State of Alaska • Department of Health and Social Services • Senior and Disabilities Services

# SDS Critical Incident Report

***In case of emergency, call 911 or appropriate local emergency services.***

*Within 24 hours or one business days of a reportable incident or notice of such an incident, send this form to hss.dsdsqa@alaska.gov or Fax to (907) 269-3690. For all incidents other than death, complete pages one and two; for reports of death, complete pages one and three.*

A list of incidents requiring an SDS Incident Report follows. Please check all categories which describe the incident.

- ☐ Missing person
- ☐ Harm to self or others
- ☐ Use of restrictive intervention
- ☐ Death of participant
- ☐ Accident/incident with medical intervention
- ☐ Medication error requiring medical intervention
- ☐ Law enforcement response
- ☐ Other: ______________________________

***Participant information***

Name: ______________________________

Date of Birth: ______________________________

Medicaid Number: ______________________________

Program: ☐ Home and Community-Based Waiver ☐ Personal Care Services ☐ Grant Services ☐ General Relief

Service being provided at the time of the incident:

- ☐ Adult day
- ☐ Residential supported living (assisted living home)
- ☐ Day habilitation
- ☐ Family habilitation home
- ☐ Supported living
- ☐ Group home
- ☐ Supported employment
- ☐ Other ______________________________
- ☐ Intensive active treatment
- ☐ Respite care
- ☐ Specialized private-duty nursing
- ☐ Transportation
- ☐ Meals
- ☐ PCA
- ☐ None

***Contact Information***

Date of this report: ______________________________

Date incident became known to the reporter: ______________________________

Name of reporter: ______________________________

Title of reporter: ______________________________

Provider Identification Number/ Agency Name: ______________________________

Provider agency contact person: ______________________________

Telephone number: ______________________________

Email: ______________________________

***Notifications*** (Please check other agencies and individuals you notified regarding this incident.)

- ☐ Police/law enforcement
- ☐ Adult Protective Services
- ☐ Office of Children's Services
- ☐ Care coordinator
- ☐ Other: ______________________________
- ☐ Assisted Living Home Licensing
- ☐ Long Term Care Ombudsman
- ☐ Guardian/Legal representative

***If this report is about the death of a participant, skip page two and fill out page three.***

Name of Participant:

***Incident information*** (Provide all information known; if not a direct observer; include sources of the information.)

Date of incident: ______________________________ Time of incident: ____________________________________

**Where did it happen?**

Name of facility: _________________________________________________________________________________

Address: _________________________________________________________________________________________

This location is ☐ a private residence ☐ an assisted living home/family habilitation home/group home

☐ a community setting ☐ other (describe) ____________________________________________

Names of all persons present at the time of the incident:

**What happened?** (Describe the incident including circumstances or events leading to the incident.)

**What did you or others do when it happened?** (Describe actions taken in response to the incident.)

**How will you or others help the participant now?** (Describe plans for provider agency follow-up.)

***Incident analysis***

**What do you think was the cause of the incident?** (Describe contributing factors.)

**What could be changed, or has been changed so a similar incident does not happen again?**

# Death of a Participant

Name of Participant:
Date of death: ________________________________ Time of death: ______________________________________

**Residence at time of death**.

- ☐ a skilled nursing facility
- ☐ an assisted living home/family habilitation home/group home
- ☐ a private residence
- ☐ other (describe) ___________________________________________________________

**Location at time of death**.
Name of facility: ___________________________________________________________________
Address: _________________________________________________________________________

**This location is**

- ☐ a hospital
- ☐ a skilled nursing facility
- ☐ an assisted living home/family habilitation home/group home
- ☐ a private residence
- ☐ a community setting
- ☐ other (describe) ___________________________________________________________

**What happened?** (Describe the circumstances leading to the death.)

**Who was present at the time of death or discovered the death?**

**Were there health or safety issues that contributed to the death?**(Describe recent illnesses, hospitalizations, or accidents.)

**Was there an emergency response?**(Describe who called 911 or other emergency service and what was done for the participant upon arrival.)

**Was the participant taken to an emergency room or clinic prior to death? If so, how was he/she transported**?

- ☐ by emergency services/ambulance/ Medivac
- ☐ by family or other natural supports
- ☐ by provider staff or volunteer
- ☐ other: ___________________________________

Was the participant receiving any of the following at the time of death?

- ☐ Hospice services. Name of hospice: ________________________________________________________
- ☐ Do-Not-Resuscitate (DNR) order
- ☐ Comfort One enrollment