



RISK, INCIDENT & FEEDBACK | User Guide

2026

Written by Giselle Latta (RN)



www.riskclear.com.au

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FOR RISKCLEAR USERS

RISK, INCIDENT AND FEEDBACK MANAGEMENT

Risk, Incidents and Feedback can be entered into **RiskClear** via the **Safety Tab** by clicking on **New Incident**, **New Risk/Hazard**, or **New Feedback**. Click the **Learning Resources** symbol to access user guides and videos.

RiskClear is typically utilised by senior staff/ management.

DEFINITIONS:

INCIDENT	An event or circumstance which lead to an unintended and/or unnecessary harm to a patient/ consumer / business (<i>an incident <u>has</u> happened</i>).
RISK	An event or circumstance which could lead to unintended and/or unnecessary harm to an individual or business (<i>a risk <u>could</u> happen</i>).
FEEDBACK	Views and opinions of patients and service users on the care they have experienced.



ENTERING AN INCIDENT INTO RISKCLEAR

Click **New Incident** on the **Safety Page** (* denotes Aged Care version)

STEP ONE: Select from the drop-down whom the incident involved (e.g. patient, staff, resident, contractor)

STEP TWO: Type in a **description** of the incident and enter the incident date and time.

STEP THREE: Complete **Reporter, Location, Area, and Contributing Factor**

STEP FOUR: Select the **Incident Category, Sub-categories** from the dropdowns or **Quick Pick**

STEP FIVE: Complete the **Harm Score** (aka SAC/ISR)

*in Aged Care the **SIRS** (refer to Appendices A&B respectively for further information > pages 11-13)

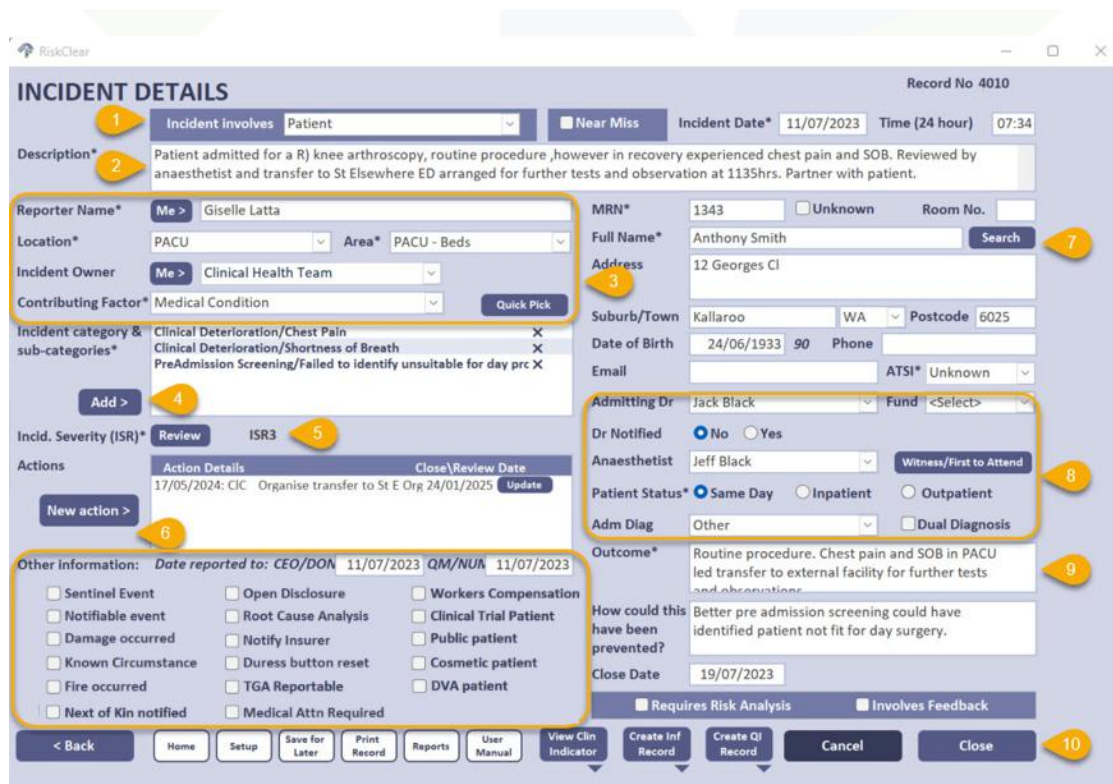
STEP SIX: Complete/assign any **actions** to staff (an email notification can also be sent) and **complete/tick** any of the relevant **Other Information**

STEP SEVEN: Complete **MRN/*Resident ID, Name**, and patient fields (if linked to your Patient Administration System you can click search and details will auto populate)

STEP EIGHT: Complete **Admitting Dr, Anaesthetist, Patient Status and Admission diagnosis** details (*in Aged Care this will be Primary Physician and Case Manager details)

STEP NINE: If known enter the Outcome and Prevention details and a close date if its ready to close. If you are not ready to close the incident leave it and complete when appropriate.

STEP TEN: Click **Close/Summary** to go to the next screen which is a Summary of the record and allows other functions to manage the record, such as forwarding, linking documents, discussion at Committee's and alignment to Standards.



The screenshot shows the 'INCIDENT DETAILS' form in the RiskClear system. The form is divided into several sections with numbered callouts (1-10) indicating the steps for data entry:

- 1:** Incident Involves (Patient)
- 2:** Description (Patient admitted for a R knee arthroscopy, routine procedure, however in recovery experienced chest pain and SOB. Reviewed by anaesthetist and transfer to St Elsewhere ED arranged for further tests and observation at 1135hrs. Partner with patient.)
- 3:** Reporter Name (Me > Giselle Latta)
- 4:** Location (PACU) and Area (PACU - Beds)
- 5:** Incident Owner (Me > Clinical Health Team)
- 6:** Contributing Factor (Medical Condition)
- 7:** MRN (1343) and Full Name (Anthony Smith)
- 8:** Address (12 Georges Cl)
- 9:** Suburb/Town (Kallaroo) and Postcode (6025)
- 10:** Date of Birth (24/06/1933) and Phone (90)

Other visible fields include: Incident Date (11/07/2023), Time (07:34), Incident category & sub-categories (Clinical Deterioration/Chest Pain, Clinical Deterioration/Shortness of Breath, PreAdmission Screening/Failed to identify unsuitable for day prc), Incid. Severity (ISR3), Actions (Organise transfer to St E Org 24/01/2025), Other Information (Sentinel Event, Notifiable event, Damage occurred, Known Circumstance, Fire occurred, Next of Kin notified, Open Disclosure, Root Cause Analysis, Notify Insurer, Duress button reset, TGA Reportable, Medical Attn Required, Workers Compensation, Clinical Trial Patient, Public patient, Cosmetic patient, DVA patient), Admitting Dr (Jack Black), Fund (<Select>), Dr Notified (No), Anaesthetist (Jeff Black), Patient Status (Same Day), Adm Diag (Other), Outcome (Routine procedure. Chest pain and SOB in PACU led transfer to external facility for further tests and observations), How could this have been prevented? (Better pre admission screening could have identified patient not fit for day surgery), Close Date (19/07/2023), Requires Risk Analysis, and Involves Feedback.

☐ Medical Attn Required
 ☐ Requires Risk Analysis
 ☐ Involves Feedback

< Back
 Home
 Setup
 Save for Later
 Print Record
 Reports
 User Manual
 View Clin Indicator
 Create Inf Record
 Create QI Record
 Cancel
 Close

Additional features:

- ✓ Tick whether the record requires **risk analysis**, **involves feedback** or not. If it, does you will be directed to those screens. You can also click **Save for Later** if needed.
- ✓ **Other information** includes notifiable events, workers compensation, Clinical Trial patient etc
- ✓ Note you can also **create a linked record** if the incident relates to a **clinical indicator** or **infection record** – and you can also create a linked **QI (quality improvement)** record
- ✓ * denotes a **mandatory** field
- ✓ In the instance where an **incident involves staff member/s**, there is a **multiple people** drop-down selector to enable all staff involved in the incident to be recorded/listed (below).

INCIDENT DETAILS

Incident involves

Staff member(s)

Multiple people ▼

☐ Unknown

Single person ▲

Full Names*

Anthony Smith
 John Jones
 Mary Lamb
 Laura Ingles

Occupation

ENTERING A RISK/HAZARD INTO RISKCLEAR

Click **New Risk/Hazard** on the **Safety Tab/Page**

STEP ONE: Enter the **Date**, **Time**, and **Risk Description** and **Reported By** details. You can also tick the **To Risk Register** box if you wish this record to appear on the Risk Register and what Risk Register Area (e.g., Clinical, Business, WHS, etc)

STEP TWO: Complete **Risk Rating details** by clicking **Add/Change** and use the inbuilt risk matrix to determine the risk level.

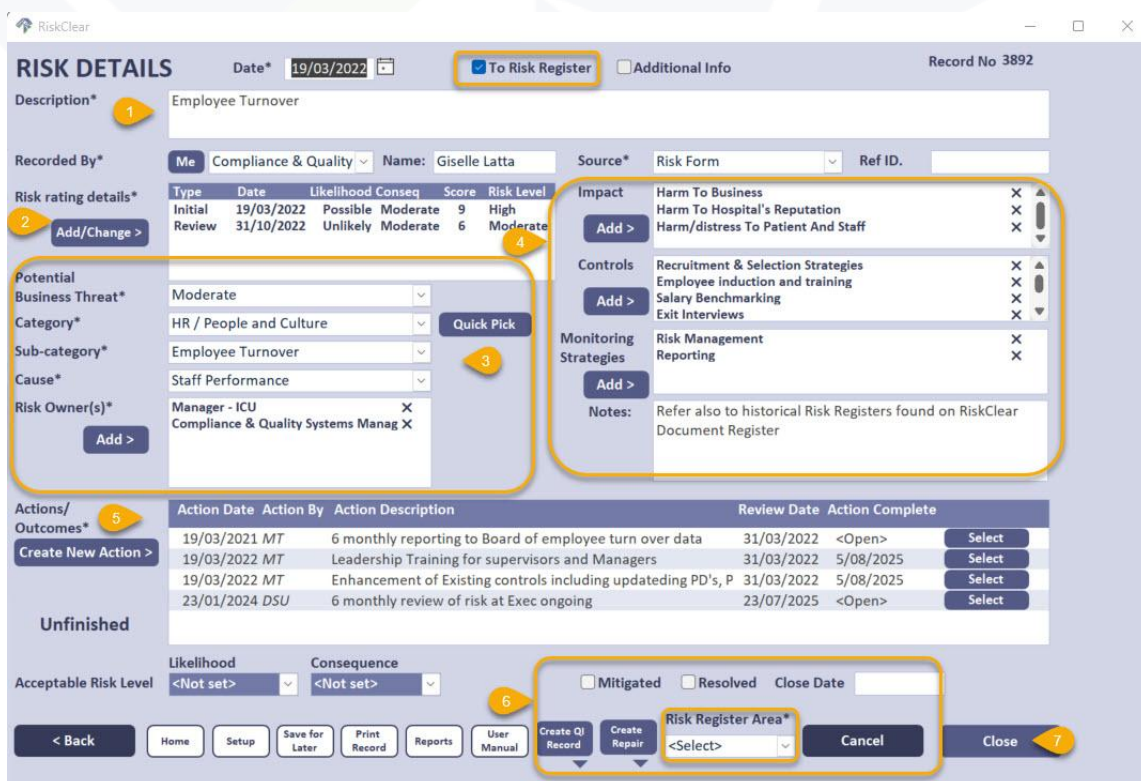
STEP THREE: Select the **Potential business threat**, **Category** and **Sub-category** as well as the **Cause** and assign the **Risk owners** by clicking on the **Add>** button.

STEP FOUR: Click **Add>** to list **Impact**, **Controls** and **Monitoring strategies**.

STEP FIVE: Click **Create New Action** to complete and assign actions to mitigate or resolve the risk.

STEP SIX: Tick the **mitigated** or **resolved** box and assign an acceptable risk level (optional). Click on Summary to close and save the record and to proceed to the summary page.

STEP SEVEN: Enter the Close Date (remembering that all actions need to be closed off before the risk record can be closed. Click **Close/Summary>** to save the record and proceed to the Summary Page/Screen.



Note: you can also **Create QI (Quality Improvement) Record** if the risk record requires quality improvement actions to help mitigate or resolve. **Creating QI record** will also link it to this Risk record. You can also **Create Repair** if a risk highlights the need for a repair to be completed as part of the risk management process. **Creating Repair** record will also link it to this Risk record and vice versa.

* = mandatory fields

ENTERING FEEDBACK INTO RISKCLEAR

Click **New Feedback** on the **Safety Page**

STEP ONE: Select from the top of the page whether it is a **Complaint, Suggestion** or **Compliment** record. Select complaint for the example below.

STEP TWO: Type in a **description** of the complaint.

STEP THREE: Fill in the Complainant details (this is the person making the complaint or acting on behalf of another)

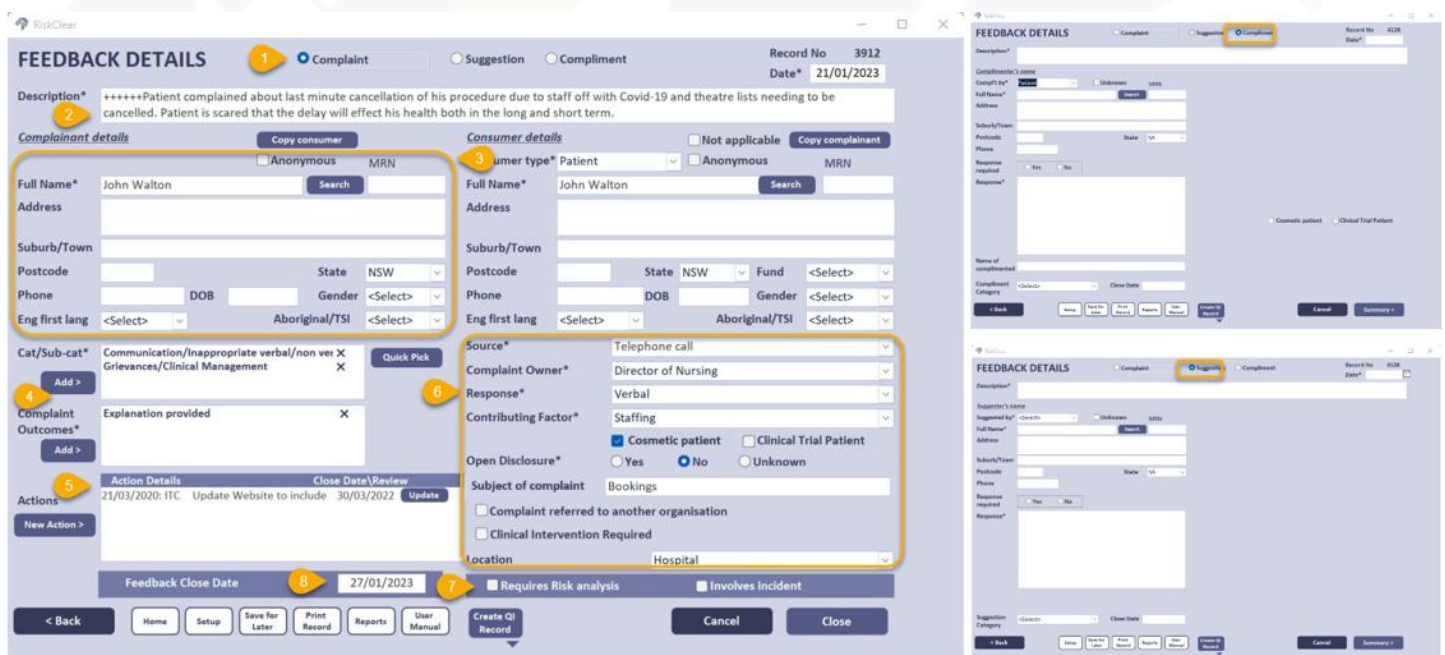
STEP FOUR: Select the **Category/Sub-category** by clicking **Add/Chng>** and the **Complaint Outcomes** by clicking **Add>**

STEP FIVE: Add any actions required to address the complaint by clicking **New Action>**

STEP SIX: Complete the **Source, Complaint Owner, Response, Contributing Factor, Open Disclosure, Subject of Complaint, Referral and Location** fields, and tick if the patient is a Cosmetic or Clinical Trial patient

STEP SEVEN: Enter the **Feedback Close Date** (remember any actions created need to have a close date to be able to close the entire record).

STEP EIGHT: Enter the Close Date (if able) > click on **Close/Summary** to take you to the **Summary Page** and save this record.



The other 2 feedback functions are **Suggestion** and **Compliment** and can be selected by clicking on **Suggestion** or **Compliment** across the top of the **Feedback Details** page. Both pages are similar to complete (as per right hand side of the diagram below).

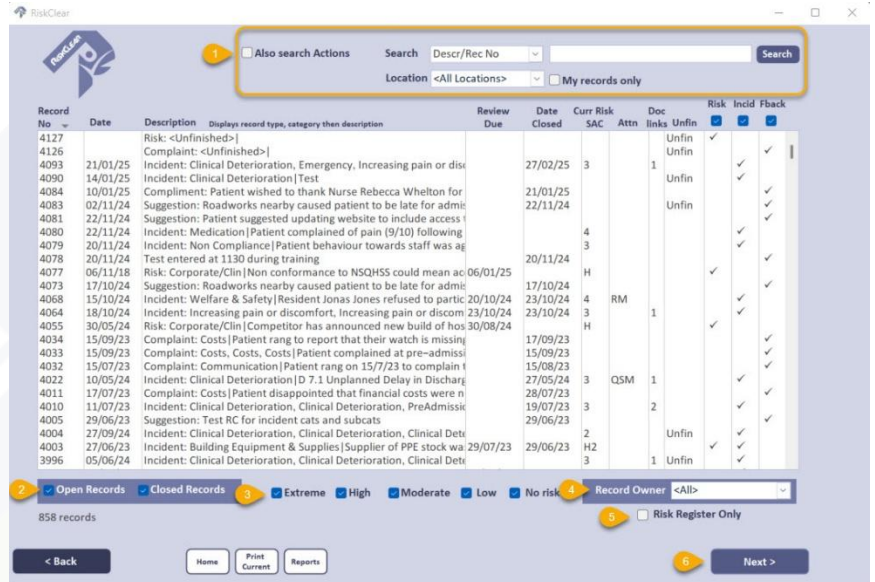
- ✓ Enter a description of the suggestion or compliment and by whom.
- ✓ Enter name of the person making the compliment or suggestion
- ✓ Type in any response.
- ✓ Enter the close date and click on summary to save the record and move to the Summary page.

SEARCHING RECORDS IN RISKCLEAR

Click **Search RiskClear** to open this screen > You can search/see all risk, incident and feedback records that have been entered.

You can search the following ways:

1. **Description/Record Number/MRN, Location** and tick **also search actions**. You can also tick the **My Records only** box.
2. **Open** and/or **Closed** Records
3. **By Risk Rating**
4. **By Record Owner**
5. **Risk Register only**
6. **Confidential** Records only (only visible to those with access)



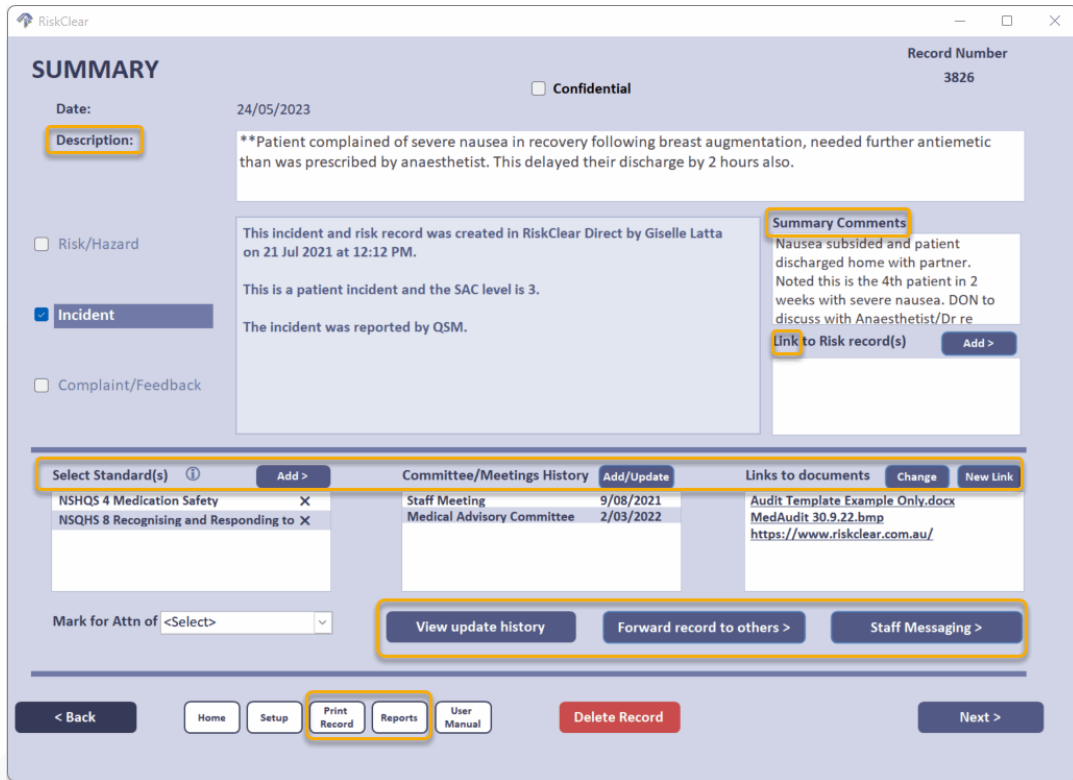
The screenshot shows the RiskClear search interface. At the top, there is a search bar with a dropdown menu for 'Search' (set to 'Descr/Rec No') and a 'Search' button. Below the search bar, there is a 'Location' dropdown menu (set to '<All Locations>') and a checkbox for 'My records only'. The main area displays a table of records with columns: Record No, Date, Description, Review Due, Date Closed, Curr Risk, SAC, Attn, Doc links, Unfin, Risk, Incid, and Back. The table contains 39 records. At the bottom, there are filters for 'Open Records' (checked), 'Closed Records' (checked), 'Extreme' (checked), 'High' (checked), 'Moderate' (checked), 'Low' (checked), 'No risk' (checked), and 'Record Owner' (set to '<All>'). There is also a checkbox for 'Risk Register Only' (unchecked). The bottom of the interface shows '858 records' and buttons for '< Back', 'Home', 'Print Current', 'Reports', and 'Next >'.

You can also access a suite of reports by clicking **Reports**

Clicking on any of the listed **records** (diagram above) will open a **Summary Page** (diagram to right >) of the RiskClear record. On this page as well as a summary of the record you can **link the record** to others, **link documents**, **select Standard/s** and **flag it to discuss at a meeting**.

Other functions include **viewing the update history** of that record, **forward record** to others and **staff messaging of feedback to staff involved**. The record can be **marked for the attention** of as well as be printed off.

You can also click **Reports** to go to the extensive Reports suite.



SUMMARY

Record Number: 3826

☐ Confidential

Date: 24/05/2023

Description: **Patient complained of severe nausea in recovery following breast augmentation, needed further antiemetic than was prescribed by anaesthetist. This delayed their discharge by 2 hours also.

☐ Risk/Hazard

☒ Incident

☐ Complaint/Feedback

This incident and risk record was created in RiskClear Direct by Giselle Latta on 21 Jul 2021 at 12:12 PM.

This is a patient incident and the SAC level is 3.

The incident was reported by QSM.

Summary Comments

Nausea subsided and patient discharged home with partner. Noted this is the 4th patient in 2 weeks with severe nausea. DON to discuss with Anaesthetist/Dr re

[Link to Risk record\(s\)](#) [Add >](#)

Select Standard(s) [Add >](#)

Standard	Status
NSHQ5 4 Medication Safety	X
NSQHS 8 Recognising and Responding to	X

Committee/Meetings History [Add/Update](#)

Meeting	Date
Staff Meeting	9/08/2021
Medical Advisory Committee	2/03/2022

Links to documents [Change](#) [New Link](#)

[Audit Template Example Only.docx](#)

[MedAudit 30.9.22.bmp](#)

<https://www.riskclear.com.au/>

Mark for Attn of: <Select>

[View update history](#) [Forward record to others >](#) [Staff Messaging >](#)

[< Back](#) [Home](#) [Setup](#) [Print Record](#) [Reports](#) [User Manual](#) [Delete Record](#) [Next >](#)

Clicking on any of the listed **records** will open a **Summary Page** (above). On this page as well as a **summary** of the record you can **link the record** to others, **link documents**, **select Standard/s** and **flag it to discuss at a meeting**.

Other functions include **viewing the update history** of that record, **forward record** to others and **staff messaging of feedback to staff involved**. The record can be **marked for the attention** of as well as be printed off.

You can also click **Reports** to go to the extensive Reports suite.

FOR RISKCLEAR DIRECT USERS

RISK, INCIDENT AND FEEDBACK MANAGEMENT IN RISKCLEAR DIRECT



Risk, Incidents and Feedback can be entered into **RiskClear Direct** via the **Safety Tab** by clicking on **New Incident**, **New Risk/Hazard**, or **New Feedback**. Clicking the **Learning Resources** symbol will take you to user guides and videos.

RiskClear Direct is utilised by general nursing and administration staff for a convenient streamlined experience.

Staff report incidents, hazards and feedback and nominated management staff are notified via email of the new RiskClear Direct record. The manager can then analyse, assign further actions, and finalise the record. RiskClear provides feedback to the staff member via **messaging log** and email.

DEFINITIONS:

INCIDENT	An event or circumstance which lead to an unintended and/or unnecessary harm to a patient/ consumer / business (<i>an incident <u>has</u> happened</i>).
RISK	An event or circumstance which could lead to unintended and/or unnecessary harm to an individual or business (<i>a risk <u>could</u> happen</i>).
FEEDBACK	Views and opinions of patients and service users on the care they have experienced.

ENTERING AN INCIDENT INTO RISKCLEAR DIRECT

Click **New Incident** on the **Safety Tab**

STEP ONE: Select from the pulldown menu whom the incident involved (e.g. patient, staff, resident etc) and enter the incident date and time. Click **Me** or type in Reporter's name.

STEP TWO: Enter a **description** of the incident.

STEP THREE: Select the **Location, Area,** and **Contributing Factor.**

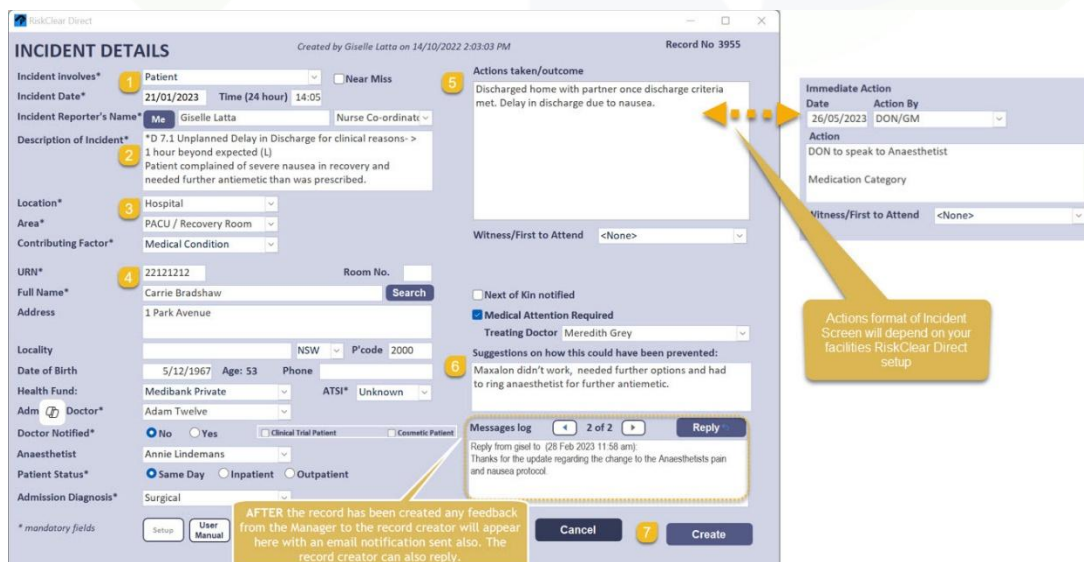
STEP FOUR: Complete patient **Name, MRN/*Resident ID, Dr (or *Primary Physician)** details and **Patient status.** You can also tick if they are a Cosmetic or Clinical Trial Patient.

STEP FIVE: Enter any **actions/or outcomes.**

STEP SIX: Enter any **suggestions.**

STEP SEVEN: Click **Create** to create and save the record.

Nominated management staff are notified via email of the new RiskClear Direct record. The manager will review, assign further actions, and finalise the record. RiskClear provides feedback to the staff member of the outcome of their reported event via the messages log



Note: You can click **UserMan** to view the RiskClear Direct User Manual

* = mandatory fields

ENTERING A RISK/HAZARD INTO RISKCLEAR DIRECT

Click **New Risk/Hazard** on the **Safety Tab**

STEP ONE: Enter the **Date**, **Reporters Name** and **Reporters Position** details.

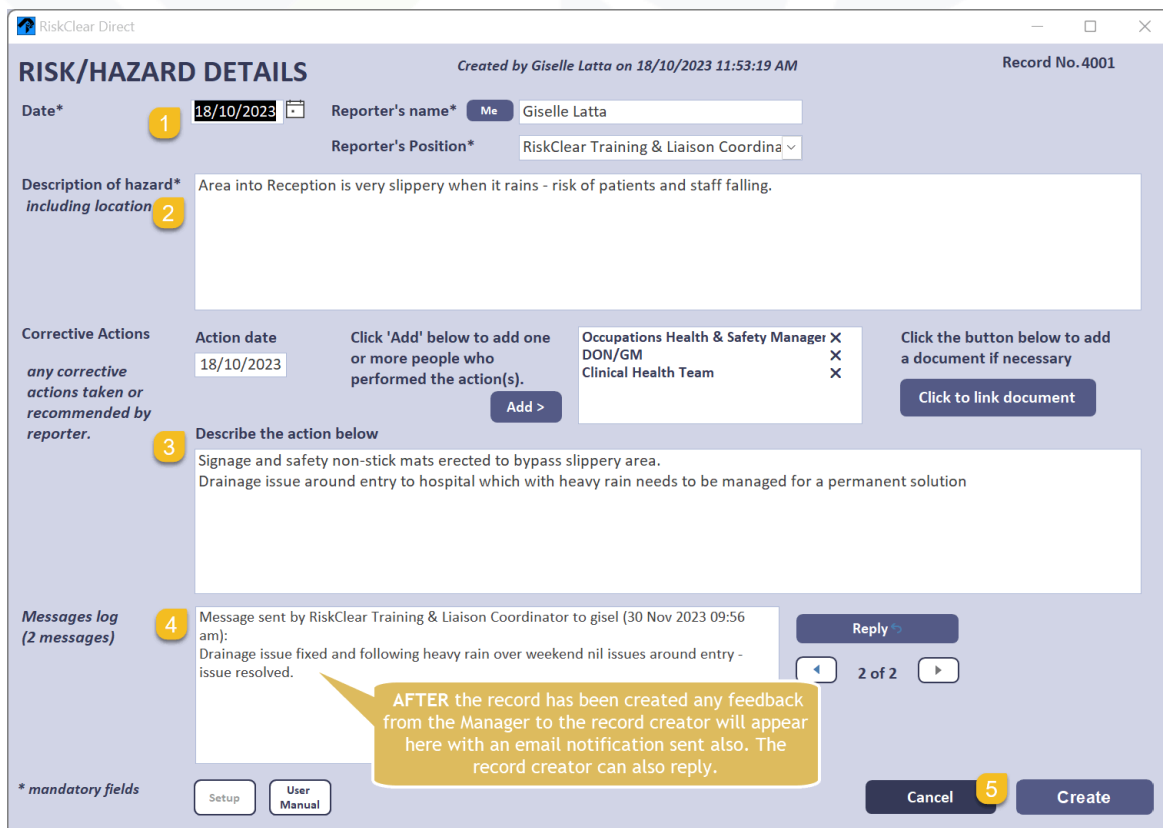
STEP TWO: Enter a **Description of Hazard** including location.

STEP THREE: Enter any **Corrective Actions** taken.

STEP FOUR: **Message Log** is where any comments or feedback from management will appear.

STEP FIVE: Click **Create** to complete and save the record.

Nominated management staff are notified via email of the new RiskClear Direct record. The manager will then review, assign further actions, and finalise the record. RiskClear provides feedback to the staff member of the outcome of their reported event via Message Log and



RISK/HAZARD DETAILS Created by Giselle Latta on 18/10/2023 11:53:19 AM Record No.4001

Date* 18/10/2023 Reporter's name* Me Giselle Latta
Reporter's Position* RiskClear Training & Liaison Coordina

Description of hazard* including location 2
Area into Reception is very slippery when it rains - risk of patients and staff falling.

Corrective Actions
any corrective actions taken or recommended by reporter. 3
Action date 18/10/2023
Click 'Add' below to add one or more people who performed the action(s).
Occupations Health & Safety Manager X
DON/GM X
Clinical Health Team X
Add >
Click the button below to add a document if necessary
Click to link document

Describe the action below
Signage and safety non-stick mats erected to bypass slippery area.
Drainage issue around entry to hospital which with heavy rain needs to be managed for a permanent solution

Messages log (2 messages) 4
Message sent by RiskClear Training & Liaison Coordinator to gisel (30 Nov 2023 09:56 am):
Drainage issue fixed and following heavy rain over weekend nil issues around entry - issue resolved.
Reply
2 of 2

* mandatory fields
Setup User Manual
Cancel 5 Create

Note: You can click **UserMan** to view the RiskClear Direct User Manual

* = mandatory fields

ENTERING FEEDBACK INTO RISKCLEAR DIRECT

Click **New Feedback** on the **Safety Tab**

STEP ONE: Select from the top of the page whether it is a **Complaint**, **Suggestion** or **Compliment**.

STEP TWO: Type in a **description** and enter the **date**.

STEP THREE: Fill in the **details of the person** making the complaint, suggestion, or compliment.

STEP FOUR: Note if a **response is required**. Any updates from your Manager using RiskClear will show here also. **Select the Feedback category** and enter the **Close Date** if appropriate or leave for Manager.

STEP FIVE: Click on **Create** to create and save this record.

Nominated management staff are notified via email of the new RiskClear Direct record. The manager will then review, assign further actions, and finalise the record. RiskClear provides feedback to the staff member of the outcome of their reported event.



FEEDBACK DETAILS 1 ☒ Complaint ☐ Suggestion ☐ Compliment

Record No. 3191
Date* 26/03/2022

Description* Patient complained of unexpected costs associated with her surgery. Wasn't told prior. Wishes to discuss concerns with DON

Complainant details 2 ☐ Anonymous ☐ URN

Full Name* Jan Bland Search
Address 7 Main St
Locality HERESVILLE
Postcode 7777 State TAS
Phone 03 12345678 DOB 1/01/1985 Sex Male
Eng first lang Yes Aboriginal/TSI No

Consumer details Consumer type* ☐ Not applicable ☒ Patient ☐ Anonymous ☐ URN

Full Name* Jan Bland Search
Address 7 Main St
Locality HERESVILLE
Postcode 7777 State TAS Fund: <Select>
Phone 03 12345678 DOB 1/01/1985 Sex Male
Eng first lang Yes Aboriginal/TSI No

Copy complainant

3 Location Day Surgery Feedback Close Date 30/11/2023

4 Messages log (2 messages)
Reply from gisel to RiskClear Training & Liaison Coordinator (30 Nov 2023 10:28 am)
Thanks for update

5 Cancel Create

FEEDBACK DETAILS ☐ Complaint ☒ Suggestion ☐ Compliment

Record No. 3192
Date* 26/03/2022

Description* Patient Mary Lamb visited to thank Nurse Grey and Dr Black for their extra TLC. Was feeling very nervous and feels very well cared for and less anxious about coming back for her other planned surgery knowing how well she will be looked after.

Compliment by* Patient ☐ Unknown ☒ URN

Full Name* Janet Jackowski Search 12345
Address 3 Main St
Locality HERESVILLE
Postcode 6777 State TAS
Phone 03 12345678

Response required ☐ Yes ☒ No

Response Message passed onto DON and Manager. Message relayed to Nurse and Dr personally as well as at Staff Meeting.

Compliment Category Clinical Practice Close Date 27/09/2020

Cancel Save & Close

FEEDBACK DETAILS ☐ Complaint ☒ Suggestion ☐ Compliment

Record No. 3193
Date* 27/09/2023

Description* Updated directions to access hospital on website due to roadworks for roadworks needed for next 3 months.

Suggester's name Suggester by* Other ☐ Unknown ☒ URN

Full Name* Jane Black Search 12345
Address 1 Main St
Locality HERESVILLE
Postcode 6777 State TAS
Phone 03 12345678

Response required ☐ Yes ☒ No

Response Web Design Company requested to update information. Information updated on website 14/4/23

Suggestion Category Organisational Close Date 14/4/2023

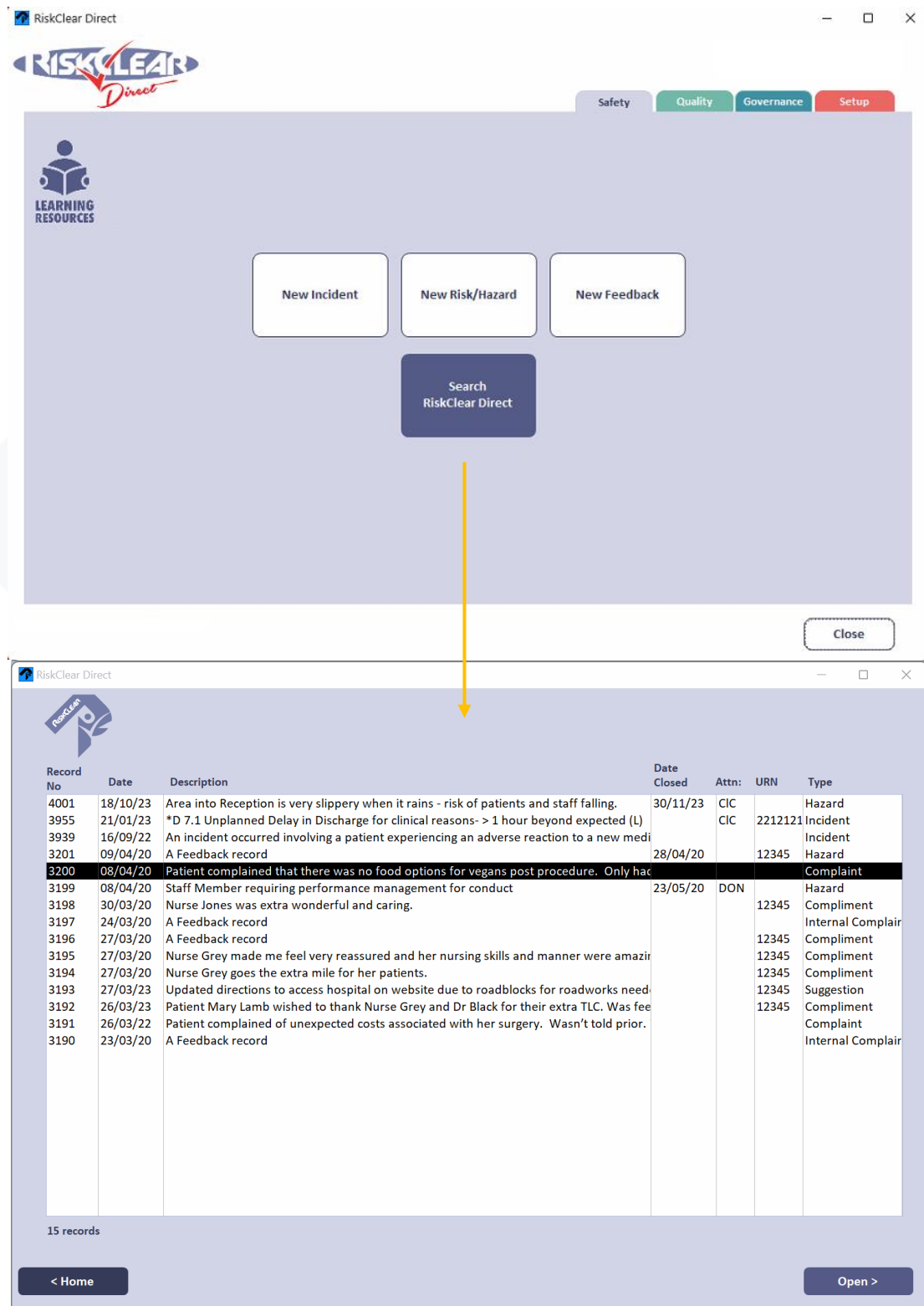
Cancel Save & Close

Note the Compliment and Suggestion Screens are similar (as shown above right) in diagram.

* = mandatory fields

SEARCHING RECORDS IN RISKCLEAR DIRECT

Click **Search RiskClear Direct** and you will see a list of the records that (only) you have entered into RiskClear Direct.



RiskClear Direct

Safety Quality Governance Setup

LEARNING RESOURCES

New Incident New Risk/Hazard New Feedback

Search RiskClear Direct

Close

RiskClear Direct

Record No	Date	Description	Date Closed	Attn:	URN	Type
4001	18/10/23	Area into Reception is very slippery when it rains - risk of patients and staff falling.	30/11/23	CIC		Hazard
3955	21/01/23	*D 7.1 Unplanned Delay in Discharge for clinical reasons- > 1 hour beyond expected (L)		CIC	2212121	Incident
3939	16/09/22	An incident occurred involving a patient experiencing an adverse reaction to a new medi				Incident
3201	09/04/20	A Feedback record	28/04/20		12345	Hazard
3200	08/04/20	Patient complained that there was no food options for vegans post procedure. Only had				Complaint
3199	08/04/20	Staff Member requiring performance management for conduct	23/05/20	DON		Hazard
3198	30/03/20	Nurse Jones was extra wonderful and caring.			12345	Compliment
3197	24/03/20	A Feedback record				Internal Complai
3196	27/03/20	A Feedback record			12345	Compliment
3195	27/03/20	Nurse Grey made me feel very reassured and her nursing skills and manner were amaz			12345	Compliment
3194	27/03/20	Nurse Grey goes the extra mile for her patients.			12345	Compliment
3193	27/03/23	Updated directions to access hospital on website due to roadblocks for roadworks need			12345	Suggestion
3192	26/03/23	Patient Mary Lamb wished to thank Nurse Grey and Dr Black for their extra TLC. Was fee			12345	Compliment
3191	26/03/22	Patient complained of unexpected costs associated with her surgery. Wasn't told prior.				Complaint
3190	23/03/20	A Feedback record				Internal Complai

15 records

< Home Open >

APPENDIX A – INCIDENT SEVERITY RATINGS HOSPITALS & HEALTHCARE

Incident Management in Healthcare requires a standardised objective measure of severity (or degree of harm) to be allocated to each incident. The purpose of this is to determine the level of investigation and action required.

- Please refer to your Health Service's Incident Management Policy and Procedures for relevant information.
- You can also refer to the [Incident management guide | Australian Commission on Safety and Quality in Health Care](#) for further information including State-based resources

RiskClear enables users to objectively measure the severity of an incident. Each State in Australia utilises their own objective measure to measure the severity of an incident and this field will display differently according to the state you are in.

Incident Example (refer to diagram below)

Incident Details – Patient experienced a post operative bleed requiring a return to theatre for cauterisation following their booked D&C procedure. (SAC/ISR/HARM SCORE = 2)

To determine the **Harm Score/ Incident Severity Rating (ISR) or Severity Assessment (SAC)** in RiskClear use the "Set" button (or select from drop-down selector) to access the Harm/Severity Scoring Matrix.



Once a rating has been set the **Set>** button will say **Review**



INCIDENT DETAILS Record No 3979

Incident involves Patient Near Miss Incident Date* 09/01/2024 Time (24 hour) 13:40

Description*
A 2.0 Unplanned return to Theatre
Patient experienced a post op bleed in recovery requiring a return to theatre for cauterisation following a routine D&C.

Reporter Name* Me > Giselle Latta MRN* 4444444 Unknown Room No.

Location* PACU Area* PACU - Beds Full Name* Josie Posey Search

Incident Owner DON/GM Address

Contributing Factor* Known but unexpected outcome Quick Pick

Incident category & sub-categories*
Clinical Deterioration/Hypotension Clinical Deterioration/Bradycardia

Add >

Harm Score* Review Harm Sc 2

Actions
New action >

Action Details	Close/Review Date
02/01/2024: DON Reportable event to Dept of	03/01/2024 Update
27/01/2024: DON Follow up phone call with p;	27/01/2024 Update
27/03/2024: DON Investigation closed	27/03/2024 Update

Other information:
Reported to:
GM/DON/CEO 9/01/2024
QM/MANAGER 9/01/2024

☐ Sentinel Event ☐ Open Disclosure ☐ Workers Compensation
☐ Notifiable event ☐ Root Cause Analysis ☐ Clinical Trial Patient
☐ Damage occurred ☐ Notify Insurer ☐ Public patient
☐ Known Circumstance ☐ Duress button reset ☐ Cosmetic patient
☐ Fire occurred ☐ TGA Reportable ☐ DVA patient
☐ Next of Kin notified ☐ Medical Attn Required

How could this have been prevented?
Extensive endometriosis

Close Date 27/03/2024 ☒ Send overdue reminders

☐ Requires Risk Analysis ☐ Involves Feedback

< Back Home Setup Save for Later Print Record Reports User Manual View Clin Indicator Create Inf Record Create QI Record Cancel Close

***State Based Harm Score/Incident Severity Ratings are calculated within RiskClear (based on information provided by *State Health Departments)**

- For Clients in (1) VIC, (2) SA, (3) ACT & (4) NSW the selector will allow for the selection of the SAC level by choosing a Consequence and Likelihood. As you click each option a full definition description will appear underneath.

1 Incident Severity Rating (ISR) & SDC (VIC)

Choose the incident type then harm, care and actions.

☒ Patient ☐ Worker ☐ Hazard

Level of Harm
Harm - Temporary (Moderate)

Required Level of Care
Current setting - Increased observation or monitoring

Actions required
Intermediate treatment

☒ Statutory Duty of Candour (SDC) ☐ SDC opted out

1. SAPSE identified on
2. SDC Apology given on
An apology must be provided within 24 hours
3. SDC Meeting held on
Within 10 business days of the SAPSE being identified, SDC meeting must be held
4. SDC meeting report delivered on
Within 10 business days of the SDC meeting, a copy of the meeting report must be provided to the patient
5. Report post review of SAPSE to patient/family
Within 50 business days of the SAPSE being identified, a report must be created which reviews the SAPSE and provided to the patient and/or their NOK/family

Cancel Link paperwork/evidence Folder Apply

2 Incident Severity Rating (ISR)

Select an outcome and then a treatment below. Only relevant treatments are shown.

Pt. outcome Near Miss No Harm/Inj Harm/Injury Perm Loss Sentin Event Death ISR

Harm or injury

Treatment req. No change Incr Monitor Clin Review Unplanned Pt Lng Term Care Immed emerg

Unplanned procedure resulting in higher level of care/therapy

Cancel Apply

3 Harm Score (ACT)

Select a Harm Score to see more information below.

Harm Score 1 Harm Score 2 Harm Score 3 Harm Score 4

Major Harm to a Patient/client/consumer/person as the result of an incident:
- requiring life saving surgical or medical intervention or
- shortened life expectancy or
- permanent or long-term physical harm or long-term loss of function.
Attempted Suicide of a Mental Health consumer discharged from a CHS inpatient facility within the previous seven days:
- requiring life saving surgical or medical intervention or
- shortened life expectancy or
- permanent or long-term physical harm or long-term loss of function.
Note: If the incident meets the definition of a Sentinel Event it is a Harm Score 1

4 Harm Score (NSW)

Please choose a likelihood and consequence. Click on a level to get more information

Likelihood Rare Unlikely Possible Likely Frequent Harm Score

Will probably occur in most circumstances (several times a year)

Consequence Minimum Minor Moderate Major Serious

• Patient: Patient with permanent reduction in bodily functioning (sensory, motor, physiologic, or psychologic) unrelated to the natural course of the illness and differing from the expected outcome of patient management.
Any of the following:
- Increased length of stay as a result of the incident
- Surgical intervention required as a result of the incident
• Staff: Medical expenses, lost time or restricted duties or injury / illness for 1 or more staff.
• Visitor: Medical expenses incurred or treatment of up to 2 visitors not requiring hospitalization.
• Service: Disruption to users due to agency problems.
• Financial: Loss of assets replacement value due to damage, fire, etc. \$50K to \$100K.
Loss of cash, investments, assets due to fraud, overpayment or theft to \$10K.
• Environmental: Off-site release contained with outside assistance.
Fire incident stage or less.

- **For clients in (5) WA and (6) QLD** the selector will show SAC 1 – 3 and SAC 1 – 4, respectively. As you click each level a full definition will appear underneath.
- For (7) other states/territories, the standard original SAC drop-down selector will appear.

SAC Rating (WA)

5

Please choose a likelihood and consequence. Click on a level to get more information

SAC1

SAC2

SAC3

Physical/psychological Moderate harm that has, or could have (near miss), be attributed to health care provision (or lack thereof) rather than the patient's underlying condition or illness.
SAC 2 clinical incidents include, but are not limited to the following:

- Increased length of stay (More than 72 hours to 7 days)
- Additional investigations performed
- Referral to another clinician
- Surgical intervention
- Medical intervention
- Increased frequency of mental health clinician review
- Near miss that could have resulted in moderate harm.

7

SAC Rating*

Level 2 Harm

Actions

New action >

<Select>
Level 1 Harm
Level 2 Harm
Level 3 Harm
Level 4 Harm

SAC Rating (QLD)

6

Select a SAC Level to see more information below.

SAC1

SAC2

SAC3

SAC4

Temporary harm which is not reasonably expected as an outcome of healthcare. Includes the following as a result of a clinical incident:

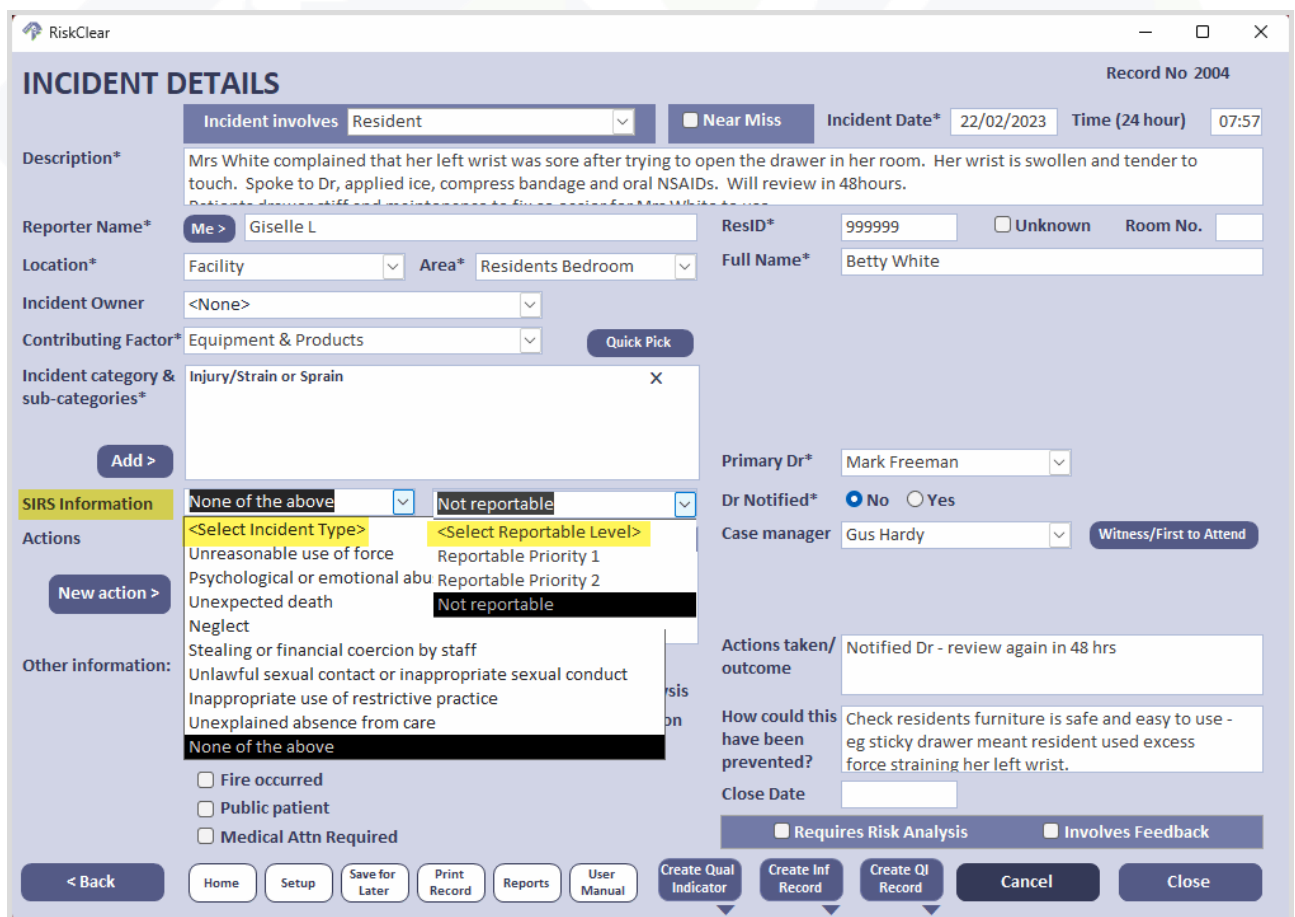
- Additional investigations performed.
- Surgical intervention.
- Procedures involving the wrong patient or body part resulting in temporary harm.

APPENDIX B – INCIDENT RATINGS (SIRS) AGED CARE

Incident Management Systems in Aged Care are required to safeguard older people and to acknowledge, respond to and effectively manage and learn from incidents. The Serious Incident Response Scheme (SIRS) is a nationwide initiative and responsibility for providers to manage and take reasonable steps to prevent incidents and focus on the safety, health, and wellbeing of aged care consumers.

- Please refer to your Aged Care Service's Incident Management Policy and Procedures for relevant information.
- Refer also to the [Incident management | Aged Care Quality and Safety Commission resources for further information.](#)

In RiskClear you are required to select from the **Incident Type** and **Reportable Level** dropdowns which determine the **SIRS rating and action required**.



INCIDENT DETAILS Record No 2004

Incident involves: Resident ☐ Near Miss Incident Date*: 22/02/2023 Time (24 hour): 07:57

Description*: Mrs White complained that her left wrist was sore after trying to open the drawer in her room. Her wrist is swollen and tender to touch. Spoke to Dr, applied ice, compress bandage and oral NSAIDs. Will review in 48hours.

Reporter Name*: Me > Giselle L ResID*: 999999 ☐ Unknown Room No.

Location*: Facility Area*: Residents Bedroom Full Name*: Betty White

Incident Owner: <None>

Contributing Factor*: Equipment & Products

Incident category & sub-categories*: Injury/Strain or Sprain

SIRS Information None of the above Not reportable

Actions

Other information:

- ☐ Fire occurred
- ☐ Public patient
- ☐ Medical Attn Required

Primary Dr* Mark Freeman **Dr Notified*** ☒ No ☐ Yes

Case manager Gus Hardy

Actions taken/ outcome Notified Dr - review again in 48 hrs

How could this have been prevented? Check residents furniture is safe and easy to use - eg sticky drawer meant resident used excess force straining her left wrist.

Close Date

☐ Requires Risk Analysis ☐ Involves Feedback