SRH NURSE STAFFING CONCERN FORM

You must contact your immediate supervisor/charge or house supervisor if you consider your assignment poses a serious threat to your patient's health and or safety; or your personal health and safety

COMPLETE FORM (INCLUDING BACK AND ADDITIONAL PAGES IF NEEDED) AND SIGN THIS FORM AND GIVE IT YOUR CHARGE NURSE/IMMEDIATE SUPERVISOR AND TO A WSNA LOCAL OFFICER
RETAIN A COPY OF THIS FORM – BACK AND FRONT - FOR YOURSELF

- ❖ **Submitted to Charge Nurse/Supervisor [print] _________________**
- ❖ **Nurse Name [print] ___________________________**
- ❖ **Nurse Signature ___________________________________ Submitted on Date ______________**
- ❖ **At the time of my concern I was working on Unit _________And Shift ______ as a**
  ☐ **Charge Nurse** ☐ **Staff Nurse**
- ❖ **During my shift I made my concern(s) known to [print name(s)] _________________________ who is a**
  ☐ **Charge Nurse** ☐ **Supervisor** ☐ **House Supervisor**

My concern(s) discussed with my charge nurse/supervisor were (check all that apply):

☐ Unable to perform charge nurse duties, secondary to increased patient care assignment **[list on back of form how many patients were assigned]**

☐ Inadequate nurse to patient ratios based on my clinical judgment **[explain situation on back of form and list how many patients were assigned]**

☐ Insufficient support staff required me to assume additional duties [**list additional duties on back of form**]

☐ Not oriented to this unit/case load**[identify what unit/caseload on back of form]**

☐ Patient care equipment missing or unusable or necessary equipment is not available **[identify equipment/ problem with equipment on back of form]**

☐ Not trained or experienced to use equipment in assigned area **[identify equipment and area assigned on back of form]**

☐ Not trained or experienced in area assigned **[identify area assigned on back of form]**

☐ Mandatory Overtime **[explain on back of form]**

☐ System failure e.g.: computer, phone, Omnicel, call system **[identify failed system on back of form]**

☐ Other **[explain on back of form]**

☐ Filled out Kronos Form For Missed ☐Meal ☐Rest

SHIFT INFORMATION IF APPLICABLE TO CONCERN [to be completed by Charge Nurse/Immediate Supervisor] :

Census on Unit:__________

Matrix RN:__________

Actual RN:___________

Matrix CNA:_____________

Actual CNA:____________

Matrix UA:___________

Actual UA:________________

OTHER INFORMATION: (To be completed by Staff RN)

ANY ACTIONS TAKEN/RESPONSE BY CHARGE NURSE/IMMEDIATE SUPERVISOR/HOUSE SUPERVISOR (To be completed by Charge Nurse/Immediate Supervisor)

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Charge Nurse /Immediate Supervisor____Date_______________

ANY ACTIONS TAKEN/RESPONSE BY DIRECTOR/MANAGER:

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DIRECTOR/ MANAGER ____Date_________