Montana Nurses Association #15 at CMC
MNA Phone: 406-442-6710 Website: mtnurses.org / CNEbyMNA.com

Assignment Despite Objection (ADO)

***Complete all sections of this form. Keep original and give a copy to your Supervisor. Provide a copy in-person, via email or text photo to MNA #15, and the MNA office at emily@mtnurses.org or 406-465-9126.

I, _____, a Registered Nurse employed at Community Medical Center's Hospital hereby object
(Name)

to the assignment given to me on _____,_____,_____, as
(Unit) *(Shift)* *(Date)* *(Time)*

made to me by _____ . The length of time the ADO situation existed_____.
(Charge Nurse)

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 because I've been instructed to do so, but I do object to the conditions surrounding it. It is not my intention to refuse the assignment. The purpose of this form is to notify facility supervisory staff that I've been given an assignment I believe is potentially unsafe for patients and/or staff. Date ADO filed:

RN Notification:

You must notify your IMMEDIATE Director/House Supervisor ASAP with your concern(s). You are ultimately reporting a concern and asking for assistance. When did you notify the chain of command?

Charge Nurse _____ *(Include Time)*

House Supervisor _____ *(Include Time)*

Director_____ *(Include Time)*

My objections to this assignment are (check all that apply):

____ Short Staffed for Census
____ Short staffed for acuity/complexity
____ 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
____ Charge nurse unable to perform charge nurse duties
____ Inadequate nurse to patient ratios
____ Not provided with adequate assistant(s)
____ Forced/Mandatory Overtime
____ System Failure
____ Missed Breaks/Lunch
____ Other (please explain)

Acuity Factors (check those that apply and indicate number of patients):

____ Ventilator: # of patients____
____ Restraints: # of patients ____
____ Total Care: # of patients ____
____ Unstable new admission: # of patients ____
____ Suicide Precautions: # of patients ____
____ Medicated gtts (insulin, pressors, etc.): # of patients ____
____ Requires frequent vital signs/assessment: # of patients ____
____ Immediate Post-op: # of patients ____
____ Receiving Blood Products: # of patients ____
____ Isolation Precaution: # of patients ____
____ Head Injury/Confused: # of patients ____
____ Procedure on unit (chest tube, etc.): # of pts __
____ Procedure off unit (CT, etc.): # of patients ____
____ Other (please explain): _____# of patients ____

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Census on Date and Shift of Objection:

Unit Capacity: ____ # of patients @ start: ____ Admissions/Transfers: ____ Discharges/Transfers: ____ # of patients @ end: ____

Unit Secretary? No O Yes O Charge Nurse has patients? No O Yes O Number of Pts CN has _____

RN Additional Information:

_____
_____
_____
_____
_____
_____
_____

RN thoughts on appropriate safe staffing level for the situation:

_____
_____
_____
_____

Director/House Supervisor Response:

_____
_____
_____
_____
_____
_____

_____**Date of Response**: _____

Signatures:

_____ _____ _____
RN Signature Print Name Date

_____ _____ _____
Director/House Supervisor Signature Print Name & Title Date

Follow-up:

Date Discussed at PCC: _____ **Notes:** _____

_____

_____