**DDS Required Follow Up Information**

Updated 2/12/25

**LATE REPORTING REMINDER**

Special incidents are required by Title 17 to be verbally reported by vendors to San Diego Regional Center within 24 hours of occurrence and a written report must be provided within 48 hours of occurrence.

If your SC is out of the office when an incident occurs, please leave your SC a voicemail **AND** contact the On-Call SC to ensure that a SIR is submitted within DDS reporting timelines.

Submit [written SIR](https://www.sdrc.org/_files/ugd/01f2b0_ef66e20383924b0a94fa0dea2281cc52.pdf?index=true) within 48 hours by email: [vendorsirs@sdrc.org](mailto:vendorsirs@sdrc.org) **OR** enter incident information via the SIR Service Provider Portal. If you submit a SIR via the SIR Service Provider Portal, it will count as the written report. Please make sure you are notifying your SC that a SIR has been submitted via the portal so that they are aware of the client’s condition and health/safety status.

If you require additional assistance with information collection or SIR reporting protocols, feel free to contact the SIR Team at [sirs@sdrc.org](mailto:sirs@sdrc.org).

**A SIR should be entered for all special incidents affecting a client’s health, wellbeing, and safety.**

--

**Please provide DDS compliance-specific follow-up information below to complete the SIR within 14 days of the incident date:**

**Alleged Abuse/Neglect/Failure to Protect/Restraints:**

Result of investigation: (check outside agencies notified)

Reported to:

[ ] APS/CPS [ ] Long Term Care Ombudsman

[ ] Law Enforcement [ ] CCL/Health Care Licensing

Outcome:

[ ] Substantiated [ ] Inconclusive

[ ] to DA [ ] Arrest made

[ ] Unsubstantiated/unfounded

Action:

[ ] Referred to Criminal Action [ ] Client relocated

[ ] Plan of Corrective Action [ ] Citation

[ ] Deficiency [ ] Cross-reported to Law Enforcement

Any pertinent/relevant information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does client require any support/equipment for daily mobility? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prevention Plan (immediate response & moving forward): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Alleged Abuse/Neglect/Failure to Protect (Unit 10/CPP Movers)**

Please provide DDS compliance-specific follow-up information below to complete the SIR within 14 days of the incident date:

Was Ombudsman/APS notified of incident? \_\_\_\_\_\_\_

Any recommendations by Ombudsman/APS? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was the result of the Ombudsman/APS/police investigation (substantiated, unfounded, inconclusive), if shared with SDRC? \_\_\_\_\_\_

Any recommendation by Ombudsman/APS? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Will client continue to reside in the same residence? \_\_\_\_\_\_\_\_\_

Other than relocation, will the consumer require any new or modified services/supports because of the incident? \_\_\_\_\_\_\_\_\_

If so, what are the new or modified services/supports? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

What actions, if any, were taken against the alleged perpetrator(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_

What will SDRC to do to assist the vendor? \_\_\_\_\_\_\_\_\_When? \_\_\_\_\_\_\_\_\_\_

Is SDRC investigating the incident? \_\_\_\_\_\_\_\_\_\_ Outcomes? \_\_\_\_\_\_\_\_\_\_\_\_\_

Any QA investigations? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provide an update (outcomes) re: SDRC's interaction with the vendor\_\_\_\_\_\_\_\_\_\_

Prevention Plan (immediate response & moving forward): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COVID:**

Test date: \_\_\_\_\_\_\_\_\_\_\_

Positive result date: \_\_\_\_\_\_\_\_

Symptoms: \_\_\_\_\_\_\_\_

Was hospitalization required? \_\_\_\_\_

Vaccination status: \_\_\_\_\_

**Crime / Assault**

Police Report No./Case No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (most important)

Any arrests made? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Outcome of investigation by police: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

APS/CPS involvement/outcome? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was case submitted to DA? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other pertinent/relevant information? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prevention Plan (immediate response & moving forward): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Deaths:**

What is the exact date of death? \_\_\_\_\_\_\_\_\_\_\_\_

What is the exact location of death?  \_\_\_\_\_\_\_\_\_ (hospital, home, SNF name etc.)

Where did the client reside before their passing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Please format as follows: Vendor # - Vendor Name – Vendor Type – Move in date)

If conserved, who was the conservator and what was their level of involvement? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was the client receiving care for a medical / psych condition prior to passing? (Please format response as follows: Diagnosis - MM/DD/YY – Treatment Details) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was the client taking medications to treat a medical / psych condition prior to passing? (Please format response as follows: Medication Name - MM/DD/YY – Reason for use) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was the client last at their baseline health prior to date of passing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was client on a diet plan or have any special feeding needs? Were feedings being tolerated normally? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was client last seen by a physician / PCP prior to date of passing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was client last seen by a nurse prior to date of passing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was client last given a nursing health assessment and what were the findings? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What were the events leading up in the weeks/days prior to death? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What did the client do the day before he/she died? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

If death occurred in hospital, what day were they admitted to the hospital? \_\_\_\_\_\_\_\_\_\_\_\_\_

If death occurred in hospital & client was under vendored care, when did vendor last visit client at the hospital? \_\_\_\_\_\_\_\_\_

Were HOSPICE services active at time of death? (If yes, by who?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why was HOSPICE initiated (diagnosis & date)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was an SDRC doctor or nurse involved in this case? (i.e. did they provide a consult, assisted /advised on hospital treatment, assessment) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was there a DNR in place? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was any type of intervention or resuscitation attempted? If so, what was done? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any concerns of abuse/neglect? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was Community Care Licensing / Health Care Licensing / California Department of Public Health notified? If not, why not? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ER Visits:**

Was client admitted to the hospital? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Discharge Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_

Date of ER visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_

Discharge Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Released to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (location)

Reason for going to ER: ­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Follow up needed after ER: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any concerns regarding abuse and/or neglect?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does client require any support/equipment for daily mobility? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prevention Plan (immediate response & moving forward):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Falls (under vnd care):**

Where did fall occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did a medical condition contribute to fall?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a history of falling: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does client require any support/equipment for daily mobility? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fall Prevention Plan (immediate response & moving forward): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Fracture:**

Was client admitted to the hospital? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Discharge Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client was discharged to: \_\_\_\_\_\_\_\_\_\_\_ (location)

Any appliance (cast, sling, splint, brace, boot, cane, or walker, wheelchair, etc.) prescribed? \_\_\_\_\_\_

Any related surgeries? \_\_\_\_\_\_ (please include dates)

Any specialist referrals? \_\_\_\_\_\_ (please indicate medical specialty)

Date and location where appliance (cast, sling, splint, brace, boot, cane, or walker, etc.) was removed/discontinued\_\_\_\_\_\_\_\_\_\_\_\_\_

Does client require any support/equipment for daily mobility? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does client have a history of falling? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prevention Plan  (immediate response & moving forward): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hospitalizations:**

Discharge Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Discharge Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client discharged to: \_\_\_\_\_\_\_\_\_\_\_ (location)

Follow up needed after discharge (i.e. PT): ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any concerns regarding abuse and/or neglect?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does client require any support/equipment for daily mobility? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prevention Plan (immediate response & moving forward):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication Errors:**

Name and dosage of the medication(s) \_\_\_\_\_\_\_\_\_\_\_\_ (most important)

Any adverse reactions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did staff determine if there was or was not an adverse reaction? \_\_\_\_\_\_\_\_\_\_

Days medication was to be given: \_\_\_\_\_\_\_\_\_\_\_\_\_

Time medication was to be given: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was the medication error by the same staff member on the same shift?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was med error reported to CCL/HCL (include notification date)? \_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician (MD, NP, PA, or Psychiatrist) notification: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name and date)

Prevention plan (immediate response & moving forward): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Missing Person –** **Client Leaves Unexpectedly**

Client was missing for approximately: \_\_\_\_\_\_\_\_\_\_\_ (days/hours)

Did client return to residence on his/her own?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (yes/no)

Specify location and date client located?   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who located client? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (police, vendor staff, relative, etc.)

Who transported client?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical condition when found:  \_\_\_\_\_\_\_\_\_\_\_\_ (unharmed, unkempt, bruised, etc.)

Current community safety or elopement behavioral IPP outcome (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preventative/Community Access Plan (immediate response & moving forward): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Psych. Hospitalization 5150 / 5250:**

Please ***confirm🡪*** this incident is considered an involuntary psych hospitalization \_\_\_\_\_ (🡨**yes or no**) according to legal guidelines in Section **5150** of the California Welfare and Institutions Code (specifically, the [Lanterman-Petris-Short Act](http://en.wikipedia.org/wiki/Lanterman-Petris-Short_Act) or "LPS") which allows a qualified officer or clinician to [involuntarily confine](http://en.wikipedia.org/wiki/Involuntary_commitment) a person deemed to have a mental disorder that makes them a danger to him or herself, and/or others and/or gravely disabled. A qualified officer, that includes any California [peace officer](http://en.wikipedia.org/wiki/Peace_officer), as well as any specifically designated [county](http://en.wikipedia.org/wiki/County) clinician, can request the confinement after signing a written declaration. If those characteristics are not met, the incident is NOT reportable to DDS.

Discharge date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where client is discharged to: \_\_\_\_\_\_\_\_\_\_\_

Any other pertinent/relevant information (behavior consultant meeting, new DX, assessments etc): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prevention Plan (immediate response & moving forward): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Serious Injury/Accident (Lacerations, Puncture Wounds, Bites, Burns, Internal Bleeding, Dislocation, and Medication Reactions that require medical attention beyond first aid):**

**Discharge Date (if admitted):** \_\_\_\_\_\_\_\_\_\_\_\_\_

Dates of follow-up MD visits, if applicable\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of stitches \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (most important)

Where and when stitches/sutures/staples/casts removed (if any) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (location and date)

Does client have a history of falling? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prevention Plan (immediate response & moving forward)? \_\_\_\_\_\_\_\_\_\_\_



