ONA - PROFESSIONAL RESPONSIBILITY
WORKLOAD REPORT FORM

SECTION 1: GENERAL INFORMATION

Name(s) Of Employee(s) Reporting: (Please Print)

Rose 1, Rose 2, Ross 3.

Employer: **_Pleasant Place**_____ Unit/Area/Program: _Long term care Behaviour unit.

Date of Occurrence: **___00/00/2006____** Time: **___1430_____** **X** 7.5 hr. shift 11.25 hr. shift
Day/Month/Year

Name of Supervisor: **____Jesse Smith**_____ Date/Time Submitted: **__00/00/2006**_____

SECTION 2: DETAILS OF OCCURRENCE

Provide a concise summary of the occurrence: **_Short 1 RN & RPNs had not been bumped up to cover. Short two 8 hour HCAs leaving 2 units (4th & 5B) short and no coverage for serving on 5th.**

No time to do MDCs, care plans or supervise properly on all villas. Watclimate alarmed but staff not aware. Alarm also needs to be off on 3rd as well as door.

Check one: Is this an isolated incident? _____ An ongoing problem? **__X_____** (Check one)

SECTION 3: WORKING CONDITIONS

In order to effectively resolve workload issues, please provide details about the working conditions **at the time of occurrence** by providing the following information:

# Regular Staff:	RN	**__4__**	RPN	**__4__**	Unit Clerk	**_3__**	Service Support **_5___**
# Actual Staff:	RN	**__3__**	RPN	**__4__**	Unit Clerk	**_3__**	Service Support **_3___**
Agency/Registry RN	Yes	____	No	____	How many? ____		
Junior Staff*	Yes	____	No	____	How many? ____		
RN Staff Overtime:	Yes	____	No	____	If yes, how many staff? _____		Total Hours _____

**as defined by your unit/area/program.*

If there was a shortage of staff at the time of the occurrence (including support staff), please check one or all of the following that apply:

Absence/Emergency Leave Sick Call(s) **X** Vacancies

SECTION 4: PATIENT CARE FACTORS CONTRIBUTING TO THE OCCURRENCE

Please check off the factor(s) you believe contributed to the workload issue:

X Change in patient acuity. Provide details: **palliative residents, treatments taking 1 or more hours to do by RN, unstable blood pressure on resident on 2nd floor requiring RN assessment**

☐ Shortage of beds Patient census at time of occurrence _____

☐ Number of Admissions _____ Number of Discharges _____

X Lack of equipment/malfunctioning equipment. Please specify: **Pagers not working now x 3 days, back door not locking at the required time of 1440.**

X Visitors/Family Members

☐ Non-Nursing Duties: (Please specify) _____

X Other: (Please specify) **RNs required to feed on units short of the HCAs, needed too assist with feeding in the dining room, no time to do care plans**

SECTION 5: REMEDY

(A) At the time the workload issue occurred, did you discuss the issue within the unit/area/program?

Yes **X** No ☐

Provide Details: **RNs spoke with the DRC about coverage.**

Was it resolved? Yes No **X**

(B) Failing resolution at the time of the occurrence, did you seek assistance from the person designated by the employer as having responsibility for timely resolution of workload issues? Yes **X** No ☐

Provide Details: **As above**

Was it resolved? Yes No **X** **to be discussed at the next labour management meeting**

(C) Did you discuss the issue with your manager (or designate) on her/his next working day?

Yes **✕** No Provide details:

Discussed options to prevent this from occurring in the future and if it should happen in the future what are the priority work issues to be completed

_____

_____

_____

Was it resolved? Yes No **✕**

SECTION 6: RECOMMENDATIONS

Please check-off one or all of the areas below you believe should be addressed in order to prevent similar occurrences:

- ☐ Inservice ☐ Orientation ☐ Review nurse/patient ratio
- ☐ Change unit lay-out ☐ Float/casual pool ☐ Review policies & procedures
- ☐ Change Start/Stop times of shift(s). Please specify: _____
- ☐ Review Workload Measurement Statistics
- ☐ Perform Workload Measurement Audit
- **X** Adjust RN staffing **X** Adjust support staffing
- **X** Replace sick calls
- **X** Equipment (Please specify) ___**Fix the equipment immediately**_____
- ☐ Other: _____

SECTION 7: MANAGEMENT COMMENTS

Please provide any information/comments in response to this report, including any actions taken to remedy the situation, where applicable.

No comments

Management Signature ____**Signed Jesse Smith**_____ Date: ___**00/03/06**_____

SECTION 8: EMPLOYEE SIGNATURES

I/We do not believe the response adequately addresses our concerns. I/We therefore request these concerns be forwarded to the Employer-Association Committee in accordance with the collective agreement.

Signature ____**Rose 1, Rose 2**_____ Phone No. ___**000-000-0000**_____

Signature: ____**Ross 3**_____ Phone No. ____**000-000-0000**_____

Date Submitted: ___**00/00/2006**_____

Copies: (1) Manager/ Chief Nursing Officer (or designate) (2) ONA Rep (3) RN (4) LRO

ONA PROFESSIONAL RESPONSIBILITY - WORKLOAD REPORT FORM
GUIDELINES AND TIPS ON ITS USE

The parties have agreed that patient care is enhanced if concerns relating to professional practice, patient acuity, fluctuating workloads and fluctuating staffing are resolved in a timely and effective manner. The Collective Agreement provides a problem solving process for nurses to address concerns relative to patient care. This report form provides a tool for documentation to facilitate discussion and to promote a problem-solving approach.

THE FOLLOWING IS A SUMMARY OF THE PROBLEM SOLVING PROCESS AS OUTLINED IN THE COLLECTIVE AGREEMENT. PRIOR TO SUBMITTING THE WORKLOAD REPORT FORM, PLEASE FOLLOW ALL STEPS AS OUTLINED IN THE COLLECTIVE AGREEMENT.

STEPS IN PROBLEM SOLVING PROCESS

1) **At the time the workload issue occurs**, discuss the matter within the Unit/Area/Program to develop strategies to meet patient care needs using current resources. If necessary, using established lines of communication, seek immediate assistance from an individual identified by the Employer (e.g. team leader/charge nurse/co-ordinator/supervisor) who has responsibility for timely resolution of workload issues.

2) Failing resolution of the workload issue at the time of the occurrence, discuss the issue with your Manager (or designate) on the Manager's or designate's next working day.

3) If no satisfactory resolution is reached during steps (1) and (2) above, then you may submit a professional responsibility workload report form to the Employer-Association Committee within fifteen (15) calendar days of the alleged improper assignment. (SEE BLANK REPORT FORM ATTACHED TO THESE GUIDELINES.)

4) As per the Collective Agreement, the Employer-Association Committee shall hear and attempt to resolve the complaint to the satisfaction of both parties.

5) If the issue is not resolved at the meeting in (4) above, the form may be forwarded to an independent assessment committee within the requisite number of days of the meeting in (4) above, as outlined in your Collective Agreement.

6) The Association and the Employer may mutually agree to extend the time limits for referral of the complaint at any stage of the complaint procedure.

TIPS FOR COMPLETING THE FORM

1) Review the form before completing it so you have an idea of what kind of information is required.
2) Print legibly and firmly as you are making multiple copies.
3) Use complete words as much as possible. Avoid abbreviations.
4) As much as possible, you should report only facts about which you have first-hand knowledge. If you use second-hand or hearsay information, identify the source if permission is granted.
5) Identify the CNO standards of practice/policies and procedures you feel you were unable to meet.
6) Do not, under any circumstances, identify patients/residents.