

CARE INCIDENT REPORT TEMPLATE

QUEENSTAR MANTE-BONSRA

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: _____

