ONA - PROFESSIONAL RESPONSIBILITY WORKLOAD REPORT FORM

SECTION 1: GENERAL INFORMATION

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

Employer: Caressant Care Woodstock Unit/Area/Program: Nursing

Date Of Occurrence: 29/3/2011 Time: 2300
Day/Month/Year

(7.5 hr. shift) 11.25 hr. shift

Name of Supervisor: Helen Crombez DOD Date/Time Submitted: April 1/11 - 1006

SECTION 2: DETAILS OF OCCURRENCE

Provide a concise summary of the occurrence: Short RPN on 2300 - 0700 therefore writer responsible for 164 residents (approximately). 3 residents palliative, and one passed away. 2 people on HIR; One [redacted] other [redacted]. Nursing Home in Gastro Outbreak twenty plus residents on line listing with symptoms. Had to replace PSW is shift in morning. No time to complete MDS

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	1	RPN	1	Unit Clerk	0	Service Support 7
# Actual Staff:	RN	1	RPN	0	Unit Clerk	0	Service Support 7
Agency/Registry RN	Yes	___	No	X	How many?	___	
Junior Staff*	Yes	___	No	X	How many?	___	
RN Staff Overtime:	Yes	___	No	X	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) RPN) 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: 3 palliative residents, 2 HIR, Blood Sugars, Suppositories.
- [ ] Shortage of beds Patient census at time of occurrence _____
- [ ] # of Admissions 0 # of Discharges 0
- [ ] Lack of equipment/malfunctioning equipment. Please specify: _____
- [ ] Visitors/Family Members
- [x] Non-Nursing Duties: (Please specify) staffing, sick calls
- [ ] Other: (Please specify)

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:

DOC aware of short staffing

Was it resolved? Yes (No)

(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 [ ] No [x]

Provide Details:

short-staffing on N ongoing issues

Was it resolved? Yes (No)

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

Yes No Provide details:

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
- ☒ Adjust RN staffing ☒ Adjust support staffing
- ☐ Replace sick calls
- ☐ Equipment (Please specify) _____
- ☐ Other: I was qualified to give supp & then could coordinated timing with to, let use.

SECTION 7: MANAGEMENT COMMENTS

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

Management Signature _____ Date: _____

SECTION 8: EMPLOYEE SIGNATURES

~~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 _____ Phone No: [redacted]

Signature _____ Phone No. _____

Signature: _____ Phone No. _____

Date Submitted: _____

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