ID#: _____
(for internal use only)

SEIU Healthcare

NURSING WORKLOAD REVIEW TRACKING FORM
LONG-TERM CARE SECTOR

Nursing Professional Practice Workload Review Form Instructions

First welcome and thank you for taking the time to help improve resident care, safety and professional nursing practice by completing this form. Together we can all contribute to the best possible experience for those we care for and for those who provide that professional care.

1. For SEIU members, please complete the professional practice workload review form and include your contact information, phone number & email.

   Phone: (M): _____ (H):_____
   Name: _____
   Email: _____

2. Please keep a copy of the completed form for yourself, provide a photo copy to your steward and **fax to the MRC: 1-855-233-8238.**

3. The steward may provide a copy to the Worker Health & Safety Rep if they identify a Health & Safety issue within your Work Load Review Form.

What will happen to the form once I send in the WLRF?
The form will be directed to your SEIU Healthcare Union Representative in efforts to track the Professional Practice issues that you are attempting to resolve with your employer in your workplace.

At the next scheduled Labour Management meeting your Union Representative will address the Workload Review Form you have submitted. You should follow up with a Steward following that meeting.

Again, thank you for strengthening the profession and advocating for the safest work environments that will allow residents to thrive and your practice to remain safe.

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Nurses should complete sections 1-4 of this form prior to faxing to the MRC. Resident 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 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 Employer (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 provide a copy to the MRC.

SECTION 2: General Information

Date of Occurrence: Time of Occurrence:

Date form submitted to Employer: Department/ unit:

Site/ Location:

SERVICE EMPLOYEES INTERNATIONAL UNION LOCAL 1 CANADA

P 905-695-1767 TF 1-800-267-SEIU F 905-695-1768
125 Mural Street, Richmond Hill, Ontario L4B 1M4

SEIUHEALTHCARE.CA

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

Absence ☐ Sick Calls ☐

Vacancies ☐ Off Unit ☐

Which classifications are vacant and/or absent:

SECTION 3: Factors/ Details of Occurrence

I/ We the undersigned Nurse(s), 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) ☐

Resident/ Work Preparation Concerns ☐

Resident/ Work Volume ☐

Details of occurrence. Nurse(s) must provide written details of the occurrence with specifics for each check box identified as a factor:

Admissions: ☐ # Discharges: ☐ # Transfers: ☐ #

Number of Residents in Isolation:

Lack of Resources/ Supplies:

Interdepartmental Challenges:

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

Other:

SECTION 4: Nurse(s) Recommended Solution

Nurse(s) must provide written details of the solution with specifics for each check box identified:

- ☐ Review Staff/ Resident 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 Nurse(s) & Printed Name(s):

Name: Signature:_____

Name: Signature:_____

Name: Signature:_____