Development of the Guidelines for Professional Registered Nurse Staffing for Perinatal Units

All of these changes in perinatal care have implications for nurse staffing of perinatal units. Therefore, based on recommendations from the AWHONN Perinatal Patient Safety Advisory Panel, the AWHONN Board of Directors convened a task force in 2009 to evaluate nurse staffing standards for perinatal units and to revise as necessary. The task force developed these guidelines for nurse staffing in perinatal units.

In June 2010, AWHONN members were invited to respond to a survey posted to the AWHONN website over two weeks. The survey included an open-ended question to avoid the bias inherent in predetermined content of structured survey items: “Please give the staffing task force your input on what they should consider in the development of recommendations for staffing of perinatal units.” The goal was to solicit suggestions on any staffing issues that members felt had merit and that needed consideration by the task force. Nearly 900 perinatal nurses responded.

In general, AWHONN members reflected concerns about the existing AAP & ACOG staffing standards relative to their ability to meet the needs of pregnant women, mothers and babies in contemporary perinatal clinical practice. Consistent themes were identified and specific areas of concern raised by AWHONN members are clarified and updated in these new nurse staffing guidelines.

The original staffing standards (AAP & ACOG, 1983 to 2007) included both types of patients (such as patients in labor and antepartum and postpartum patients with complications, but in stable condition) and types of clinical situations (such as oxytocin induction or augmentation of labor, coverage for initiation of epidural anesthesia, and second stage of labor), but do not specifically delineate the two patients that a pregnant woman represents (the mother and the fetus in a singleton pregnancy). As a result, some of the clinical situations in which “patient” is not mentioned, such as oxytocin induction or augmentation of labor, have been interpreted by some to mean 1 nurse to 1 woman receiving oxytocin (1:2 staffing ratio when considering the fetus), while others have interpreted this to mean 1 nurse to 2 women receiving oxytocin (1:4 staffing ratio when considering the fetus). For clarity, we have specified the number of women in the ratio, rather than using the generic term “patient.” Clarification of the staffing standards relative to pregnancy, representing two distinct patients for each of the types of patients and clinical situations described, is needed. The fetus as the second patient must be considered when staffing ratios are designated for care for pregnant women.

The current (AAP & ACOG, 1983 to 2007) staffing standards assume that there will be ancillary personnel to perform nonnursing duties as well as provide support and comfort to perinatal patients. Adding licensed practical nurses, licensed vocational nurses, OB technicians, or nurses’ aides to the staffing numbers does not preclude requirements to meet staffing standards for registered nurses. Other personnel, including clerical support, are necessary for indirect patient care activities (AAP & ACOG). This assumption has been incorporated in these guidelines. The absence of additional support must be considered in modifying these guidelines, since they already account for the presence of these additional personnel. Without ancillary support personnel, more nurses may be needed. For the purposes of this document, “nurse” means “registered nurse.”