

CLINICAL CAPACITY REPORT

EMPLOYER NAME: _____

SITE: _____

(1) NAME: _____ DATE: (YYYY/MM/DD): _____

PATIENT UNIT: _____ SHIFT/TIME OF OCCURRENCE: _____

(2) STAFFING (NUMBERS) SCHEDULED: _____ THIS SHIFT: _____

RN's _____

LPN's _____

OTHER _____

Number of patients in isolation: _____

(3) NUMBER OF PATIENTS ON UNIT: _____

(4) Describe workload situation, including acuity of patients:

(5) Detail actions you took in response to the workload situation to address patient needs:

(6) Name of Manager/Supervisor/Designate Contacted: _____

Time Contacted: _____

(7) Describe action/response given by Manager/Supervisor/Designate:

(8) Describe your response: _____

(9) What other options might have been considered:

Date: (YYYY/MM/DD) & Time of Submission

Signature

Copies to:
Constituent Union; Employer, Nurse

GUIDELINES FOR USE

- (1) A Nurse who believes that adequate and safe care of patients cannot be provided because of that Nurse's workload should bring the matter to the attention of the immediate Supervisor, or where appropriate, the Supervisor's Designate. Where the issue has not been satisfactorily resolved, the Nurse may complete this form.
- (2) Briefly outline:
 - (a) the work situation; and
 - (b) identify specific problem(s). If the form does not provide sufficient space, please add further information on a separate sheet.
- (3) **DO NOT** identify clients/residents or doctors involved in the incident described, use Dr. X or client/resident A.
- (4) **Clinical Capacity Reports** are not intended to replace any incident report form or other internal documentation required under Employer Policies.

Fax form to NSGEU 902-424-4832 or email: inquiry@nsgeu.ca