



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

Time of incident 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

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)

Date returned to work (if known)

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)	
<input type="checkbox"/> Exposure to Bite (Human) <input type="checkbox"/> Exposure to Bite (Insect / Animal) <input type="checkbox"/> Exposure to Bodily Fluids <input type="checkbox"/> Exposure to Needle Stick <input type="checkbox"/> Inhalation/Airborne <input type="checkbox"/> Equipment, Implements, Facilities, Sharps (Non Needle) <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____	

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

✓ **Outcome**

<input type="checkbox"/> Injury not requiring first aid	Category 3
<input type="checkbox"/> Injury or illness, requiring first aid	
<input type="checkbox"/> Injury requiring medical treatment	Category 2
<input type="checkbox"/> Long-term disability / Incapacity (incl. psychosocial)	Category 1
<input type="checkbox"/> Permanent Incapacity (incl. Psychosocial)	
<input type="checkbox"/> Death	

SECTION L: REPORTED BY:

First name _____

Surname _____

Date notified

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

Local system reference no. _____

Reporter Signature: _____

Date

Contact Details _____

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

SAO Name: _____

Date notified to SAO:

SAO Email and Contact Details:

Line/Department Manager name:

Date:

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

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

QPS Advisor Name: _____

Date: