

AORN PROPOSED POSITION STATEMENT ON NURSE-TO-PATIENT RATIOS

PREAMBLE

Perioperative nursing is a specialized area of nursing practice. The perioperative nurse is a registered nurse who plans, coordinates, delivers, and evaluates nursing care to patients whose protective reflexes or self-care abilities are potentially compromised during surgical or other invasive procedures. Although the perioperative registered nurse works collaboratively with other perioperative professionals (eg, surgeons, anesthesia care providers, surgical technologists) to meet patient needs, the perioperative registered nurse is accountable for the patient outcomes resulting from the nursing care provided during the surgical or invasive procedure. Possessing clinical knowledge, judgment, and critical-thinking skills based on scientific principles, the perioperative nurse plans and implements nursing care to address the physical, psychological, and spiritual responses of the patient having a surgical or invasive procedure. The goal of perioperative nursing practice is to assist patients, their families, and significant others to achieve a level of wellness equal to or greater than that which they had before the procedure. The perioperative registered nurse may delegate certain patient care tasks to suitably trained and competent allied health providers and assistive personnel, but retains accountability for the outcome of perioperative nursing care. Core nursing activities that, by licensure, may not be delegated are assessment, diagnosis, outcome identification, planning, and evaluation.¹

In conjunction with the escalating changes in health care, there is a continuous need to provide optimal care that is high quality, safe, accessible, cost effective, and affordable for patients undergoing invasive procedures in any setting. Evolving models of health care delivery are affecting perioperative nursing practice across diverse settings where surgical or other invasive procedures are performed. Past staff reengineering attempts that were part of cost-savings initiatives have not demonstrated improvement, and may in fact have a deleterious effect on patient care outcomes. Health care systems have unsuccessfully attempted to replace RN staff with allied health providers and assistive personnel who lack the education and critical-thinking skills to provide quality patient outcomes. Studies have demonstrated that patient-centered outcome measures are more positive when there is a higher nurse-patient ratio. Better outcomes are inversely proportional to cost. In other words, better outcomes equals lower cost for the health care system.²

The aging of the population has resulted in patients who are more acutely ill upon admission to health care facilities. Despite the decreased lengths of stay in acute care facilities, patients continually require more sophisticated care to maintain their health. This situation has been further complicated by an absence of standardized, mandatory public reporting of data that could objectively quantify the effects of altered staffing configurations. National use of the AORN Perioperative Nursing Data Set (PNDS) will provide perioperative leaders with a standardized means of gathering reliable and valid data to make informed decisions regarding staffing, scheduling, and purchasing.³

Registered nurses are familiar with anecdotal reports of health care errors resulting in patient injuries and even death. The media has continued to fuel the health care controversy with many of these stories. In 1999, the Institute of Medicine (IOM) published its report *To Err Is Human: Building a Safer Health System*, which opened the issue of medical errors to public debate and identified national, state, and local policy directions for a safer health care system capable of reducing medical errors and improving patient safety.⁴ To improve patient safety, the establishment of nurse-to-patient ratios in surgical settings must include awareness of community needs and the needs of the population served and must provide for appropriate perioperative nursing staff to meet those needs. The economic situation of the provider organization should not serve as the sole basis for determining services offered. At no time should economic concerns supersede the priority for patient safety.

Since its 1999 report, the IOM's Committee on the Adequacy of Nurse Staffing in Hospitals and Nursing Homes has begun to illustrate the relationship between nurse staffing, patient outcomes, and cost of care.⁵ This report acknowledges that patient care provided by a registered nurse does affect patient outcomes and has a positive impact on cost of care.⁵

The *Code of Federal Regulations* "Conditions of participation for hospitals" (42 CFR §482) sets forth national staffing standards for hospitals receiving Medicare reimbursement. Under these regulations, the health care organization must have adequate numbers of qualified registered nurses to provide nursing care, which includes circulating duties.⁶ The Centers for Medicare and Medicaid Services interpretive guidelines in §482.51(a)(3) states, "The circulating nurse must be an RN." If a licensed practical nurse or surgical technologist assists with delegated circulating duties, in accordance with local, state, and federal regulations, they must be supervised by a registered nurse who is physically present in the operating room for the entire procedure.⁷ Several states have legislation requiring a registered nurse as circulator.⁸

Perioperative RNs should know their individual state statutes regarding the role of the registered nurse as the circulator in the perioperative setting.

Administrators, directors, and managers responsible for providing staff for perioperative services should refer to the "Statement on mandate for the registered professional nurse in the perioperative practice setting,"⁹ "AORN position statement: Operating room staffing skill mix for direct caregivers,"¹⁰ and "AORN guidance statement: Perioperative staffing."¹¹

POSITION STATEMENT

AORN is committed to the provision of safe perioperative nursing care by ensuring that every patient undergoing a surgical or other invasive procedure is cared for by a registered nurse, regardless of the setting.⁹ To this end, AORN believes the following.

- The minimum nurse-to-patient ratio is one perioperative registered nurse dedicated to each patient during that patient's entire intraoperative experience.¹¹
- The competencies of the perioperative nurse are a key factor in the establishment of nurse-to-patient ratios.
- Patient care in the perioperative setting is dynamic in nature and depends on the clinical knowledge, judgment, and critical-thinking skills possessed by the perioperative registered nurse.
- The foundation of perioperative nursing practice is based on both the art and science of nursing, including evidence-based practice and patient advocacy.
- A practice environment that acknowledges the unique education of a registered nurse supports perioperative nurses to provide the highest quality of patient care in the surgical arena.
- Scientific research and the identification of nursing quality indicators, such as those found in the language of the PNDS, are the best means to monitor the relationship between appropriate nurse staffing and patient outcomes in the surgical setting.
- Having a practice environment with adequate nurse-to-patient ratios will encourage perioperative nurses to continue providing safe, quality patient care in the surgical arena.
- Administrative and collegial support, as well as effective relationships with physicians and surgeons, contributes to the perioperative nurse's ability to provide safe, quality patient care.

Furthermore, AORN affirms

- support for ongoing research to determine proper nurse staffing to sustain safe quality patient outcomes;
- continued collaboration with all organizations endeavoring to reduce and eliminate health care errors; and
- adequate staffing as an essential element of error prevention.

NOTES

1. "Perioperative patient focused model," in *Standards, Recommended Practices, and Guidelines* (Denver: AORN, Inc, 2005) 13-16.
2. J Needleman et al, "Nurse-staffing levels and the quality of care in hospitals," *The New England Journal of Medicine* 346 (May 30, 2002) 1715-1722.
3. S Beyea, ed, *Perioperative Nursing Data Set*, second ed (Denver: AORN, Inc, 2002) 7.
4. L T Kohn, J M Corrigan, M S Donaldson, "Errors in health care: A leading cause of death and injury," in *To Err Is Human: Building a Safer Health System* (Washington, DC: National Academy Press, 2000) 26-48.
5. Institute of Medicine, "Maximizing workforce capability," in *Keeping Patients Safe: Transforming the Work Environment of Nurses* (Washington, DC: National Academies Press, 2004) 171.
6. "Conditions of participation for hospitals," 42 CFR §482, Centers for Medicare and Medicaid Services, <http://frwebgate3.access.gpo.gov/cgi-bin/waisgate.cgi?WAISdocID=4568225784+1+0+0&WAISSaction=retrieve> (accessed 4 Oct 2005).
7. "Conditions of participation for hospitals; surgical services," 42 CFR §482.51(a)(3), Centers for Medicare and Medicaid Services, <http://frwebgate3.access.gpo.gov/cgi-bin/waisgate.cgi?WAISdocID=4568225784+1+0+0&WAISSaction=retrieve> (accessed 4 Oct 2005).
8. B Beu, A Riera, "A summary of AORN's 2004 legislative activities," (Health Policy Issues) *AORN Journal* 80 (December 2004) 1135.
9. "Statement on mandate for the registered professional nurse in the perioperative practice setting," in *Standards, Recommended Practices, and Guidelines* (Denver: AORN, Inc, 2005) 230.
10. "Statement on operating room staffing skill mix for direct caregivers," in *Standards, Recommended Practices, and Guidelines* (Denver: AORN, Inc, 2006) in press.
11. "AORN guidance statement: Perioperative staffing," in *Standards, Recommended Practices, and Guidelines* (Denver: AORN, Inc, 2005) 209-218.

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