

In the interest of patient safety and safe nursing practice, as per Articles 9.03, 56 and Appendix B of the SUN/SAHO Collective Bargaining Agreement, SUN and the Employer/SAHO, have agreed to a proactive process to low level resolution to address concerns raised which involve:

- Nursing Practice Concerns
- Safety of patients and registered nurses
- Workload/Staffing Levels/Patient Acuity
- Other factors which negatively affect patient care

## Steps in the Problem Solving Process – Article 56

### STEP 1: LOW LEVEL RESOLUTION

56.03 Where an individual Employee or group of Employees have cause to believe that she or they are being asked to perform more work than is consistent with proper client care, or to perform work in violation of her professional responsibilities, she shall first discuss concerns with co-workers/team and In-Charge nurse on the unit, as provided in Joint Nursing Advisory Process Algorithm Chart (Appendix B).

### STEP 2: NOTIFICATION OF MANAGER OR DESIGNATE

IF THE ISSUE IS NOT RESOLVED:

The registered nurse notifies the Manager or On-Call Manager/designate of the situation for further discussion and timely resolution. Resolution may include attempting to find more staff subject to criteria as per Article 9.03.

9.03 *If additional staff are necessary and no registered nurse management personnel are available, the registered nurse designated in charge shall have the authority to call such additional staff subject to criteria established by the Employer in consultation with the registered nurses in the work Unit. In the event the Employer has not established criteria, the registered nurse shall have the authority to call additional staff that in her professional opinion are necessary.*

**NOTIFICATION:** May include a face-to-face discussion or a telephone call.

- if the issue remains unresolved, a SUN Work Situation Report (WSR) is filled out; or
- if no Manager or On-Call Manager/designate is available, a voice message is left or email will be sent and a WSR filled out.

### STEP 3: WSR REPORT COMPLETED

The WSR gets filed with the SUN Local and the Manager/designate. The SUN Local provides a copy to the Union.

### STEP 4: MANAGER TO FOLLOW UP WITHIN 96 HOURS OF NOTICE

56.04 It is the Employer's responsibility to follow up within 96 hours of notice. If not resolved, the WSR will be discussed at the Joint Nursing Advisory Committee meeting with the Employer.



# SUN Work Situation Report

WSR Tracking Number: **SAMPLE**

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: \_\_\_\_\_

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

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

### PATIENT/CLIENT CENSUS:

# of Beds on Unit: \_\_\_\_\_

Overcapacity: \_\_\_\_\_

RN/RPN to Patient Ratio: \_\_\_\_\_

Planned Patient Hours: \_\_\_\_\_

Actual Patient Hours: \_\_\_\_\_

## STEP 1: 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 for trending purposes?**

Yes  No

## STEP 2: 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)*

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

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

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> SRNA Standards     | <input type="checkbox"/> RPNAS Standards        | <input type="checkbox"/> OHS Legislation          |
| <input type="checkbox"/> CNA Code of Ethics | <input type="checkbox"/> Employer/Region Policy | <input type="checkbox"/> 24 Hours RN/RPN Coverage |
| <input type="checkbox"/> National Standards |   |   |

Please provide additional detail including the specific reference:

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

- |  |  |
|--|--|
| <input type="checkbox"/> It was not rectified  | <input type="checkbox"/> Obtained correct number of staff                        |
| <input type="checkbox"/> Obtained correct skill mix of staff                             | <input type="checkbox"/> Refused assignment/I was reassigned                     |
| <input type="checkbox"/> Closed the unit to admissions/bed closed                        | <input type="checkbox"/> Provided the necessary training/preceptor               |
| <input type="checkbox"/> Ongoing issue for further monitor <i>(please explain below)</i> | <input type="checkbox"/> Additional details/other: <i>(please specify below)</i> |

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

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

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

BRIEFLY DESCRIBE THE INCIDENT

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

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SIGNATURE OF NURSE(S)

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**STEP 3: WSR COMPLETED**

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

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

**STEP 4: NOTIFICATION OF MANAGER OR DESIGNATE**

For Manager Use Only

Date + Time:

Manager Name:

Copy sent to SAHO  
*(scanned and emailed)*

How was the issue addressed:

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