GUIDELINES FOR RNs WHEN REQUESTED TO WORK BEYOND A SCHEDULED SHIFT

The following guidelines are meant to assist Registered Nurses in extraordinary situations where they:

A. are requested to work extra hours or shifts beyond the posted work schedule

AND

B. in their professional judgment, their fitness to practice is compromised by personal health issues, including fatigue.

STEPS TO FOLLOW:

1. Immediately notify your supervisor that you do not feel safe to practice and that the employer should try to find alternative relief. Collaborate and discuss with your supervisor to find alternative relief options.

2. If your supervisor refuses to find alternative relief, complete the attached *Letter re: Concern about Safety to Work beyond a Scheduled Shift*, present it to your supervisor and request that your supervisor complete her section.

3. If your supervisor requires you to remain on duty despite steps 1 and 2, follow your supervisor's instructions, work as safely as possible and complete the attached *Work Situation Report*.

IMPORTANT TO REMEMBER

Registered Nurses are members of a regulated profession. As professionals, RNs are solely responsible for their practice and decisions. RNs must exercise judgement at all times and assess every situation on a case-by-case basis. **These guidelines are not meant to apply systematically to all circumstances where an RN is requested to work extra hours**, nor does it release an RN from her/his ethical and professional obligations. Please see attached *Information Bulletin* from NANB.

New Brunswick Nurses Union Syndicat des infirmières et infirmiers du Nouveau-Brunswick

Nurses Association OF NEW BRUNSWICK Association des infirmières et infirmiers DU NOUVEAU-BRUNSWICK

Letter Re: Concern about Safety to Work beyond a Scheduled Shift

This letter confirms that on the following date: _________________, on the following unit/facility: ___________________________ you, _____________________________________, my supervisor, have requested that I, _____________________________________, remain on duty beyond my scheduled shift. I have also notified you that, in my professional opinion, I do not feel safe to practice beyond my scheduled shift due to personal health reasons (including fatigue), and I have requested that you make every reasonable effort to find alternative relief.

Please be advised that the Collective Agreement governing my employment does not provide for mandatory overtime. Please be further advised that practice guidelines of the Nurses Association of New Brunswick provide that the following situations are not considered abandonment: refusing to work extra hours or shifts beyond the posted work schedule when the nurse has given proper notice, and withdrawing from care due to fitness to practice concerns (personal health issues, including fatigue) with appropriate notice.

Please confirm your decision in writing:

Authorization to Leave
I acknowledge that I have read and understood the above, and that you have advised me that you do not feel safe to practice during the extra hours that I have asked you to work. I will find an alternative relief and allow you to leave work at _______________.

OR

Requirement to Work
I acknowledge that I have read and understood the above, and that you have advised me that, in your professional opinion, you do not feel safe to practice during these extra hours. Notwithstanding your professional opinion, I am nonetheless requiring you to work from _______________ to _______________.

____
Signature of Supervisor

____
Signature of Supervisor

____
Signature of Registered Nurse

New Brunswick Nurses Union
Syndicat des infirmières et infirmiers du Nouveau-Brunswick

Nurses Association OF NEW BRUNSWICK
Association des infirmières et infirmiers DU NOUVEAU-BRUNSWICK

Ask a PRACTICE CONSULTANT

By DAWN TORPE

YOU'VE ASKED

What is meant by patient abandonment?

The practice of registered nurses (RNs), is guided by standards which outline the expected conduct of members of the profession. The *Standards of Practice for Registered Nurses* in New Brunswick state that an RN "is responsible for practising safely, competently and ethically and is accountable to the client, employer, profession and the public". This is demonstrated when they act in accordance with relevant legislation, NANB standards, and the Code of Ethics.

The concept of abandonment is directly related to the therapeutic nurse-client relationship, which is formed for the purpose of meeting the client's health care needs. The relationship is planned, time-limited and goal directed and RNs enter into the relationship with a commitment to provide quality service. Once care of a patient has been undertaken, an RN has the ethical and legal responsibility to provide care for the assigned period of time. Abandonment occurs when an RN has engaged with a client or has accepted an assignment and then discontinues care without:

- negotiating a mutually acceptable withdrawal of service with the client; or
- arranging for suitable, or replacement services; or
- allowing the employer a reasonable opportunity for alternative or replacement services to be provided.

An RN, who discontinues care without meeting the above conditions, could face disciplinary action from their employer as per policy and/or contractual stipulations, and this could also include a complaint being lodged with NANB for professional misconduct.

RNs are accountable for their actions, decisions and professional conduct and are responsible for appropriately establishing, maintaining and terminating the therapeutic nurse-client relationship. In most circumstances, this relationship ends when the episode of care ends. However, there may be circumstances (e.g. serious threat of harm to the RN, a conflict of interest that compromises the RN's duty) that require an RN to terminate the relationship before the episode of care has ended. When handled appropriately this is not considered abandonment, however, this should not be undertaken lightly and should only occur when all other avenues have been considered. Further guidance can be found in the Standards for the *Therapeutic Nurse-Client Relationship*.

Situations Which Could Be Considered Abandonment

- leaving in the middle of a scheduled shift without notifying your supervisor and without transferring care to another appropriate care provider
- being unavailable to provide care due to other activities (e.g. phone, gaming, sleeping)
- refusing to care for a client after accepting responsibility without transferring care to another nurse or allowing your manager to find a replacement

Situations That Would Not Be Considered Abandonment

- refusing to work extra hours or shifts beyond the posted work schedule when you've given proper notice
- withdrawing from care due to fitness to practice concerns (personal health issues, including fatigue) with appropriate notice

Community Health - Professional Practice Committee
Work Situation Report

Section 1: General Information

Name(s) of Employee(s): ____________________

Employer: ____________________

Main Office/Team/Area/Program: ____________________

Date of Occurrence: __________ Time: __________

Hours Worked: __________ On Call Hours: __________

Regular Staff: RN __________ Clerical Support: __________

Actual Regular Staff: RN __________ Clerical Support: __________

Staff Shortage Due to: ☐ Sick Call ☐ Vacancies ☐ Emergency Leave ☐ Vacation

RN Staff Overtime: ☐ Yes ☐ No How Many Staff __________ Total Hours __________

Did This Cause You to Miss Your: Meal Period: ☐ Yes ☐ No Rest Period/Break: ☐ Yes ☐ No

Name of Supervisor Reported to: ____________________

Section 2: Details Of Occurrence

Provide a concise summary of the occurrence and how it impacted client care:

____

____

____

Was the safety of the client or the nurses compromised? ☐ Yes ☐ No How? __________

Workload not completed: ____________________

____

____

Is this an isolated incident? ☐ Yes ☐ No Ongoing problem? ☐ Yes ☐ No

Section 3: Client Care and Other Ongoing Factors to the Occurrence

- ☐ Change in Client Acuity : Provide details ____________________
- ☐ # Family Members
- ☐ Clients Assigned at Time of Occurrence
- ☐ Non-Nursing Duties: Specify ____________________
- ☐ Standards Not Met
- ☐ # Of New Clients to be Assessed (Ongoing Referrals)
- ☐ Safety in Jeopardy: Please Specify ____________________
- ☐ Lack of/Malfunctioning Equip: Details ____________________
- ☐ Weather/Conditions
- ☐ Travel/Distance
- ☐ Presentation Cancelled
- ☐ # Of Transfers From Service:
- ☐ Unanticipated Assignment/Uncontrolled Variables: Specify ____________________
- ☐ # Of Discharges From Program
- ☐ Other - Specify:

Section 4: Workload

At the time of the occurrence, the planned workload was:	Planned (P)	Actual (A)	Time Planned	Actual Time
Home visits/School visits/Clinics/Telephone Calls/Hospital/etc				
Public Meetings/Team Meetings/Office Work etc				
Documentation/Administration (i.e. Phone, paperwork. supplies)				
In-service Education/Presentations				
Travel (number of trips)				
Number of Clients Assessed				
Other (i.e. giving a presentation, etc)				

If staff made available, please identify the number of staff provided, their category :

Category (PHN, Clerk, Other)	Amount of Time Staff Available	Orientation to Site Required: Yes/No State Orientation Time

Section 5: Recommendations

Please check-off one or all of the areas below you believe should be addressed in order to prevent similar occurrence:

- ☐ In-service
- ☐ Caseload Review of client/family needs
- ☐ Orientation
- ☐ Part-time pool
- ☐ Professional standards
- ☐ Review: RN: Client Ratio
- ☐ # Support staffing
- ☐ Review policies and procedures
- ☐ Perform Workload Measurement audit

Equipment: Specify ____________________

Other: please specify: ____________________

____

____

Section 6: Employee Signature

I/We request these concerns be forwarded to the Professional Practice Committee

Signature: ____________________ Date: __________

Signature: ____________________ Date: __________

Signature: ____________________ Date: __________

Signature: ____________________ Date: __________

Date Submitted: ____________________ Time: __________

Section 7: Management Comments

Please provide any information in response to this report, including any actions taken to remedy the situation where applicable

Management Signature: ______________________ Date: ____________

Section 8: Recommendations of Professional Practice Committee

The Professional Practice Committee recommends the following in order to prevent similar occurrences:

Is this issue resolved? ☐ Yes ☐ No

Copies to: 1. Manager 2. NBNU Local President 3. Member

Dated: ______________________

Hospital - Professional Practice Committee
Work Situation Report

Section 1: General Information

Name(s) of Employee(s): ______

Employer: ______

Unit/Area/Program: ______

Date of Situation: ______ Time: ______

Shift:

☐ 7.5 Hours # Regular Staff: RN ____ LPN ____ PSW ____ Clerical Support

☐ 11.25 Hours # Actual Regular Staff: RN ____ LPN ____ PSW ____ Clerical Support

☐ Other Staff Shortage Due to: ☐ Sick Call ☐ ELOA ☐ Vacancies

Did This Cause You to Miss Your: Meal Break: ☐ Yes ☐No Rest Period/Break: ☐ Yes ☐ No

Required Overtime: ☐ Yes ☐No

Name of Nurse Manager or Supervisor Reported to: ______

Section 2: Details of Situation

Provide a detailed summary of the situation and how it impacted patient care (what, when, where, why):

______

Was the safety of the patient or nurse compromised? ☐ Yes ☐No How? ______

Workload not completed: ______

(e.g. Insulin or heparin was not double checked; patient rounds not done on an hourly basis, other)

______

Is this an isolated incident? ☐ Yes ☐No Ongoing problem? ☐ Yes ☐No

Section 3: Patient Care Factors Contributing to the Occurrence

Please check off the factor(s) you believe contributes to the workload issue and provide details

☐ Change in patient acuity

☐ Patient Census at time of situation ______

☐ # of Admissions ______ # of discharges ______ # of transfers ______

☐ Lack of equipment/malfunctioning equipment/supplies. Please specify ______

☐ Visitors/Family Members : Please specify ______

☐ Number of patients on infections precaution ______

☐ Over capacity protocol in effect? ______

☐ Please specify ______

☐ Other: (non- nursing duties, student supervision, mentorship, etc) Please specify ______

Section 4: Recommendations

Hospital - Professional Practice Committee
Work Situation Report

Please check-off one or all of the areas below you believe should be addressed in order to prevent similar situations:

- ☐ In-service
- ☐ Orientation
- ☐ Change unit layout
- ☐ Review Workload Measurement Statistics
- ☐ RN Staffing
- ☐ Support staffing
- ☐ Float/casual pool
- ☐ Review policies and procedures
- ☐ Replace sick calls, vacation, paid holidays, other absences
- ☐ Other:

____

____

____

Section 5: Employee Signatures and Contact Information

Signature:	______________	Contact Information :	______________
Signature:	______________	Contact Information :	______________
Signature:	______________	Contact Information :	______________
Signature:	______________	Contact Information :	______________

Section 6: Management Comments

Please provide any information in response to this report, including any actions taken to remedy the situation where applicable

____

____

____

____

Management Signature: ______________________ Date: ______________

Section 7: Recommendations of Professional Practice Committee

The Professional Practice Committee recommends the following in order to prevent similar situations:

____

____

____

____

Is this issue resolved? ☐ Yes ☐ No

Copies to: 1. Manager 2. NBNU Local President 3. Member

Dated: ______________________________

Nursing Homes Professional Practice Committee
Work Situation Report

SECTION 1: GENERAL INFORMATION

Name(s) of Employee(s) (please print)
____

Employer: ____Number of beds________

Date of occurrence: ____________(calendar) Time: ______________

Shift:
- ☐ 7.5 hour
- ☐ 11.25
- ☐ Other

Regular Staffing: # RN ____ LPN____ RA ____ Clerk ____
Actual Staffing: # RN ____ LPN ____ RA ____ Clerk ____

Were you the charge nurse?____
RN Staff Overtime: Yes___No____How Many Staff_____Total hours? _____
Did this cause you to miss your meal break? Rest periods?/ Breaks Yes___No___

Name of Director of Nursing reported to______________________________

SECTION 2: DETAILS OF OCCURENCE

Provide a concise summary of the occurrence and how it impacted resident care;
____
____
____
____
____
____
____
____

Was the safety of resident or nurse compromised or workload not completed? (e.g. Insulin or heparin not double checked; resident rounds or turns not done on an hourly basis, etc)
Yes___No___How? (Provide details below)
____
____
____
____
____

Is this an isolated incident? ____ Ongoing problem? _____

SECTION 3: NURSE/RESIDENT/ENVIRONMENT CARE FACTORS CONTRIBUTING TO THE OCCURRENCE/CONCERN/ISSUE

Please check off the factor(s) you believe contributes to the workload issue and provide details

- ☐ Change in resident acuity e.g. falls – provide details____
- ☐ Number of residents on isolation precautions____
- ☐ # of deaths___# of transfers to hospital____
- ☐ Lack of equipment/supplies/resources/malfunctioning equipment, please specify__________________________
- ☐ Visitors/family members
- ☐ Home in outbreak situation
- ☐ Doctor's or Nurse Practioner orders;
- ☐ Non nursing duties ____
- ☐ Communication/Process issues
- ☐ Exceptional Resident Factors(i.e. significant amount of time required to meet resident needs/expectations) please specify____

SECTION 4: RECOMMENDATIONS

Please check-off one or all of the areas below you believe should be addresses in order to prevent similar occurrences:

- ☐ In-service
- ☐ Orientation
- ☐ Review RN/resident ratio
- ☐ Change unit layout
- ☐ Change Start/Stop times of shift(s)
- ☐ Develop workload Measurement Tool
- ☐ Adjust RN Staffing
- ☐ Adjust support staffing
- ☐ Casual pool
- ☐ Review policies and procedures
- ☐ Replace sick calls, vacation, paid holidays, other absences
- ☐ Equipment – please specify____
- ☐ Other: ____

SECTION 5: EMPLOYEE SIGNATURES

SIGNATURE__________________________Phone #/personal email________________________________

SIGNATURE__________________________Phone #/personal email________________________________

Date Submitted: ______________________ Copies to: 1. Manager 2. NBNU Local President 3. Member

SECTION 6: MANAGEMENT COMMENTS
Please provide any information in response to this report, including any actions taken to remedy the situations where applicable. ____ ____ ____ ____ ____ __________________________________ Management Signature________________________________Date:_______________________
SECTION 7: RECOMMENDATIONS OF PROFESSIONAL PRACTICE COMMITTEE
The Professional Practice committee recommends the following in order to prevent similar occurrences: ____ ____ ____ ____ ____ Is this issue resolved? Yes____No____