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* |