APPENDIX 6
ONTARIO NURSES' ASSOCIATION (ONA)/HOSPITAL
PROFESSIONAL RESPONSIBILITY WORKLOAD REPORT FORM

Article 8 – Professional Responsibility provides a problem-solving process for nurses to address concerns relative to patient care. This form is intended to appropriately identify employee concerns relative to their workload issues in the context of their professional responsibility. These issues include but are not limited to: gaps in continuity of care, balance of staff mix, access to contingency staff and appropriate number of nursing staff. This report form provides a tool for documentation to facilitate discussion and to promote a problem-solving approach.

SECTION 1: GENERAL INFORMATION

Name(s) of Employee(s) Reporting (Please Print)

Sally Sunshine _____ _____ _____

Fred Friendly _____ _____ _____

Suzie Smiles _____ _____ _____

Employer: St. Elsewhere Unit/Area/Program: Medicine

Date of Occurrence: July 29, 2021 Time: 1930 7.5 hr. shift ☐ 11.25 hr. shift ☒ Other _____

Date/ July 29, 2021

Name of Supervisor/Charge Nurse: Ms Ratchet

Time notified: 2100

Manager/Designate notified: B. Boss Date: July 30, 2021 Time: 0730

SECTION 2: WORKING CONDITIONS

In order to effectively resolve workload issues, please provide details about the working conditions at the time of occurrence by providing the following information:

Regular Staffing #: MD/NP _____ RN 4 RPN 2 Unit Clerk 0 Service Support 0

Actual Staffing #: MD/NP _____ RN 3 RPN 2 Unit Clerk 0 Service Support 1

Agency/Registry RN: Yes ☐ No ☐ How many? _____

Novice RN Staff on duty*: Yes ☒ No ☐ How many? 2

RN Staff Overtime: Yes ☐ No ☒ If yes, how many staff? _____

**as defined by your unit/area/program.*

If there was a shortage of staff at the time of the occurrence (including support staff), please check one or all of the following that apply:

Absence/Emergency Leave ☐ Sick Calls ☒ Vacancies ☒ Off Unit ☐

Management Support available on site? Yes ☒ No ☐

SECTION 3: PATIENT CARE FACTORS CONTRIBUTING TO THE OCCURRENCE

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

☐ Rounds

☐ Consultation with MD/Delay _____

☐ Change in patient acuity ☐ Telemedicine _____

RPN patient became hemopdynamically unstable - beyond scope

☐ Normal number of beds on unit 36 Beds closed _____ Beds opened during tour 4

☒ Patient census at time of occurrence 40

☒ # of Admissions 4 # of Discharges _____ # of Transfers _____

☐# of assigned patients 8

☐ Lack of/or equipment/malfunctioning equipment. Please specify:
Over bedding - lack of safe space for care.

☒ Visitors/Family Members. Please specify:
Multiple Visitor calls

☒ Number of patients on infectious precautions 8

☒ Over Capacity Protocol. Please specify:
4 patients over capacity - should get an extra RN as per OCP

☐ Resources/Supplies _____

☒ Interdepartmental Challenges ED pushing patients up to floor when not able to take safely

☒ System Issues Overcapacity protocol not followed

☒ Exceptional Patient Factors (i.e. significant time and attention required to meet patient expectations). Please specify:
4 patients in hallway. 1 patient became hemodynamically unstable that was assigned to RPN, pt not pre assigned to RN

☐ Other (e.g. Non-nursing duties, student supervision, mentorship, etc.). Please specify:

_____

SECTION 4: DETAILS OF OCCURRENCE

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

Short an RN, should have gotten an extra registered nursing staff member for overcapicaty pts as well as replacements for sick calls. ED in surge and pushed 4 patients up to floor, causing us to be over census with patients in the hallway. OCP should trigger 1 more RN but no nurses available. Essentially working 2 nurses short.

Greater time needed for isolated patients due to donning and doffing safety.

Pts were divided up as best we could, meds and treatments were late. Only able to do minimum personal care. Unable to do hourly rounding as per hospital policy. Novice RNs struggling with own acute assignments and senior RN unable to support fully.

RPN assigned to unstable patient. Required many interventions that were beyond her scope of practice, knowledge, skills and judgement. Not able to switch patient from RN assignment or other RN assignments as those patients too acute as well and RPN needed constant help from RN's on unit and could not help with RN assignments, causing delay in RN work.

2 patient falls as unable to observe regularly. PSW an added relief but not helpful with acuity and lack of RN support- still not able to watch/check on all falls risks.

Pt families calling frequently - not able to support their needs.

No breaks or meal breaks. All staff put in OT. One new RN left in tears.

Identify the Nursing Standard(s)/Practice Guidelines or hospital/unit policies that are believed to be at risk and why:

☒ Medication

☒ Documentation

☒ Professional Standards – Specify Accountability, Leadership

☒ Therapeutic nurse/client relationship
☒ RN and RPN Practice, The Client, The Nurse and the Environment
☒ Working with Unregulated Care Providers (Check all that apply)
  ☒ Personal Support Workers/Aides
  ☐ Volunteers
  ☐ Students
  ☐ Physician Assistants
☐ Working in different roles
☐ Telepractice
☐ Consent
☐ Clinical pathways/medical directives
☒ Supporting Learners
☐ Disagreeing with the Plan of Care
☐ Guiding Decisions about End-of-Life Care
☐ Nurse Practitioner
☐ Employer policy – Specify Overcapacity policy, hourly rounding (include policy if able)
☐ Other _____

Why: Not enough RN staff to support skill mixes required by patients on unit

Is this an ☐ Isolated incident? ☒ Ongoing problem? (Check one)

SECTION 5: REMEDY

(A) At the time the workload issue occurs, discuss the issue within the unit/area/program to develop strategies to meet patient care needs. Provide details of how it was or was not resolved.

We were not able to resolve as the acuity on unit too high and Registered staffing mix inappropriate to support. Admin on call could not find anyone in another area to float to our unit. Tried calling co-workers to come in, no one available

(B) Failing resolution at the time of the occurrence, seek assistance from an individual(s) who has responsibility for timely resolution of workload issues. Discussion details including name of individual(s):

Supervisor aware short staffing at beginnning of shift, novice staff present that needed support - one just off oreitntation last week and the other yesterday. Aware again when adding more patients to unit was unsafe and beyond the scope of staff present but continued to do so. States she has no options for help, do the best you can.

Was it resolved? Yes ☐ No ☒

SECTION 6: RECOMMENDATIONS

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

☐ In-service ☐ Orientation ☒ Review nurse/patient ratio
☐ Change unit layout ☒ Float/casual pool ☒ Review policies & procedures
☐ Change Start/Stop times of shift(s). Please specify:

_____

☒ Review Workload Measurement Statistics
☐ Perform Workload Measurement Audit

☒ Adjust RN staffing ☐ Adjust support staffing

☒ Replace sick calls, vacation, paid holidays, other absences

☐ Equipment. Please specify:

_____

☒ Other:

Do not let ED push patients to unit when we cannot accommodate these patients safely.

SECTION 7: EMPLOYEE SIGNATURES

Signature: Sally Sunshine Date: July 29, 2021 Phone #: 1 234 567 8912 Personal Email: SSunshine@yahoo.ca

Signature: F Friendly Date: July 29, 2021 Phone #: 1 234 789 3214 Personal Email: FFreindly@gmail.com

Signature: Suzie Smiles Date: July 29,2021 Phone #: 1 234 654 9874 Personal Email: SmilesS@gmail.com

Signature: _____ Date: _____ Phone #: _____ Personal Email: _____

Date Submitted: July 30,2021 Submitted to (Manager Name): B.Boss

SECTION 8: MANAGEMENT COMMENTS

The manager (or designate) will provide a written response to the nurse(s) within 10 days of receipt of the form with a copy to the Bargaining Unit President as per Article 8.01 (a) iv). Please provide any information/comments in response to this report, including any actions taken to remedy the situation, where applicable.

_____

Management Signature: _____ Date: _____

Date response to the employer: _____ Date response to the union: _____

SECTION 9: RECOMMENDATIONS OF HOSPITAL-ASSOCIATION COMMITTEE

The Hospital-Association Committee recommends the following in order to prevent similar occurrences:

_____

Dated: _____

Copies: (1) Manager
(2) Chief Nursing Officer (or designate)
(3) ONA Rep
(4) ONA Member
(5) ONA LRO

ONTARIO NURSES' ASSOCIATION (ONA)/HOSPITAL PROFESSIONAL RESPONSIBILITY WORKLOAD REPORT FORM GUIDELINES AND TIPS ON ITS USE

The parties have agreed that patient care is enhanced if issues relating to professional practice, patient acuity, fluctuating workloads and fluctuating staffing are resolved in a timely and effective manner. The collective agreement provides a problem-solving process for nurses to address concerns relative to their workload issues in the context of their professional responsibility. These issues include but are not limited to gaps in continuity of care, balance of staff mix, access to contingency staff and appropriate number of nursing staff. This report form provides a tool for documentation to facilitate discussion and to promote a problem-solving approach.

PROBLEM SOLVING PROCESS

1) At the time the workload issue occurs, discuss the matter within the Unit/Area/Program to develop strategies to meet patient care needs using current resources. Using established lines of communication as identified by the hospital, seek immediate assistance from an individual(s) (e.g. team leader/charge nurse/manager /supervisor) who has responsibility for timely resolution of workload issues.
2) Failing resolution of the workload issue at the time of the occurrence or if the issue is ongoing, discuss the issue with the Manager (or designate) on the next day that both the employee and Manager (or designate) are working or within ten (10) calendar days, whichever is sooner, and complete the form. The Manager will provide a written response within ten (10) calendar days of the receipt of the form.
3) When meeting with the manager, you may request the assistance of a Union representative to support/assist you in the meeting. Every effort will be made to resolve the workload issues at the unit level. A Union representative shall be involved in any resolution discussions at the unit level. All discussions and action will be documented.
4) Failing resolution, submit the Professional Responsibility Workload Report Form to the Hospital-Association Committee within twenty (20) calendar days from the date of the Manager's response or when they ought to have responded under Article 8.01 (a) iv). (SEE BLANK REPORT FORM ATTACHED TO THESE GUIDELINES.)
5) As per Article 8, the Hospital-Association Committee shall hear and attempt to resolve the issue to the satisfaction of both parties and report the outcome to the nurse(s) using the Workload/Professional Responsibility Review Tool to develop joint recommendations. Any settlement/resolution under 8.01 (a) (iii) (iv) or (v) of the collective agreement will be signed by the parties.
6) Failing resolution of the issues through the development of joint recommendations it shall be forwarded to an Independent Assessment Committee as outlined in Article 8 of the Collective Agreement within the requisite number of days of the meeting in 4) above.
7) The Union and the Employer may mutually agree to extend the time limits for referral of the issue at any stage of this procedure.

TIPS FOR COMPLETING THE FORM

1) Review the form before completing it so you have an idea of what kind of information is required.
2) Print legibly and firmly as you are making multiple copies.
3) Use complete words as much as possible. Avoid abbreviations.
4) As much as possible, you should report only facts about which you have first-hand knowledge. If you use second-hand or hearsay information, identify the source if permission is granted.
5) Identify the CNO standards/practice/guidelines/hospital policies and procedures you believe to be at risk. College of Nurses Standards can be found at www.cno.org.
6) Do not, under any circumstances, identify patients.