Quality Assurance Performance Improvement Meeting Minutes

All Information included in this report and the attachments hereto were prepared as part of the Facility Risk Management program and are to be considered confidential and privileged

Facility: ______________________

Meeting Date: __________

Month Reviewed: __________

Administrator ______________________

Medical Director ______________________

Director of Nursing ______________________

Activities Director ______________________

Admissions Director ______________________

Assistant Director of Nursing ______________________

Business Office Manager ______________________

Dietary Manager ______________________

Housekeeping Director ______________________

Human Resources Director ______________________

MDS / Care Plan Coordinator ______________________

Medical Records / EHR ______________________

Social Services Director ______________________

Maintenance Director ______________________

Pharmacist ______________________

Plant Operations Director ______________________

Rehab / Therapy Director ______________________

Consultant ______________________

Other ______________ ______________________

______________ ______________________

____

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Ancillary Services Reports: (Attach Copy Of All Reports)

Pharmacy:

Action Plan Decision: Check All That Apply: (Attach Copy of Reports and Action Plans)

	No Trend Identified		Trend Identified		Performance Improvement Plan (PIP)
	Isolated Event/Quick Fix- No Action Plan Needed		Action Plan to be Developed		Initate PIP
			Action Plan Ongoing/No Change		PIP Ongoing/No Change
			Action Plan Revised		PIP Revised
Comments/Trends:					

Lab:

Action Plan Decision: Check All That Apply: (Attach Copy of Reports and Action Plans)

	No Trend Identified		Trend Identified		Performance Improvement Plan (PIP)
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Radiology:

Action Plan Decision: Check All That Apply: (Attach Copy of Reports and Action Plans)

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Census Activity:

Payer	Budgeted	Actual
Private Pay		
Medicare		
Medicaid		
Insurance		
Hospice		
TOTAL		
New Admissions		
Discharges (Total)		
30-Day Returns to Hospital		
Deceased		
Home		
AMA		
Discharged to Other Location		

Marketing / Admissions:

Total # Of Referrals:	
Total # Of Denials:	
List # For Each Reason: High Cost Meds: Not Able to Provide Clinical Service: Violent/Severe Behaviors: Drug/Alcohol Abuse: Insurance/Payer Source: Other (Specify) :	
Total # Of Referrals Converted to Admission:	
Reason for Referral Not Converted if Accepted: (List # For Each Reason) Family/Resident Chose Another Facility Delay in Accepting Location Other (Specify)	

Action Plan Decision: Check All That Apply: (Attach Copy of Reports and Action Plans)

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Risk Management / Falls:

Occurance And Incident Types:	Number of Occurrences
Falls (Total)	
Fall with Minor Injury (laceration, bruising, abrasion, skin tear, etc)	
Fall with Major Injury (subdural hematoma, fracture)	
Fall with Transfer to Acute Care/ER	
Residents with Two or More Repeat Falls	

Falls By Shift/Location:

Unit/Floor	Day Shift	Eve. Shift	Night Shift	Total	Comments
Total Falls					

Action Plan Decision: Check All That Apply: (Attach Copy of Reports and Action Plans)

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Other Risk Management Occurrences:

Bruises	
Lacerations	
Skin Tears	
Burns	
Choking	
Medication Errors (Total)	
Medication Errors with Incident (Negative Outcome)	
Pharmacy-Related Medication Errors (Improper labeling, dosage, etc.)	

Action Plan Decision: Check All That Apply: (Attach Copy of Reports and Action Plans)

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Comments/Trends:					

Pressure Injuries:	STG 1	STG 2	STG 3	STG 4	UNSTG	DTI	COMMENTS
# Facility Acquired							
# Admitted (Community Acquired)							
# Of New Facility Acquired							
# Of Worsening Wounds							

Action Plan Decision: Check All That Apply: (Attach Copy of Reports and Action Plans)

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Infection Control: Attach copies of monthly reports.

Total # of HAI (Nosocomial) Infections Treated:	
Total # of HAI Treated Meeting McGeer's Criteria:	
HAI Infection Rate:	
Any Outbreaks Reported?	
Any Infections/ Diseases Reported to Health Dept?	

Action Plan Decision: Check All That Apply: (Attach Copy of Reports and Action Plans)

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Weights:

Total # of Residents with New Significant Weight Loss	
# of Residents with G-tube/ Tube Feeding	
# of G-Tube with significant weight loss:	
# of Significant Weight Loss under Hospice:	
# of Planned Weight Loss:	

Action Plan Decision: Check All That Apply: (Attach Copy of Reports and Action Plans)

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Restraints:

Total # of Restraints:	
Type of Restraint(s) Used:	
# of Restraints Reduced / Eliminated:	
# of New Restraints This Month	

Action Plan Decision: Check All That Apply: (Attach Copy of Reports and Action Plans)

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Abuse Reporting:

Type of Allegation	Total #	# Substantiated
Staff to Resident Abuse:		
Resident to Resident:		
Neglect:		
Misappropriation:		
Involuntary Seclusion		

Action Plan Decision: Check All That Apply: (Attach Copy of Reports and Action Plans)

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Social Service/Grievance Officer

Concern Form Completed For Each Resident Council Meeting Concern? __________

Total # Of Grievances:	**# Of Investigation/Follow-Up Completed Within Five Business Days**	**# Of Grievances/ Concerns That Met Reporting Criteria:**
Resident Care/ADL		
Missing Items		
Food Service/Meals		
Environment/Cleanliness		
Financial/Billing		
Customer Service		
Notifications		
Other (Specify)		

Action Plan Decision: Check All That Apply: (Attach Copy of Reports and Action Plans)

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Environment/Line Safety

List Areas of Concern/Equipment Failure/Repairs	**List Corrective Steps Taken and Current Status**

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Emergency Preparedness/Drill(s)

Review Drill(s) Performed

Drill Performed	Steps Taken for Performance Improvement
Fire Drill(s)	
Elopement Drill(s)	
Internal Diaster Drill(s) (Specify)	
External Diaster Drill(s) (Specify)	
Evacuation	
Tornado	

Action Plan Decision: Check All That Apply: (Attach Copy of Reports and Action Plans)

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Human Resources:
Workers Compensation Current Open Claims

Employee Initials	Type of Injury	Date of Injury	Lost Time	Light Duty Time	Full Duty Release	Re-Education

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Employee Turnover:

Positions	# New Hires	# Termed	# Resigned	# Of Current Open Positions
Licensed Nurse				
CNA				
Dietary				
Housekeeping/Laundry				
Maintenance				
Social Service				
Nursing Admin (DON/ADON/ Manager/MDS)				
Administrator/Asst. Admin				
Other (Specify)				

Of Exit Interviews Completed: ______

Training Status - CNA/Nursing/Direct Care Staff:

Note: CNAs require 12 hours of combined training per year on dementia, abuse, care of cognitively impaired.

Type of Training	# Incomplete: New Hire	# Incomplete: Annual
Dementia (Six hours of new hire training to be complete in first 30 days if working on dementia unit, otherwise within six months of hire; three hours annually)		
Abuse		
Care of Cognitively Impared		

Action Plan Decision: Check All That Apply: (Attach Copy of Reports and Action Plans)

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Administrator:

Date of Last Annual Survey: ____________________
Any Open Survey Cycles? ____________________

If yes, list - Survey Date: ____________________
Compliance Date: ____________________
Denial of Payment Date: ____________________
Outstanding Tag #s: ____________________

Survey/Inspection Activity Since Last Quality Assurance Performance Improvement Meeting

Agency/Date	Type of Visit	Survey Results	Current Status

5 Star Rating:

Overall Quality # Stars	Health Inspection # Stars	Quality Measures # Stars	Staffing # Stars	RN Staffing # Stars

Action plan in place for areas of two stars or less? (Attach Copy)

Quality Measures:

(Attach copy report for most recent three month period)

Quality Measure >75th Percentile	Percentile	Rating Points	Action Plan In Place?

Action Plan Decision: Check All That Apply: (Attach Copy of Reports and Action Plans)

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Other Reports: (ATTACH COPIES)

____ Therapy Caseload Report
____ MDS/CMI/Triple Check

Committee Review of the Following Policies, Procedures, and Guidelines:

P & P / Guideline	Continued Acceptance Y/N	Revision Required? Y/N

Next Meeting Date: ____________

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