

ASSIGNMENT DESPITE OBJECTION

Documentation of Unsafe Staffing/Unsatisfactory Patient Care

I, _____ a registered nurse employed at the Washington Hospital Center on
[NAME]

_____ hereby object to the assignment as:
[SHIFT and DATE] [UNIT]

- Resource Nurse Staff Nurse Team Leader Other _____

based upon the following grounds (please check one Main Heading):

1. Floating to another unit 2. Forced Overtime/On Call 3. Inadequate Staffing 4. High Patient Acuity

Sub-headings (please check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> A. Personnel assigned lack sufficient orientation | <input type="checkbox"/> f. Improper use of nurse substitute |
| <input type="checkbox"/> b. Not trained or experienced within the last year in area of assigned practice | <input type="checkbox"/> g. Inadequate or unsafe equipment |
| <input type="checkbox"/> c. Assignment posed potential of harm to health and/or safety of myself or other staff | <input type="checkbox"/> h. Not given appropriate staff for census: |
| <input type="checkbox"/> d. Assignment posed potential of harm to safety and/or well-being of my patients | <input type="checkbox"/> inappropriate # unlicensed personnel |
| <input type="checkbox"/> e. Transferred, discharged or admitted new patients to unit without adequate staff | <input type="checkbox"/> inappropriate # agency personnel |
| | <input type="checkbox"/> inappropriate # staff |
| | <input type="checkbox"/> not provided with unit clerk |
| | <input type="checkbox"/> inappropriate use of Mandatory OT/on-call |
| | <input type="checkbox"/> other (please specify): _____ |

Conditions and workload:

Unit Staff Assigned: RN _____ LPN _____ NA _____ UAP/Tech _____ Clerical _____
Outside staff assigned: RN _____ LPN _____ NA _____ UAP/Tech _____ Clerical _____
Source of outside staff: Float from another unit _____ 110 Pool _____ Agency _____
Supervising others? Y/N _____ Resource nurse taking patients? Y/N _____ How many? _____
Patient census at time of objection _____ Unit capacity _____ Acuity: High Average Low
Admissions/Transfers In: Pending _____ Actual _____ Discharges/Transfers Out: Pending _____ Actual _____
Brief statement of problem _____

Supervisor(s) notified _____ Time _____ Response _____
Physician(s) notified _____ Time _____ Response _____

I believe the situation described is unsafe. I will continue to provide the best professional nursing care possible in this situation. However, I decline to accept any legal responsibility for any untoward events that may occur as a result of unsafe staffing by the hospital.

NURSE: Print/Sign Name _____ Date/Time _____

SUPERVISOR'S Acknowledgement Signature _____ Date/Time _____

Specific Patient Outcomes:

- Compromised Safety/Injury Delayed/Omitted Treatment Delayed/Omitted Medication Delayed/Omitted Hygiene
 Inadequate Observation/Monitoring Delayed/Incomplete Documentation Delayed/Omitted Teaching
 Omitted Psych/Social Support Other (Specify) _____