Total number of pages in this report

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Receipting homecare organisation name: | | | | | | | |  | | |
| Receipting homecare organisation complaint/incident reference number: | | | | | | | |  | | |
| Date incident reported: | |  | | Written response required: | | | | | Yes No | |
| **About the patient and reporter** | | | | | | | | | | |
| Patient details | | | | | | | | | | |
| Patient forename: |  | | | | NHS number: | | | | |  |
| Patient surname: |  | | | | Hospital number: | | | | |  |
| Date of birth: |  | | | | Homecare provider patient number: | | | | |  |
| Ethnicity: | Choose an item. | | | | Gender: | | | | | Male Female |
| Address: |  | | | | | | | | | |
| Country: | England Northern Ireland Scotland Wales | | | | | | | | | |
| Carer’s Name: |  | | | | | | | | | |
| Therapy: |  | | | | Diagnosis: |  | | | | |
| Clinical Referring Centre: |  | | | | | | | | | |
| Complaint/incident reporter details | | | | | | | | | | |
| Name of reporter: |  | | Reporter type: | | | | Choose an item. | | | |
| Telephone: |  | | Email: | | | |  | | | |
| Address: |  | | | | | | | | | |
| Complaint/incident recipient details | | | | | | | | | | |
| Name of person completing form: | | | | |  | | | | | |
| Position of person completing form: | | | | |  | | | | | |
| Contact telephone: | | | | |  | | | | | |

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| **About the complaint/incident** | | |
| Date complaint/incident occurred: | |  |
| Time complaint/incident occurred: | |  |
| Location incident occurred: | Home setting Work  School Care home  Nursing home Hospital  Other: specify | |

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| **About the complaint/incident (continued)** | |
| Was the patient actually harmed? | Yes No Don’t Know |
| If yes, what was the harm and to what part of the body? |  |
| In your opinion, was this event preventable? | Yes No Don’t know |
| Describe what happened: *(Do not use any personal identifiable data here. Instead for example say the patient, the hospital nurse or the customer service agent)* | |
| Personal identifiable information related to the complaint/incident:  *(E.g. Hospital nurse = Jane Doe*  *Customer service agent = Joe Bloggs)* |  |
| Immediate corrective and preventative actions taken: |  |
| Relevant medical history: |  |
| Where available, reference any supporting evidence to the description provided: |  |
| For medicinal products - does the reporter agree to be contacted by the manufacturer if they want more information? | Yes No |
| Does the reporter require a written response? | Yes No |

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| **Categories for complaints and incidents** *(tick all that apply)* |
| Initial categorisation:  Patient safety incident including Duty of Candour  Adverse drug reaction and/or event  Faulty medicinal product/device  Safeguarding incident  Information governance incident  Non-conformance  Complaint – informal – no written response required  Complaint – formal – written response required  Not reportable – any incident downgraded following triage/investigation |

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| **About the medicine(s) involved in a complaint or incident** | | | | | | | | | |
| Medicine 1 | | | | | | | | | |
| Approved medicine name: | | | |  | | | | | |
| Proprietary medicine name: | | | |  | | | | | |
| Manufacturer: | | | |  | | | | | |
| Form: | |  | | | Strength: | |  | | |
| Dose frequency: | |  | | | Route: | |  | | |
| Batch number: | |  | | | Expiry date: | |  | | |
| Is the medicine available for inspection? | | | Yes No | | If yes, where is the medicine now? | |  | | |
| In the reporter’s opinion how likely is this event due to the use of this medicine? | | | | | Very Unlikely  Unlikely | | | | Likely  Very Likely |
| Has this been confirmed by a healthcare professional (HCP)? | | | | | Yes No  If Yes name of HCP | | | | |
| Details of other medicines being taken at the same time: | | | | |  | | | | |
| Other relevant information about the medicine: | | | | |  | | | | |
| Medicine 2 | | | | | | | | | |
| Approved medicine name: | | | |  | | | | | |
| Proprietary medicine name: | | | |  | | | | | |
| Manufacturer: | | | |  | | | | | |
| Form: |  | | | | Strength: |  | | | |
| Dose frequency: |  | | | | Route: |  | | | |
| Batch number: |  | | | | Expiry date: |  | | | |
| Is the product available for inspection? | | | Yes No | | If yes, where is the medicine now? |  | | | |
| In the reporter’s opinion how likely is this event due to the use of this medicine? | | | | | Very Unlikely  Likely | | | Unlikely  Very Likely | |
| Has this been confirmed by a healthcare professional (HCP)? | | | | | Yes No  If Yes name of HCP | | | | |
| Details of other medicines being taken at the same time: | | | | |  | | | | |
| Other relevant information about the medicine: | | | | |  | | | | |

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| *If more than two medicines are to be reported, attach a separate sheet to this report form and reference it in the supporting documents field above* | | | | |
| **About the medical device(s)** involved in a complaint or incident | | | | |
| Device 1 | | | | |
| Name of medical device: | |  | | |
| Model: | |  | | |
| Manufacturer: |  | | | |
| Catalogue number: |  | | Serial number: |  |
| Supplier: |  | | Batch number: |  |
| Expiry date: |  | | Date of manufacture: |  |
| Is the device available for inspection? | Yes No | | If yes, where is the device now? |  |
| Other relevant information about the device: | | |  | |

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| Device 2 | | | | |
| Name of Medical Device: | |  | | |
| Model: | |  | | |
| Manufacturer: |  | | | |
| Catalogue Number: |  | | Serial number: |  |
| Supplier: |  | | Batch number: |  |
| Expiry date: |  | | Date of manufacture: |  |
| Is the device available for inspection? | Yes No | | If yes, where is the device now? |  |
| Other relevant information about the device: | | |  | |

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| *If more than two devices are to be reported, attach a separate sheet to this report form and reference it in the supporting documents field above* |