A registered nurse (RN) shortage is defined as:

* a shift where insufficient RNs meant there was a health and safety risk for residents, or when contractual requirement pertaining to RN oversight is not met.

HealthCERT collects this information on a section 31 notification form for two reasons:

1. To collect data and information to share with working groups in the Ministry of Health who are focussing on the national RN shortage
2. To ensure that any risk to the health and safety of residents is mitigated and addressed by the facility arising from the RN shortage/unavailability.

Ongoing responsibility for safe staffing within a facility remains with the facility. It is expected that the facility ensures the health and safety of residents by placing mitigations with support from the funder as appropriate.

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| 1. **Premises** |
| Legal entity name |
| Enter legal entity name. |
| Premise name |
| Enter premise name. |

District

|  |  |  |
| --- | --- | --- |
| Choose a district | | |
|  | | |
| **Notification for Week Beginning Monday** | Click or tap to enter a date. |

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| 1. **How many shifts this week were significantly impacted by an RN shortage (a shift where you were unable to safely fill a roster gap with another registered nurse)?** |

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| **Total affected shifts:** | Choose a number |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Services** | **Rest Home** | **Hospital** | **Specialist Dementia** | **Psychogeriatric** |
| Number of affected residents | Enter a number | Enter a number | Enter a number | Enter a number |

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| 1. **What was the cause of the RN shortage? (Check all that apply)** | | |
| 3.1 Sick leave  3.2 New resignation  3.3 Existing vacancy | 3.4 Long term leave  3.5 Bureau nurse unavailable |
| 3.6 Please enter any additional information here. | |

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| 1. **What immediate mitigations took place? (Check all that apply)** | | | |
| 4.1 Clinical Manager/ Facility Manager with APC/Senior Nurse covered the shift, affecting their ability to do their primary job  4.2 RN sleepover or RN oncall, able to come onsite within 20 minutes. Note this RN holds Direction and Delegation for shift (If checked, please also select all that apply below)   |  |  | | --- | --- | | 4.2.1 RN to RN handover occurred, either in person or virtually, at beginning and end of shift, including lead EN/HCA on duty | 4.2.3 EN/HCA designated Lead for the shift | | 4.2.2 Additional EN/HCA working the shift | 4.2.4 EN/HCA on shift competent in Medication Administration (including Controlled Drugs), STOP&WATCH or other Early Warning Notification methodology, ISBAR/SSBAR, use of assessments, eg, Falls Assessment. |   If any of the above (4.2.1-4.2.4) not selected, please comment:   |  | | --- | | 4.2.5 Click or tap here to enter text. |   4.3 Virtual RN Service Used. Note virtual RN holds Direction and Delegation for shift (If checked, please also select all that apply below)   |  |  | | --- | --- | | 4.3.1 RN to RN handover occurred using video call, at beginning and end of shift, including lead EN/HCA on duty | 4.3.4 EN/HCA designated Lead for the shift | | 4.3.2 Virtual RN awake for shift | 4.3.5 EN/HCA on shift competent in Medication Administration (including Controlled Drugs), STOP&WATCH or other Early Warning Notification methodology, ISBAR/SSBAR, use of assessments, eg, Falls Assessment | | 4.3.3 Additional EN/HCA working the shift |   If any of the above (4.3.1 – 4.3.5) not ticked, please comment:   |  | | --- | | 4.3.6 Click or tap here to enter text. | |  |

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| 1. **Other mitigations (Check all that apply)** | | |
| 5.1 Admissions stopped  5.2 Beds closed  5.3 Prioritisation of Care  5.4 Complex care residents transferred out | 5.5 Other, specify below   |  | | --- | | 5.6 Please specify. | |
| 1. **If there is a current RN vacancy:** | | |

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| --- | --- |
| 6.1 What is your usual (approximate) RN FTE? | Enter a number |
| 6.2 How many RN FTE vacancies do you have? | Enter a number |
| 6.3 What month/year did advertising first commence for current vacancy/vacancies? | Month/Year |
| 6.4 What stage of recruitment? | Please specify |

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| 1. **Declaration to be completed by premises manager or registered nurse** |

I declare that the information provided is true and correct.

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| --- | --- | --- | --- | --- |
| Name | | |  | Date |
| Enter your name. | | |  | Enter date. |
| Designation | | | | |
| Designation | | | | |
| Phone number Email | | | | |
| Phone number |  | Email address | | |

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| 1. **Submitting form** |

Please email the completed form to [certification@health.govt.nz](mailto:certification@health.govt.nz) and your Te Whatu Ora Regional Ageing Well Contact.

If you have any questions, please contact HealthCERT on 0800 113 813.