NIMS
National Incident Management System

HCW Covid-19 NIRF: V01
Date issued: 05/2020

Healthcare Worker COVID-19 Acquired NATIONAL INCIDENT REPORT FORM (NIRF)

NIMS record Number:

This form should be completed where a staff member/volunteer/external contractor/work placement student acquires COVID-19. For all other COVID-19 related incidents and dangerous occurrences please follow normal incident reporting processes.

SECTION A: GENERAL INCIDENT DETAILS

Date of incident D D M M Y Y Y Y

Time of incident H H M M *Use 24 hour clock*

Location *E.g. Hospital, Health Centre, Residential Centre etc.*

Specific Location *E.g. Ward, Clients home etc.* **Offsite?** ☐

SECTION B: PERSON AFFECTED DETAILS

First name _____

Surname _____

Date of birth D D M M Y Y Y Y

☐ **Female** ☐ **Male**

Description of incident:

Please provide as much detail as possible at the time of incident reporting; e.g. date symptomatic, date tested, possible cause of transmission e.g. PPE unavailable, lack of communication, insufficient isolation/quarantine etc. and the immediate action taken e.g. isolate for 14 days etc.

SECTION C: WHO WAS INVOLVED…? (tick one only ✓)

- ☐ Staff member
- ☐ Agency / Panel staff
- ☐ Volunteer
- ☐ Student
- ☐ External Contractor

SECTION D: DIVISION (tick one only ✓)

- ☐ Acute Hospital
- ☐ Social Care
- ☐ Health and Wellbeing
- ☐ Primary Care
- ☐ Mental Health
- ☐ Ambulance Service

SECTION E: STAFF MEMBER / AGENCY / PANEL STAFF / STUDENT / VOLUNTEER DETAILS ONLY

Category of person _____

Employee no. _____

Date absence commenced (if known) D D M M Y Y Y Y

Date returned to work (if known) D D M M Y Y Y Y

SECTION F: IS THIS LINKED TO A PREVIOUSLY REPORTED INCIDENT? (tick one only ✓)

- ☐ Yes
- ☐ No

If yes, please give record no(s).

SECTION G: EXTERNAL CONTRACTOR DETAILS ONLY

Company Name _____

Company no. _____

SECTION H: WAS THERE WORK RELATED CONTACT? (as defined by HPSC & Occupational Health) (tick one only ✓)

- ☐ **Known close contact (work related)-** Go to section **I**
- ☐ **Known casual contact (work related) -** Go to section **I**
- ☐ **No known contact (work related)–** Go to section **J**

SECTION I: CAUSE OF TRANSMISSION/POSSIBLE TRANSMISSION: (select max 3)

- ☐ Hygiene practices, cough etiquette and cleaning regimes
- ☐ Insufficient isolation/quarantine
- ☐ Lack of Communication
- ☐ Movement/transfers (transportation)
- ☐ PPE available not utilised
- ☐ PPE inadequate/failure/breached
- ☐ PPE unavailable
- ☐ Social distancing failures
- ☐ Contact tracing incomplete/not completed
- ☐ Delay in detecting case
- ☐ Derogated worker
- ☐ Engineering controls/facilities inadequate e.g. design, layout, ventilation
- ☐ False negative result
- ☐ Poor waste management
- ☐ Undetected case
- ☐ Violence, Harassment and Aggression

SECTION J: HAZARD CLASSIFICATION:

Biological

Sub-hazard: Virus

Problem/Cause (route of transmission)

- ☐ Exposure to Bite (Human)
- ☐ Exposure to Bite (Insect / Animal)
- ☐ Exposure to Bodily Fluids
- ☐ Exposure to Needle Stick
- ☐ Inhalation/Airborne
- ☐ Equipment, Implements, Facilities, Sharps (Non Needle)
- ☐ Unknown
- ☐ Other: _____

SECTION K: WHAT WAS THE OUTCOME AT THE TIME OF THE INCIDENT?

✓ Outcome

☐ Injury not requiring first aid ☐ Injury or illness, requiring first aid	Category 3
☐ Injury requiring medical treatment	Category 2
☐ Long-term disability / Incapacity (incl. psychosocial) ☐ Permanent Incapacity (incl. Psychosocial) ☐ Death	Category 1

SECTION L: REPORTED BY:

First name _____

Surname _____

Date notified D D M M Y Y Y Y

Category of person *E.g. Consultant, Nurse, Allied Health etc.*

Local system reference no. _____

Reporter Signature: _____

Date D D M M Y Y Y Y

Contact Details _____

SECTION M: TO BE COMPLETED BY LINE/DEPARTMENT MANAGER (CATEGORY 1 INCIDENTS ONLY)

SAO Name: _____

Date notified to SAO: D D M M Y Y Y Y

SAO Email and Contact Details:

_____

_____

Line/Department Manager name:

_____

Date: D D M M Y Y Y Y

SECTION N: WITNESS DETAILS (Name, Contact No. etc.)

_____

_____

_____

_____

_____

_____

_____

SECTION O: TO BE COMPLETED BY QUALITY AND PATIENT SAFETY OFFICE

QPS Advisor Name: _____

Date: D D M M Y Y Y Y