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| DCOP NF40 Form | Health Information and Quality Authority Designated centres for older persons (DCOP) Nil return of quarterly and or two day notification* |  Health Information and Quality Authority An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte |
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Please ensure you are completing the correct form.

This form should be submitted to the Office of the Chief Inspector every six months if there has been **no occurrence of any incident** required to be notified to the Chief Inspector[†], this includes any:

- **incident outlined** in the quarterly notifications (listed in section 2) or,
- **two day** notifications (listed in section 3).

| Section 1. Centre details. | | | For official use |
|-----------------------------------|---|--|--------------------------|
| Centre name | | | <input type="checkbox"/> |
| Centre ID (OSV) | | | <input type="checkbox"/> |
| Unit or ward name (if applicable) | | | <input type="checkbox"/> |
| Reporting year | | | <input type="checkbox"/> |
| Reporting period | Period 1 (Jan, Feb, Mar, Apr, May, Jun) <input type="checkbox"/> | | <input type="checkbox"/> |
| | Period 2 (Jul, Aug, Sep, Oct, Nov, Dec) <input type="checkbox"/> | | |

*Please complete this form with HIQA's statutory notification guidance. You can download the guidance at www.hiqa.ie

[†]As per the Health Act 2007 and regulations thereunder.

| Section 2. Nil return of any incident identified in the quarterly notifications (NF39A – NF39E Form). | | For official use |
|---|--------------------------|--------------------------|
| Please tick the relevant box or boxes to confirm that there has been no occurrence of any incident of this type in the reporting period. | Confirm | <input type="checkbox"/> |
| No occasion when restrictive practices were used including the type of restrictive practice used and the number of residents affected (NF39A). | <input type="checkbox"/> | |
| No occasion where fire alarm equipment was activated (NF39B). | <input type="checkbox"/> | |
| No recurring pattern of theft or burglary (NF39C). | <input type="checkbox"/> | |
| No death of a resident other than notified by NF01 (NF39D). | <input type="checkbox"/> | |
| No pressure ulcer (category II or higher) sustained by a resident (NF39E). | <input type="checkbox"/> | |

| Section 3. Nil return of any incident identified in the three day notifications (NF01 - NF09 Form). | | For official use |
|---|--------------------------|--------------------------|
| Please tick the relevant box or boxes to confirm that there has been no occurrence of any incident of this type in the reporting period. | Confirm | <input type="checkbox"/> |
| No unexpected death of a resident (NF01). | <input type="checkbox"/> | |
| No outbreak of any notifiable disease (NF02). | <input type="checkbox"/> | |
| No serious incident or injury to a resident which required hospital admission or resulted in death (NF03). | <input type="checkbox"/> | |
| No unexplained absence of a resident from the designated centre (NF05). | <input type="checkbox"/> | |
| No alleged or confirmed abuse of any resident (NF06). | <input type="checkbox"/> | |
| No allegation of misconduct by the registered provider or by a member of staff (NF07). | <input type="checkbox"/> | |
| No occasion when the registered provider became aware that the person in charge is the subject of review by a professional body (NF08). | <input type="checkbox"/> | |

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|---|---|--------------------------|--------------------------|
| No fire, loss of power, heating or water or event where an unplanned evacuation of the designated centre took place and where residents could not immediately return to the designated centre (NF09). | | <input type="checkbox"/> | |
| Section 4. Declaration. | | | For official use |
| I, the undersigned, declare that the information I have provided in this notification form is true to the best of my knowledge and belief. | | | |
| Name (print) | | | <input type="checkbox"/> |
| Position | Person in charge | <input type="checkbox"/> | <input type="checkbox"/> |
| | Authorised signatory for and on behalf of the registered provider | <input type="checkbox"/> | |
| Signed | | | <input type="checkbox"/> |
| Date | | | <input type="checkbox"/> |
| Contact number (during office hours) | | | <input type="checkbox"/> |

This form should be either:

- **emailed** to: rst@hiqa.ie or
- **posted** to: Regulatory Support Team, Regulatory Support Services, Health Information and Quality Authority, Dublin Regional Office, George's Court, George's Lane, Smithfield, Dublin 7, D07 E98Y.

Telephone no: (01) 814 7400

Email: rst@hiqa.ie