Work Situation Report - Extendicare

WSR Tracking Number:

Employer: _____ Facility: _____ Local #: _____

Unit/Agency: _____ Date: _____ Shift: _____

Report Filed By: _____

Personal Email: _____ Phone#: _____

Names of other SUN Members involved: _____

_____

_____

NUMBER OF BASELINE STAFF FOR SHIFT:

RN: _____ RPN: _____ LPN: _____ Others: _____

Number of staff on duty:

RN: _____ RPN: _____ LPN: _____ Others: _____

Number of staff needed:

RN: _____ RPN: _____ LPN: _____ Others: _____

PATIENT/CLIENT CENSUS: _____

# of Beds on Unit: _____

Overcapactity: _____

RN/RPN to Patient Ratio: _____

Planned Patient Hours: _____

Actual Patient Hours: _____

Charge Nurse? ☐ Yes ☐ No **On Site Management?** ☐ Yes ☐ No

If yes, does the Charge Nurse have a patient assignment? ☐ Yes ☐ No

DESCRIBE THE ACTIONS TAKEN FOR LOW LEVEL RESOLUTION

☐ Department / Unit Huddle

☐ Discussion with co-workers/Charge Nurse

☐ Discussion with RN manager/supervisor

☐ Workload discussion *(Prioritizing workload, postponing tasks, calling other units for assistance, etc)*

☐ Other (please explain below):

Is this an ongoing issue or repeat incident that should be identified?

☐ Yes ☐ No

NOTIFICATION OF MANAGER OR DESIGNATE

Manager Notified? ☐ Yes ☐ No Is Manager an ☐ RN? ☐ RPN?

Method of communication: ☐ Face-to-face ☐ Telephone conversation ☐ Voice mail ☐ Email

Name of Manager Notified:

Response by Manager:

If a Manager or On-Call Manager/designate is NOT available, was staff called in as per Article 9.03?

☐ Yes ☐ No

Was Call-In Criteria as per Article 9.03 used? ☐ Yes ☐ No **Who was called in?**

DESCRIBING THE INCIDENT

- In the following section, please check off all applicable descriptors under each question; only check off what you know to be factual. If needed, please utilize the "additional details/other" fields.
- Where applicable, please include additional information in the space(s) provided.
- The following questions are designed to focus on the environment and professional barriers, and factors that may have prohibited you from providing safe patient care or meeting your professional standards.

EXPLANATION OF WHAT MADE YOUR SHIFT UNSAFE? *(choose all that apply and provide additional detail if required)*

- ☐ Too many patients
- ☐ Wrong skill mix (i.e. need RN, LPN or 1:1)
- ☐ Inability to monitor, observe or check patient(s)
- ☐ Nursing code of ethics breached or risk of breach
- ☐ Physician related concerns
- ☐ Leaves not replaced
- ☐ Isolation precautions
- ☐ Supports not available (management, PT, SW, etc.)
- ☐ Additional details/other: *(please specify below)*
- ☐ High acuity
- ☐ Not enough qualified staff/Jr. Sr. mix
- ☐ Inadequate orientation/training/equipment
- ☐ Staff safety concerns
- ☐ Physical layout of facility/unit
- ☐ Non nursing duties
- ☐ Patient negative outcome, harm or incident
- ☐ Equipment/supply issues
- ☐ Workload

NURSING STANDARDS AND FOUNDATIONAL COMPETENCIES BREACHED, NOT MAINTAINED OR POTENTIAL FOR?

- ☐ SRNA Standards
- ☐ CNA Code of Ethics
- ☐ National Standards
- ☐ RPNAS Standards
- ☐ Employer/Region Policy
- ☐ OHS Legislation
- ☐ 24 Hours RN/RPN Coverage

Please provide additional detail including the specific reference:

HOW WAS THE UNSAFE SITUATION RECTIFIED? *(choose all that apply and provide additional detail if required)*

- ☐ It was not rectified
- ☐ Obtained correct skill mix of staff
- ☐ Closed the unit to admissions/bed closed
- ☐ Ongoing issue for further monitor *(please explain below)*
- ☐ Obtained correct number of staff
- ☐ Refused assignment/I was reassigned
- ☐ Provided the necessary training/preceptor
- ☐ Additional details/other: *(please specify below)*

WHAT IMPACT DID THIS HAVE ON PATIENT CARE? *(choose all that apply and provide additional detail if required)*

- ☐ Increased length of stay for patient(s)
- ☐ Negative outcome, harm or incident (i.e. fall, med error)
- ☐ Patient(s) left without being seen
- ☐ Delayed or cancelled treatment or programming
- ☐ Incomplete discharge planning/teaching
- ☐ Additional details/other: *(please specify below)*
- ☐ Inability to answer call lights
- ☐ Incomplete admissions
- ☐ Incomplete assessments
- ☐ Inadequate patient pain management
- ☐ Inability to give or receive report
- ☐ Inability to practice safe patient care

ACTION TAKEN *(choose all that apply and provide additional detail if required)*

What action(s) did you take or will take, to continue to advocate for your patients?

- ☐ Repeated phone calls to Manager
- ☐ Worked shift without assistance
- ☐ Notify nurses on next shift
- ☐ Notify On-Call Manager
- ☐ Stop the line
- ☐ Additional details/other: *(please specify below)*
- ☐ Unit/bed closure
- ☐ Contacted SUN Provincial
- ☐ Contacted SRNA/RPNAS/CNPS
- ☐ Notify Local
- ☐ Occurrence/Safety Report # _____

BRIEFLY DESCRIBE THE INCIDENT

HOW CAN THIS ISSUE BE RESOLVED IN THE FUTURE? *(please provide details and examples of your solutions)*

SIGNATURE OF NURSE(S)

Signature	*Signature*	*Signature*
Print Name	*Print Name*	*Print Name*
Personal Email	*Personal Email*	*Personal Email*

WSR COMPLETED

☐ Copy sent to the Local *(photo copy or scanned and emailed)*

☐ Copy to Manager *(photo copy or scanned and emailed)*

NOTIFICATION OF MANAGER OR DESIGNATE

For Manager Use Only

Date + Time: Manager Name:

How was the issue addressed:

WSR Tracking Number: _____

LOCAL USE ONLY: Additional Notes

SEND ORIGINAL COMPLETED WSR:

BY MAIL
SUN Provincial
2330 2nd Avenue
Regina, SK S4R 1A6

OR

E-MAIL
(attach a scanned file; PDF format preferred)
WSR@sun-nurses.sk.ca