A Position Statement on Acuity Based Staffing for Phase I

The American Society of PeriAnesthesia Nurses (ASPAN) has the responsibility for defining the principles of safe staffing practice in the perianesthesia setting. ASPAN's *2019-2020 Perianesthesia Nursing Standards, Practice Recommendations and Interpretive Statements* provides Practice Recommendation 1: Patient Classification/Staffing Recommendations.[1] Perianesthesia registered nurses continue to seek validation, clarification, and support regarding the staffing recommendations. In the landmark case Laidlaw v Lions Gate Hospital, Phase I PACU was deemed "the most important room in the hospital" because this phase of care "poses the greatest potential dangers to the patient."[2] Currently, ASPAN's "recommended staffing ratios are based on the best available evidence, expert opinion and consensus."[3] While there are variations in Phase I perianesthesia practice locations, it remains the responsibility of each healthcare organization to balance patient safety, acuity, census, complexity, case mix, skill mix, and nursing competencies when staffing.[4] Therefore, ASPAN sets forth expectations for acuity based staffing in Phase I perianesthesia departments with this position statement.

Background

ASPAN's Clinical Practice Committee receives weekly inquiries regarding staffing issues in Phase I perianesthesia departments across the country. The addition of interpretive statements to Practice Recommendation 1: Patient Classification/Staffing Recommendations has not resulted in nationally consistent staffing patterns in Phase I. Interpretation of this practice recommendation continues to vary throughout practice settings. As changes in healthcare continue to impact the financial bottom line of healthcare organizations, nursing remains under scrutiny to justify staffing. Facilities utilizing productivity formulas often fail to incorporate criteria related to patient acuity and/or complex needs. Attempts to standardize or predict staffing requirements in Phase I reflect a lack of understanding of the complexities of care in PACU.[5,6] These complexities include the movement of patients in and out of the unit and the constant change in patient acuities.[6] Additionally, in a study by Kiekkas et al, "nurse understaffing was associated with significantly higher incidence of hypoxemia and arterial hypotension" in the postanesthesia care unit.[7]

When creating a staffing plan for appropriate shifts, work hours, and patient care accommodations, members of the facility leadership team must account for numerous factors.[8] It is an ethical obligation to include and assure that members of the healthcare team have proper competencies and training.[8] The Joint Commission and the American Nurses Association (ANA) agree that patients have a right to high quality care delivered by members of the healthcare team with proper skill mix.[9,10] The ANA further implies that staffing patterns must be individualized to nursing units and concur that patient turnover, or environmental turbulence,[3,a] and acuity are important factors in the staffing plan.

[a]Environmental turbulence is a phrase coined in the 1990s to describe the wide variety of factors influencing clinical practice and clinician performance.[11]

Position

It is ASPAN's position that an appropriate number of perianesthesia registered nurses with demonstrated competence is available to meet the individual needs of patients and families in each phase of perianesthesia care based on patient acuity, census, patient throughput, and physical facility.[1,3] According to practice experts from ASPAN's Safety and Staffing Focus Group and the Standards and Guidelines Strategic Work Team, the factors which must be considered when calculating staffing in Phase I include, but are not limited to:

- Comorbidities and ASA classification determined by preanesthesia assessment

- Complexity of care (e.g., frequency of hemodynamic, neurovascular or neurological assessments, point of care testing, assistance with elimination needs, patient requiring ICU care, educational needs of patient and family, age and emotional status of patient)

- Case mix and necessary resources to provide appropriate care (e.g., regional anesthesia, invasive monitoring, assistance with bedside procedures, patient on precautions, rapid PACU progression and turnover)

- Potential for untoward events (e.g., unwanted sedation, malignant hyperthermia, hemorrhage)

- Compliance with medical optimization plans for disease processes and medication regimen

- Variability of scheduled and unscheduled cases

- Capacity of technology to support workflow processes (e.g., tracking systems, delays in system responsiveness)

- Workflow challenges and distractions

- Administration of multiple medications (e.g., analgesics, vasoactive agents, antiemetics, anxiolytics)

- Consideration for the complexity of safe patient handoff and transfer of care processes

- Physical capacity of the unit to meet 1:1 admission criteria, prevent operating room (OR) delays, and allow for additional resources to assist with adverse events (e.g., delirium, agitation, respiratory events, cardiac events, hemodynamic instability, excessive pain, desaturation, hypoxia, hyperthermia)

- Number of OR/procedure rooms

- Physical design and layout of the unit

Expected Outcomes

Perianesthesia registered nurses will share the data utilized to support unit staffing for Phase I units with leadership. It is the responsibility of all perianesthesia registered nurses to ensure that leadership and administration are aware of ASPAN's Patient Classification/Staffing Recommendations[1] and this position statement.

ASPAN, as the voice of perianesthesia nursing, must externalize this information by sharing this position statement with regulatory agencies and professional organizations that interface with the perianesthesia nursing specialty. In addition, perianesthesia nursing research for patient safety must include the investigation of staffing ratios that incorporate variables of acuity, unit census, patient care complexity, case mix, skill mix, and nursing competencies.

Approval of Statement

This statement was recommended by a vote of the ASPAN Board of Directors on November 7, 2015, in Ft. Lauderdale, Florida, and was approved by a vote of the ASPAN Representative Assembly on April 10, 2016, in Philadelphia, Pennsylvania.

This position statement was updated and revised at the October 2019 meeting of the Standards and Guidelines Strategic Work Team in Dallas, Texas.

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