AMERICAN ASSOCIATION of CRITICAL-CARE NURSES

AACN
STANDARDS FOR

Appropriate Staffing in Pediatric Critical Care

2026

AACN MISSION

AACN drives excellence in acute and critical care for nurses, patients and families.

AACN VISION

AACN is dedicated to creating a healthcare system driven by the needs of patients and families where acute and critical care nurses make their optimal contribution.

AACN VALUES

As AACN works to promote its mission and vision, it is guided by values that are rooted in, and arise from, the Association's rich history, traditions and culture. Our values are the foundation upon which we build our relentless pursuit of excellence. AACN's members, volunteers and staff will honor the following:

- **Integrity** – We demonstrate sound judgment, ethical behavior and accountability in all we do.
- **Inclusion** – We cultivate an inclusive culture, where everyone contributes their unique strengths and perspectives.
- **Transformation** – We drive change and innovation to positively impact the healthcare system and improve the lives of patients, families and nurses.
- **Leadership** – We advocate and influence to achieve optimal outcomes and healthy work environments.
- **Relationships** – We collaborate and advance partnerships, honoring each individual to strengthen the collective.

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TABLE OF CONTENTS

Acknowledgments	1
Introduction	2
Staffing and the Unique Role of Nurses in Pediatric Critical Care Settings	3
Appropriate Staffing Standards Overview	4
Standard 1	5
Standard 2	7
Standard 3	9
Standard 4	11
Standard 5	13
Standard 6	15
Standard 7	17
About AACN Standards for Appropriate Staffing in Pediatric Critical Care	20
Questions and Answers	21
Glossary	26
References	27
Appendix 1	29
Appendix 2	30
Appendix 3	31
Appendix 4	34

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INTRODUCTION

These *AACN Standards for Appropriate Staffing in Pediatric Critical Care* offer guidance to improve some of the many processes that lead to appropriate registered nurse staffing. When AACN created *AACN Standards for Appropriate Staffing in Adult Critical Care*,[1] the intent was for the standards to be broad enough to apply to a wide range of adult critical care settings, while also offering specific actions that support nurses and, therefore, the delivery of expert patient care. We later published *AACN Standards for Appropriate Staffing in Adult Progressive Care*[2] using the same standards, but with recommended actions specific to progressive care nursing.

Based on input from pediatric and neonatal critical care nurses who responded to an AACN survey and participated in our focus groups, the 7 standards for appropriate staffing in adult critical care also apply to the delivery of pediatric critical care. This first edition of the pediatric standards incorporates learnings from our pediatric critical care community, gathered over 2 years since publishing the adult critical care and adult progressive care staffing standards, including revised actions and resources specific to pediatric critical care.

AACN Standards for Establishing and Sustaining Healthy Work Environments: A Journey to Excellence, 2nd ed.[3] defines appropriate staffing as the effective match between patient characteristics and nurse competencies across the care continuum. In all settings and at all levels of care, many processes affect that match. These processes include organizational-level determinations of financial resources available for staffing and myriad factors at the unit level. Ensuring an appropriate number of nurses to provide care on a given shift is crucial, as is an accurate assessment of nurse competencies and patient needs. There are no easy answers or fast solutions to the challenges of appropriate nurse staffing.

Inappropriate nurse staffing poses an existential threat to the US health care system. Staffing in pediatric critical care is a unique challenge because age, developmental considerations, and patient and family-centered care can impact nursing workload. An additional concern is that escalating care complexity coexists with a decrease in the average years of experience among direct care nurses.[4] Other long-standing challenges such as inflexible models of care, noncollaborative decision-making, economic pressures, and power dynamics underpin chronically dysfunctional staffing practices.

It is important to recognize that several pediatric and neonatal nursing organizations also offer staffing recommendations. The Society of Pediatric Nurses published *SPN Position Statement: Safe Staffing for Pediatric Patients*,[5] the Association of Women's Health, Obstetric and Neonatal Nurses includes staffing recommendations for babies requiring a higher level of care in *Standards for Professional Registered Nurse Staffing for Perinatal Units*,[6] and the National Association of Neonatal Nurses includes staffing recommendations for neonatal intensive care units (NICUs) (levels II, III, and IV) in *RN Staffing in the NICU Position Statement*.[7]

Staffing standards—together with a deep commitment to collaboration and necessary change from health care leaders, nurses, and team members—provide the opportunity for evidence-based and transformational change that can profoundly improve the health care system's ability to meet patients' needs. There is no more time to spend on siloed approaches, stagnant models of care, or past grievances. The timeline is critical, the stakes are high, and patients depend on us.

STAFFING AND THE UNIQUE ROLE OF NURSES IN PEDIATRIC CRITICAL CARE SETTINGS

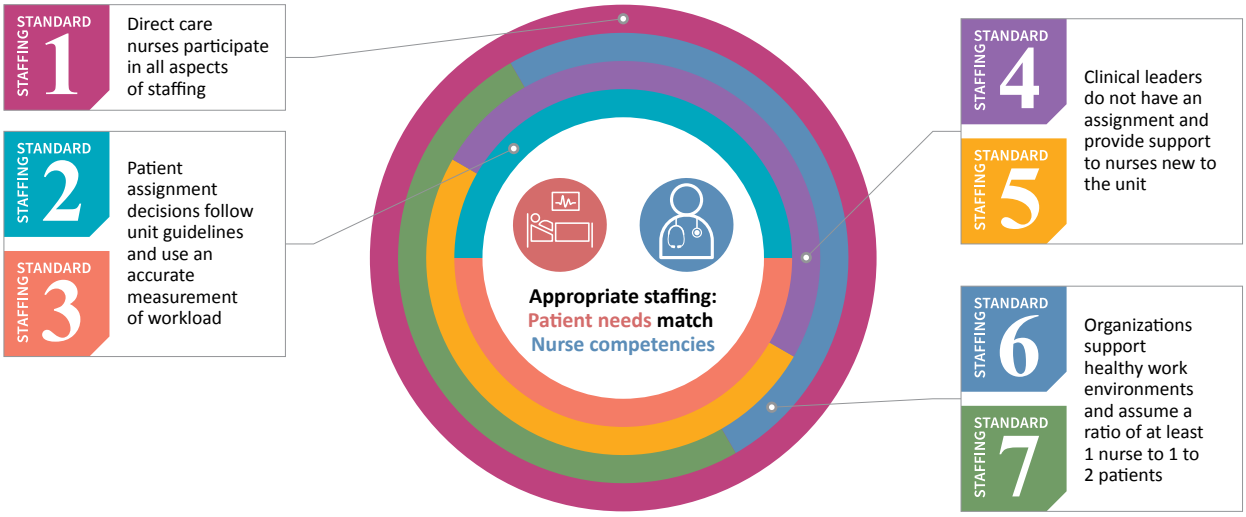
The definition of appropriate staffing, an effective match between patient needs and nurse competencies, can be applied to all levels of patient acuity and all clinical settings. In pediatric critical care, other considerations such as age, developmental level, and patient- and family-centered care influence both patient needs and the essential competencies of the nurse providing care. Patients can range from the smallest premature neonates in the NICU to young adults in the pediatric ICU (PICU). Depending on the setting, resources can vary greatly; an urban, teaching pediatric hospital will have different capabilities than a community or rural hospital with limited capacity to treat pediatric patients.

The number of children with chronic health conditions and complex medical needs is rising.[8] Comprehensive pediatric health care requires a workforce that is highly trained and specialized in age-specific and psychosocial competencies as well as essential pediatric-specific skills.[9] The course of developmental changes that affect biological, anatomical, physiological, psychological, emotional, and social differences in how children experience illnesses or injuries contributes to the complexity of pediatric care. Additionally, the communication skills of children can range from nonverbal to fully developed language skills, and the broad range of caregivers who provide emotional support and day-to-day care for children also must be considered.[8]

Because the needs of critically ill or injured pediatric patients and their families are so complex and the competencies of nurses providing their care is so specialized, AACN's staffing standards emphasize the input of direct care nurses in staffing decisions (Standard 1), objective measures of nursing workload and unit-specific guidelines to inform patient assignments (standards 2 and 3), the role of leaders on the unit (Standard 4), support for nurses new to the unit (Standard 5), and the importance of organizational support in staffing decisions (standards 6 and 7).

Considerations such as age, developmental level, and patient- and family-centered care influence both patient needs and the essential competencies of the nurse providing care.

APPROPRIATE STAFFING STANDARDS OVERVIEW



These 7 standards aim to operationalize AACN's appropriate staffing standard, and the associated actions leverage the other 5 AACN Healthy Work Environment Standards.[3] Through skilled communication, nurses and leaders can share and hear staffing concerns. Because stakeholders—nurses, leaders, other health care professionals, patients, and families—want to improve staffing, we can develop true collaboration by focusing on that shared goal. Effective decision-making ensures that those most affected by staffing decisions have a voice when those decisions are being made. Inviting nurses and clinical leaders to design unit-specific staffing guidelines illustrates meaningful recognition for their unique expertise. Authentic leadership is demonstrated by advocating for staffing plans that prioritize the health of the work environment and the well-being of patients, nurses, and teams.

STANDARD 1 Direct care nurses participate in all aspects of staffing: planning, implementation, and evaluation.



ACTIONS

- Organizational leaders, clinical leaders, and direct care nurses use skilled communication, including mutual respect and inquiry, to discuss staffing concerns.
- Organizational leaders ensure psychological safety so that nurses who voice concerns about staffing through skilled communication do not face retaliation.
- Direct care nurses participate in organizational and unit-based decisions that affect nurse staffing or workload. These decisions include recruitment and hiring efforts, staffing standards and policies, technology changes, total compensation packages, and the design of new care delivery models.
- Committees that include direct care nurses are empowered to create unit-specific staffing guidelines (Standard 2), and scheduling ensures clinical coverage (paid time) is provided for that work (Standard 6).
- Because of the high risk for instability among patients requiring pediatric critical care, protected time is vital for nurses to participate in staffing decisions, planning, and evaluation.
- Clinical and organizational leaders advocate for adoption of and adherence to the staffing guidelines that the unit committee determines.

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- See Appendix 1 for strategies to implement Standard 1.

Direct care nurses participate in organizational and unit-based decisions that affect nurse staffing or workload.

STANDARD 2

Hospital patient care areas establish, evaluate, and refine unit-specific staffing guidelines based upon their impact on patient and nurse outcomes.



ACTIONS

- Clinical leaders and direct care nurses share accountability for creation and evaluation of unit-specific staffing guidelines. These guidelines:
    - Reflect the emotional and developmental needs of pediatric patients, ensuring holistic, developmentally appropriate care
    - Ensure that family-centered care is prioritized to incorporate family preferences and ensure shared decision-making
    - Identify patient and family characteristics that typically and consistently affect the demand for nursing time and thus affect the number of patients in each assignment, including:
        - The presence or absence of family at the bedside
        - The need for developmentally appropriate care, such as play and extended time for care-related tasks
        - Support for new parents, new diagnoses of lifelong illness, and social issues
    - Account for the availability of team members, including virtual support, unlicensed personnel, unit coordinators, and staff and support from other departments, such as child life services, therapy services, transport services, environmental services, and dietary services
    - Consider the need for staff availability to leave the unit for emergency events
    - Are routinely evaluated based on patient outcomes (eg, hospital-acquired conditions) and nurse outcomes (eg, work environment assessment, employee engagement data)

- Supervisors/administrators apply unit-specific guidelines when floating staff to and from the unit, and they ensure that the competencies of nurses who float match the characteristics of the patients to whom these nurses are assigned (Standard 5).

- Clinical leaders and direct care nurses collaboratively design and test innovative care delivery models to increase efficiency and ensure nurses maximize their contributions by focusing on the care they uniquely provide.
- All unit staff and supervisors/administrators who make decisions about hospital-wide staffing are aware of the unit-specific staffing guidelines.

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STANDARD 3

For every shift, patient assignments are based on an accurate assessment of the current nursing workload generated by each patient's and family's needs and align nurse competencies with patient and family characteristics.



ACTIONS

- Clinical leaders and direct care nurses collaborate to select and test tools to measure nursing workload (eg, based on the electronic health record [EHR] or other tools). These are often referred to as acuity-based staffing tools.
- The level of family support and educational needs are components of nursing workload and should be incorporated into measurement tools.
- Developmental considerations are included in workload assessment.
- Direct care nurses routinely validate the tool that measures nursing workload.
- Charge nurses (or other nurse manager designees) use a validated tool and apply unit-specific staffing guidelines to make decisions about patient assignments on every shift (Standard 2).
- Charge nurses (or other nurse manager designees) use objective, up-to-date information about nurse competencies to assign patients to nurses or care teams each shift and ensure appropriate workloads, with specific consideration for differences in competency among contingent, newly licensed, or floating staff (Standard 5).
- Nurses in all roles are aware of the process to measure nursing workload.

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STANDARD 4

Clinical leaders such as charge nurses, educators, clinical nurse specialists, and nurse managers do not take a patient assignment, except in rare crisis situations.



ACTIONS

- Clinical leaders, including charge nurses, are not assigned patients in order to be consistently available to support nurses and patients in the dynamic clinical environment.
- Direct care nurses have access to a clinical leader when changes occur in the demand for patient care (eg, hemodynamic instability, a bedside procedure, and complex interventions such as extracorporeal membrane oxygenation or continuous renal replacement therapy).
- Direct care nurses and nurse leaders collaboratively develop a job description for the charge nurse/clinical leader role to ensure shared and consistent expectations of the role.
- Clinical leaders, who are not assigned patients, round at least every shift with direct care nurses, particularly those who are new to the unit, and provide support (Standard 5).
- Direct care nurses regularly communicate concerns about their workload to clinical leaders with the intent of using true collaboration to find solutions (Standard 1).
- Organizations support clinical leaders (such as charge nurse, nurse manager, assistant manager, clinical nurse specialist, and educator) by providing education and training in leadership skills.
- Nurse managers and directors have dedicated/protected time to implement strategies that establish and sustain a healthy work environment (Standard 6).
- Nurse educators and professional development associates and practitioners have dedicated time to measure and address the ongoing competency of the unit staff.

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Clinical leaders round at least every shift with direct care nurses.

STANDARD 5

Staffing plans and patient assignments support the unique needs of nurses who are new to the unit.



ACTIONS

- Charge nurses and preceptors collaboratively determine appropriate assignments for orientees.
- Clinical leaders advocate for staffing schedules that ensure support is available to recently oriented nurses, including on weekends and night shifts.
- Direct care nurses and clinical leaders test innovations such as virtual support, team models, residency programs, or tiered orientation processes to provide additional support for nurses who are new to pediatric critical care and/or new to practice.
- Clinical leaders (Standard 4) regularly round on the unit to:
    - Offer support for nurses new to the unit, including new graduates and contingency (float) staff by:
        - Helping them prioritize care and interventions
        - Providing clinical expertise to address knowledge gaps
        - Answering questions and guiding evidence-based practice
    - Offer support for nurses serving as preceptors
    - Serve as role models for skilled communication, true collaboration, and effective decision-making in interactions with direct care staff
- Charge nurses (or nurse manager designees) align patient and family needs with nurse or care team competencies to ensure the workload assigned to new nurses matches their abilities (Standard 3).

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Patient and family needs are aligned with nurse or care team competencies to ensure the workload assigned to new nurses matches their abilities

STANDARD 6

Organizational staffing plans are designed to prioritize the health of the work environment and thus drive nurse retention and optimal patient outcomes.



ACTIONS

- Organizational leaders invest in and support staffing plans that:
    - Accommodate nurses' meal and rest breaks (periods during which they are not responsible for patient care) to optimize their well-being
    - Ensure nurses have clinical coverage for professional development opportunities and contributions to shared governance, including staffing committees (Standard 2)
    - Include a staffing plan to address predictable periods of surge (Standard 7)
- Organizational leaders (finance and nursing) collaboratively allocate resources to staff every hospital unit in accordance with unit-specific staffing guidelines (Standard 2) and ensure that clinical leaders do not receive patient assignments (Standard 4).
- Across all hospital units, organizational leaders align staffing processes with standards set by specialty nursing organizations. (See examples in Appendix 2.)
- Teams engaging in root cause analysis of adverse events, such as incidents of patient harm and episodes of workplace violence, include staffing levels in their assessments.
- Clinical leaders implement routine and recurring assessments of the work environment and regularly plan for improvement based on identified gaps (Standard 4).

SUGGESTED EXEMPLARS, TOOLS, AND RESOURCES

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STANDARD 7

Organizational staffing plans anticipate that critically ill or injured pediatric patients generally require a ratio of at least 1 nurse for every 1 to 2 patients.



ACTIONS

- The decision to staff for a nurse-to-patient ratio of 1 nurse for every 1 to 2 patients is based on objective measures of patient acuity, workload, and the presence of additional on-site support (such as clinical leaders who are present on the unit, child life specialists, therapy services, allied health associates, patient care technicians, or nursing assistants).
- If organizational leaders allocate resources for the delivery of pediatric critical care at ratios in excess of the recommended standard, they demonstrate that this ratio is appropriate by:
    - Routinely soliciting input from clinical leaders and direct care staff
    - Regularly evaluating nursing workload and existing support staff
    - Monitoring patient outcomes (eg, hospital-acquired conditions) and benchmarking against outcomes for similar patient populations in other facilities
- In all settings where pediatric critical care is provided, staffing levels and patient assignments should be adjusted when the needs of patients and families change.
- Clinical leaders and hospital administrators anticipate and advocate for upward adjustment of staffing during predictable periods of high demand for care to ensure that appropriate nurse-to-patient ratios are maintained. For example:
    - Expand contingency staff and/or float pools during winter surges in admissions (eg, for influenza, RSV, COVID-19).
    - Offer flexible short shifts during daily variations in demand for care (eg, high volume from the operating room).

- Clinical leaders and direct care nurses collaborate to develop and routinely evaluate unit-specific criteria for a 2:1 nurse-to-patient assignment and, if appropriate, unit-specific criteria for a 1:3 nurse-to-patient assignment (Standard 2).
- Clinical leaders refer to staffing guidance from pediatric specialty organizations as appropriate; for example, the Society of Pediatric Nurses, the Association of Women's Health, Obstetric and Neonatal Nurses, and the National Association of Neonatal Nurses.

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Clinical leaders and hospital administrators anticipate and advocate for upward adjustment of staffing during predictable periods of high demand for care.

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ABOUT AACN STANDARDS FOR APPROPRIATE STAFFING IN PEDIATRIC CRITICAL CARE

AACN's primary advocacy initiative is dissemination and implementation of *AACN Standards for Establishing and Sustaining Healthy Work Environments*.[3] Created in 2005 and updated in 2016 based on new evidence, the 6 standards provide a framework for building and maintaining systems and units where patients can experience optimal outcomes and nurses can thrive.

In addition to creating resources, leading implementation programs, and offering a free work environment assessment tool, AACN conducts periodic national surveys to measure the health of clinical work environments. On every one of these surveys conducted between 2005 and 2019, nurses consistently gave lower ratings for survey items related to the appropriate staffing standard than for items related to the other standards.[10] On the most recent national survey, conducted in 2021, the item labeled "ensuring an effective match between patient needs and nurse competencies" received the lowest mean rating of any element on any of the surveys conducted to date.[11]

Because of our long-standing commitment to healthy work environments, AACN recognized the imperative to improve acute and critical care staffing well before the COVID-19 pandemic. In 2018, we demonstrated our commitment to address the root causes of inappropriate staffing in *AACN Guiding Principles for Appropriate Staffing* (Appendix 4). At the same time, AACN leaders convened meetings with leaders from 4 other professional organizations: American Nurses Association (ANA), American Organization for Nursing Leadership (AONL), Institute for Healthcare Improvement (IHI), and the Healthcare Financial Management Association (HFMA). Leaders from these organizations knew that effective change required investment from a broad group of stakeholders.

Over the subsequent years, these 5 organizations formed Partners for Nurse Staffing with the aim of identifying barriers and creating effective solutions. The Partners for Nurse Staffing Think Tank launched in January 2022 and was followed by the Nurse Staffing Task Force, which convened from April 2022 through February 2023. These 2 groups comprised diverse professional roles, including direct care nurses, organizational and finance leaders, and subject matter experts. Together, they created recommendations and actions to generate meaningful change in nurse staffing. Both the Partners for Nurse Staffing Think Tank and the Nurse Staffing Task Force recommended that specialty nursing organizations define staffing standards for the patient populations they serve. AACN, as a co-convener of the think tank and the task force, and as the largest specialty nursing organization in the world, embarked on the work of establishing standards for adult critical care settings. Those standards, which build on *AACN Guiding Principles for Appropriate Staffing* (Appendix 4), were co-created with input from diverse segments of our community of nurses.

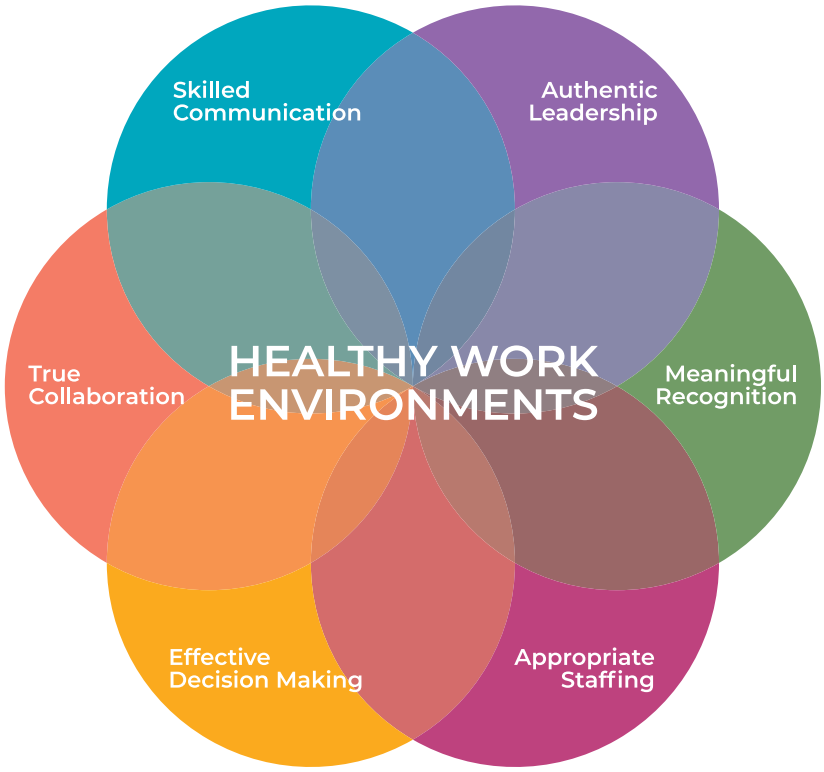

Figure:
The 6 AACN Healthy Work Environment Standards are skilled communication, true collaboration, effective decision making, appropriate staffing, meaningful recognition, and authentic leadership.

HOW WERE THESE STANDARDS DEVELOPED?

In April 2024, AACN published *AACN Standards for Appropriate Staffing in Adult Critical Care* to support direct care nurses, clinical leaders, and health care administrators to operationalize the appropriate staffing standard. Publication of *AACN Standards for Appropriate Staffing in Adult Progressive Care* followed in 2025.

With input from a work group and survey data, AACN developed these 2 documents, which are broadly applicable to the wide variety of settings in which critical care and progressive care are delivered.

In 2024 and 2025, AACN sought the perspectives of pediatric and neonatal critical care nurses on the application of the above standards to their practice. Data collection included a survey of direct care nurses working in pediatric and neonatal critical care and a series of focus group sessions. Through these methods, we determined that the AACN staffing standard statements are a framework that does not depend on patient age or developmental level.

Therefore, we created this version with resources and actions to implement the staffing standards for pediatric critical care. (A summary of the data collected is on page 23.)

WHAT IS THE EVIDENCE TO SUPPORT THESE STANDARDS?

- Inappropriate staffing negatively impacts patients. Cross-sectional and longitudinal studies demonstrate a correlation between hospital staffing levels and patient outcomes.[12,13] AACN's definition of appropriate staffing is a match between patient needs and nurse competencies. One barrier to creating that match is insufficient numbers of nurses. In other words, the ratio of nurses to patients cannot adequately meet the demand for care.

  As AACN past president Beth Wathen stated, "When there aren't enough nurses, there is a point beyond which safe care simply cannot be delivered."[14] In addition to the number of nurses, appropriate staffing depends on an accurate evaluation of patients' and families' needs and the support and time required to meet those needs.[15]

- Inappropriate staffing negatively impacts nurses. AACN's healthy work environment surveys[10,11] and surveys conducted by the American Nurses Foundation[16,17] demonstrate that inappropriate staffing is a common and persistent phenomenon. Nurses identify poor staffing as a reason for intent to leave their current positions, and they select improved staffing as an important factor that would lead them to reconsider leaving.[10,16,17] A systematic review confirms the relationship between nurse staffing and nurse well-being.[18] The association between staffing and nurse turnover creates a vicious cycle and profoundly limits the expertise available to meet the complex needs of acutely ill patients. To break that cycle, we must implement new processes for staffing, such as those described in these standards.

- Attention to improving the work environment is imperative. AACN's national surveys[10,11] demonstrate that nurses working in units that implemented the 6 Healthy Work Environment Standards are more likely to give higher ratings on staffing, quality of care, and many other indicators of unit or organizational health. The correlation between staffing and the overall health of the work environment is also demonstrated in seminal works.[19,20] Each of AACN's standards for a healthy work environment[3] has a discrete definition, and yet the standards are inextricably linked in practice. The action items for each of the staffing standards listed here depend on implementing the other 5 Healthy Work Environment Standards for true transformation to occur.

WHAT INSIGHTS DID WE GAIN FROM OUR COMMUNITY OF NURSES?

Findings from the Standards for Appropriate Staffing in Adult Critical Care Work Group, our survey of pediatric and neonatal critical care nurses, and our focus group sessions include the following:

- While some units are designated to provide pediatric critical care, patients who require this level of care are also cared for in other settings such as medical-surgical units, procedural units, long-term care settings, and at home.
- In pediatric critical care, the workload is frequently impacted by family-centered care and developmental considerations.
- Measurement of the nursing workload is rarely an objective process. When asked which resources would be most helpful when developing standards for appropriate staffing in pediatric care, 82% of survey respondents identified "tools for measuring nursing workload to inform patient assignment decisions." Participants in the pediatric critical care focus groups indicated that tools to measure nursing workload are needed and should be integrated into existing documentation processes in the EHR.
- Nurses, even those in states that require staffing committees, do not consistently have a voice in decisions that affect staffing. In our pediatric staffing standards survey, 21% of respondents indicated that there was no avenue for their voice in staffing decisions, while 78% reported that their engagement occurred through informal conversations with clinical leaders.
- The experience-complexity gap—the phenomenon in which the average experience level of direct care nurses decreases while the complexity of patient care increases—is a key challenge in pediatric critical care units.
- The work group that contributed to *AACN Standards for Appropriate Staffing in Adult Critical Care* identified that a clinical leader, such as a charge nurse, who does not carry a patient assignment, offers crucial flexibility in addressing dynamic patient care needs and supporting direct care nurses. Ninety-four percent of pediatric critical care nurses noted the value of such a leader.
- Inappropriate staffing can potentially exacerbate other challenges that nurses face, such as workplace violence, patient and family dissatisfaction, clinician mental/behavioral health challenges, moral distress, inability to provide essential developmental care to this vulnerable patient population, and documentation burden.

HOW DO THESE STANDARDS ALIGN WITH FINANCIAL PRIORITIES?

These standards describe unit and organizational processes for staffing that center on patient needs. The report, *The Business of Caring: Promoting Optimal Allocation of Nursing Resources*, authored by 3 leaders from Partners for Nurse Staffing, describes how true collaboration between nursing and finance leaders can drive effective administrative staffing decisions.[21] As nurse ethicist Cynda Hylton Rushton has noted, "An organization's budget is a reflection of their ethical values and priorities—what they invest in is what they value most" (email, December 21, 2023). Investing in staffing processes that result in appropriate staffing and thus generate optimal patient outcomes demonstrates alignment between finance and a hospital's mission.

Nurse Staffing Task Force Imperatives, Recommendations, and Actions[22] includes an imperative, "Value the Unique Contribution of Nurses." The recommendations in that imperative include quantifying the value of nursing care and exploring new payment models. In the current payment structure, acute care nursing is paid for as part of the total hospital bill, concealing nurses' crucial contributions to care delivery.[23]

AACN's appropriate staffing standards are intended to support improved processes at the unit and organizational levels. Concurrent reform of system and regulatory processes is also imperative. As described in *AACN Guiding Principles for Appropriate Staffing* (Appendix 4), the industrial model applied to hospital systems fails to acknowledge that health care is entrusted with addressing human suffering—not the production of inanimate goods.

WILL THESE STANDARDS SUPPORT NEW CARE DELIVERY MODELS?

Yes. As described in *AACN Guiding Principles for Appropriate Staffing* (Appendix 4), innovation in care delivery is essential. This priority is also demonstrated in the recommendations in *Nurse Staffing Task Force Imperatives, Recommendations, and Actions*[22] and *Nurse Staffing Think Tank: Priority Topics and Recommendations*.[24] We know that care has become increasingly complex and nursing roles have expanded, so continued use of primary nursing models may be inefficient and merit continued evaluation. The work of the Nurse Staffing Think Tank and Nurse Staffing Task Force is supported by The Joint Commission's addition of appropriate staffing as a National Performance Goal.[25]

In addition to these staffing standards, AACN offers resources such as our tele-critical care nursing practice consensus statement,[26] blogs, and staffing stories that describe the development of new models of care delivery. Key elements in the design of new models of care delivery include ensuring that technology-based strategies reduce nursing workload and having nurses leverage the support of other team members so they can focus on the care that they uniquely provide. Direct care nurses have the best understanding of their unit's workflow and opportunities for improvement. Therefore, the standards listed in this document support direct care nurses' role in leading innovations in care delivery.

DOES STANDARD 7 INDICATE THAT AACN SUPPORTS LEGISLATION TO SET MANDATORY RATIOS?

Standard 7 does not address legislation or regulation. It addresses organizational leaders' decision-making on staffing levels for acute care patients. Clinical leaders, such as charge nurses, who are in the unit and have tools to accurately measure nursing workload (Standard 3), apply unit-level staffing guidelines (Standard 2) and their own clinical judgment to make the best decisions about patient assignments.

When clinical leaders do not take patient assignments (Standard 4), they can maintain a holistic view of the hospital unit, consider the complexity of each patient's needs, and evaluate the competency of each shift's staff. The availability of an adequate number of nurses is vital to a clinical leader's success in aligning patient characteristics with nurse competencies, thus achieving appropriate staffing.

The Nurse Staffing Task Force's imperative, "Establish Staffing Standards That Ensure Quality Care," addresses regulatory and legislative options.[22] Actions to consider for that imperative include the creation of policies that set minimum patient-level ratios or minimum unit-level ratios, policies that mandate public reporting of staffing levels or staffing committees, and policies that protect those who report unsafe staffing. The task force document includes citations for the evidence related to these options.

GLOSSARY

- **Clinical leader**: a broad term that includes but is not limited to nurse managers, educators, clinical nurse specialists, assistant nurse managers, and charge nurses
- **Direct care nurses**: registered nurses who provide care to their assigned patients
- **Neonatal intensive care unit (NICU)**: a unit for premature neonates or other newborns who require specialized critical care
- **Nursing workload**: a measure of the time and support a patient and family require
- **Organizational leaders**: hospital or health system employees who are responsible for the organization's strategic direction and decisions about resource allocation; also called hospital/health system administrators
- **Patient assignment**: the workload given to a nurse or care team during a single shift
- **Patient care team**: health care professionals who are responsible for direct patient care. This team includes unlicensed assistive personnel to whom the nurse may delegate tasks and other team members such as licensed practical nurses, physical therapy, or respiratory therapy with whom the nurse collaborates to carry out the plan of care.
- **Pediatric intensive care unit (PICU)**: a specialized unit to care for critically ill or injured children, from birth to 21 years of age[27]
- **Staffing guidelines**: unit-level policies or procedures that support patient assignment decisions
- **Staffing plan**: an organization's process to determine the number, skills, and competencies of nurses required to provide safe, quality patient care. Staffing plans are developed based on an understanding of the demand for patient care and the resources to meet that demand. The term staffing grid or staffing matrix may be used, especially when the organization has developed an algorithm to determine the number of staff based on the number of patients.

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APPENDIX 1

Strategies for Implementing Standard 1

Adapted from Delgado S. Evidence-based approach to appropriate staffing. *Crit Care Nurse.* 2024;44(6):69–72. doi:10.4037/ccn2024614

- Trust your judgment about what appropriate nurse staffing is.
- Use skilled communication and true collaboration to address staffing concerns.
- Participate in surveys about nurse staffing.
- Join shared governance processes and contribute to the development of unit-level staffing guidelines.
- Support implementing and testing tools that measure nursing workload.
- Leverage empathy in interactions with nurses who are new to your unit, whether they are new graduates, travel nurses, or floating from other settings.
- Collaborate with colleagues to use AACN's Return on Investment Tool (Appendix 3) to build the financial case for investing in healthy work environments.
- Gather a team and use the Partners for Nurse Staffing Think Tank Gap Analysis Tool.
- Review AACN's staffing clinical resources page, which includes stories from nurses sharing their innovative solutions to staffing challenges.
- Advocate for protected time away from patient care responsibilities to participate in staffing committees and other professional development activities, such as charge nurse leadership education.
- Support nurse leaders who seek to improve staffing through changes in onboarding processes and implementation of healthy work environment standards.
- Recognize that healthy work environments are essential to improving nurse retention and that the work environment is composed of the relationships, attitudes, and actions of each person.

APPENDIX 2

Specialty nursing organizations that offer staffing guidance

Academy of Medical-Surgical Nurses (AMSN)

American Nephrology Nurses Association (ANNA)

American Nurses Association (ANA)

American Psychiatric Nurses Association (APNA)

American Society of PeriAnesthesia Nurses (ASPAN)

Association for Professionals in Infection Control and Epidemiology (APIC)

Association of periOperative Registered Nurses (AORN)

Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)

Emergency Nurses Association (ENA)

National Association of Neonatal Nurses (NANN)

Society of Pediatric Nurses (SPN)

APPENDIX 3

AACN's Healthy Work Environment Appropriate Staffing Return on Investment Tool*

When a unit or department invests in a new program or quality improvement project, hospital leaders need to know what kind of financial return the investment will yield. A return on investment (ROI) analysis is a way to calculate net financial gains (or losses) while considering the resources invested.

This planning tool provides a step-by-step guide to calculate the ROI associated with implementing AACN's Healthy Work Environment Standards in your unit or hospital. This tool examines the specific relationship between inadequate staffing, nurse turnover, and various other factors that might be at play in an unhealthy work environment.

A. EXPENSES RELATED TO TURNOVER

Use orientation costs to demonstrate the money lost related to nurse turnover. These are the dollars spent when new staff are being introduced to the unit environment and have not yet been included in the daily staffing plan. *Include these costs only if the employee left the organization before their two-year anniversary.*

Orientation cost for new employee:		**$**
If more than one employee, multiply by that number: *Use a one-year time frame*	**X**	
Total Orientation Cost (due to turnover)**:**	**=**	**$**

B. INCREMENTAL EXPENSES TO BACKFILL OPEN POSITIONS

Agency costs to backfill open positions can be expensive. Calculate money lost when new positions are not approved or cannot be filled. *Use incremental cost only.* **(Example: If the hospital pays the agency $75/hour, the average nurse wage is $40/hour. $75 - $40 = $35/hour. $35 is the incremental cost.)**

Agency costs:		**$**
Number of hours: *Use a one-year time frame (one full-time person = 2,080 hours; adjust for your facility.*	**X**	
Total Agency Cost:	**=**	**$**

C. INCREMENTAL COSTS RELATED TO OVERTIME

Calculate expenses associated with overtime to backfill open positions. *Use the difference between the average hourly salary and the increased hourly cost of overtime to determine the incremental cost.*
For example, if a nurse makes $40/hour, the overtime cost is $60/hour. $60 - $40 = $20/hour. $20 is the incremental cost associated with overtime.

Overtime costs: *Use the differential hourly cost difference*		**$**
Number of hours: *Use a one-year time frame*	**X**	
Total Overtime Costs:	**=**	**$**

D. LOST REVENUE DUE TO CLOSED BEDS

When beds are closed due to inadequate staffing, hospitals lose money. Collaborate with the finance department to determine the revenue generated by filling vacant beds.

Dollar amount finance uses for income per occupied bed:		**$**
Number of beds closed due to inadequate staffing: *Use a one-year time frame*	**X**	
Total Dollar Amount of Lost Revenue:	**=**	**$**

E. OTHER EXPENSES

Consider using any other costs that can be directly attributed to an unhealthy work environment. These costs may be associated with:

- Excessive sick calls
- Costs attributed to losing nurse applicants who do not accept an offer due to the hospital's reputation
- Costs associated with **"never events"** and hospital-acquired conditions

Additional costs of an unhealthy work environment: *Use a one-year time frame*	**=**	**$**

F. TOTAL ANNUAL EXPENSE

Add all the costs to determine the hospital's total annual expense due to an unhealthy work environment.

	+		**+**		**+**		**+**		**+**		**=**
A		**B**		**C**		**D**		**E**		**F**	

G. EXPENSES TO IMPROVE THE WORK ENVIRONMENT

Determine expenses that will be required to improve the work environment. These may include costs that can be related to paid committee or training time, project supplies and unit-led initiatives. Include this information when you describe the losses related to an unhealthy work environment.

CALCULATING A RETURN ON INVESTMENT

To calculate the ROI for a Healthy Work Environment initiative, use the following formula (Note: ROI is reflected as a percentage and is therefore multiplied by 100):

Total Benefit (Savings) - Total Cost (Expenses) ÷ Total Cost (Expenses) = Return on Investment

Insert the corresponding fields you calculated.

Here the Total Annual Expense/Savings corresponds to section F. This is the money that could be saved by having a healthy work environment with appropriate staffing.

Total Annual Expense/Savings		Expenses to Improve the Work Environment		Expenses to Improve the Work Environment		
	-		÷		x 100 =	
F		G		G		

When an ROI is greater than or equal to one, the returns generated by an improvement are greater than or equal to the costs for the project's development and implementation. If the ROI is greater than one, it is considered to be positive. For example, an ROI of 1.8 indicates that for every $1 invested in the quality improvement project, $1.80 will be gained for the hospital.

With an ROI of less than one, the improvement actions yield a net loss. If the ROI is less than one, it is considered to be negative. For example, an ROI of -1.5 indicates that for every $1 invested, the hospital will lose $1.50.

When an ROI is less than one, but not a negative number, the hospital still loses money. For example, an ROI of 0.8 indicates that for every $1 invested, 80 cents will be recouped by the hospital. In other words, the hospital loses 20 cents for every $1 spent on the project.

OTHER CONSIDERATIONS

Use the 2025 *NSI National Health Care Retention & RN Staffing Report* for national averages related to turnover, RN vacancies, and workforce projections.

Do not include the following fixed costs, which are constant in an organization.
• Nurse recruitment • Management • Charge nurses • Regular staff in the unit • Supplies • Education

**AACN thanks Nancy Blake, PhD, RN, CCRN, NEA-BC, NHDP-BC, FACHE, FAONL, FAAN, for creating this tool to share with our AACN community.*

APPENDIX 4

AACN Guiding Principles for Appropriate Staffing, 2018

BACKGROUND

Nurses are essential to the successful delivery of health care, and appropriate nurse staffing is key to optimal patient care and overall patient/family satisfaction.[1,2] Nurse staffing has been an enduring challenge, and the prevailing model is outdated and unable to meet the needs of patients, families, and the nurses who care for them.

The American Association of Critical-Care Nurses (AACN) has long been concerned about the nurse staffing challenge and has produced influential resources to advance widespread implementation of appropriate staffing. Two of these resources are the AACN Synergy Model for Patient Care[3] and *AACN Standards for Establishing and Sustaining Healthy Work Environments*,[4] which defines the standard for appropriate staffing. AACN's focus on staffing supports our vision, which is to create a health care system driven by the needs of patients and families where acute and critical care nurses make their optimal contribution. AACN has not been alone in these efforts, other nursing organizations and thought leaders have endeavored to solve the staffing challenge as well.

Appropriate staffing is a comprehensive, dynamic process that ensures patients receive optimal levels of care. It aligns patient needs, nurse abilities, workload, technology, and collaboration with other disciplines, the health of the work environment, and many other factors.[4] There is no one-size-fits-all answer, and the staffing challenge has defied systemic solutions. Bold steps are needed to reimagine and transform this enduring and complex issue.

PRINCIPLES

AACN asserts the following principles are essential to chart a clear course toward new staffing solutions. With these principles, we advance a call to action and invite stakeholders with shared missions in patient safety and health care quality to join us in forging innovative, collaborative solutions.

1. Nurses are essential to the successful delivery of health care.
Nurses constitute the largest body of health care practitioners and provide more direct care than any other profession. Nurses assess, develop, deliver, and optimize plans of care. They are a linchpin of the hospital health care team. Nurses make unique and vital contributions to optimal patient outcomes, higher patient and family satisfaction,[1,5] and lower morbidity and mortality.[6,7,8,9]

APPENDIX 4 (CONT'D)

2. Appropriate nurse staffing is crucial for optimal patient care.
Appropriate staffing ensures the effective match between patient and family needs and nurse knowledge, skills, and abilities. Evidence confirms that the likelihood of serious complications[7] or death increases when fewer registered nurses are assigned to care for patients.[8,10] A substantial body of evidence indicates better patient outcomes occur when registered nurses provide a higher proportion of care hours in healthy work environments.[6,11,12,13]

3. Appropriate staffing is inextricably linked to healthy work environments.
Healthy work environments are safe, healing, humane, and respectful of the rights, responsibilities, needs, and contributions of all people—including patients, their families, nurses, and other health care professionals. Studies show that investing solely in staffing resources in the absence of a healthy work environment is ineffective.[9,14,15]

4. Higher nurse job satisfaction, which leads to lower staff turnover, is closely tied to appropriate staffing.
Nurses can experience intense stress when staffing resources don't meet patient care demands. Inadequate staffing contributes to nurse dissatisfaction, burnout, compassion fatigue, and turnover.[16,17] Collaboration between hospital administrators and the professional nursing staff to achieve appropriate staffing can contribute to less turnover, improved quality of care, greater patient/family satisfaction, increased hospital financial viability, and decreased patient costs.[15]

5. The creation of appropriate staffing plans requires a nimble, comprehensive approach.
The conditions of critically ill patients fluctuate rapidly and continuously. Because of this, it is imperative that nurse staffing decisions go beyond fixed nurse-to-patient ratios. Appropriate staffing requires nurses to be involved in all aspects of staffing, from planning to evaluation. It aligns patient needs, complexity, and acuity with nurse knowledge, skills, and abilities. It also considers numerous human and technological factors and the health of the work environment. Appropriate staffing requires flexible systems and tools, dynamic scheduling options, and influential, educated leaders accountable for the outcomes of staffing decisions.

6. Progress on appropriate staffing advances national patient safety and quality goals.
The Institute of Medicine's landmark report, *To Err is Human: Building a Safer Health System*, created a national agenda intended to reduce health care errors and improve patient safety.[18] There has been progress toward these goals, but much more is needed—and appropriate staffing can make a significant impact. Evidence indicates that, in the presence of a healthy work environment, a reduction in registered nurse workload is associated with reduced mortality and failure to rescue,[6,12,14] reduced hospital readmission rates,[19,20] and fewer other adverse events such as medication errors, hospital-associated pressure injuries, and patient falls with injury.[7]

7. The complex challenge of appropriate staffing will require bold and innovative solutions.
Organizations must embrace dramatic innovation to devise and systematically test new staffing models. This includes allocated time for nurses to collaborate away from direct patient care in order to identify opportunities for improvement and create solutions to care delivery challenges. These models must require methods for ongoing evaluation of staffing decisions in relation to patient and system outcomes.[21,22,23] Evaluation is essential to provide accurate trend data for identifying targeted improvement tactics, including technologies to reduce the demand for and increase the efficiency of nurses' work.

8. A new paradigm is needed that reflects the full value nurses bring to patient care and recognizes nurse staffing as an investment.
When hospital operating structures emulate the traditional industrial model and view nurse staffing as an operating cost, hospitals can feel like factories. Nurses are highly skilled, well-educated health care professionals, who presently work in a financial model that treats them like hourly laborers.

When regarded as an investment, appropriate nurse staffing is recognized as essential to financial viability because it ensures better outcomes, patient safety, and patient/family satisfaction. New ways of thinking and transformative staffing models could fully leverage this vital investment in nurses.

OUR CALL TO ACTION

Meaningful and sustainable change to traditional staffing models is a moral imperative that requires urgent collaborative action. Nurses, interdisciplinary teams, health care executives, safety leaders, payers, and patients must come together to create new and dynamic ways to approach appropriate staffing. This is a high-stakes, high-urgency issue but, because staffing issues are so complex, there is a tendency toward the status quo. Collaborative action can produce optimal patient outcomes, lower nurse turnover, higher patient and family satisfaction, and improved financial viability for hospitals.

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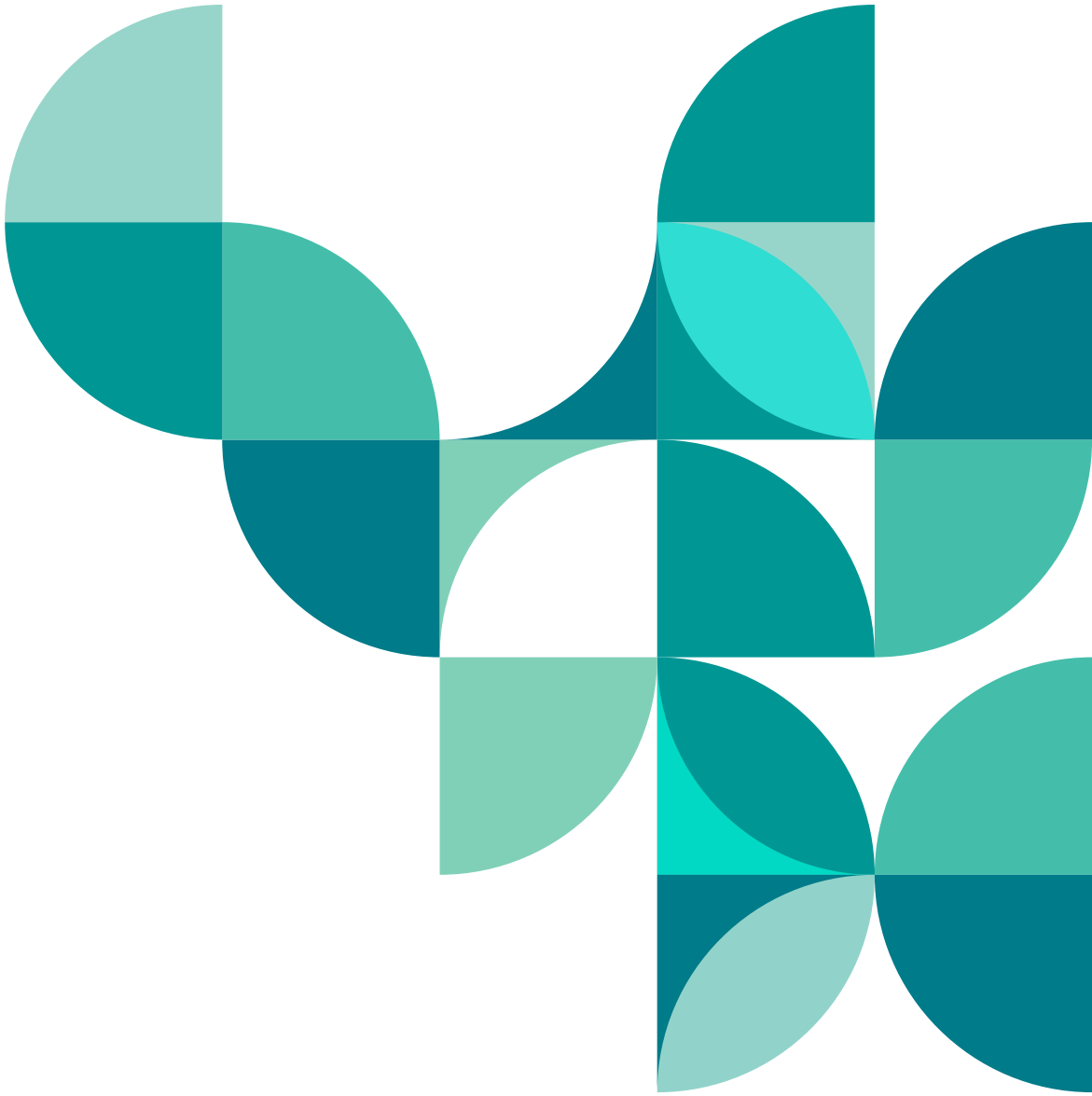

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