

ID#: _____ (a)
(for internal use only)



RPN WORKLOAD REVIEW FORM

RPNS are responsible and required to complete sections 1-4 of this form prior to submitting it to the Manager (or designate). The parties agree that patient care is enhanced if concerns relating to workloads arising from patient acuity and volumes are resolved in a timely manner using a problem solving approach.

SECTION 1: Initial Attempt at Resolution

At the time the workload issue occurred, I/we discussed the issue within unit/program to resolve the concern using current resources.

Name of person spoken to:

Date:

Time:

Failing resolution at the time of occurrence, using established lines of communication, I/we sought immediate assistance from an individual(s) identified by the Hospital (who could be within the bargaining unit) who has responsibility for timely resolution of workload issues.

Name of person spoken to:

Date:

Time:

I/ We do not agree with the resolution of my/our concern.

Name:

Signature: _____

Name:

Signature: _____

Name:

Signature: _____

Failing resolution of the workload issue at the time of occurrence, the nurse (s) will complete a workload review form and discuss the issue with their Manager or designate on the next day that the Manager (or designate) and the nurse are both working or within five (5) calendar days, whichever is sooner. The manager will provide a written response to the complainant(s), with a copy to the RPN Steward and Union Representative.

SECTION 2: General Information

Date of Occurrence:

Time of Occurrence:

Date form submitted to Employer:

Department/ unit:

Site/ Location:

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

Absence	<input type="checkbox"/>	Sick Calls	<input type="checkbox"/>
Vacancies	<input type="checkbox"/>	Off Unit	<input type="checkbox"/>

Which classifications are vacant and/or absent:

SECTION 3: Factors/ Details of Occurrence

I/ We the undersigned RPNs, believe that I was/we were given an assignment that was excessive or inconsistent with quality patient care and/or created an unsafe working environment for the following reasons. (Please check factors, and provide detail below):

Staffing Shortages (see section 2)	<input type="checkbox"/>
Patient/ Work Preparation Concerns	<input type="checkbox"/>
Patient/ Work Volume	<input type="checkbox"/>

Details of occurrence. RPNs must provide written details of the occurrence with specifics for each checkbox identified as a factor:

Admissions: <input type="checkbox"/> #	Discharges: <input type="checkbox"/> #	Transfers: <input type="checkbox"/> #
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Number of patients in isolation:

Resources/ Supplies:

Interdepartmental Challenges:

Exceptional Patient Factors (i.e. significant time and attention required to meet patient needs/ expectations):

Other:

SECTION 4: RPN Recommended Solution

RPN must provide written details of the solution with specifics for each check box identified:

- Review Staff/ Patient Ratio
- In Service
- Change Unit lay-out
- Change Start/ Stop times of shift(s)
- Replace sick calls, vacation, paid holidays, other absences
- Orientation
- Review policies and procedures
- Other solutions:

Provide details of the identified checkbox(es):

Signature of Employees & Printed Names:

Name: _____ Signature: _____

Name: _____ Signature: _____

Name: _____ Signature: _____

SECTION 5: Manager or Designates Response



Please share the contact information for the manager/nurse leader who should receive this workload review form:

Email Address: _____

Department/Unit: _____

Workplace/Site/Location: _____