PROFESSIONAL RESPONSIBILITY CONCERN FORM

Patient Safety

(PRCF) **IT IS HIGHLY RECOMMENDED TO SUBMIT THE PRCF ELECTRONICALLY,** which can be done online at https://dms.una.ca/forms/prc
If you submit a paper PRCF, please ensure you provide a copy to both your Manager and Local.
See reporting a PRCF checklist for further instructions: https://www.una.ca/document/reportingaprc   Fields marked with [!] are required.

UNA United Nurses of Alberta

It is your Employer and UNA's expectation that any information reported anywhere on the PRCF will be handled within the context of a just culture and any article outlined in the Collective Agreement including no discrimination.

> A just culture means that reporting is conducted within a psychologically safe environment where everyone (Employees and Employer representatives) is treated with care, respect, and dignity.
> The purpose of sharing and discussing this information is for system reporting, learning, and improvement purposes and should not be used to place individual blame or for coaching and/or discipline.
> The Employer and Union have made a commitment to this process including the importance of upholding the principles of joint problem-solving, collaboration, and mutual respect during every discussion and step of this process.
> There shall be no discrimination, restriction or coercion exercised or practiced by either party in respect of an Employee or an Employer exercising any right conferred under the Collective Agreement, such as reporting concerns through the PRC process.

GENERAL INFORMATION

Employer: [!] ☐ AHS ☐ Covenant ☐ Other (Specify): _____   Local: [!] _____

Worksite: [!] _____   Unit/Office/Program: [!] _____

Name of Manager you report to: _____   Email of Manager you report to: _____

DETAILS OF CONCERN(S)

When did the concern(s) occur?: [!] Date: YYYY/MM/DD   Shift: [!] ☐ Day ☐ Evening ☐ Night

Shift Length (check all that apply for a group PRC): ☐ 12-hour ☐ 10-hour ☐ 8-hour ☐ 4-hour ☐ Other (specify): _____

Check one: ☐ This is an isolated concern ☐ This is an ongoing concern   If ongoing, for how long: ☐ 0-3 months ☐ 3-6 months ☐ >6 months

Is staffing a factor for the concern(s)? ☐ Yes ☐ Partial ☐ No

Complete the following information for the shift where the concern(s) occurred, **as applicable**:

	RN/RPN	LPN	HCA	Other (specify):		
Baseline (Regular) staffing					☐ Don't know	
Number of staff actually working					☐ Don't know	
Number of staff on overtime (OT)					☐ Don't know	
Number of beds (care spaces) on unit:				☐ N/A	☐ Don't know	
Number of patients on unit:				☐ N/A	☐ Don't know	
Number of overcapacity patients on unit:				☐ N/A	☐ Don't know	
Number of patients/residents assigned to you:				☐ N/A	☐ Don't know	
Number of clients on your caseload:				☐ N/A	☐ Don't know	

Mandatory OT utilized?
The Employer is requiring (mandating) you to report to work when you are not scheduled for a shift. This could include being mandated to stay past your scheduled shift.

☐ Yes ☐ No ☐ Don't know ☐ N/A

Staffing shortage due to:

☐ Sick Call ☐ Vacancy ☐ Vacation

☐ Other (specify): _____

☐ N/A ☐ Don't know

Were attempts made to fill the staffing shortage?

☐ Yes ☐ No ☐ Don't know ☐ N/A

Detailed description of the concern(s): [!]
(Be specific, describe the actual or potential impact to patient/resident/client care, **do not use any patient/resident/client/staff identifying information**, and describe the concern(s) using professional and respectful language.)

☐ continued on page 4

What actions or steps, if any, did you or others take to try to address the concern(s) and what was the time involved in taking these steps or actions?
(E.g. Notifying charge nurse/team lead, manager, physician for support; calling in extra staff; changing the patient/resident/client assignments; prioritizing care; missing breaks; staying late, etc.)

☐ continued on attached page

RLS/Incident report #: _____

(This form does not replace the Employer's incident reporting form/system. RLS is a voluntary reporting system. You are under no obligation to indicate whether you filled out a RLS report on this form).

DISCUSSION WITH MANAGER

❯ Your Employer and UNA jointly support the PRC process and as such Employees do not need the permission of a Manager to fill out a PRCF and may fill it out prior to the discussion with a Manager; however, the Collective Agreement states that a discussion must occur before the matter is discussed at the PRC Committee.

❯ This discussion should ideally be done by the Employee(s) identifying the concern; however, depending on the nature of the concern, availability or comfort of the Employee, the meeting may be between the Employee and Manager or UNA Local and Manager, or a meeting of the UNA Local, the Employee and Manager.

❯ The Manager may reach out to the Employee and/or Local to initiate this discussion, should they receive a PRCF before a discussion has occurred, reflecting the collaborative intent of this process.

❯ These discussions must take place within a just culture where everyone feels safe, encouraged, and enabled to openly discuss patient care quality and safety concerns; and where everyone is treated with care, compassion, respect, dignity, and without fear of or actual retribution for raising and discussing such concerns.

Did you discuss the concern(s) with a Manager or Manager on Call? [!] ☐ Yes ☐ No

If yes, name of Manager: [!] _____

If no, why not? [!] ☐ Sent email to Manager to notify and arrange discussion ☐ Prefer the support of my UNA Local prior to the discussion

☐ Other: _____

Date of discussion: [!] [YYYY/MM/DD] **How did the discussion occur:** [!] ☐ In-Person ☐ Phone ☐ Other (specify): _____

Did this discussion resolve any or all of the concern(s)? [!] ☐ Yes ☐ Partial ☐ No

If yes, what resolved the Concerns?

☐ continued on attached page

If partial or no resolution, what remains unresolved?

☐ continued on attached page

RECOMMENDATIONS

What is needed to prevent the concern(s) from occurring again?: ⚠

(Be specific and describe your recommendations using professional and respectful language. E.g. replace vacant shifts even at OT, augment staffing for increased workload/acuity, increase casual pool or add regularized relief positions, proactively review schedule to ensure appropriate skill mix of staff based on experience/ qualifications.)

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CONTRIBUTING FACTORS

Please select the following categories that are **contributing factors** to the concern(s) you are raising (check all that apply):

☐ **WORKLOAD**

☐ Acuity
☐ Assistance with ADLs
☐ Wandering/Confusion
☐ Emotional Abuse/Violence

☐ Physical Abuse/Violence
☐ Overcapacity
☐ Heavy Assignment/Caseload
☐ Admissions/Discharges

☐ Non-Nursing Duties
☐ Interruptions
☐ Other, specify:

☐ **INADEQUATE STAFFING**

☐ Inadequate Baseline (Regular) Staffing
  ☐ RN ☐ RPN ☐ LPN ☐ HCA
☐ Other, specify:

☐ Vacant Shift – Not Filled
  ☐ Replacement not approved
    ☐ At Straight Time ☐ At OT
  ☐ Unable to fill

☐ Administrative/Staffing Office Issues
☐ Inappropriate Replacement
☐ Staff assigned on-call

☐ Inappropriate Skill Mix
  ☐ Inadequate Qualifications/Education
  ☐ Inadequate Experience
☐ No Charge RN/RPN or Team Lead

☐ Charge RN/RPN or Team Lead with Patient/Resident/Client Assignment
☐ Unregulated Health Care Provider
☐ Contracted/Agency Staff
☐ Inadequate Physician Coverage/Support
☐ Other, specify:

☐ **OTHER INADEQUATE RESOURCES/SUPPORTS**

☐ Policy/Procedure/Protocol
☐ Supplies/Equipment
☐ Infection Prevention & Control
☐ Technology/Software
  ☐ Connect Care
  ☐ Other, specify:

☐ Care Space
☐ Orientation/Education
☐ Communication
☐ Reduction or Loss of Service/Program

☐ Security
  ☐ Peace Officer
  ☐ Contracted Security
  ☐ Other, specify:
☐ Other, specify:

SUBMITTER(S) INFORMATION

☐ Individual ☐ Group ❗ Date Report Submitted: [YYYY/MM/DD]

FULL NAME: ❗ DESIGNATION: ❗ PHONE: ❗ PERSONAL OR UNION EMAIL: ❗

☐ RN ☐ RPN ☐ LPN

☐ Other, specify: [ ]

PRIMARY CONTACT

☐ RN ☐ RPN ☐ LPN

☐ Other, specify: [ ]

☐ RN ☐ RPN ☐ LPN

☐ Other, specify: [ ]

☐ RN ☐ RPN ☐ LPN

☐ Other, specify: [ ]

☐ RN ☐ RPN ☐ LPN

☐ Other, specify: [ ]

NOTE: To add clarity and be involved in the conversation and development of recommendations for resolution, the Employee(s) who submitted the PRCF and the applicable Manager are encouraged to attend the PRC Committee meeting where the PRCF is to be discussed.

Detailed description of the concern(s):
CONTINUED FROM PAGE 1
(Be specific, describe the actual or potential impact to patient/resident/client care, **do not use any patient/resident/client/staff identifying information**, and describe the concern(s) using professional and respectful language.)

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TO BE COMPLETED BY LOCAL:

Date Received: [YYYY/MM/DD] Date Paper PRCF entered into DMS: [YYYY/MM/DD] PRCF# assigned by DMS: [LOCAL-YYYY-####]