Directions: *This form may be used to provide feedback into the long term staffing plan for nursing departments at Community Hospital. The Master Nurse Staffing Council is convened and reviews feedback in aggregate on a quarterly basis.*

Hospital wide staffing policies and procedures are reviewed annually or more frequently as needed. Please fill this form out completely and email it to: nursestaffingfeedback@gjhosp.org.

Note: Urgent staffing concerns with acute risk to patient safety should be addressed with management immediately.

Concerns may also be submitted directly to the Colorado Department of Public Health and Emergency directly by email, fax, mail, or phone. More information about this process can be found at cdphe.colorado.gov and navigating to the health facilities complaint and occurrence contacts page.

1. I am a:
   - ☐ Nurse
   - ☐ LPN
   - ☐ CNA
   - ☐ Tech
   - ☐ Nursing Leader
   - ☐ Non-Nursing Leader
   - ☐ Other
   - ☐ Prefer not to say

2. Type of feedback:
   - ☐ Suggestion ☐ Complaint ☐ Concern ☐ Positive Feedback

3. Which AREA does this concern:
   - ☐ Overall department of nursing
   - ☐ Medical/Surgical Unit (MSU)
   - ☐ Intensive Care Unit/Stepdown (ICU/SD)
   - ☐ Pre-Op or PACU
   - ☐ Operating Room (OR)
   - ☐ Emergency Department (ED)
   - ☐ Labor, Delivery, Recovery, Postpartum (LDRP)
   - ☐ Procedure Center (PC)
   - ☐ Interventional Radiology (IR)
   - ☐ Physician Clinics
   - ☐ Clinical Improvement
   - ☐ Other: _____

4. Have you approached the relevant manager with this feedback? ☐ Yes ☐ No

   If yes, when?
   - ☐ Within the last week
   - ☐ Greater than one week ago but less than one month ago
   - ☐ Between one and three months ago
   - ☐ Greater than three months ago
   - ☐ Prefer not to say

5. Which PROCESS does this concern?

	Provide SPECIFIC details:
☐ Scheduling of shifts	
☐ Long-term staffing plan (hiring, forecasting)	
☐ Schedule pattern (shift coverage, start times)	
☐ Schedule matrix (ratio, assignments)	
☐ Flexing to acuity, census, and movement	
☐ Continuous coverage, continuity of care	
☐ Skill or experience mix	
☐ Minimum staffing	

6. Did the issue compromise patient safety? ☐ Yes ☐ No

   If yes, please provide SPECIFIC details:

Date of event (mm/dd/yy)	
Time of event (hh:mm)	
Describe the event:	
Was a risk web filled out?	☐ Yes ☐ No

7. Please provide any additional details that may be helpful.