

Mental health and addiction Severity Assessment Code (SAC) examples 2021–22

The examples below are for guidance only; they are not intended to be prescriptive or exclude other events from review. Any event should be rated on actual outcome for the consumer (mental health and addiction (MHA) service user), though there are two exceptions related to harm to a third party included below. Reviews of events, including suspected suicides (which involve multiple teams and organisations), require a partnership approach led by the service the consumer was in, with the involvement of whānau or their nominated representative.

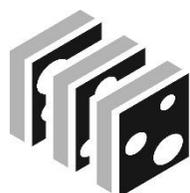
See also the Always Report and Review list 2021–22, the Severity Assessment Code examples 2019–20 and the Severity Assessment Code (SAC) rating and triage tool for adverse event reporting.¹

SAC 1 Death or permanent severe loss of function	SAC 2 Permanent major or temporary severe loss of function
<ul style="list-style-type: none"> • Suspected suicide by any consumer receiving care, treatment and services in a continuous care setting or within 72 hours of discharge; includes approved and unapproved leave status • Suspected homicide by a current MHA consumer or within 28 days of discharge from an MHA service • Medication or treatment plan error resulting in death • Delayed recognition of a consumer’s deterioration resulting in permanent severe disability or death (eg, cardiomyopathy, myocarditis or toxic megacolon while taking clozapine) • Unexpected death of a consumer due to long-term side effects of medication (eg, cardiovascular disease secondary to metabolic syndrome in a consumer in their 30s or 40s) 	<ul style="list-style-type: none"> • Suspected suicide by an MHA consumer within 72 hours of attending the emergency department (ED), whatever the presentation at ED • Suspected suicide or serious self-harm by a community MHA consumer or within 28 days of discharge from a community (secondary or specialist services) MHA service • Serious self-harm by any consumer receiving care, treatment and services in a continuous care setting or within 72 hours of discharge, including from the ED; includes approved and unapproved leave status • Serious physical harm (eg, fracture) to an MHA consumer resulting from high-risk behaviour associated with a mental disorder • Assault by an MHA (secondary or specialist services) consumer causing serious injury (physical or psychological) to another person • Delayed recognition of a consumer’s deterioration resulting in unplanned transfer to intensive care or to another hospital for higher acuity care, cardiopulmonary resuscitation and/or intubation (eg, cardiomyopathy, myocarditis or toxic megacolon while taking clozapine, lithium toxicity requiring inpatient care) • Medication error or unexpected outcome resulting in major harm (eg, requiring dialysis, intervention to sustain life, anaphylaxis, cardiomyopathy, myocarditis or toxic megacolon while taking clozapine, lithium toxicity requiring inpatient care) • Serious harm directly resulting from a clinical intervention (eg, collapse or fracture during restraint)

¹ All documents are available here: www.hqsc.govt.nz/our-work/system-safety/adverse-events/national-adverse-events-reporting-policy.

<p style="text-align: center;">SAC 3</p> <p style="text-align: center;">Permanent moderate or temporary major loss of function</p>	<p style="text-align: center;">SAC 4</p> <p style="text-align: center;">Requiring increased level of care OR no injury, no increased level of care (includes near misses)</p>
<ul style="list-style-type: none"> • Any of the following because of the event (includes self-harm or harm resulting from high-risk behaviour associated with a mental disorder): <ul style="list-style-type: none"> ○ unplanned transfer to a higher level of care, including hospitalisation (eg, from community setting) ○ increased length of stay (more than one day) ○ surgical or other significant intervention required 	<ul style="list-style-type: none"> • Near-miss suicide attempt without injury by high-lethality method (eg, attempted hanging) • Medication error with no resulting harm • Missing consumer with a risk of serious harm to self or others • Additional monitoring, investigations or minor interventions because of the event • Breaking of confidentiality involving disclosure of violence, resulting in increased risk to the consumer and/or their whānau

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