic approach to all risk assessments is followed throughout the organisation. Where the monitoring has identified deficiencies, there must be evidence that recommendations and action		Compliant		Compliant			
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3.1.7	1070	The organisation can demonstrate that	T								
3.1.7											
		there are processes in place to monitor									
		compliance with the approved									
		documentation which describes the									
		process for responding to the									
		recommendations and requirements									
		arising from external agency visits,									
		inspections and accreditations specific									
		to the organisation.									
		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:									
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		maintaining action plans to implement									
Level 1		any recommendations made as a									
		result of reviews.									
	1079	Where the monitoring has identified	<u> </u>								<u>├</u> ──┤
		deficiencies, there must be evidence									
		that recommendations and action					1				
		plans have been developed and					1				
		changes implemented accordingly.									
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3.1.8	1080	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 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									
		process for:									
Level 1		tracking records									
Level 1		retaining and disposing of records.									
	1089	Where the monitoring has identified									
		deficiencies, there must be evidence									
		that recommendations and action									
		plans have been developed and									
		changes implemented accordingly.					1				
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		there are processes in place to monitor compliance with the approved documentation which describes the process for ensuring that all clinical									
		there are processes in place to monitor compliance with the approved documentation which describes the process for ensuring that all clinical staff (temporary and permanent) are									
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	1092	there are processes in place to monitor compliance with the approved documentation which describes the process for ensuring that all clinical staff (temporary and permanent) are registered with the appropriate professional body. 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 registration checks are made directly with the relevant professional									
	1092	there are processes in place to monitor compliance with the approved documentation which describes the process for ensuring that all clinical staff (temporary and permanent) are registered with the appropriate professional body. 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 registration checks are made directly with the relevant professional body, in accordance with their									
Level 1	1092	there are processes in place to monitor compliance with the approved documentation which describes the process for ensuring that all clinical staff (temporary and permanent) are registered with the appropriate professional body. 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 registration checks are made directly with the relevant professional body, in accordance with their recommendations in respect of all									
Level 1	1092	there are processes in place to monitor compliance with the approved documentation which describes the process for ensuring that all clinical staff (temporary and permanent) are registered with the appropriate professional body. 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 registration checks are made directly with the relevant professional body, in accordance with their recommendations in respect of all permanent clinical staff both on initial									
Level 1	1092	there are processes in place to monitor compliance with the approved documentation which describes the process for ensuring that all clinical staff (temporary and permanent) are registered with the appropriate professional body. 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 registration checks are made directly with the relevant professional body, in accordance with their recommendations in respect of all									
Level 1	1092	there are processes in place to monitor compliance with the approved documentation which describes the process for ensuring that all clinical staff (temporary and permanent) are registered with the appropriate professional body. 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 registration checks are made directly with the relevant professional body, in accordance with their recommendations in respect of all permanent clinical staff both on initial									

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109	93.1	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 enniour stan.								
10	099	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			
<b>3.1.10</b> 11	100	The organisation can demonstrate that								
	1	there are processes in place to monitor								
	3	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.	
111	107									
	107									
		types of check required.				_		_		
		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.								
					Compliant		Compliant			
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Actions required to achieve compliance	Person/ Committee responsible	Target Date	Associated Cost				


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Cell: L1 Comment: Assessor Use Only

Cell: M1 Comment: Assessor Use Only

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, no. and approved and review dates	Initials of contact name for document	Compliant? (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 there are processes in place to monitor compliance with the approved documentation which describes the corporate induction arrangements for all new permanent staff.												
		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: checking that all new permanent staff												
Levern		complete corporate induction following up those who fail to attend										$\left  \right $		
Levern	2019	corporate induction. Where the monitoring has identified										$\left  \right $		
		deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.												
							Compliant			Compliant				
3.2.2		The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the local induction arrangements for all new permanent staff.												
		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		checking that all new permanent staff complete local induction following up those who fail to complete												
Level 1		Vhere the monitoring has identified										$\left  \right $		
		deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.												
							Compliant			Compliant				
3.2.3		The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the local induction arrangements for all temporary staff.												
		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		checking that all temporary staff										
e		complete local induction										
	2034	following up those who fail to complete										
Level 1		ocal induction.										
	2039	Where the monitoring has identified										
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		that recommendations and action										
		plans have been developed and										
		changes implemented accordingly.										
						Compliant		Compliant				
						Compliant	 	Compliant				
	0040											
3.2.4		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										
		t is monitoring compliance with the										
		minimum requirements contained										
		within the approved documentation										
		described at Level 1, in relation to the:										
	2042	are an a far an aurin a chaolya are made										
Level 1	2042	process for ensuring checks are made										
	0044		+				 					
the second se		procedure for notifying the NHSLA										
<u>#REF!</u>		Family Health Service Appeal Unit in										
		the event of concern.										
		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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3.2.5	2050	The organisation can demonstrate that										
0.2.0		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.										
		or an pormanent stan.			1							
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		The organisation can demonstrate that								The assessor will select two elements		
		t 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:										
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		checking that all permanent staff										
		complete the relevant training			1							
Level 1		programmes in accordance with the										
		training needs analysis			1							
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Level 1		following up those who fail to attend			1							
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		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.								
		with the above minimum requirements.								
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					Compliant		Compliant			
0.0.0	2060	The experiention can demonstrate that								
3.2.6	2060	The organisation can demonstrate that 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:								
	2065	producing an annual training report								
Level 1		covering all the topics identified within								
	0000	the TNA Minimum Data Set.		<b>↓</b>		 				
	2069	Where the monitoring has identified deficiencies, there must be evidence								
		that recommendations and action								
		plans have been developed and								
		changes implemented accordingly.								
					Compliant		Compliant			
3.2.7	2070	The organisation can demonstrate that								
		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:								
	2072	• • • • • • • • • • • • • • • • • • • •								
Level 1		identifying which permanent staff are authorised to use the equipment								
Lever		identified on the inventory								
	2074	determining the training required to								
_		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.								
	2070	W/boro the menitoring bas identified				 				
	2079	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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3.2.8	2080	The organisation can demonstrate that								
		there are processes in place to monitor								
		compliance with the approved								
		documentation which describes the process for ensuring the delivery of								
		effective hand hygiene training to all								
		relevant permanent staff groups.								
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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.							
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Actions required to achieve compliance	Person/ Committee	Target Date	Associated					
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## NHSLA Risk Management Standards for Primary Care Trusts Evidence Template 3.2.

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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	Document submitted	Electronic file hyperlink/name	Document version name, no. and approved and review dates	Initials of contact name for document	Compliant? (Organisation)	Reference	Organisation's comments	nt? (A	Comment in Report Assesso	or's comments	Proposed Future Change	Rationale	Actions required to achieve compliance
3.3.1	3010	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 the physical security of premises and other assets.														
		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	3013	assets														
Level 1	3014	arrangements for the organisational overview of the risk assessments regarding the physical security of premises and assets.														
	3019	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.														
							Compliant			Compliant						
3.3.2	3020	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 sickness absences.														
		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	3025	process for analysing sickness absence data														
Level 1	2026	arrangements for the organisational														
	3029	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.														
							Compliant			Compliant						
3.3.3	3030	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 safeguarding adults.				1										

		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 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 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 the moving and handling of patients							
Levert		9							
		and objects.	 						
		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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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							
1		patients (including falls from height)							
1		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 deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.							
				Comp	oliant	Compliant			
						Compliant			
3.3.6	3060	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 inoculation incidents.							
		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	3063	the management of an inoculation incident (including prophylaxis).							
	3069	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.							
				Comp	oliant	Compliant			
3.3.7	3070	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 the maintenance of reusable medical devices and equipment.							
		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	3073	ensuring that all reusable medical devices and equipment are properly maintained and repaired.							
	3079	Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.							
				Comp	oliant	Compliant			
3.3.8	3080	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 the harassment and/or bullying of staff.							
		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:							
Level 1	3083	for raising concerns about harassment and/or bullying							
Level 1		to be followed once a concern has been raised.							

	Where the monitoring has identified							I			
	deficiencies, there must be evidence										
	that recommendations and action										
	plans have been developed and										
	changes implemented accordingly.										
				C	ompliant		Compliant				
<u> </u>					omphane		Compliant				
3.3.9	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 the prevention and										
	management of violence and										
	aggression.										
	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										
Level 1 3092.1	risk assessments for the prevention and management of violence and										
	aggression										
	arrangements for ensuring the safety										
	of lone workers.										
	Where the monitoring has identified										
	deficiencies, there must be evidence										
	that recommendations and action										
	plans have been developed and										
	changes implemented accordingly.										
				C	Compliant		Compliant		1		
2 2 4 0	The organization can demonstrate that										
	The organisation can demonstrate that there are processes in place to monitor										
	compliance with the approved										
3100	documentation which describes the										
5100	process for managing the risks										
	associated with work-related stress.										
	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 identifying workplace stressors										
	requirement to undertake appropriate										
	risk assessments for the prevention										
Level 1 3114	and management of work-related										
	stress.										
	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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NHSLA Risk Management Standards for Primary Care Trusts Evidence Template 3.3.

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Person/ Committee responsible	Target Date	Associated Cost						

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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 name, no. and approved and review dates	Initials of contact name for document	Compliant? (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 there are processes in place to monitor compliance with the approved documentation which describes the process for managing the risks associated with the identification of inpatients. 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		process for identifying in patients procedure to be followed in cases													
Level 1		where patient misidentification occurs.													
		Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
							Compliant			Compliant					
3.4.2		The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for developing patient information associated with care, treatments and procedure.													
		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		list of the essential content to be included in leaflets or other media i.e. risks, benefits and alternatives, where appropriate													
Level 1	4029	archiving arrangements. Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.													
							Compliant			Compliant					
3.4.3		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 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						
<u></u>		procedure but are authorised to obtain						
		consent for that procedure						
		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.						
		2 (1960) A						
		Where the monitoring has identified deficiencies, there must be evidence						
		that recommendations and action						
		plans have been developed and						
		changes implemented accordingly.						
					npliant	Compliant		
				Con	npilant	Compliant		
3.4.4	4040	The organisation can demonstrate that						
5.4.4		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		methodology, conclusions, action						
		plans, etc.						
Level 1	4045	arrangements for the review of action						
		plans.						
		Where the monitoring has identified						
		deficiencies, there must be evidence						
		that recommendations and action						
		plans have been developed and						
		changes implemented accordingly.						
				Con	npliant	Compliant		
	1055							
3.4.5		The organisation can demonstrate that						
1		there are processes in place to monitor						
1		compliance with the approved documentation which describes the						
1		process for managing the risks						
1		associated with the transfer of						
1		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					above minimum requirements.	
		described at Level 1, in relation to the:						
	4057			i i	1			
	4057							
		transfer requirements which are						
Level 1		specific to each patient group						
—		documentation to accompany the						
and the second second	4053							
Level 1	4053	patient when being transferred.						

	4059	Where the monitoring has identified		1						
		deficiencies, there must be evidence								1
		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.								
					Compliant		Compliant			
3.4.6		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.								
		contra di mananananya sataranananan kataran								
		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:								
Locald	4061.1	process for ensuring the accuracy of								
Level 1		all prescription charts.		ļ						
		Where the monitoring has identified								
		deficiencies, there must be evidence								
		that recommendations and action								
		plans have been developed and changes implemented accordingly.								
						_	0			ļ
					Compliant		Compliant			
3.4.7	4070	The organisation can demonstrate that								
0.4.7		there are processes in place to monitor								
		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:								
	4073	process for the administration of blood								
Level 1		and blood products		1						
		care of patient(s) receiving transfusion.								
Level 1										
	4079	Where the monitoring has identified								
		deficiencies, there must be evidence								
		that recommendations and action		1						
		plans have been developed and								
		changes implemented accordingly.	4							
					Compliant		Compliant			
	4000	The experiencies of the second s								
3.4.8		The organisation can demonstrate that		1						
		there are processes in place to monitor compliance with the approved								
		documentation which describes the								
		process for managing the risks								
		associated with resuscitation.		1						
		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:								
	ı									

	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										 	
		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 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			
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						3.4.7	0			0		
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NHSLA Risk Management Standards for Primary Care Trusts Evidence Template 3.4.

3.4.8	0	0	
3.4.9	0	0	
3.4.10	0	0	All Standards Total
Total	0	0	44

Actions required to achieve compliance	Person/ Committee responsible	Target Date	Associated Cost					

NHSLA Risk Management Standards for Primary Care Trusts Evidence Template

3.4.

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		

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described at Level 1, in relation to the process for reporting: described at Level 1, in relation to the process for reporting: described at Level 1, in relation to the process for reporting: described at Level 1, in relation to the process for reporting: described at Level 1, in relation to the process for reporting: described at Level 1, in relation to the process for reporting: described at Level 1, in relation to the process for reporting: described at Level 1, in relation to the process for reporting: described at Level 1, in relation to the process for reporting: described at Level 1, in relation to the process for reporting: described at Level 1, in relation to the process for reporting: described at Level 1, in relation to the process for reporting: described at Level 1, in relation to the process for reporting: described at Level 1, in relation to the process for reporting: described at Level 1, in relation to the process for reporting: described at Level 1, in relation to the process for reporting: described at Level 1, in relation to the process for reporting: described at Level 1, in relation to the process for reporting: described at Level 1, in relation to the process for reporting: described at Level 1, in relation to the process for reporting: described at Level 1, in relation to the process for reporting: described at Level 1, in relation to the process for reporting: described at Level 1, in relation to the process for reporting: described at Level 1, in relation to the process for reporting: described at Level 1, in relation to the process for reporting: described at Level 1, in relation to the	
5019 Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plants have been deviloped and changes implemented accordingly. Compliant Compliant </td <td></td>	
3.5.2 5020 The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for ensuing that patients, their relatives and carers have suitable and accessible information about, and clear access to, procedures to raise concerns informally. Image: Concerns and the concerns and the concerns and the minimum requirements contained within the approved documentation described at Level 1. In relation to the process: Level 1 5024 by which the organisation aims to make changes as a result of concerns being raised. 5024 by Where the monitoring has identified deficiencies, there must be evidence that recommendiations addition	
it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process: it is monitoring concerns (informal compliants/PALS) it is monito	
Level 1complaints/PALS)complaints/PAL	
Level 1 make changes as a result of concerns being raised. make changes	
deficiencies, there must be evidence that recommendations and action	
changes implemented accordingly.	
Compliant Compliant Compliant	

3.5.

3.5.3		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 complaints.							
		it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the:							
Level 1		complaints management process, which includes internal and external communication, and collaboration with other organisations when necessary							
Level 1		process by which the organisation aims to make changes as a result of formal complaints.							
		Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.							
				Compliant		Compli	Int		
3.5.4	5040	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for managing all claims in accordance with NHSLA requirements.							
		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:							
Levert		action to be taken, including timescales							
		communication with relevant stakeholders.							
		Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly.							
				Compliant		Compli	int		
3.5.5	5050	The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for investigating all incidents, complaints and claims.							
		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 1apple evelLevel 15055proplation5059VVr def that plation6000000000000000000000000000000000000	fferent levels of investigation opropriate to the severity of the vent(s) occess for following up relevant action				
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tha pla	here the monitoring has identified				
pla	eficiencies, there must be evidence				
	at recommendations and action				
	ans have been developed and				
	anges implemented accordingly.				
		Compliant	Compliant		
3.5.6 5060 Th	ne organisation can demonstrate that				
	ere are processes in place to monitor				
	ompliance with the approved				
	ocumentation which describes the				
	ocess for ensuring a systematic				
	proach to the analysis of incidents,				
	omplaints and claims on an				
ag	gregated basis.				
	ne organisation can demonstrate that				
	is monitoring compliance with the				
	inimum requirements contained				
wit	thin the approved documentation				
	escribed at Level 1, in relation to the:				
5062	pardinated approach to aggregation				
	pordinated approach to aggregation				
Of	incidents, complaints and claims				
	inimum content required within the				
Level 1 and	alysis report, including qualitative				
	nd quantitative analysis.				
	here the monitoring has identified				
	eficiencies, there must be evidence				
	at recommendations and action				
	ans have been developed and				
ch	anges implemented accordingly.				
		Compliant	Compliant		
		Compliant	 compliant		
	ne organisation can demonstrate that				
the	ere are processes in place to monitor				
CO'	mpliance with the approved				
	ocumentation which describes the				
	ocess for encouraging learning and				
I pro	omoting improvements in practice,				
	ased on individual and aggregated				
ba	alysis of incidents, complaints and				
ba	and a set of the set o	I I			
ba: an:	aims.				
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ba: an: cla Th	aims. ne organisation can demonstrate that				
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Level 1 5074 the metric bas cla the min wit des pro- ens 5074 the metric bas	aims. The organisation can demonstrate that is monitoring compliance with the inimum requirements contained thin the approved documentation escribed at Level 1, in relation to the rocess by which the organisation insures: the implementation of risk reduction easures.				
Level 1 5074 the metric bas cla the min wit des pro- ens 5074 the metric bas	aims. The organisation can demonstrate that is monitoring compliance with the inimum requirements contained thin the approved documentation escribed at Level 1, in relation to the rocess by which the organisation insures: the implementation of risk reduction easures.				
Level 1 5079 VVr	aims. the organisation can demonstrate that is monitoring compliance with the inimum requirements contained thin the approved documentation escribed at Level 1, in relation to the pocess by which the organisation insures: the implementation of risk reduction easures. There the monitoring has identified				
Level 1 5079 5079 VVr det	aims. The organisation can demonstrate that is monitoring compliance with the inimum requirements contained thin the approved documentation escribed at Level 1, in relation to the process by which the organisation insures: the implementation of risk reduction easures. there the monitoring has identified eficiencies, there must be evidence				
Level 1 5079 Wr dei tha	aims. The organisation can demonstrate that is monitoring compliance with the inimum requirements contained thin the approved documentation escribed at Level 1, in relation to the the occess by which the organisation insures: the implementation of risk reduction easures. There the monitoring has identified efficiencies, there must be evidence at recommendations and action				
Level 1 5079 VVr dei tha pla	aims. The organisation can demonstrate that is monitoring compliance with the inimum requirements contained thin the approved documentation escribed at Level 1, in relation to the process by which the organisation insures: e implementation of risk reduction easures. There the monitoring has identified efficiencies, there must be evidence at recommendations and action ans have been developed and				
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Level 1 5079 VVr dei tha pla	aims. The organisation can demonstrate that is monitoring compliance with the inimum requirements contained thin the approved documentation escribed at Level 1, in relation to the process by which the organisation insures: e implementation of risk reduction easures. There the monitoring has identified efficiencies, there must be evidence at recommendations and action ans have been developed and	Compliant	Compliant		

3.5.8	5080	The organisation can demonstrate that								
		there are processes in place to monitor								
		compliance with the approved								
1		documentation which describes the								
1		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.								
		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:								
	5087			1 1	l l	1				
	5087	•			ł				4	
		ensuring that recommendations are								
		acted upon throughout the								
Level 1		organisation.								1
		Where the monitoring has identified		<u>├</u> ──						
/		deficiencies, there must be evidence								1
/		that recommendations and action								1
/										1
1		plans have been developed and								1
		changes implemented accordingly.								
		The assessor will select two clinical								
		guidelines from the list to assess the								
		organisation's compliance with the								
		above minimum requirement.								
				C	ompliant		Compliant			
3.5.9	5090	The organisation can demonstrate that								
/		0		1 1						
	1 I	there are processes in place to monitor								
		compliance with the approved documentation which describes the								
· · · · · ·		compliance with the approved documentation which describes the								
1		compliance with the approved documentation which describes the process for ensuring that agreed best								
		compliance with the approved documentation which describes the process for ensuring that agreed best practice, as defined in nationally								
		compliance with the approved documentation which describes the process for ensuring that agreed best practice, as defined in nationally agreed guidance, the National Service								
		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								
		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								
		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								
		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								
		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 in the context of the clinical services								
		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								
		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 in the context of the clinical services provided by the organisation.								
		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 in the context of the clinical services provided by the organisation.								
		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 in the context of the clinical services provided by the organisation.								
		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 in the context of the clinical services provided by the organisation.								
		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 in the context of the clinical services provided by the organisation.								
		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 in the context of the clinical services provided by the organisation.								
		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 in the context of the clinical services provided by the organisation. The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation								
		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 in the context of the clinical services provided by the organisation. 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:								
	5095	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 in the context of the clinical services provided by the organisation. 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 recommendations are								
Level 1	5095	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 in the context of the clinical services provided by the organisation. 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 recommendations are acted upon throughout the								
Level 1	5095	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 in the context of the clinical services provided by the organisation. 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 recommendations are acted upon throughout the organisation.								
Level 1	5095	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 in the context of the clinical services provided by the organisation. 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 recommendations are acted upon throughout the organisation. Where the monitoring has identified								
Level 1	5095	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 in the context of the clinical services provided by the organisation. 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 recommendations are acted upon throughout the organisation. Where the monitoring has identified deficiencies, there must be evidence								
Level 1	5095	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 in the context of the clinical services provided by the organisation. 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 recommendations are acted upon throughout the organisation. Where the monitoring has identified deficiencies, there must be evidence that recommendations and action								
Level 1	5095	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 in the context of the clinical services provided by the organisation. 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 recommendations are acted upon throughout the organisation. Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and								
Level 1	5095	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 in the context of the clinical services provided by the organisation. 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 recommendations are acted upon throughout the organisation. Where the monitoring has identified deficiencies, there must be evidence that recommendations and action								
Level 1	5095	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 in the context of the clinical services provided by the organisation. 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 recommendations are acted upon throughout the organisation. Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and			ompliant		Compliant			

3.5.10 5	100 The organisation can demonstrate that										
	there are processes in place to monitor										
	compliance with the 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.										
	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:										
5	i101 process for encouraging open										
Louis	communication between healthcare										
Level 1	organisations, healthcare teams, staff										
	and patients and/or their carers										
5	105 requirements for documenting all										
Level 1	communication.										
5	i109 Where the monitoring has identified										
	deficiencies, there must be evidence										
	that recommendations and action										
	plans have been developed and										
	changes implemented accordingly.										
					Compliant			Compliant			
		The follow	ing summary will be populated at	utomatically	y from informa	tion ente	red on the w	orksheet.	1		
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					3.5.6	0			0		
					3.5.7	0			0		
				_	3.5.8	0			0		
					3.5.9	0		*	0		
					3.5.10	0			0	All Standards Total	
					Total	0			0	44	

Actions required to achieve compliance Person/ Committee responsible	Target Date	Associated Cost				

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Cell: L1 Comment: Assessor Use Only

Cell: M1 Comment: Assessor Use Only

Cell: N1 Comment: Assessor Use Only

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