# LTS Regional Continuing Quality Improvement (CQI) Report

Service Name: _____ Affiliate #_____

Aspect of Care Reviewed (1 Only!): _____

Quarter: ☐ 1st (Jan. 1-Mar.31) ☐ 2nd (Apr.1-Jun. 30)
☐ 3rd (Jul. 1-Sept.30) ☐ 4th (Oct.1-Dec.31) YEAR: _____

Total # of Tripsheets/EMS Records in the Quarter: _____
Total # of Non-Responses (Please include reasons for each on separate page): _____
Total # of Tripsheets/EMS Records reviewed that met the Aspect of Care Criteria:

_____
Of the total records reviewed, how many were in compliance with Criteria? _____

Goals & Objectives: (Describe Aspect of Care to be Reviewed)

_____
_____
_____

Service Findings: (How did your service compare to the evaluation criteria?)

_____
_____
_____
_____

Plan of Corrective Action: (If necessary)

☐ Reviewed Findings at Company Meeting ☐ Post Findings at Station
☐ Reviewed Findings with individual Providers ☐ Schedule Company Training
☐ Schedule individual provider remediation ☐ Disciplinary Action Taken
☐ OTHER:_____

Evaluation of Action Taken:

_____
_____
_____
_____

_____ _____
Service Captain/Chief Date

_____ _____
Service CQI Coordinator Date

_____ _____
Medical Director Date