



SHORT STAFFING INCIDENT REPORT

(Please fill out form digitally and then either use electronic signature at the bottom or print to sign.)

To: _____, Supervisor

Date of Incident: _____ Unit: _____ Shift: _____

Reason for the Staffing Incident Report:

Insufficient number of RNs/LPNs

Insufficient number of ancillary staff

High acuity/workload patients

High census

Unit Demographics:

Census start of shift: _____ Max bed capacity: _____ Census end of shift: _____

Admissions: _____ Discharges: _____ Transfers in: _____ Transfers out: _____

Unit Staffing Overview:

# of RNs on duty		# of NAs on duty		# of LPNs on duty	
# of RNs scheduled		# of NAs scheduled		# of LPNS scheduled	
# of RN sick calls		# of NA call outs		# of LPN sick calls	
# of RN personal day calls		# of URs on duty		# of LPN personal day calls	
# of RN call outs replaced		# of URs scheduled		# of LPN call outs replaced	
# of RNs floated out of unit		# of UR call outs		# of LPNs floated out of unit	

Unit Workload Overview:

Vents: _____ Stepdowns: _____ Restraints: _____ Sitters: _____ Isolation: _____

RRT: _____ Critical Care Consult: _____ Security Alerts: _____ 1:1 Care: _____

Additional Comments:

Print Names Clearly:

Signatures: