ONTARIO NURSES ASSOCIATION - HOMECARE
PROFESSIONAL RESPONSIBILITY WORKLOAD REPORT FORM

SECTION 1: GENERAL INFORMATION

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

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Employer: _____ Area of Assignment: _____

Date of Occurrence: _____ Day | _____ Month | _____ Year Time: _____ Hours of Work _____

Date: _____ Day | _____ Month | _____ Year

Name of Supervisor/Manager: _____ Time notified: _____

SECTION 2: STAFFING

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 Staff #:	RN	_____		Regular Staff #:	NP	_____
Actual Staff #:	RN	_____		Actual Staff #:	NP	_____
Regular Staff #:	RPN	_____				
Actual Staff #:	RPN	_____				
Regular Clerical/IT Support:		_____		Actual Clerical/IT Support:		_____
Other:		_____				
Students:	Yes ☐	No ☐		How many?		_____
New/Novice Staff:	Yes ☐	No ☐		How many?		_____
Overtime:	Yes ☐	No ☐		If yes, how many?		_____
Agency Staff:	Yes ☐	No ☐				

SECTION 3: WORKING CONDITIONS

At the time of the occurrence, the planned workload was:	# Planned	# Actual	Time Planned	Actual Time
Clinics				
Home Visits/School Visits/Shift Visits				
Conferences/meetings etc.				
Documentation/administration				
New Patient Assessment				
Treatment(s)				
In-service/Education				

Travel (# of trips)				
☐ Weather				
☐ Travel/Distance				
Other (e.g. Health Promotion Classes, etc.)				

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 Call(s) ☐ Vacancies ☐

Supervisor/Management Support available on site? Yes ☐ No ☐

SECTION 4: PATIENT/CLIENT CARE FACTORS CONTRIBUTING TO THE OCCURRENCE

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

☐ Change in client acuity/complexity (psychological/physical/social). Please specify:

_____

☐ Consultation with MD/LHIN/Delay_____

☐ Overflow from previous shift

☐ Visitor/Family member

☐ Client census at time of occurrence _____

☐ # of Admissions _____

☐ # of Discharges _____

☐ Weather

☐ Travel/Distance

☐ Advanced scope of practice/client advocacy _____

☐ Abnormal diagnosis/laboratory follow-up: _____ (#)

☐ Documentation _____

☐ Reporting _____

☐ Safety in Jeopardy (please specify) _____

☐ Language barriers _____

☐ Consultation by _____ (telephone/onsite/etc.)

☐ Unanticipated clients/uncontrolled variables. Please specify:

_____

☐ Lack of/malfunctioning equipment/supplies. Please specify:

_____

☐ Incomplete referral Information

☐ Illegible orders

☐ Non-nursing/administrative duties. Please specify:

_____

☐ Emails

☐ Phone Calls/Voicemails

☐ Technology (e.g. no cell phone service/internet connection) Please Specify:

☐ Allotted time of visit

☐ Other: (e.g. Student supervision, staff orientation, mentorship, etc.) Please specify:

_____

SECTION 5: DETAILS OF OCCURRENCE

Provide a concise summary of the occurrence and how the occurrence affected your practice workload:

_____

SECTION 6: PRACTICE STANDARDS AND GUIDELINES/POLICIES AT RISK

☐ Code of Conduct
☐ Working with Unregulated Care Providers
☐ Confidentiality and Privacy: Personal Health Information
☐ Telepractice
☐ Scope of Practice
☐ Documentation
☐ Therapeutic Nurse Client Relationship
☐ Employer policy – Specify _____ (include policy if able)
☐ Nurse Practitioner
☐ Agency
☐ Other _____

Provide/identify the CNO standard(s)/practice guidelines, including the Nurse Practitioner Practice Standard, or organization/employer policies that are believed to be at risk:

_____

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

SECTION 7: REMEDY

(A) At the time the workload issue occurred, did you discuss the issue within the team/manager/supervisor.
☐ Yes ☐ No
Provide details:

_____

Was it Resolved? Yes ☐ No ☐ _____

(B) Failing resolution at the time of the occurrence, did you seek assistance from the person designated by the employer as having responsibility for timely resolution of workload issues? Yes ☐ No ☐
Please provide discussion details including name of individual(s): _____

_____

Was it resolved? Yes ☐ No ☐

(C) Did you discuss the issue with your manager/supervisor (or designate) on her or his next working day?
Yes ☐ No ☐
Please provide details: _____
Was isolated incident resolved? Yes ☐ No ☐
If an ongoing issue, was the complete issue resolved? Yes ☐ No ☐
Were measures implemented to prevent a re-occurrence? Yes ☐ No ☐
Please provide details:

_____

If staff made available, please identify the number of staff provided, their category and the amount of time they were available for:

Category (CM, RN, RPN,PHN,PSW, Clerk, etc)	**Amount of time staff Available**	**Orientation to Branch Requires Yes ☐ No ☐ Staff Orientation time (min/hrs)**
_____	_____	_____

_____	_____	_____

SECTION 8: RECOMMENDATIONS

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

- ☐ In-service
- ☐ Review **RN** patient ratio
- ☐ Increase RN Staffing
- ☐ Review Policies & Procedures _____
- ☐ Increase support Staffing
- ☐ Change Start/Stop times of shift(s). Please specify: _____
- ☐ Caseload review for acuity/activity
- ☐ Flexibility with appointments and scheduling
- ☐ Replace sick calls, vacation, paid holidays, other absences
- ☐ Perform Workload Measurement Audit
- ☐ Change Physical Layout
- ☐ Orientation
- ☐ Float/casual pool
- ☐ Equipment. Please specify: _____
- ☐ Other: _____

SECTION 9: EMPLOYEE SIGNATURES

Signature: _____ Phone # / Personal E-mail: _____

Signature: _____ Phone # / Personal E-mail: _____

SECTION 10: MANAGEMENT COMMENTS

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

_____

Management Signature: _____ Date: Click here to enter a date.

Date response to the employee: Click here to enter a date. Date response to the union: Click here to enter a date.

Copies: (1) Manager/Chief Nursing Officer (or designate) (2) ONA Representative (3) NP (4) LRO

ONA HOMECARE PROFESSIONAL RESPONSIBILITY WORKLOAD REPORT FORM GUIDELINES AND TIPS ON ITS USE

The parties agree that client care is enhanced if concerns relating to professional practice are resolved in a timely and effective manner. The parties will utilize a problem-solving process focusing on collaborative solutions at the earliest opportunity. This report form provides a tool for documentation to facilitate discussion and to promote a problem solving approach. ONA may use this information for statistical purposes and noting trends across the province.

THE FOLLOWING IS A SUMMARY OF THE PROBLEM SOLVING PROCESS. PRIOR TO SUBMITTING THE WORKLOAD REPORT FORM, PLEASE FOLLOW ALL STEPS AS OUTLINED IN THE CNO STANDARDS AND/OR APPLICABLE COLLECTIVE AGREEMENTS.

PROBLEM SOLVING PROCESS

1) At the time the workload issue occurs, discuss the matter within the program to develop strategies to meet client care needs using current resources. If necessary, using established lines of communication, seek immediate assistance from an individual identified by the Employer (e.g. co-ordinator/supervisor) who has responsibility for timely resolution of workload issues.
2) Failing resolution of the workload issue at the time of the occurrence, discuss the issue with your Executive Director/Administrator or Manager (or designate) on his or her next working day.
3) If no satisfactory resolution is reached during steps (1) and (2) above, then you may submit a Professional Responsibility Workload Report Form to the Union-Employer Committee within the specified number of days of the alleged improper assignment.
4) The Union-Employer Committee shall hear and attempt to resolve the complaint to the satisfaction of both parties.
5) If the issue is not resolved at the meeting in (4) above, the LRO shall attend a meeting with Management and attempt to resolve the complaint. Failing resolution, the LRO will request a Professional Practice Specialist to attend a follow up meeting.
6) If outlined in your Collective Agreement, the form may be forwarded to an Independent Assessment Committee within the requisite number of days of the meeting in (5) above, if outlined in your collective agreement.
7) The Union and the Employer may mutually agree to extend the time limits for referral of the complaint at any stage of the complaint procedure. The Union and the Employer may mutually agree to extend the time limits for referral of the complaint at any stage of the complaint 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) 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 RN standards/practice/guidelines/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 clients/patients/residents.