| | |
|---|---|
| Organisation Name: | Southampton City PCT |
| NHSLA Membership Number: | P163 |
| NHS or Foundation trust | NHS |
| Day 1 of Assessment: | 24 March 2010 |
| Day 2 of Assessment: | 25 March 2010 |
| Existing CNST/NHSLA Level: | 1 |
| Level Applied For: | 1 |
| Level Achieved: | 1 |
| Assigned Assessor: | Karen Lewis |
| Chief Executive: | Bob Deans |
| email address | bob.deans@scpct.nhs.uk |
| Organisation Contact: | Anne Baileff |
| designation | Head of Clinical Standards |
| email address | anne.baileff@scpct.nhs.uk |

**Evidence Template**
for use with
**NHSLA Risk Management Standards for Primary Care Trusts**
2009/10 version

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

**Data below will be populated automatically from information entered on subsequent worksheets.**

## Level 1 Summary

| | Standard 1 | | | Standard 2 | | | Standard 3 | | | Standard 4 | | | Standard 5 | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Organisation | Assessor | | Organisation | Assessor | | Organisation | Assessor | | Organisation | Assessor | | Organisation | Assessor | Organisation | Assessor |
| 1.1.1 | Yes | Yes | 1.2.1 | Yes | Yes | 1.3.1 | Yes | Yes | 1.4.1 | Yes | Yes | 1.5.1 | Yes | Yes | | |
| 1.1.2 | Yes | Yes | 1.2.2 | Yes | Yes | 1.3.2 | Yes | Yes | 1.4.2 | 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 | 1.2.5 | Yes | Yes | 1.3.5 | Yes | Yes | 1.4.5 | Yes | No | 1.5.5 | Yes | Yes | | |
| 1.1.6 | Yes | Yes | 1.2.6 | Yes | Yes | 1.3.6 | Yes | Yes | 1.4.6 | 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 | 1.2.10 | Yes | Yes | 1.3.10 | Yes | Yes | 1.4.10 | Yes | Yes | 1.5.10 | Yes | Yes | | |
| Total | 10 | 9 | Total | 9 | 9 | Total | 10 | 10 | Total | 10 | 7 | Total | 10 | 9 | 49 | 44 |

**Data above will be populated automatically from information entered on subsequent worksheets.**

**Cell:** E1
**Comment:** Your first action should be to select your organisation's name here.

Related cells will be populated automatically.

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

**Cell:** B20
**Comment:** Risk management strategy

**Cell:** G20
**Comment:** Corporate induction

**Cell:** L20
**Comment:** Secure environment

**Cell:** Q20
**Comment:** Patient identification

**Cell:** V20
**Comment:** Incident reporting

**Cell:** B21
**Comment:** Policy on procedural documents

**Cell:** G21
**Comment:** Local induction of permanent staff

**Cell:** L21
**Comment:** Sickness absence

**Cell:** Q21
**Comment:** Patient information

**Cell:** V21
**Comment:** Raising concerns

**Cell:** B22
**Comment:** Risk management committee(s)

**Cell:** G22
**Comment:** Local induction of temporary staff

**Cell:** L22
**Comment:** Safeguarding adults

**Cell:** Q22
**Comment:** Consent

**Cell:** V22
**Comment:** Complaints

**Cell:** B23
**Comment:** Risk management committee(s)

**Cell:** G23
**Comment:** Fitness to practice

**Cell:** L23
**Comment:** Moving & handling

**Cell:** Q23
**Comment:** Clinical record-keeping standards

**Cell:** V23
**Comment:** Claims

**Cell:** B24
**Comment:** Risk management committee(s)

**Cell:** G24
**Comment:** Risk management training

**Cell:** L24
**Comment:** Slips, trips & falls

**Cell:** Q24
**Comment:** Transfer of patients

**Cell:** V24
**Comment:** Investigations

**Cell:** B25
**Comment:** Risk management committee(s)

**Cell:** G25
**Comment:** Training needs analysis

**Cell:** L25
**Comment:** Inoculation incidents

**Cell:** Q25
**Comment:** Medicines management

**Cell:** V25
**Comment:** Analysis

**Cell:** B26
**Comment:** Responding to external recommendations specific to the organisation

**Cell:** G26
**Comment:** Medical devices training

**Cell:** L26
**Comment:** Maintenance of medical devices & equipment

**Cell:** Q26
**Comment:** Blood transfusion

**Cell:** V26
**Comment:** Improvement

**Cell:** B27
**Comment:** Clinical records management

**Cell:** G27
**Comment:** Hand hygiene training

**Cell:** L27
**Comment:** Harassment & bullying

**Cell:** Q27
**Comment:** Resuscitation

**Cell:** V27
**Comment:** Best practice - NICE

**Cell:** B28
**Comment:** Professional clinical registration

**Cell:** G28
**Comment:** Moving & handling training

**Cell:** L28
**Comment:** Violence & aggression

**Cell:** Q28
**Comment:** Infection control

**Cell:** V28
**Comment:** Best practice - NSFs, NCEs & High Level Enquiries

**Cell:** B29
**Comment:** Employment checks

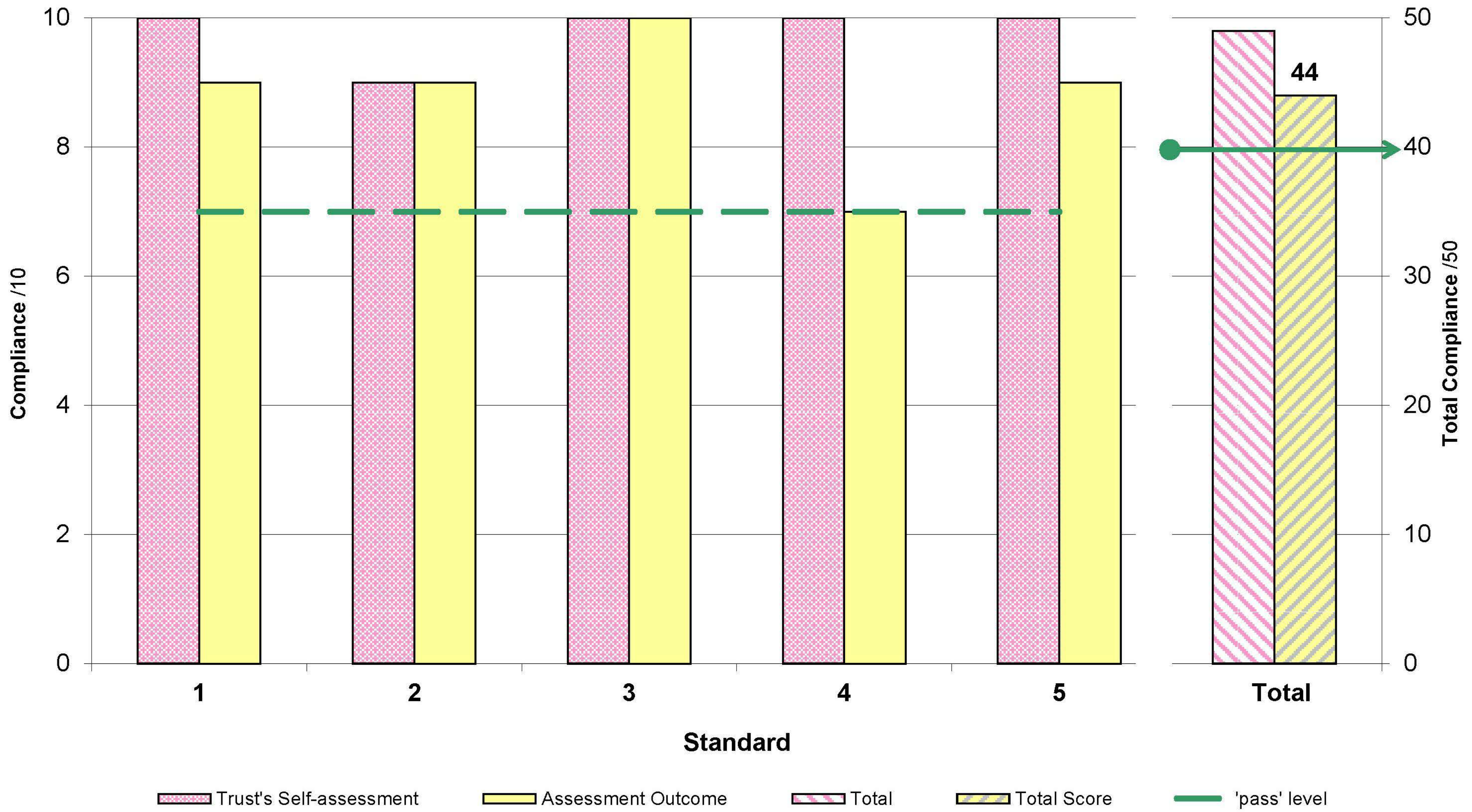
**Cell:** G29
**Comment:** Supporting staff involved in an incident, complaint or claim

**Cell:** L29
**Comment:** Stress

**Cell:** Q29
**Comment:** Diagnostic testing and screening procedures

**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 ⇨ / Criterion ⇩ | 1 Governance | 2 Competent & Capable Workforce | 3 Safe Environment | 4 Clinical Care | 5 Learning from Experience |
|---|---|---|---|---|---|
| 1 | Risk management strategy | Corporate induction | Secure environment | Patient identification | Incident reporting |
| 2 | Policy on procedural documents | Local induction of permanent staff | Sickness absence | Patient information | Raising concerns |
| 3 | Risk management committee(s) | Local induction of temporary staff | Safeguarding adults | Consent | Complaints |
| 4 | Risk awareness training for senior management | Fitness to practice | Moving & handling | Clinical record-keeping standards | Claims |
| 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 |

| 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** | 1010 | There is an organisation-wide risk management strategy which has been approved by the board. | E | SCH Risk Management Strategy | SCH Risk Management Strategy versionNHSLA FINAL 11 03 10.doc | SCH V1<br>AD - 03/10<br>RD - 03/11 | JH | | | | | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | | | | | |
| a | 1011 | 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 | 1012 | process for board or high level committee review of the organisation-wide risk register | E | SCH Risk Management Strategy | | | | Yes | Section 8 | | Yes | | | | |
| c | 1013 | **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 | 1015 | authority of all managers with regard to managing risk | E | SCH Risk Management Strategy | | | | Yes | Section 5 | | Yes | | | | |
| f | 1018 | process for monitoring compliance with all of the above. | E | SCH Risk Management Strategy | | | | Yes | Section 11 | | Yes | | | | |
| | | | | | | | **Compliant** | Yes | | **Compliant** | Yes | | | | |
| **1.1.2** | 1020 | The organisation has approved documentation which describes the process for developing organisation-wide procedural documents. | E | Policy on policies | Policy on Policies v8 200910201.doc | SCPCT/Policy/CS/06/V8<br>AD - 10/2009<br>RD - 10/2010 | RC | | | | | | | | |
| | | As a minimum, the approved documentation must include a description of the following requirements: | | | | | | | | | | | | | |
| a | 1021 | style and format | E | Policy on policies | | | | Yes | section 3 | | Yes | | | | |
| b | 1022 | an explanation of any terms used in documents developed | E | Policy on policies | | | | Yes | section 2 | | Yes | | | | |
| c | 1023 | consultation process | E | Policy on policies | | | | Yes | section 4.5 | | Yes | | | | |
| d | 1024 | **ratification process** | E | Policy on policies | | | | Yes | section 4.6<br>appendix 5 | | Yes | | | | |
| e | 1025 | review arrangements | E | Policy on policies | | | | Yes | section 4.8 | | Yes | | | | |
| f | 1026 | **control of documents, including archiving arrangements** | E | Policy on policies | | | | Yes | section 4.9 | | Yes | | | | |
| g | 1027 | associated documents | E | Policy on policies | | | | Yes | section 9 | | Yes | | | | |
| h | 1027.1 | supporting references | E | Policy on policies | | | | Yes | section 9 | | Yes | | | | |
| i | 1028 | the process for monitoring compliance with all of the above. | E | Policy on policies | | | | Yes | section 7 | | Yes | | | | |
| | | | | | | | **Compliant** | Yes | | **Compliant** | Yes | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **1.1.3** | 1030 | The organisation has approved terms of reference for the high level committee(s) with overarching responsibility for risk. | E | Integrated Governance & Performance Committee TOR | Integrated Governance & Performance Committee TOR V7 20090902 FINAL.DOC | V7<br>A - July 2009<br>R - July 2010 | RC | | | | | |
| | | As a minimum, the terms of reference must include a description of the: | | | | | | | | | | |
| a | 1031 | duties | E | Integrated Governance & Performance Committee TOR | | | | Yes | page 1 - main responsibilities | | Yes | |
| b | 1032.1 | **reporting arrangements to the board** | E | Integrated Governance & Performance Committee TOR | | | | Yes | page 6 - reporting | | Yes | |
| c | 1033 | membership, including nominated deputy where appropriate | E | Integrated Governance & Performance Committee TOR | | | | Yes | page 5 - membership | | Yes | |
| d | 1034 | required frequency of attendance by members | E | Integrated Governance & Performance Committee TOR | | | | Yes | page 6 - frequency | | No | |
| e | 1035 | **reporting arrangements into the high level committee(s)** | E | Integrated Governance & Performance Committee TOR | | | | Yes | page 6 - reporting | | Yes | |
| f | 1036 | requirements for a quorum | E | Integrated Governance & Performance Committee TOR | | | | Yes | page 6 - Quorom | | Yes | |
| g | 1037 | frequency of meetings | E | Integrated Governance & Performance Committee TOR | | | | Yes | page 6 - frequency | | Yes | |
| h | 1038 | process for monitoring compliance with all of the above. | E | | | | | Yes | page 6 - TORs reviewed annually | | Yes | |
| | | | | | | | **Compliant** | **Yes** | | **Compliant** | **No** | |
| **1.1.4** | 1041 | The organisation has approved documentation which describes the process for delivering risk management awareness training for all board members, executives and senior managers. | E | Induction & Mandatory Training Policy | Induction and Mandatory Training Policy.doc | SCPCT/POLICY/LD/02 - Version 3.0<br>A - 04/2009<br>R - 04/2010 | CC | | | | | |
| | | As a minimum, the approved documentation must include a description of the process for: | | | | | | | | | | |
| a | 1042 | **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<br>AD - 03/10<br>RD - 03/11 | JH | Yes | 9.3 and TNA | | Yes | |
| b | 1043 | recording attendance | E | Induction & Mandatory Training Policy | | | | Yes | 4.4 and 5.4 | | Yes | 88 |
| c | 1044 | **following up non-attendance** | E | Learning & Development Policy | NHSLA-LD Policy.doc | SCPCT/POLICY/LD/01 - Version 2.0<br>A - sep 05<br>R - April 10 | CC | Yes | 5.5 | | Yes | |
| d | 1048 | monitoring compliance with all of the above. | E | Induction & Mandatory Training Policy | | | | Yes | section 7 | | Yes | |
| | | | | | | | **Compliant** | **Yes** | | **Compliant** | **Yes** | |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **1.1.5** | 1051 | The organisation has approved documentation which describes the organisation-wide systematic risk management process. | E | SCH Risk Management Strategy | SCH Risk Management Strategy versionNHSLA FINAL 11 03 10.doc | SCH V1<br>AD - 03/10<br>RD - 03/11 | JH | | | | | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | | | | | |
| a | 1052 | ***process for assessing <u>all types of risk</u>*** | E | SCH Risk Management Strategy | | | | Yes | section 8 | | Yes | | | | |
| b | 1053 | **process for ensuring a continual, systematic approach to all risk assessments is followed throughout the organisation** | E | SCH Risk Management Strategy | | | | Yes | section 8.4 | | Yes | | | | |
| c | 1054 | assignment of management responsibility for different levels of risk within the organisation | E | SCH Risk Management Strategy | | | | Yes | section 5 | | Yes | | | | |
| d | 1058 | process for monitoring compliance with all of the above. | E | SCH Risk Management Strategy | | | | Yes | section 11 | | Yes | | | | |
| | | | | | | | **Compliant** | **Yes** | | **Compliant** | **Yes** | | | | |
| | | | | | | | | | | | | | | | |
| **1.1.6** | 1061 | The organisation has an approved organisation-wide risk register. | E | Board Assurance Framework Integrated Template (Strategic) and<br>Clinical Risk Register - hyperlink in comments | BAF Integrated Template 20100224CURRENT.xls | BAF Integrated Template 20100224CURRENT.xls working document - latest version | RC/SB/DC | | | | | | | | |
| | | As a minimum, the approved organisation-wide risk register must include the: | | | | | | | | | | | | | |
| a | 1062 | ***source of the risk (including, but not limited to, incident reports, risk assessment and directorate risk registers)*** | | | | | | Yes | BAF - principle risk column c Clinical Risk - risk details<br><br>Initial source of risk identified on service level risk registrers and escalted as described in risk management strategy | Clinical Risk Register 20100224CURRENT.pdf | Yes | | | | |
| b | 1063 | description of the risk | | | | | | Yes | BAF - principle risk column c Clinical RR - risk details | | Yes | | | | |
| c | 1064 | risk score | | | | | | Yes | BAF - Column D Clinical RR- risk score | | Yes | | | | |
| d | 1065 | summary risk treatment plan | | | | | | Yes | Baf - Column K ClinicalRR - action plan | | Yes | | | | |

| | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| e | 1066 | date of review | | | | | | Yes | BAF - column AL in individual register Clinical RR - Review Date column | | Yes | | | | | |
| f | 1068 | residual risk rating. | | | | | | Yes | BAF - column H Clinical RR - Residual Risk column | | Yes | | | | | |
| | | | | | | | Compliant | Yes | | Compliant | Yes | | | | | |
| | | | | | | | | | | | | | | | | |
| **1.1.7** | 1070 | The organisation has approved documentation which describes the process for preparing and responding to the recommendations and requirements arising from external agency visits, inspections and accreditations specific to the organisation. | E | Policy for the Management of External Agency Visits, Inspections and Accreditations | policy for the managementofexternalagencyvisitsinspections andaccreditationsfinalratified_0310.doc | SCPCT/Policy/SCH/CS/001/v1 A - march 2010 R - March 2011 | AB | | | | | | | | | |
| | | As a minimum, the approved documentation must include a description of the process for: | | | | | | | | | | | | | | |
| a | 1071 | nominating/appointing a suitable individual(s) to coordinate and report on any reviews carried out by external agencies | E | Policy for the Management of External Agency Visits, Inspections and Accreditations | | | | Yes | section 3.1 | | Yes | | | | | |
| b | 1072 | maintaining a schedule of review dates | E | Policy for the Management of External Agency Visits, Inspections and Accreditations | | | | Yes | section 4.5 | | Yes | | | | | |
| c | 1073 | **maintaining action plans to implement any recommendations made as a result of reviews** | E | Policy for the Management of External Agency Visits, Inspections and Accreditations | | | | Yes | section 4.5 | | Yes | | | | | |
| d | 1074 | ensuring that the organisation-wide risk register is populated with risks identified from reviews | E | Policy for the Management of External Agency Visits, Inspections and Accreditations | | | | Yes | section 4.5 | | Yes | | | | | |
| e | 1078 | monitoring compliance with all of the above. | E | Policy for the Management of External Agency Visits, Inspections and Accreditations | | | | Yes | section 7 | | Yes | | | | | |
| | | | | | | | Compliant | Yes | | Compliant | Yes | | | | | |
| | | | | | | | | | | | | | | | | |
| **1.1.8** | 1080 | The organisation has approved documentation which describes the process for managing the risks associated with clinical records in all media. | | STANDARDS OF CLINICAL RECORDS POLICY | | | | | | | | | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | | | | | | |
| a | 1081 | duties | E | STANDARDS OF CLINICAL RECORDS POLICY | | | | Yes | section 4 | | Yes | | | | | |
| b | 1082 | legal obligations that apply to records | E | STANDARDS OF CLINICAL RECORDS POLICY | | | | Yes | 4.5, 4.1.5, 12.6 | | Yes | | | | | |
| c | 1083 | **process for tracking records** | E | STANDARDS OF CLINICAL RECORDS POLICY | | | | Yes | section 9 | | Yes | | | | | |
| d | 1084 | process for creating records | E | STANDARDS OF CLINICAL RECORDS POLICY | | | | Yes | section 5 | | Yes | | | | | |
| e | 1085 | process for retrieving records | E | STANDARDS OF CLINICAL RECORDS POLICY | | | | Yes | section 4.8 | | Yes | | | | | |
| f | 1086 | **process for retaining and disposing of records** | E | STANDARDS OF CLINICAL RECORDS POLICY | | | | Yes | 4.5 and 4.6 | | Yes | | | | | |

| | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| g | 1088 | process for monitoring compliance with all of the above. | E | STANDARDS OF CLINICAL RECORDS POLICY | | | | Yes | section 15 | | Yes | | | | | |
| | | | | | | | **Compliant** | Yes | | **Compliant** | Yes | | | | | |
| | | | | | | | | | | | | | | | | |
| **1.1.9** | 1090 | The organisation has approved documentation which describes the process for ensuring that all clinical staff (temporary and permanent) are registered with the appropriate professional body. | E | Professional staff registration checking procedure | 4 Professional Registration checking procedures v4 (2).doc | Management Guide/ Human Resource 003 A - March 2010 R - March 2012 | LB | | | | | | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | | | | | | |
| a | 1091 | duties, both on initial appointment and ongoing thereafter | E | Professional staff registration checking procedure | | | | Yes | section 3 | | Yes | | | | | |
| b | 1092 | ***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 appointment and ongoing thereafter*** | E | Professional staff registration checking procedure | | | | Yes | section 3 | | Yes | | | | | |
| c | 1093.1 | ***process for monitoring/receiving assurance that registration checks are being carried out by all external agencies (e.g. NHS Professionals, recruitment agencies, etc.) used by the organisation in respect of all temporary clinical staff*** | E | Professional staff registration checking procedure | | | | Yes | 2.3 and Appendix B | | Yes | | | | | |
| d | 1094 | process in place for following up those permanent clinical staff who fail to satisfy the validation of registration process | E | Professional staff registration checking procedure | | | | Yes | 4,5 and 6 | | Yes | | | | | |
| e | 1098 | process for monitoring compliance with all of the above. | E | Professional staff registration checking procedure | | | | Yes | section 7 | | Yes | | | | | |
| | | | | | | | **Compliant** | Yes | | **Compliant** | Yes | | | | | |
| | | | | | | | | | | | | | | | | |
| **1.1.10** | 1100 | The organisation has approved documentation which describes the process for ensuring that all appropriate employment checks are undertaken for all staff (temporary and permanent). | E | Recruitment and Selection Policy | 23 Recruitment and Selection v3.doc | SCPCT /Policy/ Human Resources 023 v3 A - Oct 07 R - Oct 09 then Apr 2010 | **LB** | | | | | | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | | | | | | |
| a | 1101 | duties | E | Recruitment and Selection Policy | | | | Yes | section 4 | | Yes | | | | | |
| b | 1102 | **types of check required** | E | Recruitment and Selection Policy | | | | Yes | 7.1.3 | | Yes | | | | | |
| c | 1103 | checking procedures | E | Recruitment and Selection Policy | | | | Yes | 7.1.3 | | Yes | | | | | |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| d | 1104 | process for following up those who fail to satisfy the checking arrangements | E | Managers Actions when undertaking CRB checks | 3 Managers Action in CRB Checks v 4.doc | SCPCT/ Management Guide/ Human Resource 003 v 4 A - march 2010 D - March 2012 | | Yes | 8.3 | | Yes | | | | |
| e | 1105 | process for monitoring/receiving assurance that checks are being carried out by all external agencies (e.g. NHS Professionals, recruitment agencies, etc.) used by the organisation in respect of all temporary staff | E | Professional staff registration checking procedure | 4 Professional Registration checking procedures v4 (2).doc | Management Guide/ Human Resource 003 A - March 2010 R - March 2012 | LB | Yes | Appendix B | | Yes | | | | |
| f | 1108 | process for monitoring compliance with all of the above. | | Recruitment and Selection Policy | | | | Yes | section 8 | | Yes | | | | |
| | | | | | | | Compliant | Yes | | Compliant | Yes | | | | |
| | 9999 | | | | | | | | | | | | | | |

**The following summary will be populated automatically from information entered on the worksheet.**

| | | |
|---|---|---|
| 1.1.1 | Yes | Yes |
| 1.1.2 | Yes | Yes |
| 1.1.3 | Yes | No |
| 1.1.4 | 0 | Yes |
| 1.1.5 | Yes | Yes |
| 1.1.6 | Yes | Yes |
| 1.1.7 | Yes | Yes |
| 1.1.8 | Yes | Yes |
| 1.1.9 | Yes | Yes |
| 1.1.10 | Yes | Yes |
| **Total** | 9 | 9 |

**Cell:** B1
**Comment:** Admin Use Only

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

**Cell:** L1
**Comment:** Assessor Use Only

**Cell:** 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

| 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **1.2.1** | 2010 | The organisation has approved documentation which describes the corporate induction arrangements for all new permanent staff. | E | Induction & Mandatory Training Policy | Induction and Mandatory Training Policy.doc | SCPCT/POLICY/LD/02 - Version 3.0 A - 04/2009 R - 04/2010 | CC | | | | | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | | | | | |
| a | 2011 | duties | E | Induction & Mandatory Training Policy | | | | Yes | section 4 | | Yes | | | | |
| b | 2012 | minimum content of the corporate induction programme(s) | E | Induction & Mandatory Training Policy | | | | Yes | 5.3, page 24,25 | | Yes | | | | |
| 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 | | | | |
| e | 2015 | **process for following up those who fail to attend corporate induction** | E | Induction & Mandatory Training Policy | | | | Yes | 5.4.2, 5.7 | | Yes | | | | |
| 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 documentation which describes the local induction arrangements for all new permanent staff. | E | Induction & Mandatory Training Policy | Induction and Mandatory Training Policy.doc | SCPCT/POLICY/LD/02 - Version 3.0 A - 04/2009 R - 04/2010 | CC | | | | | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | | | | | |
| a | 2021 | duties | E | Induction & Mandatory Training Policy | | | | y | section 4 | | Yes | | | | |
| b | 2022 | minimum content of local induction programme(s) | E | Induction & Mandatory Training Policy | | | | y | 5.1.1 and appendix a | | Yes | | | | |
| c | 2023 | **process for checking that all new permanent staff complete local induction** | E | Induction & Mandatory Training Policy | | | | Y | 5.1.6 | | Yes | | | | |
| d | 2024 | **process for following up those who fail to complete local induction** | E | Induction & Mandatory Training Policy | | | | Yes | 5.1.6 | | Yes | | | | |
| e | 2028 | process for monitoring compliance with all of the above. | E | Induction & Mandatory Training Policy | | | | Yes | section 7 | | Yes | | | | |
| | | | | | | | **Compliant** | Yes | | **Compliant** | Yes | | | | |
| **1.2.3** | 2030 | The organisation has approved documentation which describes the local induction arrangements for all temporary staff. | E | Induction & Mandatory Training Policy | Induction and Mandatory Training Policy.doc | SCPCT/POLICY/LD/02 - Version 3.0 A - 04/2009 R - 04/2010 | CC | | | | | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | | | | | |
| a | 2031 | duties | E | Induction & Mandatory Training Policy | | | | Yes | 2.1 , section 4 | 2.1 policy applies to all including temporary staff | Yes | | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| b | 2032 | minimum content of local induction programme(s) | E | Induction & Mandatory Training Policy | | | | Yes | 5.1.1 and appendix a | | Yes |
| c | 2033 | **process for checking that all temporary staff complete local induction** | E | Induction & Mandatory Training Policy | | | | Yes | 5.1.6 | | No |
| d | 2034 | **process for following up those who fail to complete local induction** | E | Induction & Mandatory Training Policy | | | | Yes | 5.1.6 | | No |
| e | 2038 | process for monitoring compliance with all of the above. | E | Induction & Mandatory Training Policy | | | | Yes | section 7 | | Yes |
| | | | | | | | **Compliant** | Yes | | **Compliant** | No |
| | | | | | | | | | | | |
| **1.2.4** | 2040 | 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: | | | | | | | | | |
| a | 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 C | | Yes |
| c | 2043 | 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 | 2044 | **procedure for notifying the NHSLA Family Health Service Appeal Unit in the event of concern** | E | Managing Performance Policy for Medical and Dental Staff | 17 Managing Performance for Medical and Dental Staff.doc | SCPCT /Policy/ Human Resources 017 A - Dec 05 R - June 10 | LB | Yes | 7.7.4 | | Yes |
| e | 2045 | procedure for notification within the health community | E | Managing Performance Policy for Medical and Dental Staff | 17 Managing Performance for Medical and Dental Staff.doc | SCPCT /Policy/ Human Resources 017 A - Dec 05 R - June 10 | LB | Yes | 7.7.4 and appendix 2b | | Yes |
| f | 2048 | process for monitoring compliance with all of the above. | | | | | | No | | | Yes |
| | | | | | | | **Compliant** | No | | **Compliant** | Yes |
| | | | | | | | | | | | |
| **1.2.5** | 2050 | The organisation has approved documentation which describes the process for ensuring a systematic approach to risk management training for all permanent staff. | E | Learning & Development Policy | NHSLA-LD Policy.doc | SCPCT/POLICY/LD/01 - Version 2.0 A - sep 05 R - April 10 | CC | | | | |
| | | As a minimum, the approved documentation must include a description of the process for: | | | | | | | | | |
| a | 2051 | developing a training needs analysis which reflects the TNA Minimum Data Set | E | Learning & Development Policy | | | | Yes | 3.2 | | Yes |
| b | 2052 | developing action plan(s) to deliver the training identified within the training needs analysis | E | Learning & Development Policy | | | | Yes | 3.2 | | Yes |
| c | 2053 | developing a training prospectus to reflect the training needs analysis | E | Learning & Development Policy | | | | Yes | 3.2 | | Yes |

| | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| d | 2054 | **checking that all permanent staff complete the relevant training programmes in accordance with the training needs analysis** | E | Learning & Development Policy | | | | Yes | 4.2 | | Yes | | | | | |
| e | 2055 | **following up those who fail to attend relevant training programmes** | E | Learning & Development Policy | | | | Yes | 4.2 | | Yes | | | | | |
| f | 2056 | coordinating training records | E | Learning & Development Policy | | | | Yes | 4.3 | | Yes | | | | | |
| g | 2058 | monitoring compliance with all of the above. | E | Learning & Development Policy | | | | Yes | 7 | | Yes | | | | | |
| | | | | | | | Compliant | Yes | | Compliant | Yes | | | | | |
| | | | | | | | | | | | | | | | | |
| **1.2.6** | 2060 | The organisation has undertaken a training needs analysis to identify the risk management training requirements for all permanent staff and documented the results. | E | Training Needs Analysis (extracted from induction & mandatory training policy) | Training Needs Analysis (11032010).xls | SCPCT/POLICY/LD/02 - Version 3.0 A - 04/2009 R - 04/2010 | CC | | | | | | | | | |
| | | As a minimum, the approved documentation must include: | | | | | | | | | | | | | | |
| a | 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) | E | Training Needs Analysis (extracted from induction & mandatory training policy) | | | | Yes | column b in spreadsheet | | Yes | | | | | |
| b | 2062 | evidence that the organisation has identified which staff groups are required to attend each type of training | E | Training Needs Analysis (extracted from induction & mandatory training policy) | | | | Yes | Row 1 in spreadsheet | | Yes | | | | | |
| c | 2063 | evidence that the organisation has identified the frequency of updates required for each type of training. | E | Training Needs Analysis (extracted from induction & mandatory training policy) | | | | Yes | Column C in spreadsheet | | Yes | | | | | |
| | | | | | | | Compliant | Yes | | Compliant | Yes | | | | | |
| | | | | | | | | | | | | | | | | |
| **1.2.7** | 2070 | The organisation has 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. | 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: | | | | | | | | | | | | | | |
| a | 2071 | duties | E | Management of Medical Devices (Equipment) | | | | Yes | 5 | | Yes | | | | | |
| b | 2072 | inventory (or links to an inventory) of diagnostic and therapeutic equipment used within the organisation | E | Management of Medical Devices (Equipment) | | | | Yes | 12.5 | | Yes | | | | | |
| c | 2073 | **process for identifying which permanent staff are authorised to use the equipment identified on the inventory** | E | 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** | E | Management of Medical Devices (Equipment) | | | | Yes | 14 | | Yes | | | | | |
| e | 2075 | **process for ensuring that the identified training needs of all permanent staff are met** | E | Management of Medical Devices (Equipment) | | | | Yes | 14 appendix 15 & 16 | | Yes | | | | | |
| f | 2078 | process for monitoring compliance with all of the above. | E | Management of Medical Devices (Equipment) | | | | Yes | 24 | | Yes | | | | | |
| | | | | | | | Compliant | Yes | | Compliant | Yes | | | | | |

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

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| d | 2104 | advice available to staff in the event of their being called as a witness (internally and, if necessary, externally) | E | Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy | | | | Yes | 11.8 | | Yes |
| e | 2105 | **action for managers or individuals to take if the staff member is experiencing difficulties associated with the event** | E | Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy | | | | Yes | 11.6 | | Yes |
| f | 2108 | process for monitoring compliance with all of the above. | E | Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy | | | | Yes | 18 | | Yes |
| | | | | | | | **Compliant** | **Yes** | | **Compliant** | **Yes** |
| | 9999 | | | | | | | | | | |

**The following summary will be populated automatically from information entered on the worksheet.**

| | | |
|---|---|---|
| 1.2.1 | Yes | Yes |
| 1.2.2 | Yes | Yes |
| 1.2.3 | Yes | No |
| 1.2.4 | No | Yes |
| 1.2.5 | Yes | Yes |
| 1.2.6 | Yes | Yes |
| 1.2.7 | Yes | Yes |
| 1.2.8 | Yes | Yes |
| 1.2.9 | Yes | Yes |
| 1.2.10 | Yes | Yes |
| **Total** | 9 | 9 |

PHO119688-0026

**Cell:** B1
**Comment:** Admin Use Only

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

**Cell:** L1
**Comment:** Assessor Use Only

**Cell:** 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 | 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) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **1.3.1** | 3010 | The organisation has approved documentation which describes the process for managing the risks associated with the physical security of premises and other assets. | E | Security Management Policy | Security Management Policy V1NHSLA Final.doc | SCPCT /Policy/H&S/ V1 A - March 10 R - April 11 | MH | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | |
| a | 3011 | duties | E | Security Management Policy | | | | Yes | 4 | | Yes |
| b | 3012 | requirement to undertake a lockdown risk profile for each organisational site or other specific building/area | E | Security Management Policy | | | | No | | | No |
| c | 3013 | **requirement to undertake appropriate risk assessments regarding the physical security of premises and assets** | E | Security Management Policy | | | | Yes | 4.11 | | Yes |
| d | 3014 | **arrangements for the organisational overview of the risk assessments regarding the physical security of premises and assets** | E | Security Management Policy | | | | Yes | 4.1.2 | | Yes |
| e | 3018 | process for monitoring compliance with all of the above. | E | Security Management Policy | | | | Yes | 7 | | Yes |
| | | | | | | | **Compliant** | **Yes** | | **Compliant** | **Yes** |
| **1.3.2** | 3020 | The organisation has approved documentation which describes the process for managing the risks associated with sickness absences. | E | SCPCT /Policy/ Human Resources 016 v3 | 16 Sickness Absence Policy v 3.doc | SCPCT /Policy/ Human Resources 016 v3 A - May 2007 R - May 2011 | LB | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | |
| a | 3021 | duties | E | SCPCT /Policy/ Human Resources 016 v3 | | | | Yes | 3 | | Yes |
| b | 3022 | process for maintaining contact with absent employees | E | SCPCT /Policy/ Human Resources 016 v3 | | | | Yes | 4.1, Appendix 5, Appendix 8 | | Yes |
| c | 3023 | planning and facilitating return to work plans | E | SCPCT /Policy/ Human Resources 016 v3 | | | | Yes | 14,15.16, Appendix 3, appendix 4, appendix 5 | | Yes |
| d | 3024 | planning and undertaking workplace controls or adjustments | E | SCPCT /Policy/ Human Resources 016 v3 | | | | Yes | 15 | | Yes |
| e | 3025 | **process for analysing sickness absence data** | E | SCPCT /Policy/ Human Resources 016 v3 | | | | Yes | 3, , 22, 23.2 | | Yes |
| f | 3026 | **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 | | | | Yes | 23 | | Yes |
| | | | | | | | Compliant | Yes | | Compliant | Yes |
| | | | | | | | | | | | |
| 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 | safeguarding adults policy ratified 2010.doc | SCPCT/Policy/AP/001<br>A - Feb 10<br>R - Sep 10 | JM | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | |
| a | 3031 | duties | E | ADULT PROTECTION POLICY | | | | Yes | 3 | | Yes |
| b | 3032 | **local arrangements for managing the risks associated with safeguarding adults** | E | ADULT PROTECTION POLICY | | | | Yes | 3.1, 12.5, 23.3 | | Yes |
| c | 3033 | organisation's expectations in relation to staff training, as identified in the training needs analysis | E | ADULT PROTECTION POLICY | | | | Yes | 17 | | Yes |
| d | 3038 | process for monitoring compliance with all of the above. | E | ADULT PROTECTION POLICY | | | | Yes | 23 | | Yes |
| | | | | | | | Compliant | Yes | | Compliant | Yes |
| | | | | | | | | | | | |
| 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 | Moving and Handling policy 6-31 10 07FINAL (2)1 KB.doc | SCPCT/Policy/ OCH/002 V2<br>A - Oct 07<br>R - Mar 2010 | MH | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | |
| a | 3041 | duties | E | Moving and Handling Policy | | | | Yes | 4 | | Yes |
| 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 | | | | Yes | 11 | | Yes |
| c | 3043 | arrangements for access to appropriate specialist advice | E | Moving and Handling Policy | | | | Yes | 13 | | Yes |
| d | 3044 | **requirement to undertake appropriate risk assessments for the moving and handling of patients and objects** | E | Moving and Handling Policy | | | | Yes | 5 | | Yes |
| e | 3045 | **arrangements for the organisational overview of the risk assessments for the moving and handling of patients and objects** | E | Moving and Handling Policy | | | | Yes | 14 | | Yes |
| f | 3048 | process for monitoring compliance with all of the above. | E | Moving and Handling Policy | | | | Yes | 14 | | Yes |
| | | | | | | | Compliant | Yes | | Compliant | Yes |
| | | | | | | | | | | | |
| 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 | Management of slips, trips & Falls 016 V2 Final.doc | SCH/Policy/ HS/ 016 V 2<br>A - Oct 07<br>R Oct 2011 | MH | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | |
| a | 3051 | duties | P | Management of Slips, Trips & Falls Policy | | | | Yes | 5 | | Yes |
| b | 3052 | **requirement to undertake appropriate risk assessments for the management of slips, trips and falls involving patients (including falls from height)** | P | Management of Slips, Trips & Falls Policy | | | | Yes | 4.2 | | Yes |

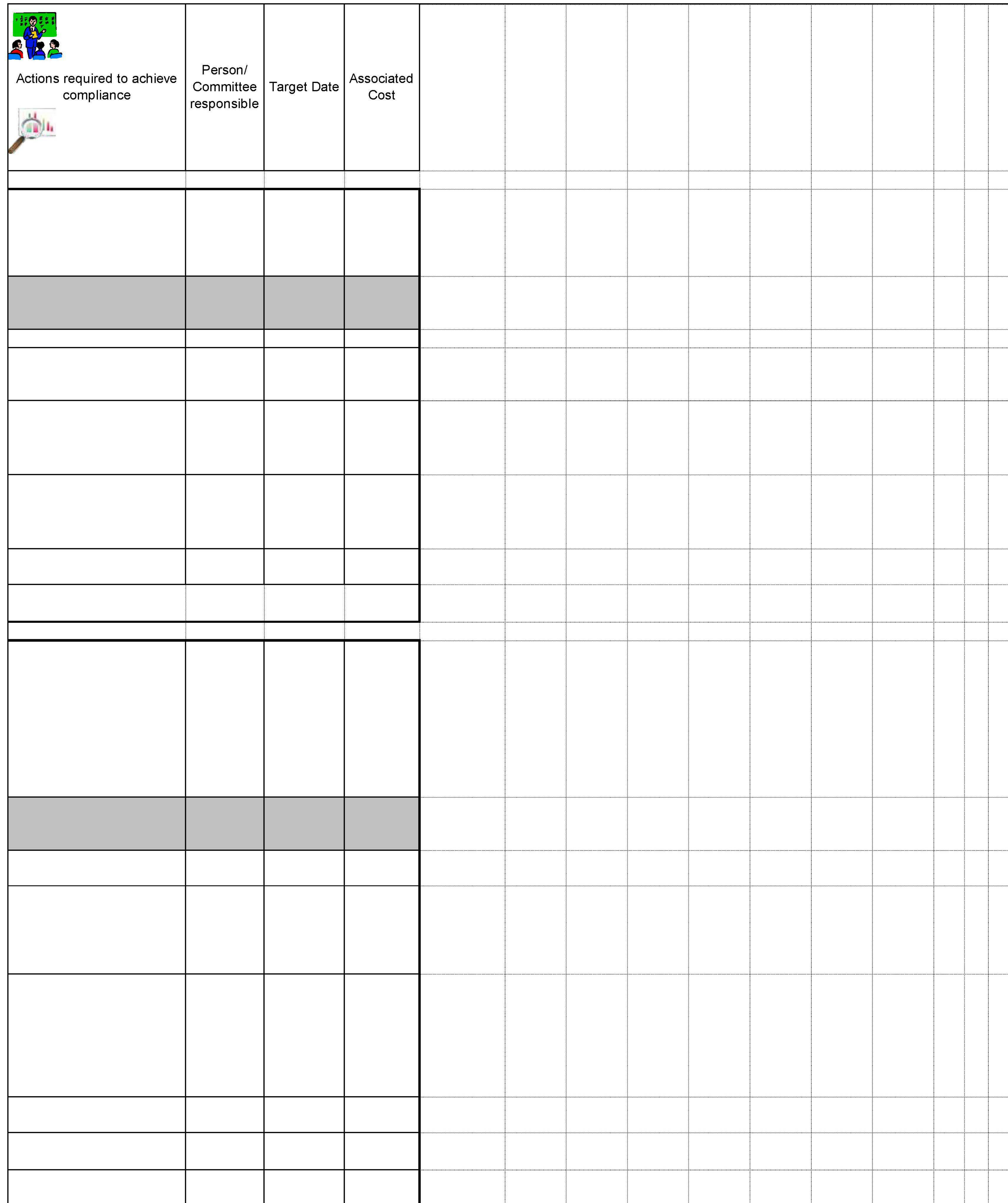
| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| c | 3053 | **requirement to undertake appropriate risk assessments for the management of slips, trips and falls involving staff and others (including falls from height)** | P | Management of Slips, Trips & Falls Policy | | | | Yes | 4.3 | | Yes |
| d | 3054 | 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 |
| e | 3055 | 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 | 3058 | process for monitoring compliance with all of the above. | P | Management of Slips, Trips & Falls Policy | | | | Yes | 7 | | Yes |
| | | | | | | | Compliant | Yes | | Compliant | Yes |
| | | | | | | | | | | | |
| **1.3.6** | 3060 | The organisation has approved documentation which describes the process for managing the risks associated with inoculation incidents. | E | POLICY ON THE MANAGEMENT OF INOCULATION OR CONTAMINATION INCIDENTS (sharps, bites, scratches, or cuts) | Management of Inoculation Incidents 11 03 10.doc | SCPCT/ Policy/ Occupational Health 007 v4<br>A - oct 07<br>R - March 2011 | CM | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | |
| a | 3061 | duties | E | POLICY ON THE MANAGEMENT OF INOCULATION OR CONTAMINATION INCIDENTS (sharps, bites, scratches, or cuts) | | | | Yes | 3 | | Yes |
| b | 3062 | reporting arrangements in relation to inoculation 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 |
| c | 3063 | **process for the management of an inoculation incident (including prophylaxis)** | E | POLICY ON THE MANAGEMENT OF INOCULATION OR CONTAMINATION INCIDENTS (sharps, bites, scratches, or cuts) | | | | Yes | Appendix B | | Yes |
| d | 3065 | organisation's requirements in relation to staff training, as identified in the training needs analysis | E | POLICY ON THE MANAGEMENT OF INOCULATION OR CONTAMINATION INCIDENTS (sharps, bites, scratches, or cuts) | | | | Yes | Appendix a - 7 | | Yes |
| e | 3068 | process for monitoring compliance with all of the above. | E | POLICY ON THE MANAGEMENT OF INOCULATION OR CONTAMINATION INCIDENTS (sharps, bites, scratches, or cuts) | | | | Yes | section 9 | | Yes |
| | | | | | | | Compliant | Yes | | Compliant | Yes |
| | | | | | | | | | | | |
| **1.3.7** | 3070 | 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<br>a Jan 09<br>r Mar 11 | NM | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | |
| a | 3071 | duties | E | Management of Medical Devices (Equipment) | | | | Yes | 5 | | Yes |
| b | 3072 | 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 |
| c | 3073 | **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 | 3074 | process for checking that calibration of all reusable medical devices are completed within the specified time frames | E | Management of Medical Devices (Equipment) | | | | Yes | 10, appendix 9 - 2 | | Yes |
| e | 3078 | process for monitoring compliance with all of the above. | E | Management of Medical Devices (Equipment) | | | | Yes | 24 | | Yes |
| | | | | | | | **Compliant** | **Yes** | | **Compliant** | **Yes** |
| | | | | | | | | | | | |
| **1.3.8** | 3080 | 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 | 20 Dignity at work Policy v2.doc | SCPCT /Policy/ Human Resources 020 v2 A - Feb 09 R - Feb 2011 | LB | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | |
| a | 3081 | duties | E | Dignity at Work (Bullying and Harassment) Policy | 20 Dignity at work Policy v2.doc | | | Yes | 8 | | Yes |
| b | 3082 | statement by the organisation that harassment and/or bullying are not acceptable | E | Dignity at Work (Bullying and Harassment) Policy | 20 Dignity at work Policy v2.doc | | | Yes | 1,3. 5.1 | | Yes |
| c | 3083 | **process for raising concerns about harassment and/or bullying** | E | Dignity at Work (Bullying and Harassment) Policy | 20 Dignity at work Policy v2.doc | | | Yes | 10 | | Yes |
| d | 3084 | **process to be followed once a concern has been raised** | E | Grievance Policy | Grievance Policy.doc | SCPCT /Policy/ Human Resources 019 A - April 09 R - April 11 | LB | Yes | 11 | | Yes |
| e | 3085 | organisation's requirements in relation to staff training, as identified in the training needs analysis | E | Dignity at Work (Bullying and Harassment) Policy | 20 Dignity at work Policy v2.doc | | | Yes | 17 | | Yes |
| f | 3088 | process for monitoring compliance with all of the above. | E | Dignity at Work (Bullying and Harassment) Policy | 20 Dignity at work Policy v2.doc | | | Yes | 15 | | Yes |
| | | | | | | | **Compliant** | **Yes** | | **Compliant** | **Yes** |
| | | | | | | | | | | | |
| **1.3.9** | 3090 | 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 Working | 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 | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | |
| a | 3091 | duties | E | The Prevention and Management of Violence and Aggression Directed at NHS Staff, including Lone Working | | | | Yes | 5 | | Yes |
| b | 3092 | **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 Working | | | | Yes | 4.11 | | Yes |
| c | 3093 | **arrangements for ensuring the safety of lone workers** | E | The Prevention and Management of Violence and Aggression Directed at NHS Staff, including Lone Working | | | | Yes | Throughout, 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 | 3 Employee Wellbeing and Stress Risk Assessment v4.doc | SCPCT/Policy/ Health and Safety 004<br>A - Nov 07<br>R - Nov 11 | CM | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | |
| a | 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 | | | | Yes | 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 | | | | Yes | section 7 - appendix 6-9 | | Yes |
| e | 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 | | | | | | | | | | |

**The following summary will be populated automatically from information entered on the worksheet.**

| | | |
|---|---|---|
| 1.3.1 | Yes | Yes |
| 1.3.2 | Yes | Yes |
| 1.3.3 | Yes | Yes |
| 1.3.4 | Yes | Yes |
| 1.3.5 | Yes | Yes |
| 1.3.6 | Yes | Yes |
| 1.3.7 | Yes | Yes |
| 1.3.8 | Yes | Yes |
| 1.3.9 | Yes | Yes |
| 1.3.10 | Yes | Yes |
| **Total** | **10** | **10** |



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

PHO119688-0036

**Cell:** B1
**Comment:** Admin Use Only

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

**Cell:** L1
**Comment:** Assessor Use Only

**Cell:** H100
**Comment:** Secure environment

**Cell:** H101
**Comment:** Sickness absence

**Cell:** H102
**Comment:** Safeguarding adults

**Cell:** H103
**Comment:** Moving & handling

**Cell:** H104
**Comment:** Slips, trips & falls

**Cell:** H105
**Comment:** Inoculation incidents

**Cell:** H106
**Comment:** Maintenance of medical devices & equipment

**Cell:** H107
**Comment:** Harassment & bullying

**Cell:** H108
**Comment:** Violence & aggression

**Cell:** H109
**Comment:** Stress

| Criterion number | Index | Criterion and minimum requirements | Paper or Electronic copy | 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** | 4010 | The organisation has approved documentation which describes the process for managing the risks associated with the identification of all patients. | E | Patient Identification Policy | Patient Identification Policy RK 011 KB amend.DOC | SCPCT/ Policy/RK/01 1<br>A - Oct 07<br>R - Oct 2010 | JH | | | | | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | | | | | |
| a | 4010.1 | definition of all patients groups | E | Patient Identification Policy | | | | Yes | 5 and 6 | | Yes | | | | |
| b | 4011 | ***process for identifying all patients*** | E | Patient Identification Policy | | | | Yes | 5 and 6 | | Yes | | | | |
| c | 4012 | process for ongoing checks throughout the patient care episode | E | Patient Identification Policy | | | | Yes | 5.4, 6.5 | | Yes | | | | |
| d | 4013 | **procedure to be followed in cases where patient misidentification occurs** | E | Patient Identification Policy | | | | Yes | 7 | | Yes | | | | |
| e | 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 documentation which describes the process for developing patient information associated with care, treatments and procedures. | E | Patient Information Development Policy | Final patient information policy V2 20010310.doc | SCPCT/ Policy/C&PR /001<br>A - Oct 07<br>R - Oct 2010 | AM | | | | | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | | | | | |
| a | 4022 | process for the development of patient information | E | Patient Information Development Policy | | | | Yes | 6 | | Yes | | | | |
| b | 4023 | **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 | | | | |
| c | 4024 | 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 | | | | |
| e | 4028 | process for monitoring compliance with all of the above. | E | Patient Information Development Policy | | | | Yes | 18 | | Yes | | | | |
| | | | | | | | **Compliant** | **Yes** | | **Compliant** | **Yes** | | | | |
| | | | | | | | | | | | | | | | |
| **1.4.3** | 4030 | The organisation has approved documentation which describes the process for managing the risks associated with consent. | E | Policy for Consent to Examination or Treatment | SCH Consent Policyfinalratified0310.doc | SCPCT/Polic y/SCH/CS/00 2/v2<br>A - Nov 06<br>R - March 11 | AB | | | | | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | | | | | |
| a | 4031 | process for obtaining consent | E | Policy for Consent to Examination or Treatment | | | | Yes | 4 | | Yes | | | | |
| b | 4032 | process for recording consent | E | Policy for Consent to Examination or Treatment | | | | Yes | 4.2.4 | | Yes | | | | |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| c | 4033 | **process for identifying staff who are not capable of performing the procedure but are authorised to obtain consent for that procedure** | E | Policy for Consent to Examination or Treatment | | | | Yes | ALL OF 5.5 | | No | | | | |
| d | 4034 | generic training on the consent process | E | Policy for Consent to Examination or Treatment | | | | Yes | 6 | | Yes | | | | |
| e | 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** | E | Policy for Consent to Examination or Treatment | | | | Yes | 5.5.2 AND 6.2 | | No | | | | |
| f | 4038 | 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** | 4040 | 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_Policy_IMT09_V10<br>A - March 10<br>R - March 12 | SC | | | | | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | | | | | |
| a | 4041 | duties | E | Standards of Clinical Records Policy | | | | Yes | 12 | | Yes | | | | |
| b | 4042 | criteria against which the clinical records must be audited for all healthcare professionals | E | Standards of Clinical Records Policy | | | | Yes | 15.6 | | Yes | | | | |
| c | 4043 | frequency of audit of clinical records | E | Standards of Clinical Records Policy | | | | Yes | 15.1 | | Yes | | | | |
| d | 4044 | **format for all audit reports i.e. methodology, conclusions, action plans, etc.** | E | Standards of Clinical Records Policy | | | | Yes | appendix I & J | | Yes | | | | |
| e | 4045 | **arrangements for the review of action plans** | E | Standards of Clinical Records Policy | | | | Yes | 15.3 | | Yes | | | | |
| f | 4048 | 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** | 4050 | The organisation has approved documentation which describes the process for managing the risks associated with the transfer of patients. | E | SCPCT//Policy/SCH/N/CH/12 V 3 | Admission transfer and discharge policy 22 3 09.doc | SCPCT//Policy/SCH/N/CH/12 V 3<br>A - March 2010<br>D - March 2011 | FB | | | | | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | | | | | |
| a | 4051 | duties | E | SCPCT//Policy/SCH/N/CH/12 V 3 | | | | Yes | 5 | | Yes | | | | |
| b | 4052 | **transfer requirements which are specific to each patient group** | E | SCPCT//Policy/SCH/N/CH/12 V 3 | | | | Yes | 11 | | No | | | | |
| c | 4053 | **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 | | | | |
| d | 4054 | process for transfer out of hours | E | SCPCT//Policy/SCH/N/CH/12 V 3 | | | | Yes | 8.1 | | Yes | | | | |
| e | 4058 | process for monitoring compliance with all of the above. | E | SCPCT//Policy/SCH/N/CH/12 V 3 | | | | Yes | 17 | | Yes | | | | |
| | | | | | | | **Compliant** | **Yes** | | **Compliant** | **No** | | | | |
| | | | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **1.4.6** | 4060 | 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/Policy/PB/03 v3 A - Nov 09 R - Nov 11 | CB | | | | | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | | | | | |
| a | 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/Policy/PB/03 v3 A - Nov 09 R - Nov 11 | CB | 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/Policy/PB/03 v3 A - Nov 09 R - Nov 11 | CB | Yes | 5.1 | | No | | | | |
| c | 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/Policy/PB/03 v3 A - Nov 09 R - Nov 11 | CB | Yes | section 6 | | Yes | | | | |
| d | 4063 | process for patient self administration | E | Policy for use of self-medication scheme at provider sites of Southampton City PCT | Self administration procedure sept 2008 City PCT(2).DOC | SCPCT/Policy/PB09 A - Sep 08 R 0 Sep 10 | CB | Yes | Entire policy | | Yes | | | | |
| e | 4064 | 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/Policy/PB/03 v3 A - Nov 09 R - Nov 11 | CB | Yes | section 9 | | Yes | | | | |
| f | 4065 | 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/Policy/PB/03 v3 A - Nov 09 R - Nov 11 | CB | Yes | throughout, Appendix B, appendix c (10) and TNA and L&D policy | | Yes | | | | |
| g | 4068 | 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/Policy/PB/03 v3 A - Nov 09 R - Nov 11 | CB | Yes | section 12 | | Yes | | | | |
| | | | | | | | **Compliant** | Yes | | **Compliant** | Yes | | | | |
| **1.4.7** | 4070 | The organisation has approved documentation which describes the process for managing the risks associated with the blood transfusion process. | N/A | NA - SCH does not do | | | | | | | | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | | | | | |
| a | 4071 | duties | | | | | | | | | Yes | | | | |
| b | 4072 | process for the request of blood samples for pre-transfusion compatibility testing | | | | | | | | | Yes | | | | |
| c | 4073 | **process for the administration of blood and blood products** | | | | | | | | | Yes | | | | |
| d | 4074 | **care of patient(s) receiving transfusion** | | | | | | | | | Yes | | | | |
| e | 4075 | training requirements of all staff, as identified in the training needs analysis | | | | | | | | | Yes | | | | |
| f | 4076 | requirements for the competency assessment of all staff involved in the blood transfusion process | | | | | | | | | Yes | | | | |
| g | 4078 | process for monitoring compliance with all of the above. | | | | | | | | | Yes | | | | |
| | | | | | | | **Compliant** | Yes | | **Compliant** | Yes | | | | |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **1.4.8** | 4080 | The organisation has approved documentation which describes the process for managing the risks associated with resuscitation. | E | Cardiopulmonary Resuscitation Policy | SCH CPR Policy final.doc | SCPCT/Policy/SD/01 V3 A - oct 07 R - Sep 11 | IB | | | | | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | | | | | |
| a | 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 | | | | |
| c | 4083 | post-resuscitation care | E | Cardiopulmonary Resuscitation Policy | | | | Yes | Appendices | 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 | | | | |
| e | 4085 | process for ensuring the continual availability of resuscitation equipment | E | Cardiopulmonary Resuscitation Policy | | | | Yes | 4.3.0 | | Yes | | | | |
| f | 4086 | 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 | | | | |
| | | | | | | | | | | | | | | | |
| **1.4.9** | 4090 | 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/Policy/IC/010 V4 A - Oct 07 R - Oct 2010 | JW | | | | | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | | | | | |
| a | 4092 | **infection control assurance framework** | E | Policy for infection prevention and control framework for the Trust | | | | Yes | Appendix 1 | | Yes | | | | |
| b | 4093 | 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 | | | | |
| c | 4094 | information available to patients and the public about the organisation's general processes and arrangements for preventing and controlling healthcare acquired infections | E | Policy for infection prevention and control framework for the Trust | | | | Yes | 12 | | Yes | | | | |
| d | 4095 | 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 | | | | |
| | | | | | | | | | | | | | | | |
| **1.4.10** | 4100 | 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. | E | 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: | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| a | 4101 | procedures for requesting clinical tests and screening | E | Clinical Diagnostic Testing Policy | | | | Yes | 4.2 | | Yes | | | | |
| b | 4102 | **process for taking action on clinical tests and screening results** | E | Clinical Diagnostic Testing Policy | | | | Yes | 4.3 | | Yes | | | | |
| c | 4103 | process for recording the actions taken | E | Clinical Diagnostic Testing Policy | | | | Yes | 4.4 | | Yes | | | | |
| d | 4104 | **process for the communication of test and screening results** | E | Clinical Diagnostic Testing Policy | | | | Yes | 4.5 | | Yes | | | | |
| e | 4108 | process for monitoring compliance with all of the above. | E | Clinical Diagnostic Testing Policy | | | | Yes | 7 | | Yes | | | | |
| | | | | | | | **Compliant** | **Yes** | | **Compliant** | **Yes** | | | | |
| | 9999 | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| | | | **The following summary will be populated automatically from information entered on the worksheet.** | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | 1.4.1 | Yes | | | Yes | | | | |
| | | | | | | | 1.4.2 | Yes | | | Yes | | | | |
| | | | | | | | 1.4.3 | Yes | | | No | | | | |
| | | | | | | | 1.4.4 | Yes | | | Yes | | | | |
| | | | | | | | 1.4.5 | Yes | | | No | | | | |
| | | | | | | | 1.4.6 | Yes | | | Yes | | | | |
| | | | | | | | 1.4.7 | Yes | | | Yes | | | | |
| | | | | | | | 1.4.8 | Yes | | | No | | | | |
| | | | | | | | 1.4.9 | Yes | | | Yes | | | | |
| | | | | | | | 1.4.10 | Yes | | | Yes | | | | |
| | | | | | | | **Total** | **10** | | | **7** | | | | |

**Cell:** B1
**Comment:** Admin Use Only

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

**Cell:** L1
**Comment:** Assessor Use Only

**Cell:** H104
**Comment:** Patient identification

**Cell:** H105
**Comment:** Patient information

**Cell:** H106
**Comment:** Consent

**Cell:** H107
**Comment:** Clinical record-keeping standards

**Cell:** H108
**Comment:** Transfer of patients

**Cell:** H109
**Comment:** Medicines management

**Cell:** H110
**Comment:** Blood transfusion

**Cell:** H111
**Comment:** Resuscitation

**Cell:** H112
**Comment:** Infection control

**Cell:** H113
**Comment:** Diagnostic testing and screening procedures

| Criterion number | Index | Criterion and minimum requirements | Paper or Electronic copy | Name of approved document | Electronic file hyperlink/name | Document version name, 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **1.5.1** | 5010 | The organisation has approved documentation which describes the process for managing the risks associated with the reporting of all internally and externally reportable incidents. | E | ADVERSE INCIDENT REPORTING (AIR) POLICY | SCH Adverse Incident Reporting ( AIR) Policy SCH V1 NHSLA Final 10.03.10.doc | SCPCT/policy/SCHRSK/ 008/ v3 A - March 2010 R - March 2011 | JH | | | | | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | | | | | |
| a | 5011 | duties | E | ADVERSE INCIDENT REPORTING (AIR) POLICY | | | | Yes | 4 | | Yes | | | | |
| b | 5012 | **process for reporting all incidents/near misses, involving staff, patients and others** | E | ADVERSE INCIDENT REPORTING (AIR) POLICY | | | | Yes | section 6 and appendix a | | Yes | | | | |
| c | 5013 | **process for reporting to external agencies** | E | ADVERSE INCIDENT REPORTING (AIR) POLICY | | | | Yes | 13 | | Yes | | | | |
| d | 5014 | reference to the processes for staff to raise concerns e.g. whistle blowing/open disclosure | E | ADVERSE INCIDENT REPORTING (AIR) POLICY | | | | Yes | 5 | | Yes | | | | |
| e | 5018 | process for monitoring compliance with all of the above. | E | ADVERSE INCIDENT REPORTING (AIR) POLICY | | | | Yes | section 15 | | Yes | | | | |
| | | | | | | | **Compliant** | **Yes** | | **Compliant** | **Yes** | | | | |
| **1.5.2** | 5020 | 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 raise concerns informally. | E | Complaints and Concerns Policy and Procedure for Patients and Staff | SCH Complaints & Concerns Policy Final ratified 0310.doc | SCPCT/Policy/SCH/CS/004 A - March 10 R - March 11 | SR | | | | | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | | | | | |
| a | 5021 | duties | E | Complaints and Concerns Policy and Procedure for Patients and Staff | | | | Yes | 9 | | Yes | | | | |
| b | 5022 | **process for raising concerns (informal complaints/Patient Advice and Liaison Services)** | E | Complaints and Concerns Policy and Procedure for Patients and Staff | | | | Yes | section 12 | | Yes | | | | |
| c | 5023 | process for ensuring that patients, relatives and their carers are not treated differently as a result of raising a concern | E | Complaints and Concerns Policy and Procedure for Patients and Staff | | | | Yes | Appendix B | | Yes | | | | |
| d | 5024 | **process by which the organisation aims to make changes as a result of concerns being raised** | E | Complaints and Concerns Policy and Procedure for Patients and Staff | | | | Yes | section 24 | | Yes | | | | |
| e | 5028 | process for monitoring compliance with all of the above. | E | Complaints and Concerns Policy and Procedure for Patients and Staff | | | | Yes | section 31 | | Yes | | | | |
| | | | | | | | **Compliant** | **Yes** | | **Compliant** | **Yes** | | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **1.5.3** | 5030 | 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. | E | Complaints and Concerns Policy and Procedure for Patients and Staff | SCH Complaints & Concerns Policy Final ratified 0310.doc | SCPCT/Policy/SCH/CS/004<br>A - March 10<br>R - March 11 | SR | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | |
| a | 5031 | duties | E | Complaints and Concerns Policy and Procedure for Patients and Staff | | | | Yes | 9 | formatting of policy needs to be revised. | Yes |
| b | 5032 | **complaints management process, which includes internal and external communication, and collaboration with other organisations when necessary** | E | Complaints and Concerns Policy and Procedure for Patients and Staff | | | | Yes | 2 | | Yes |
| c | 5033 | procedure to ensure that patients, relatives and their carers are not treated differently as a result of a complaint | E | Complaints and Concerns Policy and Procedure for Patients and Staff | | | | Yes | appendix B | | Yes |
| d | 5034 | **process by which the organisation aims to make changes as a result of formal complaints** | E | Complaints and Concerns Policy and Procedure for Patients and Staff | | | | Yes | section 24 | | Yes |
| e | 5038 | process for monitoring compliance with all of the above. | E | Complaints and Concerns Policy and Procedure for Patients and Staff | | | | Yes | section 31 | | Yes |
| | | | | | | | **Compliant** | **Yes** | | **Compliant** | **Yes** |
| **1.5.4** | 5040 | The organisation has approved documentation which describes the process for managing all claims in accordance with NHSLA requirements. | E | Claims Management Policy and Procedure | SCH Claims Management Policyratifiedfinal0310.doc | SCPCT/Policy/SCH/CS/003/V1<br>A - March 2010<br>R- March 2011 | SR | | | | |
| | | 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 |
| b | 5042 | NHSLA schemes relevant to the organisation (i.e. CNST, LTPS and PES) | E | Claims Management Policy and Procedure | | | | Yes | 3.3 | | Yes |
| c | 5043 | **action to be taken, including timescales** | E | Claims Management Policy and Procedure | | | | Yes | 3.4 | | Yes |
| d | 5044 | **communication with relevant stakeholders** | E | Claims Management Policy and Procedure | | | | Yes | 1,4, 1.5, | | Yes |
| e | 5048 | process for monitoring compliance with all of the above. | E | Claims Management Policy and Procedure | | | | Yes | section 7 | | Yes |
| | | | | | | | **Compliant** | **Yes** | | **Compliant** | **Yes** |
| **1.5.5** | 5050 | The organisation has approved documentation which describes the process for investigating all incidents, complaints and claims. | E | Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy | Incident ComplaintsConcerns Investigation Analysis Orgainsational Policy SCH V1 NHSLA Final 10.03.10.doc | SCPCT/policy/SCHRSK/004/ v2<br>a - march 2010<br>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 | 5052 | organisation's expectations in relation to staff training, as identified in the training needs analysis | E | Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy | | | | Yes | section 13 | | Yes |
| c | 5053 | **different levels of investigation appropriate to the severity of the event(s)** | E | Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy | | | | Yes | section 5 | | Yes |
| d | 5054 | 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 |
| e | 5055 | **process for following up relevant action plans** | E | Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy | | | | Yes | 14.7, 18.2, section 18 | | Yes |
| f | 5058 | process for monitoring compliance with all of the above. | E | Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy | | | | Yes | section 18 | | Yes |
| | | | | | | | **Compliant** | **Yes** | | **Compliant** | **Yes** |
| | | | | | | | | | | | |
| **1.5.6** | 5060 | The organisation has approved documentation which describes the process for ensuring a systematic approach to the aggregation of incidents, complaints and claims on an ongoing basis. | E | Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy | Incident ComplaintsConcerns Investigation Analysis Orgainsational Policy SCH V1 NHSLA Final 10.03.10.doc | SCPCT/policy/SCHRSK/ 004/ v2 a - march 2010 R - march 2011 | JH | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | |
| a | 5061 | duties | E | Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy | | | | Yes | section 3 | | Yes |
| b | 5062 | **coordinated approach to the aggregation of incidents, complaints and claims** | E | Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy | | | | Yes | section 12 | | Yes |
| c | 5063 | frequency with which an aggregated analysis of incidents, complaints and claims is to be completed | E | Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy | | | | Yes | section 12 | | Yes |
| d | 5064 | **minimum content required within the analysis report, including qualitative and quantitative analysis** | E | Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy | | | | Yes | section 12 | | Yes |
| e | 5065 | process for communicating this information to relevant individuals or groups | E | Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy | | | | Yes | section 12 | | Yes |
| f | 5068 | process for monitoring compliance with all of the above. | E | Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy | | | | Yes | section 18 | | Yes |
| | | | | | | | **Compliant** | **Yes** | | **Compliant** | **Yes** |
| | | | | | | | | | | | |
| **1.5.7** | 5070 | 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. | E | Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy | Incident ComplaintsConcerns Investigation Analysis Orgainsational Policy SCH V1 NHSLA Final 10.03.10.doc | SCPCT/policy/SCHRSK/ 004/ v2 a - march 2010 R - march 2011 | JH | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | |

| | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| a | 5071 | process by which the organisation ensures both local and organisational learning from incidents, complaints and claims | E | Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy | | | | Yes | section 14 | | Yes | | | | | |
| b | 5072 | opportunities for sharing lessons learnt from incidents, complaints and claims across the local health community | E | Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy | | | | Yes | section 14 incl 14.1 | | Yes | | | | | |
| c | 5073 | process by which the organisation ensures that lessons learnt from analysis result in a change in organisational culture and practice | E | Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy | | | | Yes | section 14 incl 14.10 | | Yes | | | | | |
| d | 5074 | **process for implementing risk reduction measures** | E | Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy | | | | Yes | section 3.5, 4.4, 8.6, 9.2, 10.22 | | Yes | | | | | |
| e | 5078 | process for monitoring compliance with all of the above. | E | Incident, Complaints / Concerns, Investigation, Analysis and Organisational Learning Policy | | | | Yes | section 18 | | Yes | | | | | |
| | | | | | | | **Compliant** | **Yes** | | **Compliant** | **Yes** | | | | | |
| | | | | | | | | | | | | | | | | |
| **1.5.8** | 5080 | The organisation has approved documentation which describes the process for ensuring that agreed best practice as defined in all NICE guidance (where appropriate), is taken into account in the context of the clinical services provided by the organisation. | E | Policy for the Implementation of National Guidance | SCH Implementation of national guidanceratifiedfinal0310.doc | SCPCT/Policy/SCH/CS/003 A - March 2010 R - March 2011 | AB | | | | | | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | | | | | | |
| a | 5081 | duties including leadership for all stages of the process | E | Policy for the Implementation of National Guidance | | | | Yes | section 4 | | Yes | | | | | |
| b | 5082 | process for identifying relevant documents | E | Policy for the Implementation of National Guidance | | | | Yes | 3.1 | | Yes | | | | | |
| c | 5083 | 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 | 5084 | process for conducting an organisational gap analysis | E | Policy for the Implementation of National Guidance | | | | Yes | appendix 1 and appendix 2 | | Yes | | | | | |
| e | 5085 | **process for ensuring that recommendations are acted upon throughout the organisation** | E | Policy for the Implementation of National Guidance | | | | Yes | 3.3 | | Yes | | | | | |
| f | 5086 | process for documenting any decision not to implement NICE recommendations | E | Policy for the Implementation of National Guidance | | | | Yes | 3.3.5 | | Yes | | | | | |
| g | 5088 | process for monitoring compliance with all of the above. | E | Policy for the Implementation of National Guidance | | | | Yes | section 7 | | Yes | | | | | |
| | | | | | | | **Compliant** | **Yes** | | **Compliant** | **Yes** | | | | | |
| | | | | | | | | | | | | | | | | |
| **1.5.9** | 5090 | The organisation has approved documentation which describes the process for ensuring that agreed best practice, as defined in nationally agreed guidance, the National Service Frameworks, National Confidential Enquiries and other High Level Enquiries that make recommendations for patient safety, is taken into account in the context of the clinical services provided by the organisation. | E | Policy for the Implementation of National Guidance | SCH Implementation of national guidanceratifiedfinal0310.doc | SCPCT/Policy/SCH/CS/003 A - March 2010 R - March 2011 | AB | | | | | | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | | | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| a | 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 | |
| c | 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 | | | | Yes | appendix 1 and appendix 2 | | No | |
| e | 5095 | **process for ensuring that 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 | | | | Yes | 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. | E | BEING OPEN POLICY | SCH-032 - Being Open PolicyV4 NHSLA Final 10 03 10.doc | SCPCT/policy/SCHRSKPES/ 032/ v1 A - March 10 R - March 2011 | | | | | | |
| | | As a minimum, the approved documentation must include a description of the: | | | | | | | | | | |
| a | 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 | |
| c | 5103 | requirements for truthfulness, timeliness and clarity of communication | E | BEING OPEN POLICY | | | | Yes | appendix 1 - communication | | Yes | |
| d | 5104 | provision of additional support as required | E | BEING OPEN POLICY | | | | Yes | appendix 1 - additional support | | Yes | |
| e | 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 | | | | Yes | section 8 | | Yes | |
| | | | | | | | **Compliant** | **Yes** | | **Compliant** | **Yes** | |
| | 9999 | | | | | | | | | | | |

**The following summary will be populated automatically from information entered on the worksheet.**

| | | |
|---|---|---|
| 1.5.1 | Yes | Yes |
| 1.5.2 | Yes | Yes |
| 1.5.3 | Yes | Yes |
| 1.5.4 | Yes | Yes |
| 1.5.5 | Yes | Yes |
| 1.5.6 | Yes | Yes |
| 1.5.7 | Yes | Yes |
| 1.5.8 | Yes | Yes |
| 1.5.9 | Yes | No |
| 1.5.10 | Yes | Yes |
| **Total** | **10** | **9** |

PHO119688-0057

**Cell:** B1
**Comment:** Admin Use Only

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

**Cell:** L1
**Comment:** Assessor Use Only

**Cell:** 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

| 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 for report? | Assessor's comments | Proposed Future Change | Rationale |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **2.1.1** | 1010 | 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** | 1020 | 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. | | | | | | | | | | | | | |
| | | | | | | | **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 | 1035 | reporting arrangements into the high level committee(s). | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| **2.1.4** | 1041 | The organisation can demonstrate 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 | 1042 | ensuring that all board members and senior managers receive relevant risk management awareness training | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Level 1 | 1044 | following up non-attendance. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | |
| **2.1.5** | 1051 | The organisation can demonstrate implementation of the approved documentation which describes the 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 | 1052 | assessing **strategic risks** | | | | | | | | | | | | | |
| Level 1 | 1053 | ensuring a continual, systematic approach to all risk assessments is followed throughout the organisation | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | |
| **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 | 1062 | incident reports | | | | | | | | | | | | | |
| Level 1 | 1062 | risk assessments | | | | | | | | | | | | | |
| Level 1 | 1062 | significant risks from directorate risk registers. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | |
| **2.1.7** | 1070 | The organisation can demonstrate implementation of 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 compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process for: | | | | | | | | | | | | | |
| Level 1 | 1073 | maintaining action plans to implement any recommendations made as a result of reviews. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | |
| **2.1.8** | 1080 | The organisation can demonstrate implementation of the approved documentation which describes the 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 | 1083 | tracking records | | | | | | | | | | | | | |
| Level 1 | 1086 | retaining and disposing of records. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **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 **ongoing** registration checks are made directly with the relevant professional body, in accordance with their recommendations, in respect of all permanent clinical staff. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | |
| **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: | | | | | | | | | | | 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: | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| 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** | | | **Compliant** | | | | | |

**The following summary will be populated automatically from information entered on the worksheet.**

| Standard | | | |
|---|---|---|---|
| 2.1.1 | 0 | 0 | |
| 2.1.2 | 0 | 0 | |
| 2.1.3 | 0 | 0 | |
| 2.1.4 | 0 | 0 | |
| 2.1.5 | 0 | 0 | |
| 2.1.6 | 0 | 0 | |
| 2.1.7 | 0 | 0 | |
| 2.1.8 | 0 | 0 | |
| 2.1.9 | 0 | 0 | |
| 2.1.10 | 0 | 0 | **All Standards Total** |
| **Total** | **0** | **0** | **44** |

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

PHO119688-0067

PHO119688-0068

**Cell:** B1
**Comment:** Admin Use Only

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

**Cell:** L1
**Comment:** Assessor Use Only

**Cell:** M1
**Comment:** Assessor Use Only

**Cell:** N1
**Comment:** Assessor Use Only

**Cell:** 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

| 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 | 2010 | 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 | 2014 | checking that all new permanent staff complete corporate induction | | | | | | | | | | | | | |
| Level 1 | 2015 | following up those who fail to attend corporate induction. | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | |
| 2.2.2 | 2020 | 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 | 2023 | checking that all new permanent staff complete local induction | | | | | | | | | | | | | |
| Level 1 | 2024 | following up those who fail to complete local induction. | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | |
| 2.2.3 | 2030 | 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 | 2033 | checking that all temporary staff complete local induction | | | | | | | | | | | | | |
| Level 1 | 2034 | following up those who fail to complete local induction. | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | |
| 2.2.4 | 2040 | 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: | | | | | | | | | | | | | |
| Level 1 | 2042 | process for ensuring checks are made | | | | | | | | | | | | | |
| #REF! | 2044 | procedure for notifying the NHSLA Family Health Service Appeal Unit in the event of concern. | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | |
| | | | | | | | | | | | | | | | |
| **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 compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process for: | | | | | | | | | | | The assessor will record below the two elements of risk management training selected at random to test the implementation of the bullet points: | | |
| | 2057 | | | | | | | | | | | | | | |
| | 2057 | | | | | | | | | | | | | | |
| Level 1 | 2054 | checking that all permanent staff complete the relevant training programmes in accordance with the training needs analysis | | | | | | | | | | | | | |
| Level 1 | 2055 | 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 | | | Compliant | | | | | |
| | | | | | | | | | | | | | | | |
| **2.2.6** | 2060 | The organisation can demonstrate the provision of the risk management training required by all permanent staff as identified in the training needs analysis at Level 1. | | | | | | | | | | | | | |
| | | The organisation can demonstrate the provision of the risk management training required by all permanent staff as identified in the training needs analysis at Level 1 by: | | | | | | | | | | | | | |
| Level 1 | 2064 | producing an annual training prospectus which reflects the training needs analysis. | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | |
| | | | | | | | | | | | | | | | |
| **2.2.7** | 2070 | The organisation can demonstrate implementation of the approved documentation which describes the process for ensuring that all permanent staff are trained to safely use diagnostic and therapeutic equipment appropriate to their role. | | | | | | | | | | | | | |
| | | The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process for: | | | | | | | | | | | | | |
| Level 1 | 2073 | identifying which permanent staff are authorised to use the equipment identified on the inventory | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Level 1 | 2074 | determining the training required to use the equipment identified on the inventory and the frequency of updates required | | | | | | | | | | | | | |
| Level 1 | 2075 | ensuring that the identified training needs of all permanent staff are met. | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | |
| **2.2.8** | 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 | 2082 | 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 | | | | | |
| **2.2.9** | 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 | 2092 | checking that all permanent staff, as identified in the training needs analysis, complete relevant moving and handling training | | | | | | | | | | | | | |
| Level 1 | 2093 | following up those who fail to attend relevant moving and handling training. | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | |
| **2.2.10** | 2100 | The organisation can demonstrate implementation of the approved documentation which describes the process for ensuring that all staff involved in traumatic/stressful incidents, complaints or claims are adequately supported. | | | | | | | | | | | | | |
| | | The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the: | | | | | | | | | | | | | |
| Level 1 | 2102 | immediate support offered to staff (internally and, if necessary, externally) | | | | | | | | | | | | | |
| Level 1 | 2105 | action for managers or individuals to take if the staff member is experiencing difficulties associated with the event. | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | |

**The following summary will be populated automatically from information entered on the worksheet.**

| Standard | | | |
|---|---|---|---|
| 2.2.1 | 0 | 0 | |
| 2.2.2 | 0 | 0 | |
| 2.2.3 | 0 | 0 | |
| 2.2.4 | 0 | 0 | |
| 2.2.5 | 0 | 0 | |
| 2.2.6 | 0 | 0 | |
| 2.2.7 | 0 | 0 | |
| 2.2.8 | 0 | 0 | |
| 2.2.9 | 0 | 0 | |
| 2.2.10 | 0 | 0 | **All Standards Total** |
| **Total** | **0** | **0** | **44** |

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

PHO119688-0079

PHO119688-0081

PHO119688-0084

**Cell:** B1
**Comment:** Admin Use Only

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

**Cell:** L1
**Comment:** Assessor Use Only

**Cell:** M1
**Comment:** Assessor Use Only

**Cell:** N1
**Comment:** Assessor Use Only

**Cell:** 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

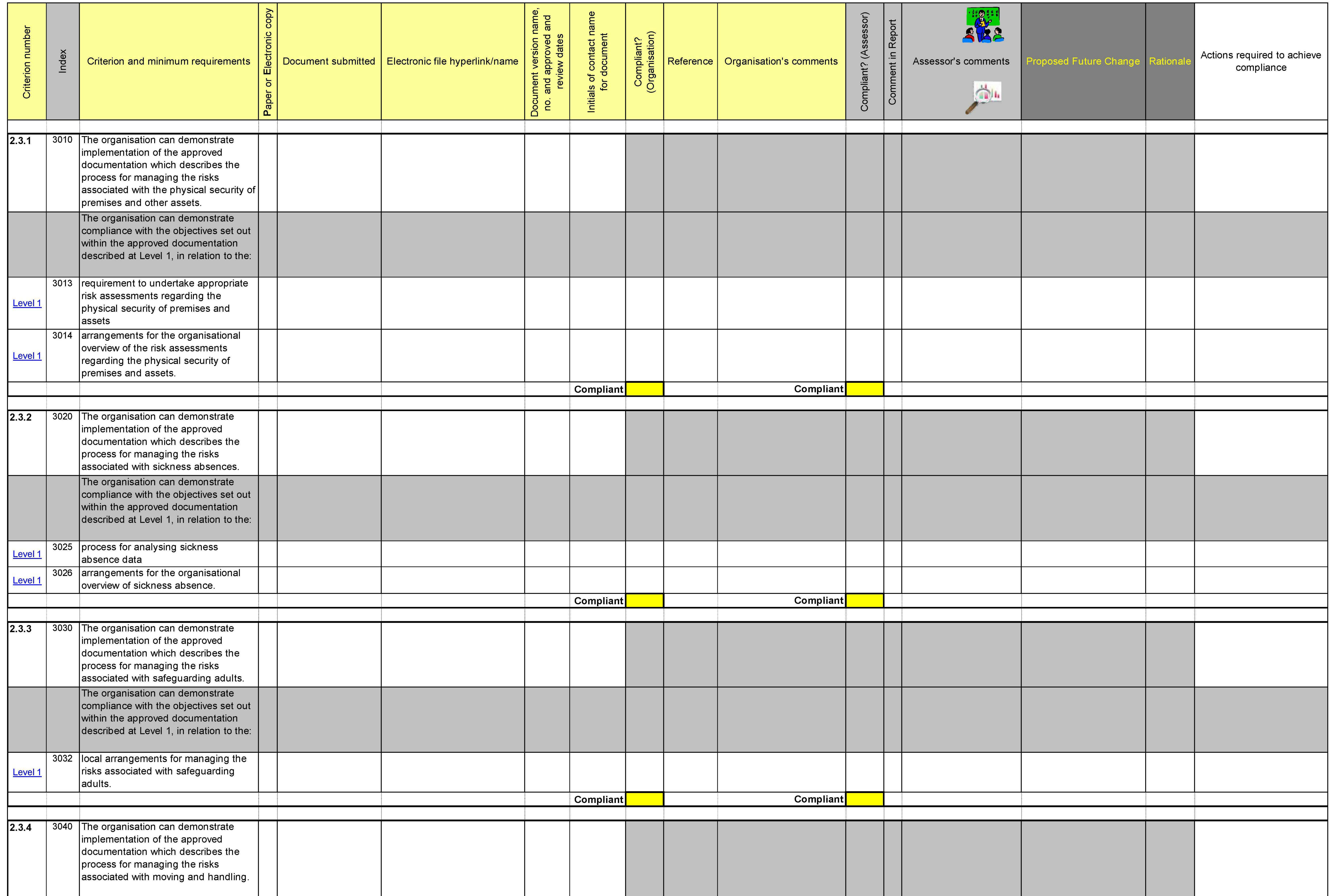
**Cell:** H74
**Comment:** Training needs analysis

**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



| 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 | Actions required to achieve compliance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2.3.1 | 3010 | The organisation can demonstrate 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 | 3013 | requirement to undertake appropriate risk assessments regarding the physical security of premises and assets | | | | | | | | | | | | | | |
| Level 1 | 3014 | arrangements for the organisational overview of the risk assessments regarding the physical security of premises and assets. | | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | | |
| 2.3.2 | 3020 | 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 | 3025 | process for analysing sickness absence data | | | | | | | | | | | | | | |
| Level 1 | 3026 | arrangements for the organisational overview of sickness absence. | | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | | |
| 2.3.3 | 3030 | 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 | 3032 | local arrangements for managing the risks associated with safeguarding adults. | | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | | |
| 2.3.4 | 3040 | 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: | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Level 1 | 3044 | requirement to undertake appropriate risk assessments for the moving and handling of patients and objects | | | | | | | | | | | | | | |
| Level 1 | 3045 | arrangements for the organisational overview of the risk assessments for the moving and handling of patients and objects. | | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | | |
| | | | | | | | | | | | | | | | | |
| 2.3.5 | 3050 | The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks associated with slips, trips and falls involving patients, staff and others. | | | | | | | | | | | | | | |
| | | The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the: | | | | | | | | | | | | | | |
| Level 1 | 3052 | requirement to undertake appropriate risk assessments for the management of slips, trips and falls involving patients (including falls from height) | | | | | | | | | | | | | | |
| Level 1 | 3053 | requirement to undertake appropriate risk assessments for the management of slips, trips and falls involving staff and others (including falls from height). | | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | | |
| | | | | | | | | | | | | | | | | |
| 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. | | | | | | | | | | | | | | |
| | | The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process for: | | | | | | | | | | | | | | |
| Level 1 | 3063 | the management of an inoculation incident (including prophylaxis). | | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | | |
| | | | | | | | | | | | | | | | | |
| 2.3.7 | 3070 | The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks associated with the maintenance of reusable medical devices and equipment. | | | | | | | | | | | | | | |
| | | The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process for: | | | | | | | | | | | | | | |
| Level 1 | 3073 | ensuring that all reusable medical devices and equipment are properly maintained and repaired. | | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | | |
| | | | | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **2.3.8** | 3080 | The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks associated with the harassment and/or bullying of staff. | | | | | | | | | | | | | | |
| | | 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 | 3083 | for raising concerns about harassment and/or bullying | | | | | | | | | | | | | | |
| Level 1 | 3084 | to be followed once a concern has been raised. | | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | | |
| | | | | | | | | | | | | | | | | |
| **2.3.9** | 3090 | The organisation can demonstrate implementation of 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 compliance with the objectives set out within the approved documentation described at Level 1, in relation to the: | | | | | | | | | | | | | | |
| Level 1 | 3092.1 | requirement to undertake appropriate risk assessments for the prevention and management of violence and aggression | | | | | | | | | | | | | | |
| Level 1 | 3093 | arrangements for ensuring the safety of lone workers. | | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | | |
| | | | | | | | | | | | | | | | | |
| **2.3.10** | 3100 | The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks associated with work-related stress. | | | | | | | | | | | | | | |
| | | The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the: | | | | | | | | | | | | | | |
| Level 1 | 3113 | process for identifying workplace stressors | | | | | | | | | | | | | | |
| Level 1 | 3114 | requirement to undertake appropriate risk assessments for the prevention and management of work-related stress. | | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | | |
| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | | | | **The following summary will be populated automatically from information entered on the worksheet.** | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | | | | | | | 2.3.1 | 0 | | | 0 | | | | | |
| | | | | | | | 2.3.2 | 0 | | | 0 | | | | | |
| | | | | | | | 2.3.3 | 0 | | | 0 | | | | | |
| | | | | | | | 2.3.4 | 0 | | | 0 | | | | | |
| | | | | | | | 2.3.5 | 0 | | | 0 | | | | | |
| | | | | | | | 2.3.6 | 0 | | | 0 | | | | | |
| | | | | | | | 2.3.7 | 0 | | | 0 | | | | | |
| | | | | | | | 2.3.8 | 0 | | | 0 | | | | | |
| | | | | | | | 2.3.9 | 0 | | | 0 | | | | | |
| | | | | | | | 2.3.10 | 0 | | | 0 | | **All Standards Total** | | | |
| | | | | | | | **Total** | **0** | | | **0** | | **44** | | | |

| Person/ Committee responsible | Target Date | Associated Cost |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Cell:** B1
**Comment:** Admin Use Only

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

**Cell:** L1
**Comment:** Assessor Use Only

**Cell:** M1
**Comment:** Assessor Use Only

**Cell:** N1
**Comment:** Assessor Use Only

**Cell:** H63
**Comment:** Secure environment

**Cell:** H64
**Comment:** Sickness absence

**Cell:** H65
**Comment:** Safeguarding adults

**Cell:** H66
**Comment:** Moving & handling

**Cell:** H67
**Comment:** Slips, trips & falls

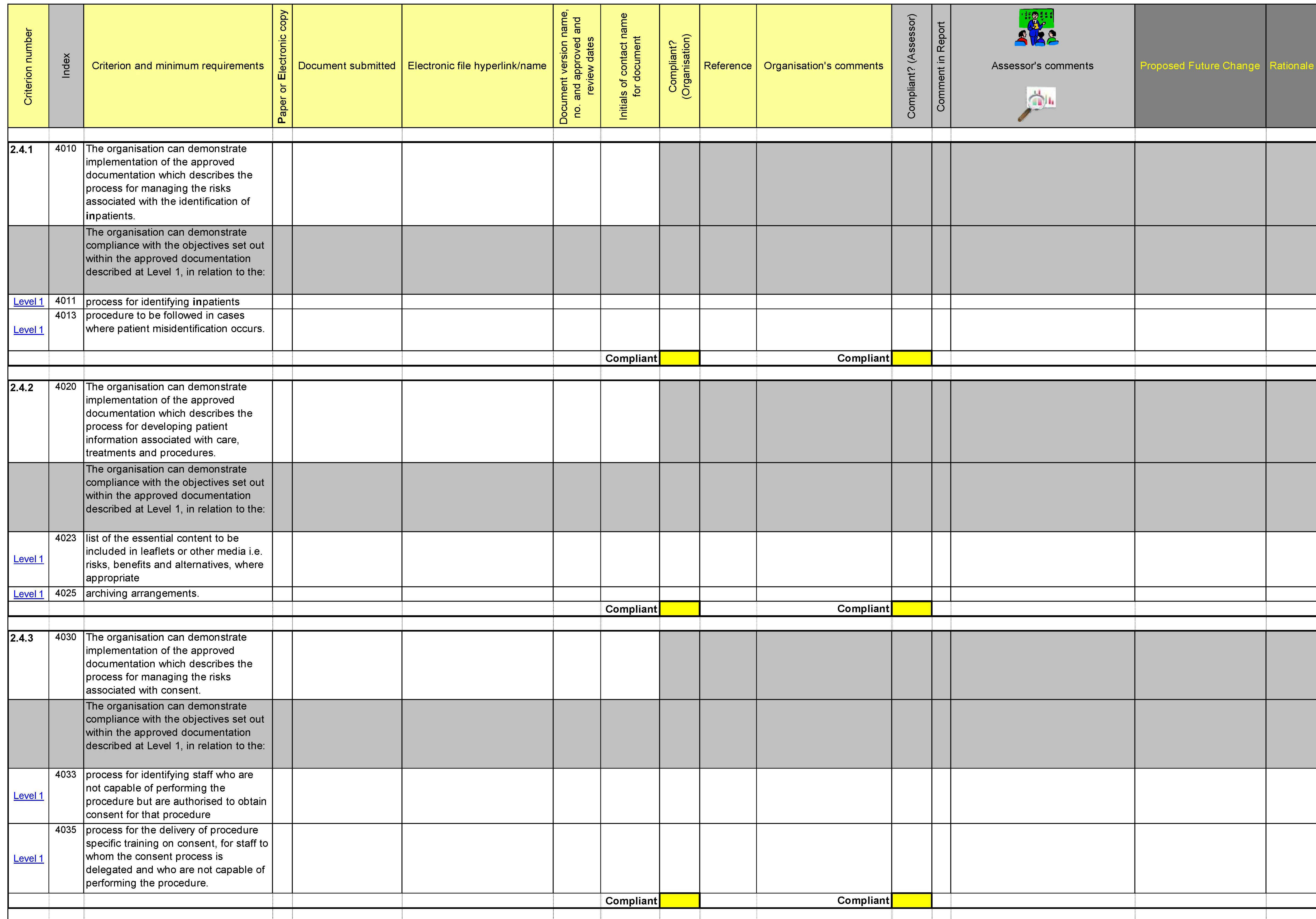
**Cell:** H68
**Comment:** Inoculation incidents

**Cell:** H69
**Comment:** Maintenance of medical devices & equipment

**Cell:** H70
**Comment:** Harassment & bullying

**Cell:** H71
**Comment:** Violence & aggression

**Cell:** H72
**Comment:** Stress



| Criterion number | Index | Criterion and minimum requirements | Paper or Electronic copy | Document submitted | Electronic file hyperlink/name | Document version name, 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **2.4.1** | 4010 | The organisation can demonstrate implementation of the approved documentation which describes the process for managing the risks associated with the identification of **in**patients. | | | | | | | | | | | | | |
| | | The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the: | | | | | | | | | | | | | |
| Level 1 | 4011 | process for identifying **in**patients | | | | | | | | | | | | | |
| Level 1 | 4013 | procedure to be followed in cases where patient misidentification occurs. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| **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. | | | | | | | | | | | | | |
| | | 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 | | | | | | | | | | | | | |
| Level 1 | 4025 | archiving arrangements. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| **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 | | | | | | | | | | | | | |
| Level 1 | 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. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **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: | | | | | | | | | | | | | |
| Level 1 | 4044 | format for all audit reports i.e. methodology, conclusions, action plans, etc. | | | | | | | | | | | | | |
| Level 1 | 4045 | arrangements for the review of action plans. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | |
| **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: | | | | | | | | | | | The assessor will select two patient groups at random to assess the organisation's compliance with the above minimum requirements. | | |
| | | | | | | | | | | | | | | | |
| Level 1 | 4052 | transfer requirements which are 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** | | | **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: | | | | | | | | | | | | | |
| Level 1 | 4061.1 | process for ensuring the accuracy of all prescription charts. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | |
| **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 | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Level 1 | 4074 | care of patient(s) receiving transfusion. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| **2.4.8** | 4080 | The organisation can demonstrate 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: | | | | | | | | | | | | | |
| Level 1 | 4082 | early warning systems in place for the recognition of patients at risk of cardio-respiratory arrest | | | | | | | | | | | | | |
| Level 1 | 4084 | do not attempt resuscitation orders (DNAR). | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **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: | | | | | | | | | | | | | |
| Level 1 | 4092 | infection control assurance framework. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| **2.4.10** | 4100 | The organisation can demonstrate implementation of the approved documentation which describes the organisation-wide process for developing local policies to manage the risks associated with the process of clinical diagnostic tests and screening procedures. | | | | | | | | | | | | | |
| | | The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process for: | | | | | | | | | | | | | |
| Level 1 | 4102 | taking action on test and screening results | | | | | | | | | | | | | |
| Level 1 | 4104 | the communication of clinical test and screening results. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |

**The following summary will be populated automatically from information entered on the worksheet.**

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | 2.4.1 | 0 | | | 0 | | | | |
| | | | | | | | 2.4.2 | 0 | | | 0 | | | | |
| | | | | | | | 2.4.3 | 0 | | | 0 | | | | |
| | | | | | | | 2.4.4 | 0 | | | 0 | | | | |
| | | | | | | | 2.4.5 | 0 | | | 0 | | | | |
| | | | | | | | 2.4.6 | 0 | | | 0 | | | | |
| | | | | | | | 2.4.7 | 0 | | | 0 | | | | |
| | | | | | | | 2.4.8 | 0 | | | 0 | | | | |
| | | | | | | | 2.4.9 | 0 | | | 0 | | | | |
| | | | | | | | 2.4.10 | 0 | | | 0 | | **All Standards Total** | | |
| | | | | | | | **Total** | **0** | | | **0** | | **44** | | |

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

**Cell:** B1
**Comment:** Admin Use Only

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

**Cell:** L1
**Comment:** Assessor Use Only

**Cell:** M1
**Comment:** Assessor Use Only

**Cell:** N1
**Comment:** Assessor Use Only

**Cell:** 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

| 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** | 5010 | 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 | 5012 | all incidents/near misses, involving staff, patients and others | | | | | | | | | | | | | |
| Level 1 | 5013 | to external agencies. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | |
| **2.5.2** | 5020 | 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 | 5022 | for raising concerns (informal complaints/PALS) | | | | | | | | | | | | | |
| Level 1 | 5024 | by which the organisation aims to make changes as a result of concerns being raised. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | |
| **2.5.3** | 5030 | 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 | 5032 | complaints management process, which includes internal and external communication, and collaboration with other organisations when necessary | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Level 1 | 5034 | process by which the organisation aims to make changes as a result of formal complaints. | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | |
| | | | | | | | | | | | | | | | |
| **2.5.4** | 5040 | The organisation can demonstrate implementation of the approved documentation which describes the process for managing all claims in accordance with NHSLA requirements. | | | | | | | | | | | | | |
| | | The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the: | | | | | | | | | | | | | |
| Level 1 | 5043 | action to be taken, including timescales | | | | | | | | | | | | | |
| Level 1 | 5044 | communication with relevant stakeholders. | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | |
| | | | | | | | | | | | | | | | |
| **2.5.5** | 5050 | The organisation can demonstrate implementation of the approved documentation which describes the process for investigating all incidents, complaints and claims. | | | | | | | | | | | | | |
| | | The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the: | | | | | | | | | | | | | |
| Level 1 | 5053 | different levels of investigation appropriate to the severity of the event(s) | | | | | | | | | | | | | |
| Level 1 | 5055 | process for following up relevant action plans. | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | |
| | | | | | | | | | | | | | | | |
| **2.5.6** | 5060 | The organisation can demonstrate implementation of the approved documentation which describes the process for ensuring a systematic approach to the aggregation of incidents, complaints and claims on an ongoing basis. | | | | | | | | | | | | | |
| | | The organisation can demonstrate compliance with the objectives set out within the approved documentation described at Level 1, in relation to the: | | | | | | | | | | | | | |
| Level 1 | 5062 | coordinated approach to the aggregation of incidents, complaints and claims | | | | | | | | | | | | | |
| Level 1 | 5064 | minimum content required within the analysis report, including qualitative and quantitative analysis. | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | |
| | | | | | | | | | | | | | | | |
| **2.5.7** | 5070 | The organisation can demonstrate implementation of the 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. | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 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 ensures: | | | | | | | | | | | | | |
| Level 1 | 5074 | the implementation of risk reduction measures. | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | |
| **2.5.8** | 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 compliance with the objectives set out within the approved documentation described at Level 1, in relation to the process for: | | | | | | | | | | | The assessor will select two clinical guidelines from the list to assess the organisation's compliance with the above minimum requirement. | | |
| Level 1 | 5085 | ensuring that recommendations are 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 | | | | | |
| **2.5.9** | 5090 | The organisation can demonstrate 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: | | | | | | | | | | | | | |
| Level 1 | 5095 | ensuring that recommendations are acted upon throughout the organisation. | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | |
| **2.5.10** | 5100 | The organisation can demonstrate implementation of 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 compliance with the objectives set out within the approved documentation described at Level 1, in relation to the: | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Level 1 | 5101 | process for encouraging open communication between healthcare organisations, healthcare teams, staff and patients and/or their carers | | | | | | | | | | | | | |
| Level 1 | 5105 | requirements for documenting all communication. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| **The following summary will be populated automatically from information entered on the worksheet.** | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | 2.5.1 | 0 | | | 0 | | | | |
| | | | | | | | 2.5.2 | 0 | | | 0 | | | | |
| | | | | | | | 2.5.3 | 0 | | | 0 | | | | |
| | | | | | | | 2.5.4 | 0 | | | 0 | | | | |
| | | | | | | | 2.5.5 | 0 | | | 0 | | | | |
| | | | | | | | 2.5.6 | 0 | | | 0 | | | | |
| | | | | | | | 2.5.7 | 0 | | | 0 | | | | |
| | | | | | | | 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 |
|---|---|---|---|
| | | | |

**Cell:** B1
**Comment:** Admin Use Only

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

**Cell:** L1
**Comment:** Assessor Use Only

**Cell:** M1
**Comment:** Assessor Use Only

**Cell:** N1
**Comment:** Assessor Use Only

**Cell:** 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

| 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | |
| 3.1.1 | 1010 | The organisation can demonstrate that there are processes in place to monitor compliance with the approved organisation-wide risk management strategy. | | | | | | | | | | | | | |
| | | 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 | 1013 | the management of risk locally, which reflects the organisation-wide risk management strategy. | | | | | | | | | | | | | |
| | 1019 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | |
| | | | | | | | | | | | | | | | |
| 3.1.2 | 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. | | | | | | | | | | | | | |
| | | 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 | 1024 | ratification process | | | | | | | | | | | | | |
| 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 | | | 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. | | | | | | | | | | | | | |
| | | 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 | 1032.1 | reporting arrangements to the board | | | | | | | | | | | | | |
| Level 1 | 1035 | reporting arrangements into the high level committee(s). | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1039 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | |
| **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: | | | | | | | | | | | | | |
| Level 1 | 1042 | ensuring that all board members and senior managers receive relevant risk management awareness training | | | | | | | | | | | | | |
| Level 1 | 1044 | following up non-attendance. | | | | | | | | | | | | | |
| | 1049 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | |
| **3.1.5** | 1050 | The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the organisation-wide systematic risk management process. | | | | | | | | | | | | | |
| | | The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process for: | | | | | | | | | | | | | |
| Level 1 | 1055 | assessing strategic risks | | | | | | | | | | | | | |
| Level 1 | 1053 | ensuring a continual, systematic approach to all risk assessments is followed throughout the organisation. | | | | | | | | | | | | | |
| | 1059 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | |
| **3.1.6** | 1060 | The organisation can demonstrate that the organisation-wide risk register is a dynamic document. | | | | | | | | | | | | | |
| Level 1 | 1067 | The organisation can demonstrate that it is monitoring the approved organisation-wide risk register. | | | | | | | | | | | | | |
| | 1069 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **3.1.7** | 1070 | The organisation can demonstrate that 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: | | | | | | | | | | | | | |
| Level 1 | 1073 | maintaining action plans to implement any recommendations made as a result of reviews. | | | | | | | | | | | | | |
| | 1079 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | |
| **3.1.8** | 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 | 1083 | tracking records | | | | | | | | | | | | | |
| Level 1 | 1086 | 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. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | |
| **3.1.9** | 1090 | 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 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: | | | | | | | | | | | | | |
| Level 1 | 1092 | 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 appointment and ongoing thereafter | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Level 1 | 1093.1 | monitoring/receiving assurance that registration checks are being carried out by all external agencies (e.g. NHS Professionals, recruitment agencies, etc.) used by the organisation in respect of all temporary clinical staff. | | | | | | | | | | | | | |
| | 1099 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | |
| **3.1.10** | 1100 | 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 appropriate employment checks are undertaken for all staff (temporary and permanent). | | | | | | | | | | | | | |
| | | The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the: | | | | | | | | | | | 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. | | |
| | 1107 | | | | | | | | | | | | | | |
| | 1107 | | | | | | | | | | | | | | |
| Level 1 | 1102 | types of check required. | | | | | | | | | | | | | |
| | 1109 | 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** | | | | | |

**The following summary will be populated automatically from information entered on the worksheet.**

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | 3.1.1 | 0 | | | 0 | | | | |
| | | | | | | | 3.1.2 | 0 | | | 0 | | | | |
| | | | | | | | 3.1.3 | 0 | | | 0 | | | | |
| | | | | | | | 3.1.4 | 0 | | | 0 | | | | |
| | | | | | | | 3.1.5 | 0 | | | 0 | | | | |
| | | | | | | | 3.1.6 | 0 | | | 0 | | | | |
| | | | | | | | 3.1.7 | 0 | | | 0 | | | | |
| | | | | | | | 3.1.8 | 0 | | | 0 | | | | |
| | | | | | | | 3.1.9 | 0 | | | 0 | | | | |
| | | | | | | | 3.1.10 | 0 | | | 0 | | **All Standards Total** | | |
| | | | | | | | **Total** | **0** | | | **0** | | **44** | | |

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

**Cell:** B1
**Comment:** Admin Use Only

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

**Cell:** L1
**Comment:** Assessor Use Only

**Cell:** M1
**Comment:** Assessor Use Only

**Cell:** N1
**Comment:** Assessor Use Only

**Cell:** 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** | 2010 | 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: | | | | | | | | | | | | | |
| Level 1 | 2014 | checking that all new permanent staff complete corporate induction | | | | | | | | | | | | | |
| Level 1 | 2015 | following up those who fail to attend corporate induction. | | | | | | | | | | | | | |
| | 2019 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | |
| **3.2.2** | 2020 | 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 | 2023 | checking that all new permanent staff complete local induction | | | | | | | | | | | | | |
| Level 1 | 2024 | following up those who fail to complete local induction. | | | | | | | | | | | | | |
| | 2029 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | |
| **3.2.3** | 2030 | 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 | 2033 | checking that all temporary staff complete local induction | | | | | | | | | | | | | |
| Level 1 | 2034 | following up those who fail to complete local induction. | | | | | | | | | | | | | |
| | 2039 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | |
| **3.2.4** | 2040 | The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for ensuring that the organisation undertakes the appropriate regulatory checks via the NHSLA Family Health Service Appeal Unit on all primary care performers (temporary and permanent). | | | | | | | | | | | | | |
| | | The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the: | | | | | | | | | | | | | |
| Level 1 | 2042 | process for ensuring checks are made | | | | | | | | | | | | | |
| #REF! | 2044 | procedure for notifying the NHSLA Family Health Service Appeal Unit in the event of concern. | | | | | | | | | | | | | |
| | 2049 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | |
| **3.2.5** | 2050 | The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for ensuring a systematic approach to risk management training for all permanent staff. | | | | | | | | | | | | | |
| | | The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process for: | | | | | | | | | | | 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. | | |
| | 2057 | | | | | | | | | | | | | | |
| | 2057 | | | | | | | | | | | | | | |
| Level 1 | 2054 | checking that all permanent staff complete the relevant training programmes in accordance with the training needs analysis | | | | | | | | | | | | | |
| Level 1 | 2055 | following up those who fail to attend relevant training programmes. | | | | | | | | | | | | | |
| | 2059 | 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 risk management training from the TNA Minimum Data Set at random to assess the organisation's compliance with the above minimum requirements. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | |
| **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: | | | | | | | | | | | | | |
| Level 1 | 2065 | producing an annual training report covering all the topics identified within the TNA Minimum Data Set. | | | | | | | | | | | | | |
| | 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: | | | | | | | | | | | | | |
| Level 1 | 2073 | identifying which permanent staff are authorised to use the equipment identified on the inventory | | | | | | | | | | | | | |
| Level 1 | 2074 | determining the training required to use the equipment identified on the inventory and the frequency of updates required | | | | | | | | | | | | | |
| Level 1 | 2075 | ensuring that the identified training needs of all permanent staff are met. | | | | | | | | | | | | | |
| | 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** | | | | | |
| | | | | | | | | | | | | | | | |
| **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. | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 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 | 2082 | 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. | | | | | | | | | | | | | |
| | 2089 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | |
| | | | | | | | | | | | | | | | |
| **3.2.9** | 2090 | 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 moving and handling training to all 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 | 2092 | checking that all permanent staff, as identified in the training needs analysis, complete relevant moving and handling training | | | | | | | | | | | | | |
| Level 1 | 2093 | following up those who fail to attend relevant moving and handling training. | | | | | | | | | | | | | |
| | 2099 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | |
| | | | | | | | | | | | | | | | |
| **3.2.10** | 2100 | 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 staff involved in traumatic/stressful incidents, complaints or claims are adequately supported. | | | | | | | | | | | | | |
| | | 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 | 2102 | immediate support offered to staff (internally and, if necessary, externally) | | | | | | | | | | | | | |
| Level 1 | 2105 | action for managers or individuals to take if the staff member is experiencing difficulties associated with the event. | | | | | | | | | | | | | |

| | 2109 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |

**The following summary will be populated automatically from information entered on the worksheet.**

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | 3.2.1 | 0 | | | 0 | | | | |
| | | | | | | | 3.2.2 | 0 | | | 0 | | | | |
| | | | | | | | 3.2.3 | 0 | | | 0 | | | | |
| | | | | | | | 3.2.4 | 0 | | | 0 | | | | |
| | | | | | | | 3.2.5 | 0 | | | 0 | | | | |
| | | | | | | | 3.2.6 | 0 | | | 0 | | | | |
| | | | | | | | 3.2.7 | 0 | | | 0 | | | | |
| | | | | | | | 3.2.8 | 0 | | | 0 | | | | |
| | | | | | | | 3.2.9 | 0 | | | 0 | | | | |
| | | | | | | | 3.2.10 | 0 | | | 0 | | **All Standards Total** | | |
| | | | | | | | **Total** | **0** | | | **0** | | **44** | | |

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

PHO119688-0133

PHO119688-0136

PHO119688-0140

PHO119688-0145

**Cell:** B1
**Comment:** Admin Use Only

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

**Cell:** L1
**Comment:** Assessor Use Only

**Cell:** M1
**Comment:** Assessor Use Only

**Cell:** N1
**Comment:** Assessor Use Only

**Cell:** 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

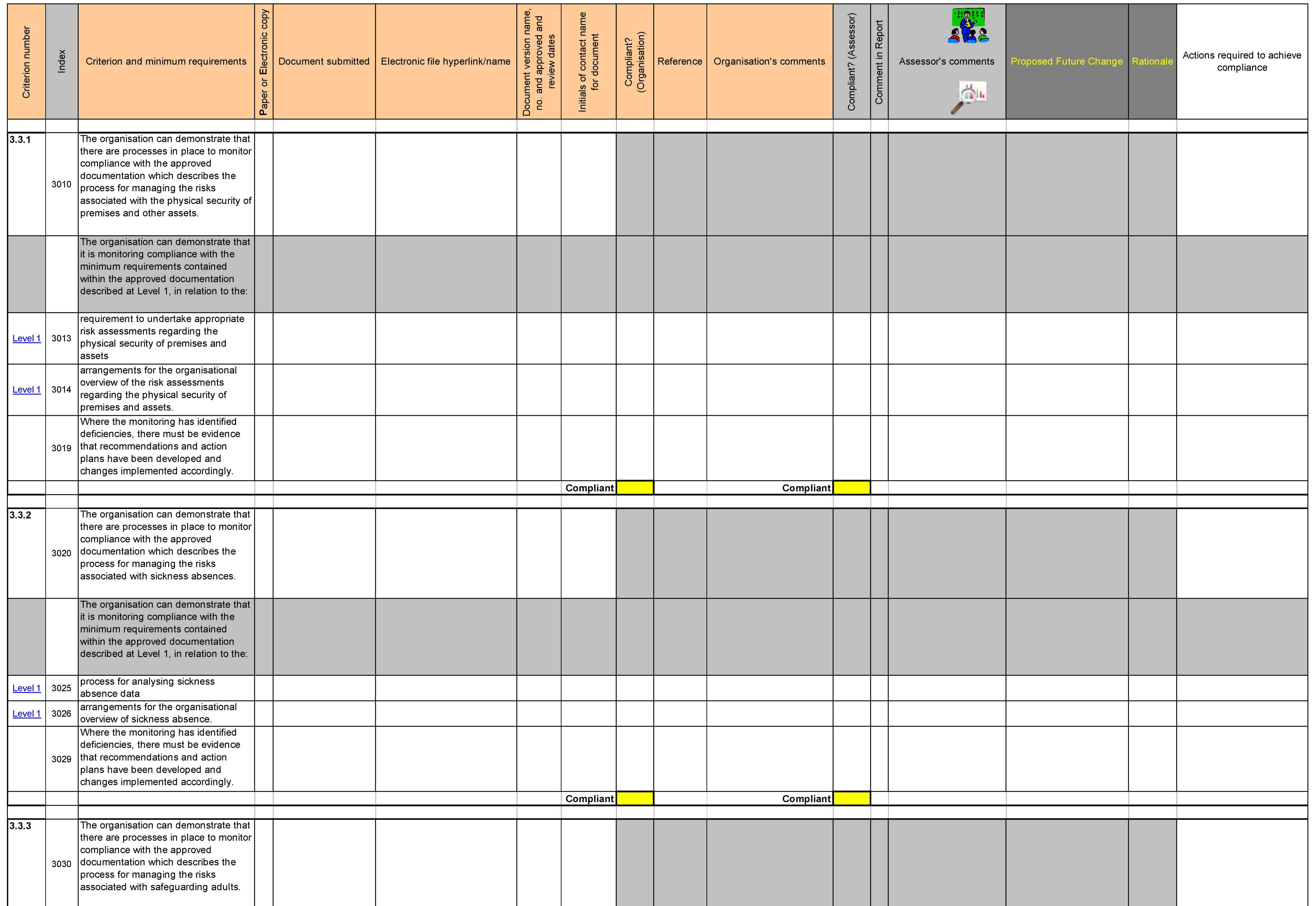
**Cell:** H84
**Comment:** Training needs analysis

**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



| 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 | 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 | requirement to undertake appropriate risk assessments regarding the physical security of premises and 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 | 3026 | arrangements for the organisational overview of sickness absence. | | | | | | | | | | | | | | |
| | 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. | | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 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 | 3032 | local arrangements for managing the risks associated with safeguarding adults. | | | | | | | | | | | | | | |
| | 3039 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | | |
| **3.3.4** | 3040 | 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 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: | | | | | | | | | | | | | | |
| Level 1 | 3044 | requirement to undertake appropriate risk assessments for the moving and handling of patients and objects | | | | | | | | | | | | | | |
| Level 1 | 3045 | arrangements for the organisational overview of the risk assessments for the moving and handling of patients and objects. | | | | | | | | | | | | | | |
| | 3049 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | | |
| **3.3.5** | 3050 | 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 slips, trips and falls involving patients, staff and others. | | | | | | | | | | | | | | |
| | | 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 | 3052 | requirement to undertake appropriate risk assessments for the management of slips, trips and falls involving patients (including falls from height) | | | | | | | | | | | | | | |
| Level 1 | 3053 | requirement to undertake appropriate risk assessments for the management of slips, trips and falls involving staff and others (including falls from height). | | | | | | | | | | | | | | |

PHO119688-0149



| | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 3059 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | | Compliant | | | | | | |
| | | | | | | | | | | | | | | | | | |
| **3.3.6** | 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. | | | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | | 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. | | | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | | 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 | 3084 | to be followed once a concern has been raised. | | | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 3089 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | | |
| **3.3.9** | 3090 | 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: | | | | | | | | | | | | | | |
| Level 1 | 3092.1 | requirement to undertake appropriate risk assessments for the prevention and management of violence and aggression | | | | | | | | | | | | | | |
| Level 1 | 3093 | arrangements for ensuring the safety of lone workers. | | | | | | | | | | | | | | |
| | 3099 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | | |
| **3.3.10** | 3100 | 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 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: | | | | | | | | | | | | | | |
| Level 1 | 3113 | process for identifying workplace stressors | | | | | | | | | | | | | | |
| Level 1 | 3114 | requirement to undertake appropriate risk assessments for the prevention and management of work-related stress. | | | | | | | | | | | | | | |
| | 3119 | 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 following summary will be populated automatically from information entered on the worksheet.**

| | | |
|---|---|---|
| 3.3.1 | 0 | 0 |
| 3.3.2 | 0 | 0 |
| 3.3.3 | 0 | 0 |
| 3.3.4 | 0 | 0 |
| 3.3.5 | 0 | 0 |
| 3.3.6 | 0 | 0 |
| 3.3.7 | 0 | 0 |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | 3.3.8 | 0 | | 0 | | | | | |
| | | | | | | | 3.3.9 | 0 | | 0 | | | | | |
| | | | | | | | 3.3.10 | 0 | | 0 | | **All Standards Total** | | | |
| | | | | | | | **Total** | **0** | | **0** | | **44** | | | |

| Person/ Committee responsible | Target Date | Associated Cost |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

PHO119688-0155

**Cell:** B1
**Comment:** Admin Use Only

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

**Cell:** L1
**Comment:** Assessor Use Only

**Cell:** M1
**Comment:** Assessor Use Only

**Cell:** N1
**Comment:** Assessor Use Only

**Cell:** 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

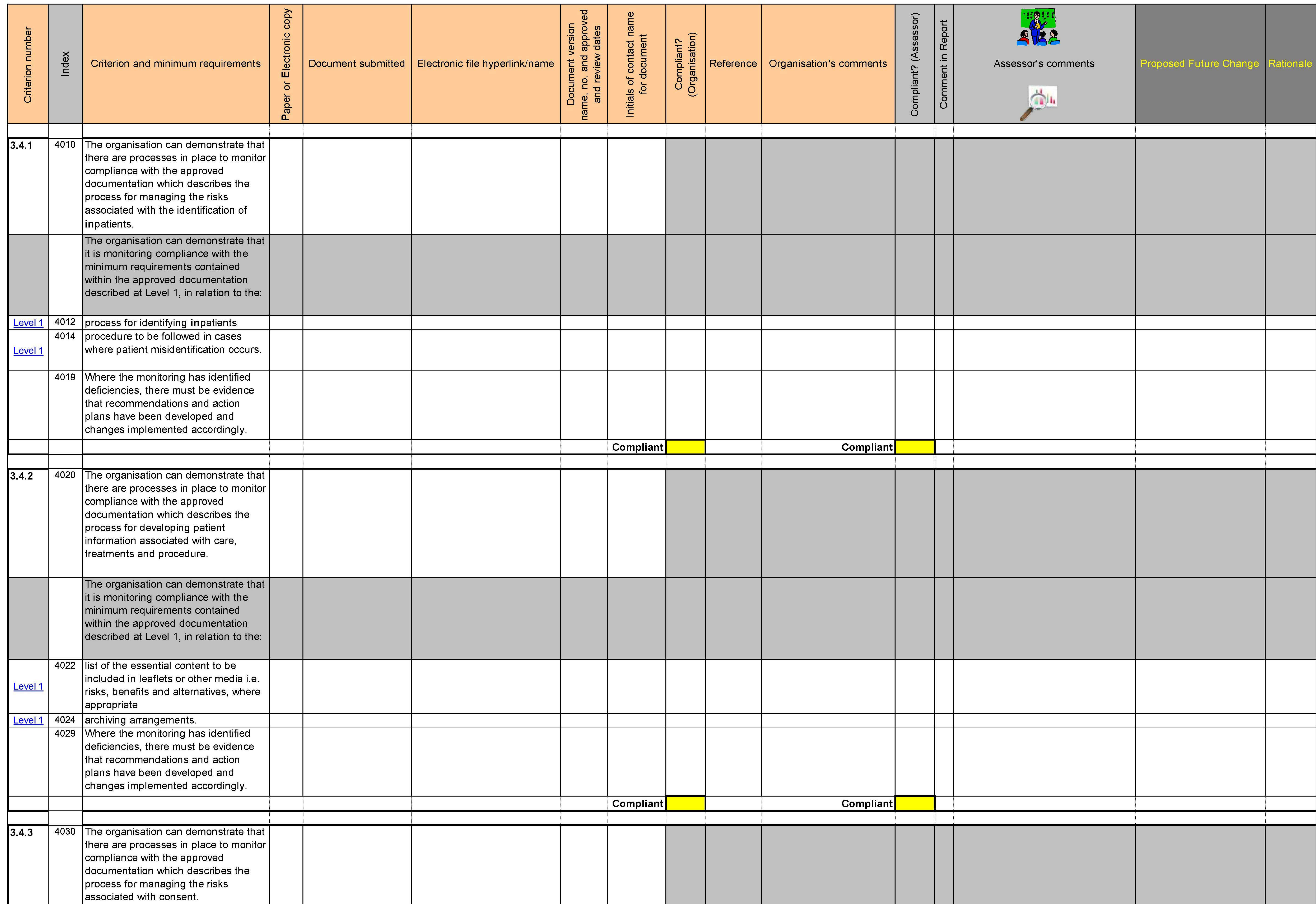
**Cell:** H78
**Comment:** Inoculation incidents

**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** | 4010 | 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 **in**patients. | | | | | | | | | | | | | |
| | | 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 | 4012 | process for identifying **in**patients | | | | | | | | | | | | | |
| Level 1 | 4014 | procedure to be followed in cases where patient misidentification occurs. | | | | | | | | | | | | | |
| | 4019 | 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** | 4020 | 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 | 4022 | list of the essential content to be included in leaflets or other media i.e. risks, benefits and alternatives, where appropriate | | | | | | | | | | | | | |
| Level 1 | 4024 | archiving arrangements. | | | | | | | | | | | | | |
| | 4029 | 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** | 4030 | 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: | | | | | | | | | | | | | |
| Level 1 | 4033 | process for identifying staff who are not capable of performing the procedure but are authorised to obtain consent for that procedure | | | | | | | | | | | | | |
| Level 1 | 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. | | | | | | | | | | | | | |
| | 4039 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | |
| **3.4.4** | 4040 | The organisation can demonstrate that 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: | | | | | | | | | | | | | |
| Level 1 | 4044 | format for all audit reports i.e. methodology, conclusions, action plans, etc. | | | | | | | | | | | | | |
| Level 1 | 4045 | arrangements for the review of action plans. | | | | | | | | | | | | | |
| | 4049 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | |
| **3.4.5** | 4050 | 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 transfer of patients. | | | | | | | | | | | | | |
| | | 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: | | | | | | | | | | | The assessor will select two patient groups at random to assess the organisation's compliance with the above minimum requirements. | | |
| | 4057 | | | | | | | | | | | | | | |
| | 4057 | | | | | | | | | | | | | | |
| Level 1 | 4052 | transfer requirements which are specific to each patient group | | | | | | | | | | | | | |
| Level 1 | 4053 | documentation to accompany the patient when being transferred. | | | | | | | | | | | | | |

PHO119688-0160



| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 4059 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | |
| | | The assessor will select two patient groups at random to assess the organisation's compliance with the above minimum requirements. | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | |
| | | | | | | | | | | | | | | | |
| **3.4.6** | 4060 | The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for managing the risks associated with medicines in all care environments. | | | | | | | | | | | | | |
| | | The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the: | | | | | | | | | | | | | |
| Level 1 | 4061.1 | process for ensuring the accuracy of all prescription charts. | | | | | | | | | | | | | |
| | 4069 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | |
| | | | | | | | | | | | | | | | |
| **3.4.7** | 4070 | 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 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: | | | | | | | | | | | | | |
| Level 1 | 4073 | process for the administration of blood and blood products | | | | | | | | | | | | | |
| Level 1 | 4074 | care of patient(s) receiving transfusion. | | | | | | | | | | | | | |
| | 4079 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | |
| | | | | | | | | | | | | | | | |
| **3.4.8** | 4080 | The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for managing the risks associated with resuscitation. | | | | | | | | | | | | | |
| | | 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 | 4082 | early warning systems in place for the recognition of patients at risk of cardio-respiratory arrest | | | | | | | | | | | | | |
| Level 1 | 4084 | do not attempt resuscitation orders (DNAR). | | | | | | | | | | | | | |
| | 4089 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | |
| | | | | | | | | | | | | | | | |
| **3.4.9** | 4090 | 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 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. | | | | | | | | | | | | | |
| | 4099 | 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 | | | | | | | | | | | | | |
| Level 1 | 4104 | the communication of clinical tests and 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 | | | | | |

**The following summary will be populated automatically from information entered on the worksheet.**

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | 3.4.1 | 0 | | | 0 | | | | |
| | | | | | | | 3.4.2 | 0 | | | 0 | | | | |
| | | | | | | | 3.4.3 | 0 | | | 0 | | | | |
| | | | | | | | 3.4.4 | 0 | | | 0 | | | | |
| | | | | | | | 3.4.5 | 0 | | | 0 | | | | |
| | | | | | | | 3.4.6 | 0 | | | 0 | | | | |
| | | | | | | | 3.4.7 | 0 | | | 0 | | | | |

| | | | | | | | 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 |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

PHO119688-0166

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |

**Cell:** B1
**Comment:** Admin Use Only

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

**Cell:** L1
**Comment:** Assessor Use Only

**Cell:** M1
**Comment:** Assessor Use Only

**Cell:** N1
**Comment:** Assessor Use Only

**Cell:** 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

| 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | |
| **3.5.1** | 5010 | 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 reporting of all internally and externally reportable 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 reporting: | | | | | | | | | | | | | |
| Level 1 | 5012 | all incidents/near misses, involving staff, patients and others | | | | | | | | | | | | | |
| Level 1 | 5013 | to external agencies. | | | | | | | | | | | | | |
| | 5019 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | |
| **3.5.2** | 5020 | The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for 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 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 | 5022 | for raising concerns (informal complaints/PALS) | | | | | | | | | | | | | |
| Level 1 | 5024 | by which the organisation aims to make changes as a result of concerns being raised. | | | | | | | | | | | | | |
| | 5029 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **3.5.3** | 5030 | The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for ensuring that patients, their relatives and carers have suitable and accessible information about, and clear access to, procedures to register formal complaints. | | | | | | | | | | | | | |
| | | 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 | 5032 | complaints management process, which includes internal and external communication, and collaboration with other organisations when necessary | | | | | | | | | | | | | |
| Level 1 | 5034 | process by which the organisation aims to make changes as a result of formal complaints. | | | | | | | | | | | | | |
| | 5039 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | |
| **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: | | | | | | | | | | | | | |
| Level 1 | 5043 | action to be taken, including timescales | | | | | | | | | | | | | |
| Level 1 | 5044 | communication with relevant stakeholders. | | | | | | | | | | | | | |
| | 5049 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | |
| **3.5.5** | 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 1 | 5053 | different levels of investigation appropriate to the severity of the event(s) | | | | | | | | | | | | | |
| Level 1 | 5055 | process for following up relevant action plans. | | | | | | | | | | | | | |
| | 5059 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | |
| | | | | | | | | | | | | | | | |
| **3.5.6** | 5060 | The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for ensuring a systematic approach to the analysis of incidents, complaints and claims on an aggregated basis. | | | | | | | | | | | | | |
| | | 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 | 5062 | coordinated approach to aggregation of incidents, complaints and claims | | | | | | | | | | | | | |
| Level 1 | 5064 | minimum content required within the analysis report, including qualitative and quantitative analysis. | | | | | | | | | | | | | |
| | 5069 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | |
| | | | | | | | | | | | | | | | |
| **3.5.7** | 5070 | The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for encouraging learning and promoting improvements in practice, based on individual and aggregated analysis of incidents, 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 process by which the organisation ensures: | | | | | | | | | | | | | |
| Level 1 | 5074 | the implementation of risk reduction measures. | | | | | | | | | | | | | |
| | 5079 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | |
| | | | | | | | Compliant | | | Compliant | | | | | |
| | | | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **3.5.8** | 5080 | The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for ensuring that agreed best practice as defined in all NICE guidance is taken into account in the context of the clinical services provided by the organisation. | | | | | | | | | | | | | |
| | | The organisation can demonstrate that it is monitoring compliance with the minimum requirements contained within the approved documentation described at Level 1, in relation to the process for: | | | | | | | | | | | The assessor will select two clinical guidelines from the list to assess the organisation's compliance with the above minimum requirement. | | |
| | 5087 | | | | | | | | | | | | | | |
| | 5087 | | | | | | | | | | | | | | |
| Level 1 | 5085 | ensuring that recommendations are acted upon throughout the organisation. | | | | | | | | | | | | | |
| | 5089 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | |
| | | The assessor will select two clinical guidelines from the list to assess the organisation's compliance with the above minimum requirement. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | |
| **3.5.9** | 5090 | The organisation can demonstrate that there are processes in place to monitor compliance with the approved documentation which describes the process for ensuring that agreed best practice, as defined in nationally agreed guidance, the National Service Frameworks, National Confidential Enquiries and other High Level Enquiries that make recommendations for patient safety, is taken into account 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: | | | | | | | | | | | | | |
| Level 1 | 5095 | ensuring that recommendations are acted upon throughout the organisation. | | | | | | | | | | | | | |
| | 5099 | Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented accordingly. | | | | | | | | | | | | | |
| | | | | | | | **Compliant** | | | **Compliant** | | | | | |
| | | | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **3.5.10** | 5100 | 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: | | | | | | | | | | | | | |
| Level 1 | 5101 | process for encouraging open communication between healthcare organisations, healthcare teams, staff and patients and/or their carers | | | | | | | | | | | | | |
| Level 1 | 5105 | requirements for documenting all communication. | | | | | | | | | | | | | |
| | 5109 | 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 following summary will be populated automatically from information entered on the worksheet.** | | | | | | | | | | | | | | | |
| | | | | | | | 3.5.1 | 0 | | | 0 | | | | |
| | | | | | | | 3.5.2 | 0 | | | 0 | | | | |
| | | | | | | | 3.5.3 | 0 | | | 0 | | | | |
| | | | | | | | 3.5.4 | 0 | | | 0 | | | | |
| | | | | | | | 3.5.5 | 0 | | | 0 | | | | |
| | | | | | | | 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 |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

PHO119688-0175

**Cell:** B1
**Comment:** Admin Use Only

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

**Cell:** L1
**Comment:** Assessor Use Only

**Cell:** M1
**Comment:** Assessor Use Only

**Cell:** N1
**Comment:** Assessor Use Only

**Cell:** 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