Risk Notification Return Guidance

This tool is to assist Providers in identifying situations that may occur whilst carrying out a Regulated service/activity that requires notification to the Quality & Market Improvement Team via completion of the Risk Notification Return; or this may be within an unregulated activity such as day support service.
This is to encourage a culture of openness and transparency within health and social care services at all levels within organisations. Submission of the Risk Notification Return will ensure that the situation is reported, learning is captured and shared, to prevent recurrence and escalation. This tool is to support decision making, it does not replace professional judgment.

Complete the Risk Notification Return and send to the Quality & Market Improvement Team:
socialservices.contractingunit@northyorks.gov.uk

The Risk Notification Return does not need completing if a CQC notification form has been completed.

Issue:	Reporting Framework:	Action to be taken:
Accident/Incident/Serious Incident	Serious Incidents Procedures	Provider to complete: • Riddor • Accident / Incident Form • Serious Incident Form • CQC notification (as outlined below)
CQC Statutory Notifications for Regulated services	• Statutory Notifications: • **Absence of a Registered Individual for 28 days or more consecutive days – Regulation 14** • **Return of a registered individual from an absence of 28 days or more – Regulation 14** • **Changes affecting a provider or manager – Regulation 15** • **Changes to a statement of purpose – Regulation 12(3)** • **Events that stop the service running safely and properly – Regulation 18(2) (g)**	Send Notification to CQC Forward CQC notification to the Quality and Market Improvement Team with actions. 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). Whether and unexpected death of a service user or serious safety incident resulting in major injury to a service user has arisen out of or in connection with work will depend,

	• **Liquidator or trustees plans for the** service – Regulation 22 • Incidents reported to or investigated by the Police – Regulation 18(2)	amongst other things, on whether the accident was related to. The way the work was carried out Any machinery, other plant substances or equipment, used for the work; and or The condition of the site or premises where the accident happened.
	Examples of issues that might fall outside safeguarding procedures and may be addressed by other means, in the following circumstances:	
Environmental (either within a Registered home or a person's own home.)	• Heating problems and supply of hot water within a home. • Inadequate lighting • Power cut • Call bells not being heard/not working • Hazards in the home; boxes/wheelchairs • Communal toilets/bathrooms out of use • Lift out of use • Fire system not working • Kitchen out of use Lack of security in the building • Insufficient fire tests not being undertaken	Complete the Risk Notification Return where this is not a notifiable incident under CQC Regulations

	• Restriction to access areas of the home • Floods • Fire Regulations are not met • Consider the impact on individuals and the resident group as a whole. Depending upon the seriousness and number of environmental issues, this may need to be addressed within organisational safeguarding. • Where an adult has a pet the support plan needs to include pet care • Lack of furniture and space in communal areas	
Physical	One off incident of person to person contact which is isolated and no injury or distress has been caused. If further incidents occur involving the same individual(s) a safeguarding concern must be raised	Complete the Risk Notification Return and send to the Quality & Market Improvement Team
Psychological / Emotional	Isolated incident where an adult with care and support needs is spoken to in a rude or other inappropriate way – respect is undermined but no or little distress caused	Complete the Risk Notification Return and send to the Quality & Market Improvement Team
Financial and Material	• All examples of financial abuse should be discussed with the safeguarding team to establish if harm has been caused and a concern needs to be raised, e.g. where staff personal benefit meals in a person's home, vouchers and loyalty points. • Requests for top ups by the provider from the third party, without the knowledge of the Council.	Complete the Risk Notification Return and send to the Quality & Market Improvement Team

Medication	- Person does not receive prescribed medication (missed/wrong dose) on one occasion – no harm occurs and appropriate action has been taken and this is an isolated incident. - Medication not received from pharmacist - Person lacks choice in prescribed meds – tablet/liquid - Provider will not administer specific medication in a domiciliary care setting in line with their own policy. - Recurring missed medication or administration errors in relation to one person that cause no harm and no ongoing concerns - Prevention measure in place such as training, supervision and auditing. - Medication stored inappropriately (care home setting) - Medication fridge broken and responded to.	Complete the Risk Notification Return and send to the Quality & Market Improvement Team
Missed Home Care Visits	Isolated missed home care visit where no harm occurs and adult is made aware and alternative support is given e.g. meal provided	Complete the Risk Notification Return and send to the Quality & Market Improvement Team
Organisational	- Lack of stimulation/ opportunities for people to engage in social and leisure activities. - Persons views not sought, person not involved in care planning process. - Adults with Care and Support needs not enabled to be involved in the	Complete the Risk Notification Return and send to the Quality & Market Improvement Team

	running of the service, able to raise a complaint. • Service design where groups of service users living together are incompatible i.e. incompatible mix of client group. • First witness of inappropriate use of equipment including wheelchairs and any further incidents to be reported as a safeguarding concern. • Care planning documentation not person-centred. • Not obtaining the appropriate consent from the relevant person. • Taking photographs for identification purposed of the adult without consent.	