

Throughout BC, nurses are advocating for patient and nurse safety by filing PRFs**North Okanagan Health Unit****Shuswap Community Health Care nurses make progress on workload**

Problem: Lack of casual staff to cover leaves; inability to add workload, working short staffed while client acuity increased; problems with evening shift all resulting in difficulty meeting care standards.

Remedy/Resolution: after 11 PRFs filed, meeting resulted in evening shift change as requested by RNs; daily workload priority planning; protocol for increased work hours; 3 casual RNs and 7 casual Home Support workers have been hired; review of home support scheduling carried out. In future: discussions on developing quality practice environment strategy; evaluation of the new evening shift, review of current rotation and creation of a Practice Council on site in the Fall.

MSA General Hospital**Worthington ECU RN gains ventilator education for co-workers**

Problem: RN was only staff member on duty with skills to care for a ventilator dependent patient at a time when her patient load was 75 patients. LPN with ventilator training normally on duty but wasn't replaced on this shift resulting in unsafe and unreasonable workload for RN.

Remedy/Resolution: More LPNs with ventilator training are now available; respiratory therapists have conducted ventilator education sessions; Resident Care Coordinator and Patient Care Coordinator have taken a train the trainer course and can provide support to the unit.

RNs on Pediatric Unit tackle practices that affect care

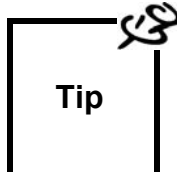
Problem: Heavy workload, lack of break relief and policy of admitting adult patients to the pediatric unit causing quality care problems.

Remedy/Resolution: Policy changed so that adults no longer admitted; 3rd RN added to night shift who floats between pediatrics and maternity for break relief but primary responsibility is to pediatric unit.

Vancouver General Hospital**Thoracic/Respiratory Unit staffing guidelines re-inforced**

Problem: Unsafe nurse to patient ratio of 1:8 occurred when one RN on break. Assignment also involved caring for patients in two separate areas so monitor alarms had to be set to maximum volume, disturbing other critically ill patients. Also, there was no AACN Procedure Manual available as a resource to review care of patients with arterial lines.

Remedy/Resolution: Staffing guidelines were reviewed at a ward meeting to ensure they would be followed. A copy of the Procedure manual was ordered for the unit.



When completing a PRF, stick to facts about which you have first-hand knowledge; if you use other information relayed to you, seek permission first and identify your source.