



Oifig an Stiúrthóra Náisiúnta, Acmhainní Daonna

Feidhmeannacht na Seirbhísí Sláinte

Ospidéal Dr. Steevens'

Baile Átha Cliath 8

Office of the National Director of Human Resources

Health Service Executive

Dr. Steevens' Hospital

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MEMORANDUM

To: Chief Executive Officer
Each National Director
Each Assistant National Director HR
Each Assistant Chief Finance Officers
Each Hospital Group CEO
Each Hospital Group Director of HR
Each Chief Officer CHO
Each CHO Heads of HR
Each CEO Section 38 Agencies
Each HR Manager Section 38 Agencies
Each Employee Relations Manager
Each Group Director of Nursing & Midwifery
Each Group Director of Midwifery
Each Clinical Director

CC: Mr. Pat Kirwan, Deputy Director and Executive Head – Business Development, SCA
Mr. Patrick Lynch, National Director – Quality Assurance and Verification Division, HSE

From: Ms. Anne Marie Hoey, National Director Human Resources

Date: 27th May 2020

Re: HR Memo - New HCW COVID-19 National Incident Report Form (NIRF)

Dear Colleagues,

Recent months have seen a dramatic change and additional challenges in our working environment. While meeting the challenges raised by the pandemic, every effort must be made to manage additional risk to staff and service users in line with legislation, the HSE Corporate Safety Statement and the People Strategy.

With reference to incident reporting, our Safety Statement requires: “ *that all incidents shall be identified, reported, and reviewed in accordance with the Safety, Health and Welfare at Work Act 2005 and as specified in the HSE Incident Management Framework 2018*”.

For further information see:

- [Corporate Safety Statement 2020](#)
- [Incident Management Framework \(IMF\) 2018](#)

In order to meet this requirement within your area of responsibility, I would request that you ensure that all appropriate COVID-19 related incidents are recorded and reported at the earliest opportunity on the National Incident Management System (NIMS) via the appropriate form (NIRF). We are actively seeking this data in order to aggregate the information and make it useful at the earliest opportunity in our management of Covid-19 related risk. We have worked closely with the State Claims Agency (SCA) to ensure that NIMS collects the right information to manage the data received.

An additional and temporary **HCW COVID-19 NIRF: V01** has been developed to allow for quicker reporting and better quality information pertaining to HC Workers acquiring COVID-19 and facilitates bespoke questions.

This new HCW COVID-19 NIRF seeks to additionally capture if there was work related contact, as defined by HPSC and Occupational Health. This definition can be found [here](#).

I also wish to address any ambiguity around the circumstances when a report must be made on NIMS. In the initial stages of the pandemic, a staff member receiving a positive Covid-19 diagnosis may have had that diagnosis attributed to foreign travel or community transmission. However, as we move through the phases of pandemic management, in the relative absence of foreign travel and with reduced community transmission, it is now more likely that staff in Health Care have contracted the disease in the workplace rather than in the community. Hence, if a staff member reports to their line manager that they have been tested and found to be positive for Covid-19, regardless of where it was acquired, the line manager **should record this on NIMS**.

For staff members working from home, a diagnosis of Covid-19 would indicate community transmission; however this should still be reported. Hence, as per the attached decision tree (see Appendix 1 - decision tree for full details) when completing the NIMS report in such cases the: “*No known work related transmission*” option should be selected under Section H: “*Was there work related contact?*”

This is an additional requirement to previous advice (last updated on 9th April 2020) and is being introduced to minimise the likelihood of underreporting. This bespoke NIRF is condensed to facilitate quicker reporting and better quality information when a staff member/volunteer/external contractor/work placement student acquires COVID-19. The decision tree attached (Appendix 1) will support managers in their decision to report.

Managers should also ensure that NIMS review screens are completed following their local investigation and that any incident reports are updated if circumstances change over time (e.g. if further information on causation comes to light or if the nature of the outcome – i.e. level of harm – changes).

Finally, I wish to confirm that there is no requirement for the HSE to notify the Health and Safety Authority (HSA) if an employee contracts COVID-19. Diseases are not reportable under the Safety, Health and Welfare at Work (Reporting of Accidents and Dangerous Occurrences) Regulations 2016 (S.I. No. 370 of 2016).

If you, or your staff, require any additional information or support, please contact the Workplace Health & Wellbeing dedicated Healthcare worker COVID-19 helpline. The helpline is available to assist staff and managers with information and advice during this Covid-19 period. It is important to stress that this number is for healthcare workers only.

Helpdesk number: 1850 420 420

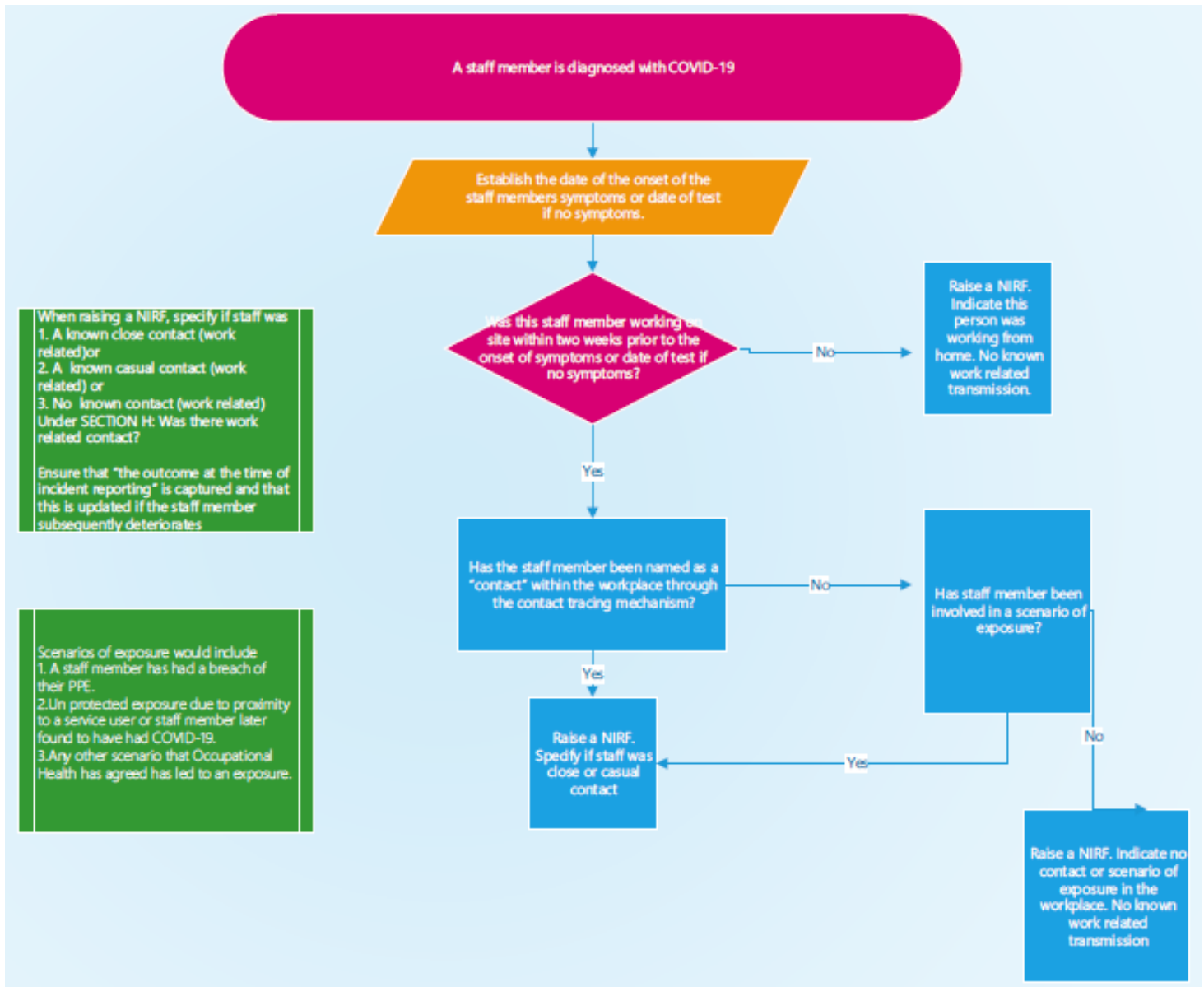
The helpdesk online self-service can be accessed through the following [link](#).

Yours sincerely




Anne Marie Hoey
National Director of Human Resources

Appendix 1 – NIMS Decision Tree



Appendix 2 – Healthcare Worker Covid-19 Acquired NIRF Form

Please note: A copy of the interactive form can be found [here](#)

 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: <input type="text"/>	
<small>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.</small>					
SECTION A: GENERAL INCIDENT DETAILS			SECTION B: PERSON AFFECTED DETAILS		
Date of incident <input type="text" value="DDMMYYYY"/>			First name <input type="text"/>		
Time of incident <input type="text" value="HHMM"/> Use 24 hour clock			Surname <input type="text"/>		
Location <u>E.g. Hospital, Health Centre, Residential Centre etc.</u>			Date of birth <input type="text" value="DDMMYYYY"/>		
Specific Location <u>E.g. Ward, Clients home etc.</u>			<input type="checkbox"/> Female <input type="checkbox"/> Male		
Offsite? <input type="checkbox"/>					
Description of incident:					
<i>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.</i>					
<i>and the immediate action taken e.g. isolate for 14 days etc.</i>					
<hr/> <hr/> <hr/> <hr/> <hr/>					
SECTION C: WHO WAS INVOLVED...? (tick one only ✓)			SECTION D: DIVISION (tick one only ✓)		
<input type="checkbox"/> Staff member			<input type="checkbox"/> Acute Hospital		
<input type="checkbox"/> Agency / Panel staff			<input type="checkbox"/> Social Care		
<input type="checkbox"/> Volunteer			<input type="checkbox"/> Health and Wellbeing		
<input type="checkbox"/> Student			<input type="checkbox"/> Primary Care		
<input type="checkbox"/> External Contractor			<input type="checkbox"/> Mental Health		
			<input type="checkbox"/> Ambulance Service		
SECTION E: STAFF MEMBER / AGENCY / PANEL STAFF / STUDENT / VOLUNTEER DETAILS ONLY			SECTION F: IS THIS LINKED TO A PREVIOUSLY REPORTED INCIDENT? (tick one only ✓)		
Category of person <input type="text"/>			<input type="checkbox"/> Yes		
Employee no. <input type="text"/>			<input type="checkbox"/> No		
Date absence commenced (if known) <input type="text" value="DDMMYYYY"/>			<input type="text"/>		
Date returned to work (if known) <input type="text" value="DDMMYYYY"/>			If yes, please give record no(s).		
SECTION G: EXTERNAL CONTRACTOR DETAILS ONLY			SECTION H: WAS THERE WORK RELATED CONTACT? (as defined by HPSC & Occupational Health) (tick one only ✓)		
Company Name <input type="text"/>			<input type="checkbox"/> Known close contact (work related) - Go to section I		
Company no. <input type="text"/>			<input type="checkbox"/> Known casual contact (work related) - Go to section I		
			<input type="checkbox"/> 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/transfer (transportation)
- ☐ PPE available not utilized
- ☐ 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: Sub-hazard:

Biological
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

- | | |
|---|------------|
| <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. Contractor, 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: