

Form no. 5944

Fareham and Gosport **NHS**
Primary Care Trust**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				
Code A	M	Retired	Code A	29/4/72	1	28	1	Q970 365	DR. LORD	F38	
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 - Code A	F	ENROLLED NURSE	Code A	06-02-57	1	15				F & C	
Others involved -											
B - When & where did the incident occur?		Date 15/08/06 Time 06:40 am/pm	Site name GWMH	Area (e.g. b/rm) B1M 5							
		Ward dept SULTAN	Service 8	Independent Practice <input type="checkbox"/>							
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) 66 For all events of assault against staff complete and attach Form B (indicate here) <input type="checkbox"/>									
Code A		found laying on the floor beside his bed. checked for injuries and assisted to into his chair. No obvious injuries noted. Observations taken and satisfactory.									
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 checked="" type="checkbox"/>	N/A <input 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 £ <input type="text"/>									
F - How was the event dealt with?		What was the outcome of the incident? (e.g. hospital or other treatment, reported to the Police)									
Code A		was encouraged not to get out of bed without 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?

Code A answer call-back and advise to call for assistance.**I.1 Why did it happen?****I.2 Future Risk?**

Causes	15	Impact Code	NM
Contributory Cause	15	Likelihood of re-occurrence	Pos
Name and Job Title of Ward/Department Manager	Code A Sister		Date 16/8/06

Top Copy to: Risk Department

Bottom Copy to be returned and kept securely by Ward/Dep Manager

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	Code A Medical Manager	Date 17/8/06
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Please attach any Continuation Sheets