Complaints Management Form

Dear participant:

Please complete the following form in the unfortunate event of any incident occurring that did not meet your expectations of care. A formal investigation will commence once we receive the completed form. If you require assistance in the completion of this form, please contact us with provided details.

Complaint details to be completed by Participant/Participant's family

Participant name: Phone:

Participant's family name: Phone:

Date of incident: DD / MM / YYYY Time: HH : MM Date of report: DD / MM / YYYY

Location:

Witness name (if applicable): Phone:

Address:

Worker encountered during the incident:

Description of Complaint:

Immediate actions and measures taken by provider in response to the issue:

Immediate actions and measures were satisfactory? ☐ Yes ☐ No

Comments:

Sign off

Report completed by:

Signature:

Complaints Management Form

Date: DD / MM / YYYY

Investigation to be completed by Provider

Preliminary findings:

Identified root causes:

☐ Skills and competence ☐ Workplace Environment ☐ Policies & procedures

☐ Communication ☐ Risk assessment ☐ Others:

Corrective Actions (CA)

Description of actions:

CA Responsible: Position: Phone:

CA Deadline: DD / MM / YYYY CA Status: ☐ Open ☐ More action required ☐ Closed effectively

Comments:

Outcomes:

☐ Run training/induction session ☐ Review/amend relevant process/documents

☐ Review/update risk register ☐ Create new procedure

☐ Others:

Notification

NDIS consultation required? ☐ Yes ☐ No If yes; date of consultation: DD / MM / YYYY

Complaint resolved? ☐ Yes ☐ No Results communicated with Participant? ☐ Yes ☐ No

Sign off

Investigation completed by:

Signature:

Date: DD / MM / YYYY