

Email a copy of the completed form to WSNA Chair Liz Rainaud at tulipcityquilt@aol.com and WSNA Nurse Representative Sue O'Donnell at sodonnell@wsna.org.

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):

- | | | |
|---|---|---|
| <input type="checkbox"/> Unable to perform charge nurse duties, secondary to increased patient care assignment [list on back of form how many patients were assigned] | <input type="checkbox"/> Not oriented to this unit/case load [identify what unit/caseload on back of form] | <input type="checkbox"/> Not trained or experienced in area assigned [identify area assigned on back of form] |
| <input type="checkbox"/> Inadequate nurse to patient ratios based on my clinical judgment [explain situation on back of form and list how many patients were assigned] | <input type="checkbox"/> Patient care equipment missing or unusable or necessary equipment is not available [identify equipment/ problem with equipment on back of form] | <input type="checkbox"/> Mandatory Overtime [explain on back of form] |
| <input type="checkbox"/> Insufficient support staff required me to assume additional duties [list additional duties on back of form] | <input type="checkbox"/> Not trained or experienced to use equipment in assigned area [identify equipment and area assigned on back of form] | <input type="checkbox"/> System failure e.g.: computer, phone, Omnicel, call system [identify failed system 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)

Charge Nurse /Immediate Supervisor _____ **Date** _____

ANY ACTIONS TAKEN/RESPONSE BY DIRECTOR/MANAGER:

DIRECTOR/ MANAGER _____ **Date** _____