Community Health - Professional Practice Committee Work Situation Report

Section 1: General Information

Name(s) of Employee(s): Are you an: ◯ RN ◯ LPN

Employer:

Main Office/Team/Area/Program:

Date of Occurrence: Time:

Hours Worked: On Call Hours:

Regular Staff: RN LPN PCA Clerical Support

Actual Regular Staff: RN LPN PCA Clerical Support

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

Nurse 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 nursing professional 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

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

- ☐ # Clients Assigned at Time of Occurrence:
- ☐ # Family Members:
- ☐ # Of Discharges from Program:
- ☐ # Of Transfers from Service:
- ☐ # Of New Clients to be Assessed (Ongoing Referrals):
- ☐ Presentation Cancelled
- ☐ Change in Client Acuity:
  Provide details
- ☐ Lack of/Malfunctioning Equipment:
  Details
- ☐ Non-Nursing Duties:
  Specify

- ☐ Safety in Jeopardy?
  Specify
- ☐ Standards Not Met
- ☐ Travel/Distance
- ☐ Weather/Conditions
- ☐ Unanticipated Assignment/Uncontrolled Variables:
  Specify
- ☐ Other:
  Specify

Section 4: Workload

At the time of the occurrence, the planned workload was:	Planned (P)	Time Planned	Actual (A)	Actual Time
Documentation/Administration (i.e. Phone, paperwork, supplies)	☐		☐	
Home visits/School visits/Clinics/Telephone Calls/Hospital/etc.	☐		☐	
In-service Education/Presentations	☐		☐	
Number of Clients Assessed	☐		☐	
Public Meetings/Team Meetings/Office Work etc.	☐		☐	
Travel (number of trips)	☐		☐	
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		State Orientation Time
		◯ Yes	◯ No	
		◯ Yes	◯ No	
		◯ Yes	◯ No	

Section 5: Recommendations

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

- ☐ Caseload Review of client/family needs
- ☐ In-service
- ☐ Orientation
- ☐ RN Staffing
- ☐ LPN Staffing
- ☐ Clerical Support
- ☐ Part-time pool
- ☐ Perform Workload Measurement audit
- ☐ Professional standards
- ☐ Review policies and procedures
- ☐ Review: RN-Client Ratio
- ☐ Review: LPN-Client Ratio
- ☐ Equipment:
  Please 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 to prevent similar occurrences:

Is this issue resolved? ◯ Yes ◯ No

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

Dated:

PRINT EMAIL RESET