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| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **SECTION 1: GENERAL INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name(s) of Employee(s) Reporting (Please Print) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Employer: | | | |  | | | | | | | | | | | | | | | | | | | | | Unit//Area/Program: | | | | | | | | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Occurrence: | | | | | | Day | | | | Month | | | | | | | | Year | | | Time: | | |  | | | | | 7.5 hr. shift  11.25 hr. shift  Other: | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | Date/ | | | | | | | | | Day | | | Month | | | Year | | |
| Name of Supervisor/Charge Nurse: | | | | | | | | | | | | | |  | | | | | | | | | | | | | | Time notified: | | | | | | | | |  | | | | | | | | |
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| **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 #: RN | | | | | | | |  | | | | | | | RPN | | | | |  | | | | Unit Clerk | | | | | | | |  | | | Service Support | | | | | | | | |  | | | |
| Actual Staffing #: RN | | | | | | | |  | | | | | | | RPN | | | | |  | | | | Unit Clerk | | | | | | | |  | | | Service Support | | | | | | | | |  | | | |
| Agency/Registry RN: | | | | | | | | | | | | | | | Yes | | | | |  | | | | No | | | | | | | |  | | | How many? | | | | | | | | |  | | | |
| Novice RN Staff on duty\* | | | | | | | | | | | | | | | Yes | | | | |  | | | | No | | | | | | | |  | | | How many? | | | | | | | | |  | | | |
| 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 Call(s)  Vacancies  Off unit  Management Support available on site? Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **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:  Change in patient acuity. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Normal number of beds on unit       Beds closed       Beds opened during tour | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient census at time of occurrence | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| # of Admissions       # of Discharges       # of Transfers | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Lack of/or equipment/malfunctioning equipment. Please specify: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Visitors/Family Members. Please specify: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Number of patients on infectious precautions | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Over Capacity Protocol. Please specify: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Resources/Supplies | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Interdepartmental Challenges | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| System Issues | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Exceptional Patient Factors (i.e. significant time and attention required to meet patient expectations). Please specify: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Other: (e.g. Non-nursing duties, student supervision, mentorship, etc.) Please specify: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **SECTION 4: DETAILS OF OCCURRENCE** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Provide a concise summary of the occurrence and how it impacted patient care: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Provide identify the Nursing Standard(s)/Practice Guidelines or hospital/unit policies that are believed to be at risk: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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 detailsof how it was or was not resolved: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| (B) Failing resolution at the time of the occurrence, seekimmediate assistance from an individual(s) who has responsibility for timely resolution of workload issues. Discussion details including name of individual(s): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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:  Inservice  Orientation  Review nurse/patient ratio  Change unit lay-out  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: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SECTION 7: EMPLOYEE SIGNATURES** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Signature: | |  | | | | | | | Date: | | | | |  | | | | | | | Phone #: | | | | |  | | | | | | | | Personal e-mail: | | | | | | |  | | | | | |
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| Signature: | |  | | | | | | | Date: | | | | |  | | | | | | | Phone #: | | | | |  | | | | | | | | Personal e-mail: | | | | | | |  | | | | | |
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| Signature: | |  | | | | | | | Date: | | | | |  | | | | | | | Phone #: | | | | |  | | | | | | | | Personal e-mail: | | | | | | |  | | | | | |
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| Signature: | |  | | | | | | | Date: | | | | |  | | | | | | | Phone #: | | | | |  | | | | | | | | Personal e-mail: | | | | | | |  | | | | | |
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| Date Submitted: | | | | |  | | | | | | | | | | | | | | Submitted to (Manager name): | | | | | | | | | | | | | | | | | | | |  | | | | | | | |
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| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Management Signature: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | Date: | | | | |  | | | | | | | | |
| Date response to the employer: | | | | | | | | | | | | |  | | | | | | | | | Date response to the union: | | | | | | | | | | | | | | | |  | | | | | | | | |
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| **SECTION 9: RECOMMENDATIONS OF HOSPITAL-ASSOCIATION COMMITTEE** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| The Hospital-Association Committee recommends the following in order to prevent similar occurrences: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Dated: |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Copies: (1) Manager  (2) ONA Rep  (3) Chief Nursing Executive (or designate)  (4) ONA Member  (5) LRO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

### ONA/HOSPITAL PROFESSIONAL RESPONSIBILITY - WORKLOAD REPORT FORM

### GUIDELINES AND TIPS ON ITS USE

The parties have agreed that patient care is enhanced if concerns 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 she or he 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 complaint 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 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) 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](http://www.cno.org).

6) Do not, under any circumstances, identify patients/residents.