MARIANHILL

RESIDENT/FAMILY CARE CONCERN
CONTINUOUS QUALITY IMPROVEMENT REPORT

Resident and/or Location: _____ Date: _____

Person Identifying Issue: _____ Phone #: _____

Person Receiving Information: _____

Issue or Concern: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Recommended Action: _____
_____
_____
_____
_____
_____
_____
_____
_____

Department/Committee/Work Area: _____

Signature of Person Completing Form: _____ Date: _____

Action Taken: _____

Recommendations to Prevent Further Occurrences: _____

Date of Review: _____

RESIDENT/FAMILY CARE CONCERNS

ATTEMPTS TO CONTACT: *DATE*	*TIME*	*OUTCOME**	*PERSON CONTACTED*	*STAFF INT.*
1) _____	_____	_____	_____	_____
2) _____	_____	_____	_____	_____
3) _____	_____	_____	_____	_____

* Message left (ML) , No answer (NA) , Busy (Bsy) , Contact made (CM)

Brief summary of discussion: _____

Staff perception of satisfaction at end of conversation: Satisfied Not satisfied Follow up required

_____ _____
Supervisor/Committee Chairperson/ Manager Date

_____ _____
Chairperson Continuous Improvement Committee Date

Follow-up/Review: _____

_____ _____
Chairperson Continuous Improvement Committee Date

_____ _____
CEO Signature Date