

**Risk Notification Return Guidance Tool**

Providers carrying out any contracted service(s) are required to notify the Quality Team (North Yorkshire Council) of any reportable incidents by completing a Risk Notification Return (RNR) without delay. Please familiarise yourself with this Guidance Tool to understand your responsibilities in reporting RNR’s. If you are unsure please seek advice from your Safeguarding Concerns Manager are unsure Please return your completed form to [HASQuality@northyorks.gov.uk](mailto:HASQuality@northyorks.gov.uk)

Areas covered by the Risk Notification Return Guidance Tool include the following:

* Falls
* Medication Errors
* Missed Home Care Visits
* Environmental
* Nutrition and Hydration
* Incidents Between Adults at Risk
* Moving and Handling
* Pressure Ulcers
* Poor Discharge/Transfer of Care
* Financial concerns
* Accidents and Serious Incidents

If you need to raise a Safeguarding concern, please ensure you follow your own organisations Safeguarding procedures in line with the Joint Multi-Agency Safeguarding Adults Policy and Procedures. [Safeguarding vulnerable adults | North Yorkshire Council](https://www.northyorks.gov.uk/adult-care/safeguarding/safeguarding-vulnerable-adults)

**You do not need to send any information relating to a Safeguarding concern to the Quality Team.**

|  | **When to submit a Risk Notification Return** | **What Does Not Require a Risk Notification Return** | **Examples of when a safeguarding referral should be made** |
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| **Falls** | Repetitive falls for unexplained reasons.  If the fall was impacted by an environmental hazard (e.g., poor lighting). | There is **no** requirement to complete a Risk Notification Return regarding the following:-  Any unobserved falls for a person living in their own home (including Extra Care)  A Controlled fall where no injury was sustained | An adult at risk sustains a significant injury that impacts on their health and wellbeing (e.g., fracture) due to a fall  Where abuse, neglect or act of omission is suspected.  There was not an appropriate risk assessment in place (if there was a history of falls).  If there was a risk assessment in place but was not followed,  The care plan had not been reviewed and updated following a fall or a change of circumstance; or there was a delay in response/medical intervention. |
| **Medication** | When a medication error has occurred, where no harm has occurred, all appropriate actions have been taken, (e.g., sought medical advice from a healthcare professional); and this is an isolated incident.  When a person does not receive the correct prescribed medication e.g.:  Missed dose(s)  Incorrect dosage  Incorrect time interval between doses  Being administered another person’s medication  When medication is stored inappropriately (except within the person’s own home).  When any medication is administered which is out of date. | There is **no** requirement to complete a Risk Notification Return regarding the following:-  Missed signature on medication administration record (MAR)  If medication is dispensed from the pharmacy which is incorrectly labelled or the medication dispensed is incorrect, and the medication has not been administered. | If an error has occurred which caused harm (or had the potential to cause harm).  The adult at risk is subjected to deliberate withholding of prescribed medication with no medical reason.  A deliberate attempt to harm or threaten an adult at risk through use of a medicine, including intentional over sedation.  Deliberate falsification of records in order to cover up a medicines administration error.  Failing to monitor the persons’ condition or seek appropriate medical advice and support following medicines administration error e.g., pain management.  Covert medication administration without a documented best interest decision and written authorisation from the GP and with DoLS/DoL authorisation in place (or applied for). |
| **Missed Home Care Visit** | When there has been a missed care and support call. |  | A planned care and support call is missed, and this has had an adverse effect on the adult at risk.  There are repeated missed care and support calls for the same person |
| **Environmental** | No heating is available.  No supply of hot water is available.  A power cut.  The call bell system is not working.  Communal toilets are out of use.  Communal bathrooms are out of use.  The lift is out of use.  A fault with the fire system  The kitchen is out of use.  Security systems in the building are compromised.  There is flooding at the service. |  | Consider the impact on individual(s) and the resident group as a whole.  Depending upon the seriousness of the situation and/or number of environmental issues, this may need to be addressed within organisational safeguarding.  Consult with the Safeguarding Lead for your organisation. |

**There is no requirement to complete a Risk Notification Return for the below incidents**

|  | **What Does Not Require a Risk Notification Return** | **Examples of when a safeguarding referral should be made** |
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| **Incidents Between Adults at Risk** | There is **no** requirement to complete a Risk Notification Return for incidents between adults.  **Please Note**  It is the responsibility of the Service Manager or Registered Manager to: -  Review the support of the individual(s) involved in the incident.  Ensure that an up-to-date risk assessment is in place for the immediate safety of all people who use the service, and this is reviewed on a regular basis. | If an adult at risk has been harmed during an incident with another adult at risk, and there is an impact on their health and wellbeing.  There are repeated incidents or a risk of repeat incident(s) by the same person |
| **Nutrition And Hydration** | There is **no** requirement to complete a Risk Notification Return for Nutrition and Hydration.  **Please Note** It is the responsibility of the Service Manager or Registered Manager to:  Review the support of the individual(s) involved in the incident.  Ensure that all mechanical equipment used to support people with nutrition and hydration is used correctly and is in good working order. | There is a failure to provide nutrition and hydration to an adult at risk.  There is unexplained weight loss or the person is at risk of showing signs of dehydration and a support plan is not in place or has not been followed and/or no referral has been made to the GP, Dietician, Speech and Language Therapy.  Where errors are made with dietary requirements e.g., soft diet, thickened fluids, allergies or adapted diet (e.g., low sugar, high fibre, restricted fluids) to an extent where it may endanger the safety or wellbeing of the person (including choking)  Where an adult’s food/fluid charts have not consistently been completed and specialist advice has not been sought or followed. |
| **Pressure Ulcers** |  | Please refer to the [Pressure Ulcer Protocol and Safeguarding guidance](https://safeguardingadults.co.uk/pressure-ulcer-protocol/). |
| **Moving and Handling** |  | Where injury or harm has occurred due to poor moving and handling practice and techniques.  Where there is no Moving and Handling Plan or Risk Assessment in place to manage the risk.  Where there is failure to follow a Moving and Handling Plan e.g., using the wrong equipment.  Failure to provide appropriate moving and handling equipment.  Where a person at risk has been moved or dragged manually.  Where inappropriate use of a wheelchair occurs (e.g., not using lap belts/foot plates).  Where poor moving and handling techniques are being used. |
| **Poor Discharge/Transfer of Care**  **(From setting to setting e.g., hospital to care home, care home to care home)** |  | There is insufficient discharge/transfer of care planning from any area resulting in a risk of abuse or neglect.  Where the adult at risk is discharged without necessary equipment, medication or personal items and this results in a risk of abuse or neglect.  Where the adult at risk is discharged with a cannula in situ but there is no record on the discharge plan, and this results in a risk of abuse or neglect.  Where the adult at risk is discharged with no/or incomplete discharge documentation and this results in a risk of abuse or neglect. |
| **Financial Concerns** |  | An adult at risk is denied access to his/her funds or possessions, where this is not part of a support plan or best interest decision.  There is a failure by a responsible person to pay care fees/charges and the adult at risk experiences distress or an adverse effect through having no, or restricted, access to personal allowances, resulting in a risk of eviction or termination of service.  Where there is a misuse or misappropriation of property, possessions, benefits or finances by a person in a position of trust or control.  Where the adult at risk is subject to theft.  Where the adult at risk is subject to doorstep crime.  Where the adult at risk is subject to being put under pressure in relation to money or other property (for example defrauding, either via mail, telephone or online)  Where someone persuades/befriends the person to gift or loan them money by any means. |
| **Accident(s) / Incident(s) / Serious incident(s)** | There is **no** requirement to complete a Risk Notification Return for accidents, incidents, or serious incidents.  **Please Note**  The Provider is to follow their own procedures regarding reporting of incidents to the following:   * [RIDDOR](https://www.hse.gov.uk/riddor/) * [CQC notification](https://www.cqc.org.uk/guidance-providers/notifications/notification-finder) (if you are a regulated service) | The provider using their own policies, procedures and guidance should determine if a safeguarding referral is required following a serious incident / accident |

**CQC Notifications**

**If you have submitted a notification to CQC under any of the regulations below, please ensure you forward a copy to** [**HASQuality@northyorks.gov.uk**](mailto:HASQuality@northyorks.gov.uk)**:**

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| **CQC Regulation Number** | **CQC Regulation Description** |
| 12 (3) | Changes to a statement of purpose |
| 14 | Absence of a Registered Individual for 28 days or more consecutive days |
| 14 | Return of a registered individual from an absence of 28 days or more |
| 15 | Changes affecting a provider or manager |
| 18 (2) | Incidents reported to or investigated by the Police |
| 18 (2) (g) | Events that stop the service running safely and properly |
| 22 | Liquidator or trustees plans for the service |

**Service Provision Not Regulated By CQC but are a service contracted by North Yorkshire Council**

If you have had any of the following incidents, please ensure you notify North Yorkshire Council at [HASQuality@northyorks.gov.uk](mailto:HASQuality@northyorks.gov.uk):

**Notification(s)**

Absence of a Manager for 28 days or more consecutive days

Changes affecting a service.

Events that stop the service running safely and properly

Liquidator or trustees plans for the service.

Incidents reported to or investigated by the Police.

Certain incidents or injuries arising out of or in connection with work are reportable to HSE under the requirements of the Reporting of Injuries Diseases and Dangerous Occurrence Regulations 2013 (RIDDOR).