



Member

FILED BY

Clark Kent

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EMPLOYER

TEST Health Authority

WORKSITE

TEST SUN Hospital

DEPARTMENT

Ambulatory Care Unit

LOCAL

Local 315, TEST Hospital SUN

Case Details

UNIT/AGENCY

Ambulatory Care

INVOLVED SUN MEMBERS

Mer Edith, RN

Shift Details

SHIFT 2026-04-15 , Day

	BASELINE	ON DUTY	NEEDED
RN	5	4	6
RPN	0	0	0
NP	0	0	0
LPN	2	2	3
Other	0	0	0

Management Onsite

Charge Nurse with patient assignment

Charge Nurse without patient assignment

Patients

NUMBER OF PATIENTS

0

RN/RPN/NP TO PATIENT RATIO

1:0.000

BEDS IN UNIT

0

PLANNED PATIENT HOURS

0

OVERCAPACITY



ACTUAL PATIENT HOURS

0

Step 1: Actions Taken for Low Level Resolution

- Department / Unit Huddle
 - Discussion with RN manager/supervisor
 - Discussion with co-workers/Charge Nurse
 - Workload discussion
- Other
- Multiple specialists with all-day clinics booked - one was unexpected.
- Ongoing issue or repeat incident that should be identified for trending purposes

Step 2: Notification of Manager or Designate

- Manager Notified
- | MANAGER NAME | METHOD OF COMMUNICATION |
|----------------------|-------------------------|
| Mgr Name, Non-RN/RPN | Telephone Conversation |
- Manager Response
- Supportive of filling our WSR - one sick call and there are no additional staff available (covering manager)
- MANAGER OR DESIGNATE NOT AVAILABLE, STAFF CALLED IN PER ARTICLE 9.03 CALL-IN CRITERIA PER ARTICLE 9.03 WHO WAS CALLED IN

Explanation of Unsafe Shift

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

Additional Details

More specialists than typically booked in a day, and all had full days. Rooms weren't appropriately set up for procedures, one room was on the complete opposite end of the hall, no where near the other rooms.

Unmet Professional Standards

- 24 Hours RN/RPN/NP Coverage (LTC)
- CRNS Standards
- National Standards
- RPNAS Code of Ethics
- CNA Code of Ethics
- Employer/Region Policy
- OHS Legislation
- RPNAS Standards

Additional Details

Unable to provide safe patient care to all patients needing to be seen, we were rushed off our feet all day.

Unsafe Situation Status

- Closed the unit to admissions/bed closed
- Obtained correct number of staff
- Ongoing issue for further monitor
- Refused assignment/I was reassigned
- It was not resolved
- Obtained correct skill mix of staff
- Provided the necessary training/preceptor

Additional Details

We just worked through breaks to take care of all booked patients to be seen in the day.

Impact on Patient Care

- Delayed or cancelled treatment or programming
- Inability to give or receive report
- Inadequate patient pain management
- Incomplete assessments
- Increased length of stay for patient(s)
- Patient(s) left without being seen
- Inability to answer call lights
- Inability to practice safe patient care
- Incomplete admissions
- Incomplete discharge planning/teaching
- Negative outcome, harm or incident

Additional Details

Rushed through vitals, assessments, and teaching to keep the clinic running as timely as possible. Felt incomplete. Several patient left without being seen because of wait times being too long and the waiting room overflowing. They will just need to be rescheduled later.

Action Taken

- | | |
|--|---|
| <input type="checkbox"/> Contacted CRNS/RPNAS/CNPS | <input type="checkbox"/> Contacted SUN Provincial |
| <input type="checkbox"/> Notify Local | <input type="checkbox"/> Notify nurses on next shift |
| <input type="checkbox"/> Notify On-Call Manager | <input type="checkbox"/> Occurrence/Safety Report # |
| <input type="checkbox"/> Repeated phone calls to Manager | <input type="checkbox"/> Stop the line |
| <input type="checkbox"/> Unit/bed closure | <input checked="" type="checkbox"/> Worked shift without assistance |

Additional Details

Manage aware, tried to get staff

Incident Description

Each physician is supposed to have 3 nurses; with one nurse as a float. But because we are short, we had no float, and one physician had only one nurse with them, with another only with 2. Multiple patients arrived at once, so waiting room was overflowing at one point, with people having to stand. Several patients left as we were delayed with one clinic due to an appointment taking longer than expected, so wait times grew longer.

Recommendations for Resolution

Having enough rooms with the appropriate set up needed for clinics we run. Looking for additional casual staff as we don't have many Pre-booking staff if there are additional clinics planned beyond what we normally see.

Communication Record

This WSR form was submitted on-line by the SUN member identified at the top of this record. Electronic copies of this record have been sent to the following participants in the roles of Union Local & Provincial Representatives and a Employer Unit Manager Representative.

2026-04-15 5:49:11 p.m.

This document was created by Clark Kent. A notice of this document was sent to the following via email:

Member: Clark Kent, sunlink.test@outlook.com

Local Representative: SUN Test (NAC), sun.test.nac@outlook.com

Provincial Representative: Name Name, name.name@sun-nurses.sk.ca

Unit Manager: Name Name, name.name@hospital.com

Message ID: 00-a3983884f64ac192b6fc82a6bd72b7cb-cc176d3ef569aa0f-00