Community Health - Professional Practice Committee
Work Situation Report

Section 1: General Information

Name(s) of Employee(s): _____

Employer: _____

Main Office/Team/Area/Program: _____

Date of Occurrence: _____ Time: _____

Hours Worked: _____ On Call Hours: _____

Regular Staff: RN _____ Clerical Support: _____

Actual Regular Staff: RN _____ Clerical Support: _____

Staff Shortage Due to: ☐ Sick Call ☐ Vacancies ☐ Emergency Leave ☐ Vacation

RN Staff Overtime: ☐ Yes ☐ No How Many Staff _____ Total Hours _____

Did This Cause You to Miss Your: Meal Period: ☐ Yes ☐ No Rest Period/Break: ☐ Yes ☐ No

Name of Supervisor Reported to: _____

Section 2: Details Of Occurrence

Provide a concise summary of the occurrence and how it impacted client care:

_____

_____

_____

Was the safety of the client or the nurses compromised? ☐ Yes ☐ No How? _____

Workload not completed: _____

_____

_____

_____

Is this an isolated incident? ☐ Yes ☐ No Ongoing problem? ☐ Yes ☐ No

Section 3: Client Care and Other Ongoing Factors to the Occurrence

☐ Change in Client Acuity : Provide details _____

☐ # Family Members

☐ Clients Assigned at Time of Occurrence

☐ Non-Nursing Duties: Specify _____

☐ Standards Not Met

☐ # Of New Clients to be Assessed (Ongoing Referrals)

☐ Safety in Jeopardy: Please Specify _____

☐ Lack of/Malfunctioning Equip: Details _____

☐ Weather/Conditions

☐ Travel/Distance

☐ Presentation Cancelled

☐ # Of Transfers From Service:

☐ Unanticipated Assignment/Uncontrolled Variables: Specify _____

☐ # Of Discharges From Program

☐ Other - Specify:

Section 4: Workload

At the time of the occurrence, the planned workload was:	Planned (P)	Actual (A)	Time Planned	Actual Time
Home visits/School visits/Clinics/Telephone Calls/Hospital/etc				
Public Meetings/Team Meetings/Office Work etc				
Documentation/Administration (i.e. Phone, paperwork. supplies)				
In-service Education/Presentations				
Travel (number of trips)				
Number of Clients Assessed				
Other (i.e. giving a presentation, etc)				

If staff made available, please identify the number of staff provided, their category :

Category (PHN, Clerk, Other)	Amount of Time Staff Available	Orientation to Site Required: Yes/No State Orientation Time

Section 5: Recommendations

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

- ☐ In-service
- ☐ Caseload Review of client/family needs
- ☐ Orientation
- ☐ Part-time pool
- ☐ Professional standards
- ☐ Review: RN: Client Ratio
- ☐ # Support staffing
- ☐ Review policies and procedures
- ☐ Perform Workload Measurement audit

Equipment: Specify _____

Other: please specify: _____

_____

_____

Section 6: Employee Signature

I/We request these concerns be forwarded to the Professional Practice Committee

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Date Submitted: _____ Time: _____

Section 7: Management Comments

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

Management Signature: _____ Date: _____

Section 8: Recommendations of Professional Practice Committee

The Professional Practice Committee recommends the following in order to prevent similar occurrences:

Is this issue resolved? ☐ Yes ☐ No

Copies to: 1. Manager 2. NBNU Local President 3. Member

Dated: _____