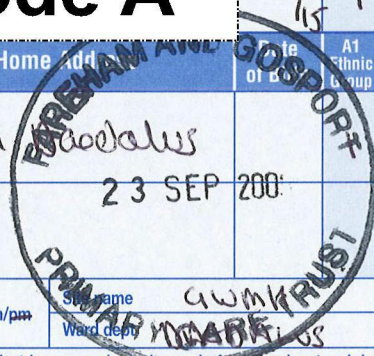


Adverse Event Report Form A

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	NA	Code A	2/10/15	1	30	1	Q361475	DR LORD	F	
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	RN	GWMH			15				F	
Others involved -											
B - When & where did the incident occur?		Date 27 20/09/15 Time 07:15 am/pm		Service name GWMH			Area (e.g. b/rm) CURTLE 4				
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)									
patient found on floor between bed & chair; no witnesses to incident											
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 type="checkbox"/>									
Description/Nature of injury and affected area		Degree of Harm/Damage None <input type="checkbox"/> Action Prevented Harm/Damage <input type="checkbox"/> Low <input checked="" 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)									
F - How was the event dealt with?		What was the outcome of the incident? (e.g. hospital or other treatment, reported to the Police)									
patient hoisted back to bed & examined for injuries small skin flap on left elbow; which was cleaned & dressed											
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?

Reviewed by doctor
nil further action

I.1 Why did it happen?	I.2 Future Risk?
Causes	Impact Code
Contributory Cause	Likelihood of re-occurrence
Name and Job Title of Ward/Department Manager	Date

Code A 20/09/15

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

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: A GRANT CLINICAL MANAGER Date: 21/9/15

Please attach any Continuation Sheets