



# Montana Nurses Association #15 at CMC

MNA Phone: 406-442-6710 Website: [mtnurses.org](http://mtnurses.org) / [CNEbyMNA.com](http://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](mailto: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):

- |   |   |
|---|---|
| <input type="checkbox"/> Short Staffed for Census   | <input type="checkbox"/> Charge nurse unable to perform charge nurse duties |
| <input type="checkbox"/> Short staffed for acuity/complexity                                | <input type="checkbox"/> Inadequate nurse to patient ratios                 |
| <input type="checkbox"/> Not trained/experienced in area assigned                           | <input type="checkbox"/> Not provided with adequate assistant(s)            |
| <input type="checkbox"/> Not oriented to this unit/case load                                | <input type="checkbox"/> Forced/Mandatory Overtime                          |
| <input type="checkbox"/> Floating to multiple units during shift                            | <input type="checkbox"/> System Failure                                     |
| <input type="checkbox"/> Necessary equipment is not available                               | <input type="checkbox"/> Missed Breaks/Lunch                                |
| <input type="checkbox"/> Not trained/experienced to use equipment                           | <input type="checkbox"/> Other (please explain)                             |
| <input type="checkbox"/> Transferred/admitted new patient(s) to unit without adequate staff |   |

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

- |  |   |
|--|---|
| <input type="checkbox"/> Ventilator: # of patients _____                               | <input type="checkbox"/> Immediate Post-op: # of patients _____               |
| <input type="checkbox"/> Restraints: # of patients _____                               | <input type="checkbox"/> Receiving Blood Products: # of patients _____        |
| <input type="checkbox"/> Total Care: # of patients _____                               | <input type="checkbox"/> Isolation Precaution: # of patients _____            |
| <input type="checkbox"/> Unstable new admission: # of patients _____                   | <input type="checkbox"/> Head Injury/Confused: # of patients _____            |
| <input type="checkbox"/> Suicide Precautions: # of patients _____                      | <input type="checkbox"/> Procedure on unit (chest tube, etc.): # of pts _____ |
| <input type="checkbox"/> Medicated gtt (insulin, pressors, etc.): # of patients _____  | <input type="checkbox"/> Procedure off unit (CT, etc.): # of patients _____   |
| <input type="checkbox"/> Requires frequent vital signs/assessment: # of patients _____ | <input type="checkbox"/> 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  Yes  Charge Nurse has patients? No  Yes  Number of Pts CN has \_\_\_\_\_

### RN Additional Information:

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### RN thoughts on appropriate safe staffing level for the situation:

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### Director/House Supervisor Response:

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Date of Response: \_\_\_\_\_

## Signatures:

\_\_\_\_\_  
RN Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Director/House Supervisor Signature

\_\_\_\_\_  
Print Name & Title

\_\_\_\_\_  
Date

## Follow-up:

Date Discussed at PCC: \_\_\_\_\_ Notes: \_\_\_\_\_

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