

**RISK NOTIFICATION RETURN FORM**

The table below is a reference guide to indicate if a Risk Notification Return (RNR) is required to be submitted.

If you are unsure about submitting a Risk Notification Return, please also refer to the [Guidance](https://eur02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.northyorks.gov.uk%2Fadult-care%2Fcontracting-adult-social-care-and-health-services%2Ftools-procedures-and-guidelines-adult-social-care-services-providers%2Frisk-notification-return-guidance-tool&data=05%7C02%7CBridgit.Stockton%40northyorks.gov.uk%7Cdbaf3d836d7d46c9389908dc589db49e%7Cad3d9c73983044a1b487e1055441c70e%7C0%7C0%7C638482681555992861%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C0%7C%7C%7C&sdata=xNdKcQLJd%2BksyWswOZ6LCIxey7wuB8vtxNL%2F%2Ft1NxDs%3D&reserved=0)

Once you have completed the form, please send it to the North Yorkshire Council Quality Team by email to: [HASQuality@northyorks.gov.uk](mailto:HASQuality@northyorks.gov.uk)

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| --- | --- | --- |
| **Category** | **Complete RNR form** | |
| **Yes** | **No** |
| Falls | ü (if no significant injury) |  |
| Medication Error | ü |
| Missed Home Care visit | ü |
| Environment | ü |
| Nutrition and Hydration |  | X |
| Incidents between adults at risk | X |
| Moving and Handling | X |
| Pressure Area Care | X |
| Poor discharge/ transfer of care | X |
| Financial concerns | X |

* If you require further advice or guidance from a member of the North Yorkshire Council Quality Team, please email: [HASQuality@northyorks.gov.uk](mailto:HASQuality@northyorks.gov.uk)
* Please retain a copy of this form for your records.

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| **Section 1: Details of the provider** | | |
| Name address and contact details of provider: | | |
| Click or tap here to enter text. | | |
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| Name, address and contact details of service: | | |
|  | | |
| Type of service: | | |
|  | | |
| Choose an item. | | |
| Name of person reporting completing the form: | | |
| Click or tap here to enter text. | | |
| E-mail address and contact telephone number of person reporting the RNR: | | |
| Click or tap here to enter text. | | |
| Role of person reporting the RNR: | | |
| Click or tap here to enter text. | | |
| Date this form was completed: | | |
| Click or tap to enter a date. | | |
| **Details of the incident** | | |
| Initials and/or LLA number of the person who the Risk Notification Return relates to: | | |
| Click or tap here to enter text. | | |
| Location where the incident occurred: | | |
| Click or tap here to enter text. | | |
| What category of incident does this form relate to | | Choose an item. |
| Date of incident : | Time of incident (24 hour clock): | |
| Click or tap to enter a date. | Click or tap here to enter text. | |
|  | | |
| **Reporting a Fall** | | |
| Please include any contributory factors  (e.g. known falls risk, uses mobility equipment, any medical condition which may affect mobility) |  | |
| Where did the fall take place? |  | |
| How were staff alerted to the fall? |  | |
| Was falls equipment in place, and if so, was it in good working order ? |  | |
| Were there any injuries sustained? | Choose an item. | |
| If yes, please describe the injuries sustained. |  | |
| Was medical advice sought? | Choose an item. | |
| Who did you contact for medical advice? |  | |
| What medical advice was given? |  | |
| Number of falls in past 7 days |  | |
| Was the fall witnessed/Unwitnessed? | Choose an item. | |
| Were any post fall observations completed? | Choose an item. | |
| Was the person’s care plans/risk assessments updated? | Choose an item. | |
| Was there a body map completed? | Choose an item. | |
| Was a referral to any professional made resulting from this fall? | Choose an item. | |
| Is there any additional information regarding this incident you would like to tell us about (no more than 200 words) | | |
|  | | |
| **Medication Errors** | | |
| Was there any harm caused following this error | Choose an item. | |
| Please describe the medication incident |  | |
| Initials of staff member(s) involved in the incident. |  | |
| Was medical advice sought? | Choose an item. | |
| Who gave the medical advice (e.g. GP, Pharmacy, 111) |  | |
| Date when medical advice was sought: | Time when medical advice was sought (please use 24 hour clock) | |
| Click or tap to enter a date. | Click or tap here to enter text. | |
| If medical advice was sought what advice was given |  | |
| Please describe any action taken regarding staff member(s) concerned with this medication error. | | |
| **Missed Home Care visit** | | |
| How was the missed visit identified? |  | |
| What was the purpose of the missed visit (meals, medication, personal care etc)? |  | |
| Number of missed calls in the past 7 days |  | |
| What action was taken to notify all relevant parties of the missed call? |  | |
| Was any harm caused due to the missed call?  If so, please describe. |  | |
| Action taken regarding staff member(s) concerned with the incident. | | |
|  | | |
| **Environmental Issues** | | |
| No heating available |  | |
| No supply of hot water available |  | |
| Power cut |  | |
| Call bell system not working. |  | |
| Communal toilets out of use |  | |
| Communal bathrooms out of use |  | |
| Lift out of use |  | |
| Faulty fire system |  | |
| Kitchen out of use |  | |
| Security systems in the building are compromised. |  | |
| Flooding |  | |
| Actions taken to resolve environmental issues (no more than 200 words) | | |