LONG-TERM CARE RPN/RN PROFESSIONAL RESPONSIBILITY FORM

RPN/RNs are required to complete every section of this form prior to submitting it to the Manager (or designate)

Section 1: General Information	
Date/Time of Occurrence:	Date Form Submitted to Employer:
Site/Location:	Department/Unit:
Type of Work Being Performed:	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 check one or all of the following that apply: Absence: Sick Calls: Vacancies: Off Unit:
Section 2: Details of Occurrence	
with quality resident care and/or created an unsafe workin description of the problem/assignment below):	
Check One: □This is an isolated Incident □This	is an ongoing problem
RPN/RN Recommended Solution:	

Section 3: Contributing Factors		
Please sel	ect the relevant factors and provide details	
	Staffing Shortages:	
	Resident / Work Preparation Concerns:	
	Resident / Work Volume:	
	Other:	

Section 4: Immediate Supervisor Notification		
Name/Title of Immediate Supervisor Notified by RPN/RN:		
Date/Time RPN Notified Immediate Supervisor:		
Response Received from Immediate Supervisor:		
Signature of Employee & Printed Name:		
Signature	Printed Name:	

A summary of workload concerns may be tabled as an agenda item at the next scheduled Labour Management Meeting.

