NON-RPN WORKLOAD COMPLAINT FORM

N.B. All sections of the form **must** be completed prior to submission for review.

The parties agree that patient care is enhanced if concerns relating to professional practice, patient acuity, fluctuating Work-Loads and fluctuating staffing are resolved in a timely and effective manner.

SECTION 1: GENERAL INFORMATION

Name(s) of Employee(s) Reporting (Please Print)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Unit/Area/Program: _____ Site/Location: _____

Date of Occurrence _____ Time of Occurrence: _____

Shift Length: ☐ 7.5 hr. ☐ 11.25 hr. ☐ Other _____

Name of Manager/Supervisor: _____ Time Notified: _____

Date Form Submitted to Employer: _____

SECTION 2: WORKING CONDITIONS

In order to effectively resolve workload issues, please provide detail about the working conditions at the time of the occurrence by providing the following information:

Type of Work Being Performed (please describe) (check all applicable)

☐ Patient care ☐ Cleaning/disinfecting ☐ Making/cleaning patient rooms
☐ Cleaning common areas ☐ Laundry/linen duties ☐ Garbage/recycling
☐ Restocking supplies ☐ Food preparation ☐ Meal delivery/service ☐ Dishwashing/clean-up
☐ Patient meal assistance ☐ Transporting patients ☐ Moving equipment or supplies
☐ Answering phones/calls ☐ Clerical/administrative work
☐ Duties normally performed by another position ☐ Unit Assistant duties
☐ Multiple jobs/tasks at the same time
☐ Other: _____

Number of Staff on Duty _____ Usual Number of Staff on Duty _____

If there was a shortage of staff at the time of the occurrence, please provide details about why there was a shortage: (check all that apply)

☐ Unknown ☐ Staff member called in sick ☐ Staff member was on vacation ☐ Staff member was on a leave
☐ Sick call was not replaced ☐ No replacement staff available
☐ Staff were reassigned to another area ☐ Position/shift was left unfilled
☐ Increased workload or unexpected demand
☐ Other: _____

SECTION 3: DETAILS OF OCCURENCE

Is this an: ☐ Isolated Incident ☐ Ongoing Problem (*Check One*)

I/We the undersigned, 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. (Provide brief description of problem/work assignment below, including what happened, how the assignment was inconsistent with quality patient care and/or created an unsafe work environment, where the incident happened.:

☐ Too many patients/residents assigned ☐ Too many tasks to complete safely
☐ Additional duties added to my workload ☐ Unit Assistant duties added to my workload
☐ Not enough staff available ☐ Unable to complete all required duties during my shift
☐ Unable to take required breaks ☐ Patient care was delayed ☐ Increased risk to patient/resident safety
☐ Increased risk to staff safety ☐ Frequent interruptions made it difficult to complete my work
☐ Unexpected workload or staffing issue
☐ Other:

SECTION 4: REMEDY

a) At the time the workload issue occurs, discuss the issue within the unit/area/program to develop strategies to meet patient care needs. Provide details of how it was or was not resolved:

☐ Asked manager/supervisor for help ☐ Asked manager/supervisor what work should be prioritized ☐ Asked another staff member for help ☐ Staff from another area helped
☐ Staff were reassigned ☐ Work was delayed ☐ Some work could not be completed
☐ Break was missed or delayed ☐ Work was carried over to the next shift
☐ Tasks were completed after the shift ☐ Patient/resident care was delayed
☐ Workload remained unmanageable ☐ No solution was provided
☐ Other: _____

b) Failing resolution at the time of the occurrence, seek immediate assistance from your immediate supervisor/manager who has responsibility for timely resolution of workload issues. Discussion details:

☐ Spoke with manager/supervisor ☐ Asked for additional staff ☐ Asked for help with the workload ☐ Asked what work should be prioritized ☐ Asked for tasks to be reassigned
☐ Manager/supervisor provided assistance ☐ Additional staff were provided
☐ Work was reassigned ☐ No additional help was provided ☐ No change to the workload
☐ Told to continue with the assigned work ☐ Told to leave lower-priority work until later
☐ Concern was not addressed ☐ Manager/supervisor was not available
☐ Other: _____

c) Was it resolved: ☐ Yes ☐ No

Provide details of how it was or was not resolved: _____

_____

_____

_____

SECTION 5: RECOMMENDATIONS

To correct this problem, I/we recommend:

☐ Add more staff ☐ Fill vacant positions ☐ Replace staff who are absent
☐ Replace sick calls ☐ Provide staff from another area/unit when needed
☐ Review staffing levels ☐ Review workload and staffing needs ☐ Reassign some duties
☐ Clarify which duties should be prioritized ☐ Stop assigning duties from other positions
☐ Restore or replace lost support positions ☐ Ensure adequate time to complete assigned work ☐ Provide additional training/support

- ☐ Other: _____

SECTION 6: EMPLOYEE SIGNATURE(S)

Signature: _____ Date: _____

Phone #: _____ Email: _____

Signature: _____ Date: _____

Phone #: _____ Email: _____

Signature: _____ Date: _____

Phone #: _____ Email: _____

Signature: _____ Date: _____

Phone #: _____ Email: _____

SECTION 7: MANAGEMENT COMMENTS

The manager (or designate) will provide a written response to the individual(s) with a copy to the Bargaining Unit President. Please provide any information/comments in response to this report, including any actions taken to remedy the situation, where applicable:

_____

_____

_____

_____

_____