

12 MAY 2005

# 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>	M	Retired	<b>Code A</b>	24/2 21	1	28	CPN	Q110 9629	DR. LOGAN	F + G	
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 -											
<b>Code A</b>	F	s/nurse	Dryad		1	15				F + G	
Others involved -											
<b>Code A</b>	F	s/nurse	Dryad		1	15					
B - When & where did the incident occur?		In CAPITALS, please describe briefly what happened, stating only facts and not opinion (Please use Continuation Sheet if required)									
Date 5/5/05 Time 19:50 am/pm		Site name Corridor GwmH Area (e.g. b/rm) Corridor									
		Ward dept Dryad Service 8 Independent Practice <input type="checkbox"/>									
C - What happened?		What type of incident (see codes) 70 For all events of assault against staff complete and attach Form B (indicate here) <input type="checkbox"/>									
<b>Code A</b>		was walking with rotator along corridor + tripped + fell to knees. NO apparent injuries Assisted to feet + <b>Code A</b> wanted to continue walking with rotator									
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 apparent									
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?		YES <input type="checkbox"/> NO <input type="checkbox"/>									
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)									
<b>Code A</b>		appeared to have no injuries + upset, assisted to feet walked around walk to rotator.									
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 <input type="checkbox"/>		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?

Physio referred + asked to receive mobility guidance

I.1 Why did it happen?	I.2 Future Risk?
Causes 2	Impact Code NH
Contributory Cause 3	Likelihood of re-occurrence POS
Name and Job Title of Ward/Department Manager <b>Code A</b> WARD MANAGER	Date 9.5.05

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

Occupational Health  Medicines & Healthcare Products Regulations Agency (MHRA)

Human Resources  Health and Safety Executive (RIDDOR)

Agency/Bank Co-ordinator  Emergency Services called

Complaints Manager

What other action will be taken to prevent reoccurrence & share learning?

Name and Job Title of Service/Senior Manager **Code A** Manager Date 10/5/05