



AORN Position Statement on Perioperative Safe Staffing and On-Call Practices

POSITION STATEMENT

Staffing for the perioperative setting is dynamic in nature and depends on clinical judgment, critical thinking, and the administrative skills of the perioperative registered nurse (RN) administrator. Patients undergoing operative and other invasive procedures require perioperative nursing care provided by a perioperative RN, regardless of the setting. This position statement articulates AORN's position regarding safe staffing and on-call practices for perioperative RNs based on the available research. It is intended to serve as a guide for perioperative RN administrators; however, it is the responsibility of each facility to determine specific policies and procedures based on patient need and available resources to ensure safe staffing and on-call practices. The purpose of this position statement is to provide a framework for developing a staffing plan throughout the continuum of perioperative patient care, beginning with scheduling an operative or other invasive procedure through the postoperative phase, and provide staffing strategies to accommodate safe perioperative patient care while promoting a safe work environment. It includes an addendum with suggested staffing formulas to meet safe staffing and on-call practices.

Perioperative RN administrators should identify workforce requirements with a focus on the effect of environmental factors, the setting in which the procedure will be performed, and the unique needs of the patient. AORN believes that patient and workforce safety must be the foundation for all staffing plans. To this end AORN supports the following:

- Perioperative clinical staffing guidelines should be based on individual patient needs, patient acuity, technological demands, staff member competency, skill mix, practice standards, health care regulations, accreditation requirements, and state staffing laws.¹⁻³ Staffing requirements are relative to department functions and assigned role expectations.
- An effective staffing plan should be flexible and responsive to short-term and long-term patient and organizational demands. Effective planning involves determining staffing needs, planning for the appropriate staffing mix and number of staff members, budgeting for personnel costs, and scheduling personnel.
- Perioperative nurse managers should determine both direct and indirect care patient caregivers for the unit. Additionally, productive and nonproductive time should be considered.^{1,2,4}
- The perioperative staffing policy should state the minimum number of nursing personnel that will be provided for various types of operative or other invasive procedures.² Complexity of the procedure, individual team member competency, patient acuity, patient monitoring requirements (eg, local or moderate sedation), trauma, or the use of complex technology (eg, laser, minimally invasive techniques) may require more diverse direct care personnel than the minimum number of staff members originally identified.

- Perioperative RNs should not be required to work in direct patient care for more than 12 consecutive hours in a 24-hour period and not more than 60 hours in a seven-day work week. All work hours (ie, regular hours and call hours worked) should be included in calculating total work hours.
- The staffing plan should promote quality patient outcomes by using patient acuity and nursing workload guidelines to deliver safe patient care and support a safe work environment. The plan should identify strategies for cost-effective and efficient staffing priorities without compromising perioperative patient safety and outcomes.⁵
- The perioperative staffing plan should include provisions for unplanned, urgent, or emergent procedures and how to provide care for patients when procedures run over the scheduled time.
- On-call staffing plans should be based on strategies that minimize extended work hours, allow for adequate recuperation, and retain the perioperative RN as circulator.
- Call staffing should be provided in accordance with standards of perioperative and perianesthesia nursing practice.

RATIONALE

Patient safety is the primary focus of perioperative nurses and other health care providers. One of the most important responsibilities of the perioperative RN administrator is to develop an effective staffing plan that is relevant to the individual practice setting and meets the safety needs of both patients and health care workers. The health care system is affected by increasing demand for health care, continued economic pressures, the projected nursing shortage, and financial ramifications from medico-legal issues. Perioperative RN administrators have an ethical and legal responsibility to maintain staffing levels that are appropriate for providing safe patient care while balancing financial responsibilities.

A systematic approach based on the operational needs of the department is required to develop a staffing plan. Identifying the hours of operation defined by the department or facility, in addition to the hours required to cover off-shift schedules (eg, holidays, nights, weekends), emergent and urgent procedures, and the number of OR and procedure rooms, is the initial step in determining staffing needs. Review of historical data regarding minutes and hours of service, procedure volumes, procedure mix, technology demands, and projections for the coming year are essential for staff scheduling and budgeting.¹

Staffing plans must take into consideration the effect of extended shift hours. Requirements for on-call schedules are subject to facility type, location, nature of services provided, and patient population served. Using 12-hour shifts, although a staff satisfier, has been identified in recent studies to be linked to an increase in patient care errors, and worker injuries such as needle-stick injuries, musculoskeletal injuries, and subsequent health issues from fatigue and sleep deprivation.^{2,6,7}

GLOSSARY

Direct care: Time spent providing hands-on care to patients. Individuals who provide direct patient care include registered nurses, surgical technologists, nursing assistants, orderlies, RN first assistants, and surgical assistants.

Indirect care: Time spent on activities that support patient care and direct care providers but does not involve hands-on patient care activities. Indirect care providers include the director, manager, charge nurse, educator, environmental services personnel, instrument processing

personnel, materials management personnel, and clerical and business personnel.

Nonproductive hours: Time not directly associated with patient care activities (ie, down time) and paid hours not worked. Nonproductive hours include benefit hours (eg, vacation, sick time, funeral leave, education, holiday) in budgeting processes.

Operating room: A room within the surgical suite that meets the requirements of a restricted environment and is designated and equipped for performing operative and other invasive procedures.

Procedure room: A room designated for the performance of procedures that do not require a restricted environment but may require the use of sterile instruments or supplies.

Productive hours: Time spent working (ie, actual hours worked). Productive hours include direct and indirect hours, and worked hours are those that are needed to staff the unit.

RN Circulator: A role performed by the perioperative registered nurse, without sterile attire, during the preoperative, intraoperative, and the postoperative phases of surgical patient care. In collaboration with the entire perioperative team, the RN circulator uses the nursing process to provide and coordinate the nursing care of the patient undergoing operative or other invasive procedures.

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ADDENDUM

INTRAOPERATIVE STAFFING FORMULA FOR TOTAL NUMBER OF FULL TIME EQUIVALENTS (FTEs)

Step 1—Calculate total staff coverage hours per week.

Step 2—Calculate total working hours per week.

Step 3—Calculate basic FTEs.

Step 4—Calculate benefit relief FTEs.

Step 5—Calculate total minimum direct care staff members.

Step 6—Calculate indirect care staff members.

Step 7—Calculate call replacement relief.

Step 8—Calculate the orientation staffing.

The Number of Personnel per Room

- Generally, there are at least two staff members for every surgical or other invasive procedure: one RN in the circulator role and one scrub person.
- The scrub position role can be filled by an RN or surgical technologist.
- Use a figure of 2.5 people per room in computing staffing needs if half of the procedures performed in the OR require a third person for part or all of the procedure (eg, to monitor patients receiving sedation, operate complex technology, additional patient care because of high patient acuity).
- If more or less than half of the procedures performed in the OR require a third person, or if a percentage of procedures require a fourth person, the number of personnel per room will need to be adjusted accordingly.
- The following calculation can be used to determine a 67%:33% (2:1) RN-to-technologist ratio using 2.5 people per room:
Determine the number of RNs per room by multiplying $2.5 \times .67 = 1.7$ RNs
Determine the number of technologists per room by multiplying $2.5 \times .33 = 0.8$ technologists

The above calculation can be applied to any number of total people needed per room. If an institution's FTE is greater or less than 2,080 hours per year, this also must be adjusted in the formula.

Indirect Staff Calculation

For the purposes of this calculation, indirect staff members include, but are not limited to, the budgeted positions of surgical services director, clinical nurse manager, charge nurse, perioperative educator, schedulers, administrative assistant, nursing assistants, and environmental services personnel as appropriate. The number of indirect care staff members will vary according to function, but a traditional complement is one indirect caregiver to two direct caregivers.

Relief Replacement

Benefit hours (ie, nonproductive hours) are hours such as vacation time, holiday time, available sick time (whether paid or unpaid), education days, and any other time that personnel policies determine an employee might take off. The number of benefit hours is proportionate to the amount of vacation time and the number of long-term employees. Some organizations use an

established percentage to calculate benefit hours. In the OR, benefit hours also should include breaks and lunches, unless the OR ceases work during those times.

When determining relief for lunch, it is necessary to add approximately 15 minutes to the allotted time at either end to allow for nurse-to-nurse report about what has transpired during the procedure in progress. It may take less than seven minutes for the RN circulator to report to the relief nurse, but relief of the scrub person needs to include time needed to scrub, gown, and glove, so 15 minutes is average.

When computing relief for breaks and lunches, the number of minutes is multiplied by 260 days (ie, 52 weeks multiplied by five days per week).

Call Hours Replacement Calculation

The maximum number of call hours is determined by identifying the number of shifts multiplied by the number of hours multiplied by two FTEs (this may be increased if the call team is more than two people). The actual hours on-call personnel are called in to work per year divided by 2,080 equals the replacement FTEs for call-time worked (Table 1).

Table 1. Call Replacement Calculation

Call coverage	Maximum possible hours	Historical usage in hours
	<i>Hours x staff = total</i>	<i>Total</i>
260 night shifts	$8 \times 2 = 4,160$	3,342
52 weekends	$48 \times 3 = 7,488$	5,256
12 holidays	$24 \times 3 = 864$	689
Total	12,512	9,287 ^a
^a <i>The difference between the maximum possible call hours and actual usage of call hours is 3,225 hours worked. The 3,225 call hours worked per year divided by 2,080 hours (ie, one full-time equivalent [FTE]) equals 1.55 FTE replacement for call time worked.</i>		

Orientation for New Staff Members

Nonproductive time for orienting new staff members also needs to be included. Calculating the orientation time for new employees depends on several factors, including, but not limited to, the size and type of OR, anticipated turnover time, and increase in the number of staff members from growth of services and volume.

Example Calculation

An OR suite has eight rooms, which are to be staffed as follows:

- 8 rooms, 7 AM to 3 PM, Monday through Friday
- 2 rooms, 3 to 6 PM, Monday through Friday
- 1 room, 6 PM to 7 AM, seven days per week
- 1 room, 7 AM to 6 PM, Saturday and Sunday

Step 1—Calculate Total Staff Coverage Hours Per Week

Number of rooms multiplied by number of hours per day multiplied by number of days per week equals total hours staff coverage hours per week.

$$8 \times 8 \times 5 = 320$$

$$2 \times 3 \times 5 = 30$$

$$1 \times 13 \times 7 = 91$$

$$1 \times 11 \times 2 = 22$$

Total staff coverage hours per week = 463

Step 2—Calculate Total Working Hours Per Week

Total hours (from step 1) to be staffed per week multiplied by number of people per room equals total working hours per week.

$$463 \text{ hours} \times 2.5 = 1,157.5 \text{ total working hours per week}$$

Next, determine the working hours per week using a 67%:33% RN-to-technologist ratio.

$$\text{Determine the number of RNs per room by multiplying } 2.5 \times .67 = 1.7 \text{ RN}$$

$$\text{Determine the number of technologists per room by multiplying } 2.5 \times .33 = 0.8 \text{ technologists}$$

$$\text{RNs: } 1.7 \times 463 \text{ hours} = 787.1 \text{ total RN working hours per week}$$

$$\text{Surgical technologists: } 0.8 \times 463 = 370.4 \text{ total surgical technologist hours per week}$$

$$\text{Total working hours per week} = 1,157.5$$

Step 3— Calculate Basic FTEs

Total working hours per week divided by 40 hours worked per week equals basic FTEs.

$$1,157.5 \div 40 = 28.9 \text{ basic FTEs}$$

Next, determine the basic RN and surgical technologist FTEs for a 67%:33% RN-to-technologist ratio.

$$\text{RNs: } 787.1 \text{ hours} \div 40 = 19.7 \text{ basic RN FTEs}$$

$$\text{Surgical technologists: } 370.4 \div 40 = 9 \text{ basic surgical technologist FTEs}$$

Step 4—Calculate Benefit Relief FTEs

Determine the average number of benefit hours per employee based on the rates provided at the facility.

$$\text{Vacation hours per year} = 100$$

$$\text{Holiday hours per year} = 56$$

$$\text{Available sick hours per year} = 96$$

$$15 \text{ minute break} \times 260 \text{ days} \div 60 \text{ minutes} = 65 \text{ hours}$$

$$45 \text{ minute lunch} \times 260 \text{ days} \div 60 \text{ minutes} = 195 \text{ hours}$$

$$\text{Total benefit hours} = 512$$

Basic FTEs multiplied by benefit hours per FTE per year divided by 2,080 hours equals relief FTEs.

$$28.9 \times 512 \text{ hours} \div 2,080 = 7.1 \text{ relief FTEs}$$

Next, determine the RN and surgical technologist relief FTEs for a 67%:33% RN-to-technologist ratio.

$$\text{RNs: } 19.7 \times 512 = 10,086.4 \div 2,080 = 4.8 \text{ RN relief FTEs}$$

$$\text{Surgical technologists: } 9 \times 512 = 4,608 \div 2,080 = 2.2 \text{ surgical technologists FTEs}$$

Step 5—Calculate Total Minimum Direct Care Staff Members

Basic FTEs added to relief FTEs equals total minimum direct care staff members.

$$28.9 + 7.1 = 36 \text{ FTEs}$$

Next, determine the RN and surgical technologist direct care FTEs for a 67%:33% RN-to-technologist ratio.

$$\text{RN: } 19.7 \text{ basic FTEs} + 4.8 \text{ benefit relief FTEs} = 24.5 \text{ RN FTEs}$$

Surgical technologist: 9 basic FTEs + 2.2 benefit relief FTEs = 11.2 surgical technologist FTEs

Step 6—Calculate Indirect Care Staff Members

1 indirect caregiver per 2 direct caregivers = 1.25×463 hours per week = $578.8 \div 40 = 14.5$ FTEs

Next, calculate indirect care staff member benefit hours

512 benefit hours $\times 14.5 = 7,424 \div 2,080 = 3.6$ relief FTEs

Then, calculate indirect care staff members

3.6 relief FTEs + 14.5 indirect caregiver FTEs = 18.1 indirect care staff members

Step 7—Calculate Call Replacement Relief

Calculate call hours: Multiply the call coverage periods, times the hours per period, times the number of people needed per call coverage period minus the historical usage hours.

260 night shifts $\times 8$ hours $\times 2$ people = $4,160 - 3,342 = 818$

52 weekends $\times 4$ hours $\times 3$ people = $7,488 - 5,256 = 2,232$

12 holidays $\times 24$ hours $\times 3$ people = $864 - 689 = 175$

Total call hours = $3,225$

Next, divide the total call hours by $2,080$ (ie, one FTE) to obtain the FTEs required for call replacement.

$3,225 \div 2,080 = 1.55$ total call replacement FTEs

Step 8—Calculate the Orientation Staffing

If four people with experience were expected to be hired for a year and each receives 12 weeks of orientation, use the following calculation:

4 staff members $\times 40$ hours per week $\times 12$ weeks = $1,920$ hours of orientation $\div 2,080 = 0.9$ FTEs for orientation

TOTAL NUMBER OF FTEs

Based on 100% utilization, the total number of FTEs calculated in this example is:

Direct caregiver RNs: 24.5 FTEs

Direct caregiver surgical technologists: 11.2 FTEs

Indirect caregivers: 18.1 FTEs

Call replacements: 1.5 FTEs

Orientation FTEs: 0.9 FTEs

Total: 56.3 FTEs

PERIANESTHESIA CARE UNIT (PACU) STAFFING FORMULA

There are no standardized staffing formulas at this time for calculating perianesthesia staffing in the PACU. Neither the American Society of PeriAnesthesia Nurses nor AORN has a recommended staffing formula at this time. Refer to Table 2 for PACU staffing recommendations.

Table 2. Minimum Staffing Recommendations

Surgical phase	Minimum requirements	Comments
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Scheduling	1 clerical person under the supervision of a perioperative RN	Depending on the size of the facility, this activity may be combined with other business or clerical duties. Additional staff members may be required depending on volume and the hours that the scheduling office is open.
Preplanning	1 RN ^{1,2}	Depending on the setting and level of activity, this stage may require additional RNs and ancillary support. This may include preoperative telephone calls/interviews or planning for special supplies and equipment to meet patient needs.
Registration	Clerical person	The number of clerical staff members depends on the setting, level of activity, number of patients scheduled, patient acuity, and types of procedures and may be combined with other tasks.
Day of surgery: Preoperative	1 RN ^{1,2}	The number of additional RNs should be based on the number of patients, the number of ORs/procedure rooms, patient acuity, types of procedures, complexity/intensity of patient care requirements, time required to perform tasks, a patient's age-specific needs, and the average time for individual patient preparation. Licensed practical nurses (LPNs) and unlicensed assistive personnel (UAP) may be included in preoperative staffing plans. Unlicensed assistive personnel may be assigned to help with delegated patient care tasks as determined by the RN and according to individual state boards of nursing scope of practice and other local, state, and federal regulations. ^{3,4}
Intraoperative	1 RN per patient per OR in the role of the RN circulator. ⁵ 1 scrub person per patient per room; may be RN, surgical technologist, or LPN. In some circumstances, a scrub person may not be required.	Additional staff members, with appropriate competencies, may be used as appropriate for the following: <ul style="list-style-type: none"> • moderate sedation—1 RN dedicated to monitoring the patient and separate from the dedicated RN circulator; • local anesthesia—depending on patient needs, nursing assessment, and type of procedure, 1 RN may be needed to

		<p>monitor the patient in addition to the RN circulator;</p> <ul style="list-style-type: none"> • complex surgical procedures and patients with compound needs may require an additional RN circulator and scrub person; • technological demands (eg, lasers, robotics, audiovisual equipment, auto transfusion device); • first assist requirements. <p><i>Note: See formula for calculating additional staffing.</i></p>
Postoperative Phase I level of care ²	<p>“Two registered nurses, one of whom is a[n] RN competent in Phase I postanesthesia nursing, are in the same unit where the patient is receiving Phase I level of care.”²</p> <p>Staffing will reflect the American Society of PeriAnesthesia Nurses’ (ASPAN’s) “Patient classification/recommended staffing guidelines.”</p>	<p>Phase I level of care^a</p> <p>Class 1:2—1 nurse to 2 patients who are</p> <ul style="list-style-type: none"> • 1 unconscious, stable, without artificial airway, and over the age of 8 years; and 1 conscious, stable, and free of complications. • 2 conscious, stable, and free of complications. • 2 conscious, stable, 8 years of age and under, with family or competent support staff member present.² <p>Class 1:1—1 nurse to 1 patient</p> <ul style="list-style-type: none"> • At the time of admission, until the critical elements^b are met. • Unstable airway.^c • Any unconscious patient 8 years of age and under. • A 2nd nurse must be available to assist as necessary.² <p>Class 2:1—2 nurses to 1 patient</p> <ul style="list-style-type: none"> • 1 critically ill, unstable, complicated patient.² <p>Additional staff members may include support staff. Unlicensed assistive personnel may be assigned to help with delegated patient care tasks according to local, state, and federal regulations.⁴</p>
Phase II level of care ²	<p>“Two competent personnel, one of whom is a[n] RN competent in Phase II</p>	<p>Phase II level of care^a</p> <p>Class 1:3—1 nurse to 3 patients</p>

	<p>postanesthesia nursing, are in the same room where the patient is receiving Phase II level of care. A[n] RN must be in the Phase II PACU at all times while a patient is present.”²</p> <p>Staffing will reflect ASPAN’s “Patient classification/recommended staffing guidelines.”</p>	<ul style="list-style-type: none"> • Over 8 years of age. • 8 years of age and under with family present.² <p>Class 1:2—1 nurse to 2 patients</p> <ul style="list-style-type: none"> • 8 years of age and under without family or support staff member present. • Initial admission of patient postprocedure.² <p>Class 1:1—1 nurse to 1 patient</p> <ul style="list-style-type: none"> • Unstable patient of any age requiring transfer.² <p>Additional staff members may include support staff. Unlicensed assistive personnel may be assigned to help with delegated patient care tasks according to local, state, and federal regulations.⁴</p>
<p>Extended observation level of care²</p>	<p>“Two competent personnel, one of whom is a[n] RN possessing competence appropriate to the patient population, are in the same unit where the patient is receiving extended observation level of care. The need for additional RNs and support staff is dependent on the patient acuity, patient census, and the physical facility.”²</p> <p>Staffing will reflect ASPAN’s “Patient classification/recommended staffing guidelines.”</p>	<p>Extended observation level of care^a</p> <p>Class 1:3/5—1 nurse to 3 to 5 patients</p> <ul style="list-style-type: none"> • Examples of patients that may be cared for in this phase include, but are not limited to, <ul style="list-style-type: none"> – patients awaiting transportation home; – patients with no caregiver; – patients who have had procedures requiring extended observation/intervention (ie, potential risk for bleeding, pain management, postoperative nausea, vomiting); and – patients being held for an inpatient bed.² <p>Additional staff members may include support staff. Unlicensed assistive personnel may be assigned to help with delegated patient care tasks according to local, state, and federal regulations.⁴</p>
<p>Discharge from service</p>	<p>An RN assesses the discharge readiness of the patient and confirms the order from</p>	<p>“The perianesthesia nurse uses sound judgment in determining the appropriate method of communication and mode of</p>

	<p>anesthesiologist/surgeon for discharge according to facility protocol.⁶</p>	<p>transport to transfer care of the perianesthesia patient.”⁶</p> <ol style="list-style-type: none"> 1. “A policy exists to ensure safe transportation of patients. <ul style="list-style-type: none"> • The professional nurse determines the mode, number, and competency level of accompanying personnel based on patient need. • The professional nurse ensures the availability of appropriate transportation of the patient from the facility. • An appropriate means of transportation from a freestanding facility to a full-service hospital will be used in emergency situations. 2. A professional nurse should accompany patients who <ul style="list-style-type: none"> • require continuous cardiac monitoring. • require evaluation and/or treatment during transport (ie, vasopressor infusions or pulse oximetry).”⁶
<p>Postoperative follow-up</p>	<p>An RN completes discharge follow-up.</p>	<p>Ambulatory surgery patients are reassessed postoperatively. The time frames for reassessment are based on patient needs and the care, treatment, and services provided. Individual organizations should develop policies and procedures regarding the mechanism chosen (eg, postoperative telephone calls) based on the patients it serves and the services or care it provides.⁷</p>
<p>^a <i>Phases of postanesthesia care were developed by the American Society of PeriAnesthesia Nurses. 2012-2014 Perianesthesia Nursing Standards, Practice Recommendations and Interpretive Statements. Cherry Hill, NJ: American Society of PeriAnesthesia Nurses; 2012.</i></p> <p>^b <i>Critical elements can be defined as:</i></p> <ul style="list-style-type: none"> • <i>Report has been received from the anesthesia professional, questions have been answered, and the transfer of care has taken place.</i> • <i>Patient has a secure airway.</i> • <i>Initial assessment is complete.</i> • <i>Patient is hemodynamically stable.</i> <p>^c <i>Examples of an unstable airway include, but are not limited to, the following:</i></p> <ul style="list-style-type: none"> • <i>Requiring active interventions to maintain patency, such as manual jaw lift or chin lift.</i> 		

- *Evidence of obstruction, active or probable, such as gasping, choking, crowing, or wheezing.*
 - *Symptoms of respiratory distress, including dyspnea, tachypnea, panic, agitation, or cyanosis.*
1. *Standard III: Staffing and personnel management. In: 2012-2014 Perianesthesia Nursing Standards, Practice Recommendations and Interpretive Statements. Cherry Hill, NJ: American Society of PeriAnesthesia Nurses; 2012:19-20.*
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STRATEGIES FOR DEVELOPING A SAFE ON-CALL SCHEDULE

- Perioperative RNs should not be required to work in direct patient care for more than 12 consecutive hours in a 24-hour period and not more than 60 hours in a seven-day work week. All work hours (ie, regular hours and call hours worked) should be included in calculating total work hours.¹⁻³
- Off-duty periods should be inclusive of an uninterrupted eight-hour sleep cycle, a break from continuous professional responsibilities, and time to perform individual activities of daily living.⁴⁻⁶
- Arrangements should be made to relieve a perioperative RN who has worked on-call during his or her shift and who is scheduled to work the following shift to accommodate a recuperation period, as outlined above.
- Exception: Under extreme conditions, exceptions to the 12-hour limit may be required (ie, internal or external disasters). Organizational policy should outline the events that would create exceptions to the 12-hour limitation.
- An individual's ability to meet the anticipated work demand should be considered for on-call requirements. Limited research indicates that older people are more likely than younger

people to be adversely affected by sleep deprivation; however, there is no research specific to the effects of on-call assignment and a person's age.

- Orientation to on-call should be included in the orientation process and should be accomplished using the preceptor system (ie, having an experienced perioperative RN serve as an immediate resource for the orientee). The timeframe depends on the type of facility, the types of procedures, and the scope of services.
- Perioperative RNs should uphold their ethical responsibility to patients and themselves to arrive at work adequately rested and prepared for duty.^{2,7}
- Health care organizations should support perioperative RNs in changing cultural attitudes so that fatigue is recognized as an acceptable risk to patient and employee safety rather than a sign of a worker's dedication to the job.²

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