

Hospital - Professional Practice Committee Work Situation Report

Section 1: General Information

Name(s) of Employee(s): _____

Employer: _____

Unit/Area/Program: _____

Date of Situation: _____ Time: _____

Shift:

7.5 Hours # Regular Staff: RN _____ LPN _____ PSW _____ Clerical Support _____

11.25 Hours # Actual Regular Staff: RN _____ LPN _____ PSW _____ Clerical Support _____

Other Staff Shortage Due to: Sick Call ELOA Vacancies

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

Required Overtime: Yes No

Name of Nurse Manager or Supervisor Reported to: _____

Section 2: Details of Situation

Provide a detailed summary of the situation and how it impacted patient care (what, when, where, why):

Was the safety of the patient or nurse compromised? Yes No How? _____

Workload not completed: _____

(e.g. Insulin or heparin was not double checked; patient rounds not done on an hourly basis, other)

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

Section 3: Patient Care Factors Contributing to the Occurrence

Please check off the factor(s) you believe contributes to the workload issue and provide details

Change in patient acuity

Patient Census at time of situation _____

of Admissions _____ # of discharges _____ # of transfers _____

Lack of equipment/malfunctioning equipment/supplies. Please specify _____

Visitors/Family Members : Please specify _____

Number of patients on infections precaution _____

Over capacity protocol in effect? _____

Please specify _____

Other: (non- nursing duties, student supervision, mentorship, etc) Please specify _____

Section 4: Recommendations

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

- In-service
- Orientation
- Change unit layout
- Review Workload Measurement Statistics
- RN Staffing
- Support staffing
- Float/casual pool
- Review policies and procedures
- Replace sick calls, vacation, paid holidays, other absences
- Other:

Section 5: Employee Signatures and Contact Information

Signature: _____	Contact Information : _____
Signature: _____	Contact Information : _____
Signature: _____	Contact Information : _____
Signature: _____	Contact Information : _____

Section 6: 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 7: Recommendations of Professional Practice Committee

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

Is this issue resolved? Yes No

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

Dated: _____