Professional Responsibility Concern Form (PRCF)

United Nurses of Alberta

Electronic submission of this form is available on the UNA app (available for iOS and Android) and online at dms.una.ab.ca/forms/prc

Purpose

Nurses are required by the standards of their professional licensing bodies to advocate for practice environments that have the organizational and human support systems, and the resources necessary for safe, competent, and ethical nursing care.

Instructions

1. Complete this form as soon as possible after observing conditions in which you believe the safety of patients/clients/residents may be at risk, or in situations where you believe administrative action needs to be taken to prevent risks to patients/residents/clients.
2. You do not have to obtain permission from a manager to complete this Professional Responsibility Concern Form. However, you should inform a management representative of the conditions you are documenting in this form.
3. This form and the information contained in it is the property of the United Nurses of Alberta. The concerns documented in this form will be presented to the Professional Responsibility Committee or alternate in your worksite for resolution as provided in the Collective Agreement between UNA and the Employer.
4. Deliver or send the white copy of the PRC Report Form to the Local/Local office of the United Nurses of Alberta in your worksite.

   Keep the pink copy for your personal records.

   Deliver or send the yellow copy to the Unit/Program Manager.
5. Stay in contact with your local executive as to the status of your PRC.

United Nurse of Alberta
Provincial Office
700-11150 Jasper Avenue NW
Edmonton AB T5K 0C7

(780) 425-1025/1-800-252-9394
(780) 426-2093 (fax)

www.una.ab.ca
nurses@una.ab.ca

TO BE COMPLETED BY LOCAL:

Local File #: _____

Date Received: yyyy/mm/dd

Professional Responsibility Concern Form - July 2017

Employer: ☐ AHS ☐ Covenant ☐ Other (Specify) _____ Local #: _____ *if known*

Worksite: _____ Unit/Office: _____

Manager: _____

Manager/Manager on call contacted? ☐ No ☐ Yes Date yyyy/mm/dd Time _____

Name of Manager on call contacted: _____

When did the incident or issue occur? Date yyyy/mm/dd Time _____ Shift _____

Is staffing a factor for this issue? ☐ No ☐ Yes If yes complete the following, as applicable:

	RN	RPN	LPN	HCA
Baseline staffing				
Number of staff working				

Number of patients on unit: _____

Number of over-capacity patients on unit: _____

Number of patients/residents/clients assigned to you: _____

Detailed Description of Incident/Issue *(Do not use names of patients, residents, clients, staff, doctors, or others):* _____

If more space is needed, please attach a sheet of paper.

RLS (or other incident report) completed? ☐ No ☐ Yes RLS/Incident Report #: _____ *if known*

(This form does not replace the Employer's incident reporting form/system. RLS is a voluntary reporting system. You are under no obligation to indicate whether you filled out a RLS report on this form).

Recommendations (What is needed to prevent this incident or issue from occurring again?): _____

Name (Printed) _____

Designation: ☐ RN ☐ RPN ☐ LPN ☐ Other (Specify) _____

Signature _____ Date Report Filed yyyy/mm/dd

Personal E-Mail _____ Phone _____