OHA Hospital Staffing Investigation
RN Staffing Tool

OHA Hospital Staffing Program completes the fields in this box to be provided with the Investigation Needs List at the initiation of the investigation.

Hospital _____ **Date Under Investigation** _____

Unit _____ **Shift/Time Under Investigation** _____

Instructions: This form is to be completed by the Nurse Staffing Committee Direct Care Unit Representative and Unit Nurse Manager (or designees). Initial and date each page of the form when complete. Attach additional pages as necessary.

Section 1 - Charge RN Staffing

1. How many Charge RNs worked on the unit for this shift? _____

2. Complete the table below for Charge RN staffing during the shift under investigation

#	Name of Charge RN	Time Charge RN Shift Started	Time Charge RN Shift Ended	Time of Charge RN Lunch Break	If Charge RN covered breaks, list name(s) of RN(s) whose breaks were covered and number of patient assignments covered. Otherwise, write N/A	If Charge RN took a patient assignment not related to meal/rest breaks, list identifier of patients assigned to RN. Otherwise, write N/A
1						
2						
3						
4						
5						

DC Unit Representative (or designee)
Initials _____ Date _____

Nurse Manager (or designee)
Initials _____ Date _____

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Section 2 - Number of RNs on the Unit & Break Coverage

3. How many RNs (excluding the Charge RN) were assigned to the unit during the shift/time under investigation? _____

4. What was the maximum number of patients on the unit during the shift/time under investigation? _____

5. How were breaks covered for this shift? For example, did Charge RN cover shifts, was there a Break RN, did RNs cover each other's breaks, etc.

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Section 3: RN Assignments

Complete the following page for each RN who worked on the unit during the shift/time under investigation.

a. RN Name: _____ b. Time Shift Started _____ d. Time Lunch Started _____

c. Time Shift Ended _____ e. Time Lunch Ended _____

f. If this RN covered breaks, list name(s) of other RN(s) whose breaks were covered by this RN. Otherwise, write N/A.

#	Identifier of patient assigned to RN (e.g. MRN, Initials, etc.)	Staffing Level Required for Patient & Reason (e.g., 1:1 d/t active labor)	Did patient start being assigned to the RN partway through the shift?		If Yes: Time Assignment Started	Did the patient stop being assigned to the RN partway through the shift?		If Yes: Time Assignment Ended
1			◯ Yes	◯ No		◯ Yes	◯ No	
2			◯ Yes	◯ No		◯ Yes	◯ No	
3			◯ Yes	◯ No		◯ Yes	◯ No	
4			◯ Yes	◯ No		◯ Yes	◯ No	
5			◯ Yes	◯ No		◯ Yes	◯ No	
6			◯ Yes	◯ No		◯ Yes	◯ No	
7			◯ Yes	◯ No		◯ Yes	◯ No	
8			◯ Yes	◯ No		◯ Yes	◯ No	
9			◯ Yes	◯ No		◯ Yes	◯ No	

DC Unit Representative (or designee)
Initials _____ Date _____

Nurse Manager (or designee)
Initials _____ Date _____

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Complete the following page for each RN who worked on the unit during the shift/time under investigation. Draw a single line through page if there were not additional RNs who worked.

a. RN Name: _____ b. Time Shift Started _____ d. Time Lunch Started _____

c. Time Shift Ended _____ e. Time Lunch Ended _____

f. If this RN covered breaks, list name(s) of other RN(s) whose breaks were covered by this RN. Otherwise, write N/A.

#	Identifier of patient assigned to RN (e.g. MRN, Initials, etc.)	Staffing Level Required for Patient & Reason (e.g., 1:1 d/t active labor)	Did patient start being assigned to the RN partway through the shift?		If Yes: Time Assignment Started	Did the patient stop being assigned to the RN partway through the shift?		If Yes: Time Assignment Ended
1			◯ Yes	◯ No		◯ Yes	◯ No	
2			◯ Yes	◯ No		◯ Yes	◯ No	
3			◯ Yes	◯ No		◯ Yes	◯ No	
4			◯ Yes	◯ No		◯ Yes	◯ No	
5			◯ Yes	◯ No		◯ Yes	◯ No	
6			◯ Yes	◯ No		◯ Yes	◯ No	
7			◯ Yes	◯ No		◯ Yes	◯ No	
8			◯ Yes	◯ No		◯ Yes	◯ No	
9			◯ Yes	◯ No		◯ Yes	◯ No	

DC Unit Representative (or designee)
Initials _____ Date _____

Nurse Manager (or designee)
Initials _____ Date _____

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Complete the following page for each RN who worked on the unit during the shift/time under investigation. Draw a single line through page if there were not additional RNs who worked. If additional pages are needed, use the RN Staffing Tool: Additional Pages form.

a. RN Name: _____ b. Time Shift Started _____ d. Time Lunch Started _____

c. Time Shift Ended _____ e. Time Lunch Ended _____

f. If this RN covered breaks, list name(s) of other RN(s) whose breaks were covered by this RN. Otherwise, write N/A.

#	Identifier of patient assigned to RN (e.g. MRN, Initials, etc.)	Staffing Level Required for Patient & Reason (e.g., 1:1 d/t active labor)	Did patient start being assigned to the RN partway through the shift?	If Yes: Time Assignment Started	Did the patient stop being assigned to the RN partway through the shift?	If Yes: Time Assignment Ended
1			◯ Yes ◯ No		◯ Yes ◯ No	
2			◯ Yes ◯ No		◯ Yes ◯ No	
3			◯ Yes ◯ No		◯ Yes ◯ No	
4			◯ Yes ◯ No		◯ Yes ◯ No	
5			◯ Yes ◯ No		◯ Yes ◯ No	
6			◯ Yes ◯ No		◯ Yes ◯ No	
7			◯ Yes ◯ No		◯ Yes ◯ No	
8			◯ Yes ◯ No		◯ Yes ◯ No	
9			◯ Yes ◯ No		◯ Yes ◯ No	

DC Unit Representative (or designee)
Initials _____ Date _____

Nurse Manager (or designee)
Initials _____ Date _____

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Are additional pages attached to this packet? ◯ Yes ◯ No Number of additional pages attached: _____

Have you initialed and dated each page in this packet and additional pages? (Including this page)

DC Unit Representative	Nurse Manager
◯ Yes ◯ No	◯ Yes ◯ No

By signing below, I confirm that the answers provided in this tool and the attached pages, if applicable, are complete and true to the extent of my knowledge and after review of the staffing documentation for the date and shift under investigation.

I confirm that I have sufficient knowledge about this unit's operations to be able to complete this form.

Direct Care Unit Representative

Direct Care (or designee) Printed Name

Direct Care (or designee) Job Title

Direct Care (or designee) Signature

Direct Care (or designee) Date Signed

Nurse Manager

Nurse Manager (or designee) Printed Name

Nurse Manager (or designee) Job Title

Nurse Manager (or designee) Signature

Nurse Manager (or designee) Date Signed

DC Unit Representative (or designee)
Initials _____ Date _____

Nurse Manager (or designee)
Initials _____ Date _____

RN Staffing Tool
Additional Pages

This is an additional page to be included in the packet provided by OHA to document RN staffing assignments. **Date & Shift** _____

a. RN Name: _____ b. Time Shift Started _____ d. Time Lunch Started _____

c. Time Shift Ended _____ e. Time Lunch Ended _____

f. If this RN covered breaks, list name(s) of other RN(s) whose breaks were covered by this RN. Otherwise, write N/A.

#	Identifier of patient assigned to RN (e.g. MRN, Initials, etc.)	Staffing Level Required for Patient & Reason (e.g., 1:1 d/t active labor)	Did patient start being assigned to the RN partway through the shift?		If Yes: Time Assignment Started	Did the patient stop being assigned to the RN partway through the shift?		If Yes: Time Assignment Ended
1			◯ Yes	◯ No		◯ Yes	◯ No	
2			◯ Yes	◯ No		◯ Yes	◯ No	
3			◯ Yes	◯ No		◯ Yes	◯ No	
4			◯ Yes	◯ No		◯ Yes	◯ No	
5			◯ Yes	◯ No		◯ Yes	◯ No	
6			◯ Yes	◯ No		◯ Yes	◯ No	
7			◯ Yes	◯ No		◯ Yes	◯ No	
8			◯ Yes	◯ No		◯ Yes	◯ No	
9			◯ Yes	◯ No		◯ Yes	◯ No	

DC Unit Representative (or designee)
Initials _____ Date _____

Nurse Manager (or designee)
Initials _____ Date _____