Aged residential care Severity Assessment Code (SAC) examples 2024

The examples below are for **guidance only; they are not intended to be prescriptive or exclude other events from review.** The final SAC rating can be changed after the review based on the experience of harm for the consumer, regardless of the number or type of learning opportunities developed. The viewpoints and experiences of consumers and whānau must be incorporated into the provisional and final SAC ratings. See also the SAC rating and process tool.

For adverse events related to primary care, aged residential care, maternity, pre-hospital, mental health and addiction services or healthcare-acquired infections, please refer to the specific SAC examples here.

Psychological, cultural and spiritual harm

Psychological, cultural and spiritual harm is unlikely to occur in isolation of each other and is dependent on the values and experiences of individual consumers, which makes identifying specific examples difficult. When rating an event, engage with the consumer and whānau to identify their perspective and ability to function as a result. For example, consider the psychological effect on a consumer when consent isn't obtained before an examination or procedure.

Psychological, cultural and spiritual harm can result from such events as unconsented student involvement, not being offered the opportunity for whānau support in the room during a procedure or advanced care plan discussion, care providers not being supportive of tino rangatiratanga and providers dismissing or undermining consumer wishes.

SAC 1 – Severe: death or harm causing severe loss of function and/or requiring life-saving intervention

- Not related to natural course of illness or treatment
- Differs from the immediate expected outcome of care
- Can be physical, psychological, cultural or spiritual

- Fall resulting in death or severe loss of function (eg, severe traumatic brain injury) or requiring life-saving intervention
- Delayed recognition of resident's deterioration or medical assistance when escalation is required within their goals of care, resulting in cardiopulmonary resuscitation, severe loss of function or death
- Medication or treatment plan error resulting in death or the need for permanent therapy (eg, renal dialysis)
- Death or severe harm as result of care plan not being followed (eg, choking when resident not given a soft/liquid diet as recommended)
- Death due to suicide or self-harm by resident
- Delayed referral, diagnosis or treatment resulting in treatment options being limited to a palliative care pathway
- Advance directive[1] not accessed and/or not followed, which leads to the delivery of the treatment the person stated they do not want

[1] An advance directive is consent to or refusal of a specific treatment that may or may not be offered in the future when the person no longer has capacity. A valid advance directive is legally binding. To be valid, the advance directive must have been created by a person with capacity, who was informed and undertook the process voluntarily. The directive only comes into play when the person has lost capacity, and it must relate to the current situation.

SAC 2 – Major: harm causing major loss of function and/or requiring significant intervention

- Not related to natural course of illness or treatment
- Differs from the immediate expected outcome of care
- Can be physical, psychological, cultural or spiritual

- Fall resulting in fracture of major bone (ie, vertebrae, skull, jaw, neck of femur, femur, tibia, fibula, humerus, radius, ulna, pelvis), head injury or laceration requiring significant intervention (eg, skin grafting)
- Delayed recognition of resident's deterioration or medical assistance, resulting in unplanned transfer to hospital or untimely transfer to end-of-life care pathway
- Medication or treatment plan error resulting in major harm (eg, requiring temporary dialysis, reversal agent administered, eg, naloxone)
- Major loss of function or significant intervention required as a result of care plan not being followed (eg, anaphylactic reaction to documented food allergy, choking episode when resident not given soft/liquid diet as directed resulting in need for transfer to higher-level care)
- Stage 3, 4 or unstageable pressure injuries, suspected deep tissue injury or mucosal (include in the report whether the injury is facility or community acquired; hospital-acquired injury should be reported by the hospital and an ACC form completed)- report hospital acquired if in ARC they worsen to become a SAC 2 pressure injury.
- Injury or fracture as a result of a resident being offsite (if it occurs when a resident is missing or involved in activities run by the residential care staff)
- Resident is reassessed as requiring an additional level of care (eg, dementia-level care), but lack of beds means they cannot be escalated and the resident experiences significant harm as a direct result
- Serious self-harm by a resident within 72 hours of receiving mental health care, treatment or services
- Advance care plan,[2] whānau ora plan or shared goals of care are not recognised, unable to be accessed and/or not followed, which leads to unwanted significant interventions (eg, active treatment provided for patient on the palliative pathway)

[2] Advance care planning is a process of thinking and talking about your values and goals and what your preferences are for current and future health care. A person may write down what is important to them, their concerns and care preferences in an advance care plan. Some advance care plans contain an advance directive.

SAC 3 – Moderate: Harm causing short term loss of function and / or requiring moderate additional intervention

- Not related to natural course of illness or treatment
- Differs from the immediate expected outcome of care
- Can be physical, psychological, cultural or spiritual

- Stage 2 pressure injury
- Fall resulting in minor fracture, dislocation of a joint, dental injuries or laceration
- Resident is reassessed as requiring an additional level of care (eg, dementia-level care), but lack of beds means they cannot be escalated
- Resident felt unheard in the development of a shared goals of care[3] or advance care plan, and it didn't reflect the consumer and whānau preferences

SAC 4 – Minor: harm causing no loss of function and requiring little or no intervention (includes near misses)

- Extra investigation or observation
- Review by another clinician
- Minor treatment
- Not related to natural course of illness or treatment
- Differs from the immediate expected outcome of care
- Can be physical, psychological, cultural or spiritual

- Fall of resident resulting in soft tissue injury, contusion or no injury
- Additional monitoring, investigations or minor interventions related to an event of harm
- Medication error with no resulting harm
- Stage 1 pressure injury
- Additional monitoring, minor investigation or interventions because of the event of harm

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[3] Shared goals of care are when clinicians, patients and whānau explore patients' values, the care and treatment options available and agree the goal of care for the current admission/episode of care and if the patient deteriorates.