Workplace Concern

Pleases DO NOT use ANY Identifiers on this form. Example: Resident/Patient/Client names so confidentialtiy is not compromised. The purpose of this form is to identify the issues our members are facing in the Workplace.

The form should be completed and submitted as soon as possible after the incident being described.

1) Date: _____ Time of Incident:_____ Worksite: _____

   Name: _____ Position: _____

   Specific Workplace Concern:
   _____

2) Staffing Scheduled
   RN ____ RCW ____
   LPN ____ Other ____

   Actual
   RN ____ RCW ____
   LPN ____ Other ____

3) Number of Patients on Unit: _____

4) Were you short staffed at the time of the incident? _____

5) Describe the workplace concern in detail (including the workload situation, acuity of patients and any contributing factors). If you need more space, please attach a document to this form.

6) Was there an incidence of violence(verbal/ physical) or psychological harm. Leave blank if not applicable.

7) Please detail the action taken in response to the workplace concern, and any result.

8) Was your Manager/Supervisor/Designate contacted _____ Time Contacted _____

9) Describe the action/response by Manager/Supervisor/Designate

10) Are there any other alternative measures which should have been considered?

_____ _____

Date yyyy/mm/dd Time --:-- Signature of Member

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