# Nursing Home - Professional Practice Committee Work Situation Report

## Section 1: General Information

Name(s) of Employee(s):

Employer:

Number of beds: Date of Occurrence: Time:

Shift: ◯ 7.5 Hours ◯ 11.25 Hours ◯ Other

# Regular Staff: RN LPN PCA Clerk

# Actual Regular Staff: RN LPN PCA Clerk

Were you the charge nurse? ◯ Yes RN ◯ No Staff Shortage Due to: ◯ Sick Call ◯ ELOA ◯ Vacancies

Overtime: ◯ Yes ◯ No How many staff? Total hours?

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

Name of Director of Nursing reported to:

## Section 2: Details of Occurrence

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

Was the safety of the resident or nurse compromised or workload not completed? (e.g. Insulin or heparin was not double checked; patient rounds not done on an hourly basis, other) ◯ Yes ◯ No

How? (Provide details below)

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

## 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 patients on isolation precautions:
- ☐ # of admissions # 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 Practitioner orders
- ☐ Communication/Process Issues
- ☐ Exceptional Resident Factors (i.e. significant amount of time to meet resident needs/expectations) Please specify:
- ☐ Non-nursing duties. Please specify:

## Section 4: Recommendations

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

- ☐ 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 LPN Staffing
- ☐ Adjust PCA Staffing
- ☐ Adjust Clerical Support
- ☐ Casual pool
- ☐ Review policies and procedures
- ☐ Replace sick calls, vacation, paid holidays, other absences
- ☐ Equipment – please specify:
- ☐ Other:

**Section 5: Employee Signatures and Contact Information**

Signature: Phone #/personal email :

Signature: Phone #/personal email :

Date Submitted :

**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

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