Nursing Homes Professional Practice Committee
Work Situation Report

SECTION 1: GENERAL INFORMATION

Name(s) of Employee(s) (please print)

_____

Employer: _____Number of beds_____

Date of occurrence: _____(calendar) Time: _____

Shift:

- ☐ 7.5 hour
- ☐ 11.25
- ☐ Other

Regular Staffing: # RN ____ LPN____ RA ____ Clerk ____
Actual Staffing: # RN ____ LPN ____ RA ____ Clerk ____

Were you the charge nurse?____
RN Staff Overtime: Yes___No____How Many Staff_____Total hours? _____
Did this cause you to miss your meal break? Rest periods?/ Breaks Yes___No___

Name of Director of Nursing reported to_____

SECTION 2: DETAILS OF OCCURENCE

Provide a concise summary of the occurrence and how it impacted resident care;

_____
_____
_____
_____
_____
_____
_____
_____

Was the safety of resident or nurse compromised or workload not completed? (e.g. Insulin or heparin not double checked; resident rounds or turns not done on an hourly basis, etc)
Yes___No___How? (Provide details below)

_____
_____
_____
_____
_____

Is this an isolated incident? ____ Ongoing problem? _____

SECTION 3: NURSE/RESIDENT/ENVIRONMENT CARE FACTORS CONTRIBUTING TO THE OCCURRENCE/CONCERN/ISSUE

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

- ☐ Change in resident acuity e.g. falls – provide details_____
- ☐ Number of residents on isolation precautions____
- ☐ # of deaths___# of transfers to hospital____
- ☐ Lack of equipment/supplies/resources/malfunctioning equipment, please specify_____
- ☐ Visitors/family members
- ☐ Home in outbreak situation
- ☐ Doctor's or Nurse Practioner orders;
- ☐ Non nursing duties _____
- ☐ Communication/Process issues
- ☐ Exceptional Resident Factors(i.e. significant amount of time required to meet resident needs/expectations) please specify_____

SECTION 4: RECOMMENDATIONS

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

- ☐ In-service
- ☐ Orientation
- ☐ Review RN/resident ratio
- ☐ Change unit layout
- ☐ Change Start/Stop times of shift(s)
- ☐ Develop workload Measurement Tool
- ☐ Adjust RN Staffing
- ☐ Adjust support staffing
- ☐ Casual pool
- ☐ Review policies and procedures
- ☐ Replace sick calls, vacation, paid holidays, other absences
- ☐ Equipment – please specify_____
- ☐ Other: _____

SECTION 5: EMPLOYEE SIGNATURES

SIGNATURE_____Phone #/personal email_____

SIGNATURE_____Phone #/personal email_____

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

SECTION 6: MANAGEMENT COMMENTS

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

_____
_____
_____
_____
_____
_____

Management Signature_____Date:_____

SECTION 7: RECOMMENDATIONS OF PROFESSIONAL PRACTICE COMMITTEE

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

_____
_____
_____
_____
_____

Is this issue resolved? Yes____No____