

# Adverse Event Report Form A

For guidance see 'How to complete the Form' information sheet and when completing the blue tinted columns refer to the 'Code Guidance' sheet.

To be completed by any member of staff in BLOCK CAPITALS using a black ballpoint pen. Incomplete or illegible forms will be returned. Serious untoward Incidents such as unexpected death must be reported IMMEDIATELY to your PCT HQ regardless of the day or time. A Critical Incident is a serious, untoward event i.e. accident or incident, which has caused severe harm or injury to PCT services, premises or property, the organisation as a whole or in particularly upsetting cases staff, patients, volunteers or members of the public.

A - Who was involved in the incident?		Please complete details of all those involved in the incident - the persons affected, witnesses etc. (See Section A guidance for further information). If necessary use Form B for continuation.									
Name of Person Affected	Sex M/F	Occupation (as applicable)	Home Address	Date of Birth	See Section A of Code Guidance			A4 Patient No.	A5 Patient's Consultant	A6 PCT	
					A1 Ethnic Group	A2 Person Status	A3 Mental Health				
<b>Code A</b>	F	-	<b>Code A</b>	12/1/1915	1	RS	-	RN 107874	DR LORD	F 997	
Names of:	Sex M/F	Job Title/Occupation (as applicable)	Base/Home Address	Date of Birth	A1 Ethnic Group	A2 Person Status	A3 Mental Health	A4 Patient No.	A5 Patient's Consultant	A6 PCT	
Person reporting -	F	RON	SULTAN WARD	3/10/61	1	IS	-	-	-	F 997	
Others involved -											
B - When & where did the incident occur?		Date 1/5/06 Time 9:15 am/pm	Site name GWMH	Area (e.g. b/rm) BEDROOM							
			Ward dept SULTAN	Service 8			Independent Practice -				
C - What happened?		In CAPITALS, please describe briefly what happened, stating only facts and not opinion (Please use Continuation Sheet if required)									
		What type of incident (see codes) 74		For all events of assault against staff complete and attach Form B (indicate here)							
<b>Code A</b>		FOUND ON THE FLOOR BESIDE HER BED FLAT ON HER BACK.									
D - Impact on person affected/Impact on PCT?		(See Section D guidance for further information) - PLEASE USE FORM B TO DETAIL EFFECTS ON OTHERS INVOLVED									
Physical - Eg. Musculoskeletal, Unexpected deterioration		<input type="checkbox"/> Psychological <input type="checkbox"/> Social <input type="checkbox"/> Unknown <input type="checkbox"/> N/A <input checked="" type="checkbox"/>									
Description/Nature of injury and affected area		None									
Degree of Harm/Damage		None <input checked="" type="checkbox"/> Action Prevented Harm/Damage <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unexpected Death/Catastrophic event <input type="checkbox"/>									
If Staff, did they complete their shift?		<input type="checkbox"/> YES <input type="checkbox"/> NO									
E - What property was affected?		DAMAGE/THEFT/LOSS/FAILURE OF/TO *Delete as appropriate. (Please include details of property on Continuation Sheet). (See Section B guidance for further information)									
		Approx Value £									
F - How was the event dealt with?		What was the outcome of the incident? (e.g. hospital or other treatment, reported to the Police)									
<b>Code A</b>		EXAMINED FOR INJURY NONE APPARENT AT TIME OF EVENT. HOISTED BACK INTO BED, SETTLED INTO A COMFORTABLE SLEEPING POSITION, MRS PEERS ASKED NOT TO GET OUT OF BED UNAIDED. TO CALL FOR ASSISTANCE									
G - Medication adverse events		Please tick and complete Form B <input type="checkbox"/>		H - Medical device/equipment incidents		Any defective equipment should be detained for inspection		Please tick and complete Form B <input type="checkbox"/>			

This section MUST be completed by the Ward/Area/ Department Manager before passing the form to the Senior Manager

I - Ward/Area/Department Managers action			
What action will be taken immediately and longer term to prevent reoccurrence?			
BED RAILS IN PLACE AND CALL BELL GIVEN TO <b>Code A</b>			
I.1 Why did it happen?		I.2 Future Risk?	
Causes	IS	Impact Code	NM
Contributory Cause	IS	Likelihood of re-occurrence	Pos
Name and Job Title of Ward/Department Manager H. Russell, Clinical Manager Date 3/5/06			

This section to be completed by the service/senior manager (See Section J guidance for further information)

J - Service/Senior Managers action	
Who else has been informed? (PLEASE TICK RELEVANT BOXES)	
Copies of forms relating to staff accidents must be sent to Occupational Health and Human Resources	
<input type="checkbox"/> Occupational Health	<input type="checkbox"/> Medicines & Healthcare Products Regulations Agency (MHRA)
<input type="checkbox"/> Human Resources	<input type="checkbox"/> Health and Safety Executive (RIDDOR)
<input type="checkbox"/> Agency/Bank Co-ordinator	<input type="checkbox"/> Emergency Services called
<input type="checkbox"/> Complaints Manager	
What other action will be taken to prevent reoccurrence & share learning?	
Name and Job Title of Service/Senior Manager <b>Code A</b> Date 4/5/06	