2024

CARE INCIDENT REPORT TEMPLATE

QMB

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Care Company Name: [Enter the name of the care company]
Report Number: [Incident report number/reference]
Date of Incident: [DD/MM/YYYY]
Time of Incident: [HH:MM AM/PM]
Location: [Specify the exact location (client's home, care facility, etc.)]

1. Individuals Involved

Client Name: [Full Name, Age]

Staff Member(s) Involved: [Full Name, Job Title]

Witnesses (if any): [Full Name, Job Title/Relationship]

2. Incident Details

- **Type of Incident:**
  ☐ Fall
  ☐ Medication Error
  ☐ Behavioural/Emotional Incident
  ☐ Medical Emergency
  ☐ Property Damage
  ☐ Other: [Specify]

- **Detailed Description of the Incident:** [Provide a clear and objective description. What occurred? What were the contributing factors? What was the client doing prior to the incident?]

3. **Immediate Response and Actions Taken**

- **Immediate Actions Taken:** [Describe the steps taken immediately after the incident (e.g., first aid administered, client reassured, equipment checked).]

- **Was First Aid Administered:**
  ☐ Yes
  ☐ No

  - If Yes, Provide Details: [e.g., applied bandages, assisted client to sit up]

- **Was Medical Attention Required:**
  ☐ Yes
  ☐ No

- If yes, specify:
  ☐ Ambulance Called
  ☐ GP/Doctor Contacted
  ☐ Hospital Visit

- **Environmental or Equipment Issues Involved:**
  ☐ Yes
  ☐ No

- If Yes, Explain: [e.g., broken equipment, faulty appliances]

4. Communication and Notification

- **Client's Next of Kin Notified:**
  ☐ Yes
  ☐ No
- If Yes, By Whom: [Name of staff]

- Date and Time of Notification: [DD/MM/YYYY, HH:MM AM/PM]

- **Manager/Supervisor Notified:**
  ☐ Yes
  ☐ No
- If Yes, By Whom: [Name of staff]

- Date and Time of Notification: [DD/MM/YYYY, HH:MM AM/PM]

- **Other Authorities/Agencies Notified (if applicable):**
  ☐ Yes
  ☐ No
- If Yes, Specify: [e.g., Local Authority, Safeguarding Team]

5. Impact and Follow-Up

- **Client's Condition After the Incident:**
  [Describe the client's physical and emotional condition following the incident.]

- **Staff Support Required:**
  ☐ Yes
  ☐ No
- If Yes, Provide Details: [e.g., counselling offered, team meeting]

- **Follow-Up Action Needed:**
  ☐ Yes
  ☐ No

- If Yes, Describe: [e.g., additional monitoring, care plan update, equipment maintenance]

6. Risk Assessment

- **Risk Level After Incident:**
  ☐ Low
  ☐ Moderate
  ☐ High

- **Was this Incident Part of a Recurring Issue or Pattern?:**
  ☐ Yes
  ☐ No
- If yes, describe: [e.g., client has had repeated falls, equipment issues, behavioural incidents]

- **Preventative Measures Recommended:**
  [Describe any actions or steps to prevent future incidents (e.g., changes in client care plan, equipment replacement, staff training).]

7. Manager's Review and Action Plan

- **Name of Reviewing Manager:** [Full Name]
- **Date of Review:** [DD/MM/YYYY]
- **Manager's Comments and Observations:**
  [Include any feedback on the incident, suggestions for improvement, and whether procedures were followed.]
- **Action Plan/Recommendations:**
  [Outline any required changes or recommendations, such as environmental adjustments, equipment checks, or training.]
- **Follow-Up Date for Review:** [DD/MM/YYYY]
- **Signature of Manager:** _____

8. **Final Outcome**

- **Final Resolution and Outcome:**
  [Summarize what actions have been taken and the result of any follow-up actions.]
- **Resolution Date:** [DD/MM/YYYY]
- **Resolved By (Staff/Manager Name):** [Full Name]

9. **Sign-Off**

- **Report Completed By (Staff Member):** [Full Name]
  Date: [DD/MM/YYYY]
  Signature: _____
- **Report Reviewed and Filed By (Manager):** [Full Name]
  Date: [DD/MM/YYYY]
  Signature: _____