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.
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 _________________.

________________________________
Signature of Supervisor

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 Registered Nurse
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
**Section 1: General Information**

<table>
<thead>
<tr>
<th>Name(s) of Employee(s):</th>
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<tbody>
<tr>
<td>Employer:</td>
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<tr>
<td>Main Office/Team/Area/Program:</td>
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<tr>
<td>Date of Occurrence:</td>
<td>Time:</td>
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<tr>
<td>Hours Worked:</td>
<td>On Call Hours:</td>
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<td># Regular Staff: RN</td>
<td>Clerical Support:</td>
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<td># Actual Regular Staff: RN</td>
<td>Clerical Support:</td>
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<td>Staff Shortage Due to:</td>
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<td></td>
<td>Sick Call</td>
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<td>RN Staff Overtime:</td>
<td>Yes</td>
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<tr>
<td>Did This Cause You to Miss Your:</td>
<td>Meal Period:</td>
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<td>Name of Supervisor Reported to:</td>
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**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:

<table>
<thead>
<tr>
<th></th>
<th>Planned (P)</th>
<th>Actual (A)</th>
<th>Time Planned</th>
<th>Actual Time</th>
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<tbody>
<tr>
<td>Home visits/School visits/Clinics/Telephone Calls/Hospital/etc</td>
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<tr>
<td>Public Meetings/Team Meetings/Office Work etc</td>
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<tr>
<td>Documentation/Administration (i.e. Phone, paperwork, supplies)</td>
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<tr>
<td>In-service Education/Presentations</td>
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<tr>
<td>Travel (number of trips)</td>
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<tr>
<td>Number of Clients Assessed</td>
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<tr>
<td>Other (i.e. giving a presentation, etc)</td>
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</table>

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

<table>
<thead>
<tr>
<th>Category (PHN, Clerk, Other)</th>
<th>Amount of Time Staff Available</th>
<th>Orientation to Site Required: Yes/No State Orientation Time</th>
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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

Page 2 of 3
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:  

Management Signature: ____________________________  Date: ____________________________
Section 1: General Information

<table>
<thead>
<tr>
<th>Name(s) of Employee(s):</th>
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<td>Employer:</td>
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<tr>
<td>Date of Situation:</td>
<td>Time:</td>
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<tr>
<td>Shift:</td>
<td>7.5 Hours</td>
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<td>11.25 Hours</td>
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<td>Other</td>
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<td>Did This Cause You to Miss Your: Meal Break:</td>
<td>Yes No</td>
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<td>Required Overtime:</td>
<td>Yes No</td>
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<td>Name of Nurse Manager or Supervisor Reported to:</td>
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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
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

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<tr>
<th>Signature</th>
<th>Contact Information</th>
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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 OCCURRENCE

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
- Lack of equipment/supplies/resources/malfunctioning equipment, please specify
- Visitors/family members
- Home in outbreak situation
- Doctor’s or Nurse Practitioner 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____