

## Montana Nurses Association

20 Old Montana State Highway  $\sim$  Clancy, MT 59634  $\sim$  406-442-6710 406-442-1841 (fax)  $\sim$  www.mtnurses.org

## Assignment Despite Objection

In my professional opinion, as a licensed Registered Nurse, the situation described on this form is not adequate to meet the needs of the patients assigned to me at this time. I indicate my acceptance of the assignment despite objection. It is not my intention to refit the assignment. The purpose of this form is to notify facility supervisory staff that I have been given an assignment I believe is potentially unsafe for patients and/or staff. This form will document this situation.  **This assignment is accepted because I have been instructed to do so, despite my objections*  **My objections to this assignment are (check all that apply):  Short Staffed for Census  Short staffed for acutyl/complexity  Short staffed for acutyl/complexity  Not trained experienced in ear assigned  Not provided with adequate assistant[-]  Not rolled experienced in sufficient in the staff of patients in not available  Not trained experienced to use equipment  Transferred admirted new patient[-] to unit without adequate staff  **Ventilator: # of patients  Ventilator: # of patients  Total Care: # of patients  Linateler and admission: # of patients  Unstable new admission: # of patients  Linateler and admission: # of patients  Welcated give fineual in the staff of patients  Linateler and admission: # of patients  Linateler and admission: # of patients  Linateler and admission: # of patients  Procedure on unit (chest tube, etc.) # of psi-  Requires frequent vital signs/ assessment: # of patients  Other [please explain]: # of patients  Linit Secretary? No Oyes O Charge nurse has patients? No Oyes O Number of Patients  diditional Information:  **RN Signuture**  Print Name  Print Name  Date  **Date  **D	,	, a Registered Nurse em	ployed at	
Made to me by	(Name)			
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Not trained/experienced in area assigned Not oriented to this unit/case load Floating to multiple units during shift Necessary equipment is not available Not trained/experienced to use equipment Transferred/admitted new patient(s) to unit without adequate staff  **Aculty Factors (check those that apply and indicate number of patients)**  Ventilator: # of patients Restraints: # of patients Bload Products: # of patients Restraints: # of patients Unitable new admission: # of patients Builded Precaution: # of patients Unitable new admission: # of patients Medicated gtts (insulin, pressors, etc.): # of patients Requires frequent vital signs/assessment: # of patients Discharges/Transfers:  Unit Secretary? No Oyes O Charge nurse has patients? No Oyes O Number of Patients  Unit Capacity:  **Basignature**  **Rending Admissions/Transfers: Discharges/Transfers: # of patients @ end: Unit Capacity:  **Basignature**  **Print Name**  **Print Name** **Title**  **Date  **Print Name** **Title**  **Date	(Supervisor)  In my professional opinion, as a licensed Registe the patients assigned to me at this time. I indicate the assignment. The purpose of this form is potentially unsafe for p  *This assignment is accepted.  My objection  Short Staffed for Census	red Nurse, the situation descree my acceptance of the assign to notify facility supervisory statients and/or staff. This for the decause I have been instructed ons to this assignment are (checked)	(Time) ibed on this form ment despite object staff that I have be m will document the d to do so, despite m eck all that apply):  _ Charge nurse unal	(Date) is not adequate to meet the needs of tion. It is not my intention to refuse en given an assignment I believe is nis situation.  The objections *  The objections *  The objection of the o
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Restraints: # of patients	Acuity Factors (cl	heck those that apply and indi	cate number of par	tients):
ensus on Date and Shift of Objection: of patients @ start: Admissions/Transfers: Discharges/Transfers: # of patients @ end: Unit Capacity:   dditional Information:  RN Signature Print Name Print Name & Title Date	Restraints: # of patients Total Care: # of patients Unstable new admission: # of patients Suicide Precautions: # of patients Medicated gtts (insulin, pressors, etc.): # of patier	   nts	Receiving Blood Isolation Precauti Head Injury/Cor Procedure on un Procedure off un	Products: # of patients on: # of patients ifused: # of patients it (chest tube, etc.): # of pts it (CT, etc.): # of patients
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Supervisor Signature Print Name & Title Date				
	RN Signature	Print Name		
	Supervisor Signature	Drint Nama & Titla		Date
			for your records and	
	Follow-up: ODiscussed at PCC Meeting with	MNA: Date	OMNA Local Preside	ent: Date

ODept. Supervisor: \_\_\_\_\_