Results of the 2015 AORN Salary and Compensation Survey

DONALD R. BACON, PhD; KIM A. STEWART, PhD

ABSTRACT

AORN conducted its 13th annual compensation survey for perioperative nurses in June and July 2015. A multiple regression model was used to examine how a number of variables, including job title, education level, certification, experience, and geographic region, affect nurse compensation. Comparisons between the 2015 data and data from previous years are presented. The effects of other forms of compensation (eg, on-call compensation, overtime, bonuses, shift differentials, benefits) on base compensation rates also are examined. Additional analyses explore the effect of the economic downturn on the perioperative work environment. AORN J 102 (December 2015) 561-574. © AORN, Inc, 2015. http://dx.doi.org/10.1016/j.aorn.2015.10.008

Key words: nurse salaries, compensation, economy.

From late June to early July 2015, AORN surveyed its members and some nonmembers to examine the status of perioperative nursing compensation in the United States. This market research study tracks compensation changes on a yearly basis and seeks to identify factors that influence how much perioperative nurses are presently paid. The survey also addressed potential nursing turnover and the reasons why some nurses are actively considering leaving their jobs.

RESPONDENT PROFILE

In mid-June, 50,836 potential respondents (including 32,782 AORN members) received an electronic invitation to participate in the survey. As an incentive, participants were eligible to enter a raffle for a $100 gift card. By mid-July, 4,310 unique responses were received. Because the focus of this survey is perioperative nursing compensation, respondents who did not answer key compensation-related questions were excluded. This criterion reduced the usable sample to 3,641 individuals, for a 7.2% net response rate. The final sample is 6% larger than the 2014 sample.

As shown in Figure 1, 46% of the respondents are staff nurses, 20% are managers (ie, nurse manager, supervisor, coordinator, team leader, business manager), 12% are high-level managers (ie, director, vice president [VP], assistant director of nursing) or hospital/facility administrators, 6% are educators (ie, faculty or staff development), 5% are charge nurses, 4% are RN first assistants (RNFAs), and 2% are clinical nurse specialists. Less than 1% are nurse practitioners or consultants.

Some of the demographic information from the sample is represented in Figure 2. Approximately 36% of the respondents are in their 50s, 23% are in their 40s, 18% are in their 30s, 8% are younger than 30 years of age, and 14% are at least 60 years of age. Approximately 89% of the sample is female. Hourly-paid employees comprise 68% of the sample, and 32% are salaried employees. Most of the respondents work in acute care hospitals (73%), and 27% work in an ambulatory surgery center (ASC), whether it be hospital based (14%), free-standing (11%), or office based (2%). Approximately 57% of the sample have more than 20 years of experience in perioperative nursing, and 27% have more than 25 years of experience. Approximately 23% of the respondents have from 11 to 20 years of experience in perioperative nursing and 40% have 10 or fewer years of experience, which is 6% larger than in the 2014 sample. Additionally, approximately 80% work in an urban or
suburban area and approximately 20% work in a rural location. Overall, the respondents’ demographic profile is quite similar to the 2014 sample.

Geographically, the sample is well dispersed across the country. As shown in Table 1, approximately 22% of the respondents live in the upper eastern coastal region (ie, New England and the Mid-Atlantic), 16% reside in the South Atlantic region, 28% are located in the East North Central and West North Central regions, 15% reside in the East South Central and West South Central regions, and 20% are located in the Mountain and Pacific regions.

Approximately 48% of the respondents have a bachelor’s degree in nursing, 6% have a bachelor’s degree in another field, and 27% have a diploma or associate degree. Approximately 11% of respondents have a master’s degree in nursing, 2% of respondents have a master’s degree in business administration, and 4% have a master’s degree in another field. Approximately 1% have a doctorate in nursing or in another field, and 2% have some other type of degree (Table 2).

**BASE COMPENSATION**

We performed statistical analyses to identify which factors have the most influence on perioperative nursing compensation. It should be noted that the sample is not perfectly random because the net response rate was modest (7.2%). Still, the sample is sufficiently representative of the perioperative nurse population that statistical tests can provide insight. A summary of the salary findings, categorized by job title and size of facility, is shown in Table 3. This analysis and the salary analyses that follow include only nurses who were employed full time in the United States at the time they took the survey. Facilities are categorized as small or large based on a median split of the number of ORs reported, with small defined as 10 or fewer ORs and large defined as more than 10 ORs. These findings show the calculated average compensation for nurses who spend an average amount of time on direct patient care for their title. As can be seen, nurses generally receive more compensation in larger facilities.

On closer examination, the relationship between facility size and compensation may also be influenced by facility type. Table 4 shows how the average number of ORs varies by facility type and how the number of ORs is related to staff nurse compensation. Taking facility size into account, university or academic facilities tend to be larger than other facility types.

The challenge in understanding perioperative nursing compensation is in estimating the simultaneous influence of the many different variables that can affect compensation. We used multiple regression as the primary analytical tool in this study because so many variables are involved. The multiple regression model makes it possible to estimate the effects of one variable on compensation while statistically holding the other variables constant. The influence of each variable can then be identified independently of the others. For the analysis, we used hierarchical regression by entering the variables expected to explain the most variance into the model first and then entering the less important variables. We entered several variables with related effects initially and simultaneously. These variables are...
job title,
facility type,
facility size,
facility ownership,
population setting (ie, urban, suburban, rural),
geographic region, and
percentage of time spent on direct patient care.

State was only entered for states with 50 or more respondents. We then entered other variables one at a time. These secondary variables are

- years of work experience,
- compensation basis,
- certification,
- education level,
- participation in a collective bargaining unit,
- household status, and
- gender.

To obtain the most reliable results, we limited the sample for the regression analyses to respondents who are full-time employees and who work in the United States. We eliminated statistical outliers (eg, unusually high or low pay reported by a very small number of nurses) to avoid skewing the results. We conducted checks to ensure that the statistical assumptions behind the regression model were met (eg, linear relationships and normally distributed errors). The final model explains 63% of the variation in base compensation.

What follows is an overview of the results concerning each variable included in the regression analysis that was found to
be significantly related to base compensation level. All variables were significant at the $P \leq .05$ level. Readers can obtain the estimates of compensation for any particular nursing position by using the compensation calculator on the AORN web site at http://www.aorn.org/CareerCenter/SalarySurvey (accessed September 4, 2015).

### Job Title

More than any variable, differences in job title are linked to differences in base compensation. The average staff nurse, for example, earns $68,600 ($800 more than in 2014), and the average VP/director of nursing earns $112,800 ($2,100 more than in 2014). Note that we combined VPs, assistant VPs, directors, and assistant directors for this longitudinal analysis to allow comparisons with prior years. Part of the difference in salary across titles is explained by the difference in the percentage of time spent in direct patient care versus the percentage of time spent on other tasks, such as management or administration.

To explore the trends in compensation for nurses and nurse managers over time, we combined data from 13 years of AORN salary surveys. Figure 3 shows that staff nurses and directors/VPs/assistant directors of nursing have generally seen increases in average base compensation. The overall annual rate of growth has been similar for staff nurses (2.6%) and for directors/VPs/assistant directors of nursing (2.4%). For comparison, the average annual inflation rate is 2.2% over the past 13 years. Thus, during this time period, base compensation of staff nurses averaged a 0.4% raise above inflation and of directors/VPs/assistant directors of nursing averaged a 0.2% raise above inflation.

On average, staff nurses spend 89.5% of their time delivering direct patient care (a 1.7% increase over 2014) and nurse managers spend 39.8% of their time providing direct care (a 2.2% increase over 2014). As expected, high-level managers average a relatively small amount of time on patient care (18.5% for facility/hospital administrators [a 2.1% increase over 2014] and 18.7% for directors/VPs/assistant directors of nursing [a 2.6% increase over 2014]). In the past five years, the average time spent in direct patient care has increased 6% among managers, 3.9% among directors and assistant directors of nursing, and 1.5% among staff nurses. The time has declined by less than 1% among hospital/facility administrators. Lastly, the percentage of time spent in direct patient care varies among nurses with the same title. For example, some nurse managers

---

**Table 1. Geographic Location of Respondents**

<table>
<thead>
<tr>
<th>Region</th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New England (New Hampshire, Vermont, Maine, Connecticut, Rhode Island, Massachusetts)</td>
<td>210</td>
<td>5.8</td>
</tr>
<tr>
<td>Mid-Atlantic (New Jersey; Delaware; Maryland; Pennsylvania; New York; Washington, DC)</td>
<td>573</td>
<td>15.7</td>
</tr>
<tr>
<td>South Atlantic (West Virginia, Virginia, North Carolina, South Carolina, Georgia, Florida)</td>
<td>579</td>
<td>15.9</td>
</tr>
<tr>
<td>East North Central (Wisconsin, Michigan, Illinois, Indiana, Ohio)</td>
<td>698</td>
<td>19.2</td>
</tr>
<tr>
<td>West North Central (North Dakota, South Dakota, Minnesota, Nebraska, Iowa, Kansas, Missouri)</td>
<td>322</td>
<td>8.8</td>
</tr>
<tr>
<td>East South Central (Kentucky, Tennessee, Mississippi, Alabama)</td>
<td>152</td>
<td>4.2</td>
</tr>
<tr>
<td>West South Central (Oklahoma, Arkansas, Texas, Louisiana)</td>
<td>380</td>
<td>10.4</td>
</tr>
<tr>
<td>Mountain (Montana, Idaho, Wyoming, Nevada, Utah, Colorado, Arizona, New Mexico)</td>
<td>280</td>
<td>7.7</td>
</tr>
<tr>
<td>Pacific (Alaska, Washington, Oregon, California, Hawaii)</td>
<td>447</td>
<td>12.3</td>
</tr>
<tr>
<td>Total</td>
<td>3,641</td>
<td>100.0</td>
</tr>
</tbody>
</table>

**Table 2. Respondents’ Education Levels**

<table>
<thead>
<tr>
<th>Education</th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diploma</td>
<td>205</td>
<td>5.6</td>
</tr>
<tr>
<td>Associate degree</td>
<td>780</td>
<td>21.4</td>
</tr>
<tr>
<td>Bachelor’s degree in nursing</td>
<td>1,732</td>
<td>47.6</td>
</tr>
<tr>
<td>Bachelor’s degree in another field</td>
<td>211</td>
<td>5.8</td>
</tr>
<tr>
<td>Master’s degree in nursing</td>
<td>408</td>
<td>11.2</td>
</tr>
<tr>
<td>Master’s degree in another field</td>
<td>136</td>
<td>3.7</td>
</tr>
<tr>
<td>Master of business administration</td>
<td>69</td>
<td>1.9</td>
</tr>
<tr>
<td>Doctorate in nursing</td>
<td>22</td>
<td>0.6</td>
</tr>
<tr>
<td>Doctorate in another field</td>
<td>5</td>
<td>0.1</td>
</tr>
<tr>
<td>Other</td>
<td>71</td>
<td>2.0</td>
</tr>
<tr>
<td>Total</td>
<td>3,639</td>
<td>100.0</td>
</tr>
</tbody>
</table>
spend as much time on direct patient care as does the average staff nurse, whereas other nurse managers spend as little time on patient care as the typical director or VP.

**Facility Type**

The regression model indicates several differences in base compensation related to facility type. Hospital-based nurses often receive more compensation, whereas nurses in ASCs receive less compensation. This year, nurses in office-based ASCs received $10,600 less than other nurses in general and nurses in free-standing ASCs received $4,500 less. Nurses in specialty hospitals received $2,700 more and nurses in university/academic medical centers received $1,300 more than nurses in general/community hospitals.

**Facility Size**

The size of the facility is an important differentiator in nursing compensation. This difference is particularly pronounced for those who work in higher-level management positions. After controlling for facility type, hospital/facility administrators, chief nursing officers, directors/assistant directors of nursing, and VPs/assistant VPs earn on average $1,800 more per OR in the facility. This difference may be due to the greater number and range of responsibilities that these upper-level positions entail. No statistically significant relationship was found between staff nursing compensation and facility size. Such is the case because different types of facilities (eg, acute care hospitals compared with ASCs) also differ in size; thus, after facility type is considered, facility size makes little difference for nurses.

**Facility Ownership**

Approximately 3% of the sample is employed by government/federal hospitals. The findings indicate that nurses in these facilities earn $7,000 more than nurses in facilities with different ownership structures (eg, non-government, non-profit). This year, we also asked respondents whether their facility is part of a larger network. Approximately two-thirds (68%) are so employed, and these nurses receive $2,000 more per year than nurses in non-network facilities.

**Population Setting**

The location of the facility (ie, urban, suburban, rural) substantially influences base compensation. Nurses in rural settings earn an estimated $6,000 less per year than if they were employed in a suburban or urban setting.

**Geographic Region**

Controlling for all variables previously discussed, geographic region explains significant differences in base compensation.
across the United States. Nurses in the Pacific region receive $18,200 more than the average staff nurse. The other regions with higher incomes are New England ($10,600 more), Mid-Atlantic ($11,200 more), and Mountain ($5,000 more).

Nurses also reported the specific state where they reside. Our total sample is large enough that meaningful estimates for state differences could be made for many states. Only states with more than 50 respondents were examined for state-specific effects. Of the 27 states with sufficient sample sizes, 11 states showed significantly different effects than their region would otherwise suggest. The states requiring specific adjustments and those adjustments are shown in Table 5. After adjusting for region, compensation in these states should be adjusted again for the respective state effect. For example, nurses in New England make $10,600 more than the model estimate, and nurses in Massachusetts make an additional $27,600 on top of that, for a total of $38,200 more in combined region and state effects. Consequently, nurses in Massachusetts are among the best paid in the nation.

### Time Spent on Direct Patient Care

Nurses in a particular position who spend more or less time than the average for direct patient care in that position should expect to receive different base compensation than the amounts shown in the table. On average, staff nurses earn approximately $400 more per year than the average staff nurse for each 10% decrease in time spent on direct patient care per week and, correspondingly, for each 10% increase in time spent doing managerial tasks. This relationship is the same for nurse managers, educators, RNs, nurse practitioners, private scrub nurses, and other nurses. Hospital/facility administrators, VPs/assistant VPs, and directors/assistant directors of nursing earn approximately $600 more per year for each 10% increase in time spent on managerial tasks and, correspondingly, $600 less per year for each 10% increase in time spent on direct patient care.

### Table 5. States With Adjustments Different From Their Regions

<table>
<thead>
<tr>
<th>State</th>
<th>Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>$27,600</td>
</tr>
<tr>
<td>California</td>
<td>$16,400</td>
</tr>
<tr>
<td>Minnesota</td>
<td>$14,900</td>
</tr>
<tr>
<td>New Jersey</td>
<td>$8,500</td>
</tr>
<tr>
<td>Texas</td>
<td>$5,600</td>
</tr>
<tr>
<td>Illinois</td>
<td>$4,100</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>$3,600</td>
</tr>
<tr>
<td>Louisiana</td>
<td>$5,600</td>
</tr>
<tr>
<td>Tennessee</td>
<td>$6,500</td>
</tr>
<tr>
<td>Iowa</td>
<td>$7,300</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>$7,600</td>
</tr>
</tbody>
</table>
Work Experience
The regression model suggests that nurses generally see larger increases related to experience early in their careers compared with later in their careers. For example, the increase in base compensation from the first to the second year is close to $1,300, but the jump from the 25th to the 26th year is only approximately $300. In this sample, the average nurse has 16 years of experience (one year less than the 2014 sample). Nurses with more or less than this amount of experience should add or subtract some compensation amount per year of experience to estimate their base compensation. Interestingly, hospital/facility administrators, chief nursing officers, directors/assistant directors, and VPs/assistant VPs earn approximately $500 per year of experience, and this positive relationship continues through 30 years of experience. On average, these individuals reported 22 years of work experience (unchanged from 2014).

Compensation Basis
The compensation survey generally finds that whether a nurse is paid by hourly rate or salary is related to base compensation, with salaried nurses earning approximately $1,900 more than hourly-paid nurses.

Certification
The survey asked about 17 types of certification:

- BC (board certified),
- CASC (certified administrator surgery center),
- CCRN (critical care RN),
- CIC (certification in infection prevention and control),
- CNOR® (certified OR nurse),
- CRNFA® (certified RNFA),
- CPAN (certified peri-anesthesia nurse) and/or CAPA (certified ambulatory perianesthesia nurse),
- CPSN (certified plastic surgical nurse),
- CNA (certified in nursing administration),
- CNAA (certified in nursing administration advanced),
- CPN (certified pediatric nurse),
- CST (certified surgical technologist),
- NE-BC (nurse executive board certified),
- ONC (certified orthopedic nurse),
- CNS (clinical nurse specialist), and
- NP (certified nurse practitioner).

Of all these certifications, only two certifications were held by more than 50 respondents: CNOR (1,898 nurses) and CRNFA (69 nurses). This year, only one of these two certifications was significantly associated with higher compensation. Staff nurses with CNOR certification earned $2,100 more than other nurses. The other certification counts were considered too small to provide reliable results.

Approximately 41% of the respondents said that their facility pays more for holding a nursing certification (approximately the same percentage as in the past two years). Approximately 90% of these respondents said that they receive extra compensation for CNOR, 37% mentioned CCRN, 32% mentioned CPAN and/or CAPA, 23% mentioned CRNFA, 13% mentioned NP, 18% mentioned ONC, 11% mentioned CNS, and 10% or fewer respondents mentioned other certifications. These percentages are similar to those reported in 2014.

Thus, while the regression model did not show large differences in pay related to certification, a substantial number of nurses reported that their facility pays for certification. To gain more insight, we asked nurses in this paid-for-certification subsample whether the certification pay was in addition to base pay or a one-time bonus. Less than half (41%) of the nurses reported that the pay was in addition to their base pay, and 20% reported that the pay was an annual bonus. The remainder of our sample (39%) provided a variety of responses, including a one-time bonus or better opportunities for promotion.

Although it appears that some nurses receive extra compensation for a variety of certifications, this compensation often varies by hospital. Also, nurses with some certifications, such as CNOR, may find work in facilities that offer more compensation, or they may spend more time on management tasks. After we control for facility type and time spent on direct patient care, the effect of certification on compensation by itself is less pronounced.

Education Level
Nurses with a master’s degree in nursing receive an additional $4,100 in annual base compensation, and nurses with a master’s degree in science in another field receive an additional $5,700 in base compensation. This year, we specifically asked about having a master of business administration degree. Although only 2% of our sample had a master of business administration degree, these nurses were found to receive $6,700 more than other nurses. No other significant differences in compensation related to education were found in this year’s sample. When asked directly, 28% of the respondents said that their facility pays more for having a degree in nursing.

It may seem surprising that other levels of education have so little effect on compensation in this analysis, but it should be noted that the analysis has already controlled for job title, and a nurse’s education level may well affect the level of
responsibility attained. Table 6 provides an analysis of education by the positions of nurses, nurse managers, and directors or assistant directors of nursing. Those with higher-paying jobs, especially directors, are less likely to have only a diploma or associate degree and are more likely than staff nurses to have a master’s degree in nursing, a master’s degree in business administration, or a master’s degree in another field. Thus, although level of education does not always have a strong direct effect on compensation for nurses with the same title, education may well affect the title each nurse holds.

Collective Bargaining Unit
Approximately 12% of respondents reported working in an environment with a union or collective bargaining unit (unchanged since 2013). Staff nurses working in a unionized setting earn an average $8,600 more in base compensation than do nurses employed in a nonunion workplace ($9,200 in 2014, $7,000 in 2013, and $6,100 in 2012). Our analysis suggests that this increase in pay may not hold for all job titles (eg, nurse managers or directors), but the data did not include enough respondents of each title in union and nonunion settings to form firm conclusions.

Household Status and Gender
In the past several years, nurses with fewer commitments outside of work received a higher base wage. In some years, any nurse with children in the home was found to earn less money than other nurses. This year, women (but not men) with children in the home earned $900 less than other nurses.

In past years, gender was not always significantly related to nursing compensation, and we concluded that the effect was inconsistent and small relative to the other factors that influence perioperative nursing compensation. However, this year, the gender-compensation relationship was significant, with men on average receiving $4,200 more than women respondents. Men have significantly outearned women in four of the past five years ($3,200 in 2014, $2,800 in 2012, $3,300 in 2011, and $2,700 in 2010). The size of the difference in compensation this year is noteworthy and, coupled with the emergent trend, leads us to conclude that gender differences are related to perioperative nursing compensation.

Other Variables
As a cautionary note, the results from the complete regression analysis represent general patterns and do not address several variables that can affect compensation, such as the unique needs of facilities, interpersonal skills, and leadership ability. The results are generally accurate enough that two-thirds of nurses or managers who fit a particular profile will have a base compensation within $15,700 of the base compensation estimated by the model.

In questions unrelated to the regression model, 72% of the respondents said they received a raise this year, compared with 70% in 2014 and 71% in 2013. The mean year-over-year pay raise for staff nurses is 2.7%. The highest raise (4.1%) was seen for RNFAs, and directors and assistant directors of nursing averaged a 3.3% raise, the second-highest raise across the eight groups. Table 7 shows the average pay raises during a seven-year period (2009–2015) by job title. Average pay raises are shown for job titles with at least 30 respondents.

OTHER FORMS OF COMPENSATION
The regression analysis previously described applies to base compensation. In the present sample, 63% of the respondents

<table>
<thead>
<tr>
<th>Table 6. Education by Selected Job Titles</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Education</strong></td>
</tr>
<tr>
<td>Diploma</td>
</tr>
<tr>
<td>Associate degree</td>
</tr>
<tr>
<td>Bachelor’s degree in nursing</td>
</tr>
<tr>
<td>Bachelor’s degree in another field</td>
</tr>
<tr>
<td>Master’s degree in nursing</td>
</tr>
<tr>
<td>Master’s degree in another field</td>
</tr>
<tr>
<td>Master’s degree in business administration</td>
</tr>
</tbody>
</table>
received additional compensation from a variety of sources, including on-call compensation, overtime, bonuses, shift and other differentials, and benefits (unchanged since 2014). The amount of additional pay differs substantially by title. The average percentage of additional compensation by job title is shown in Figure 4. As shown, RNFAs (13.6%) received the largest additional compensation relative to base pay, followed by charge nurses (12%), hospital/facility administrators (11%), and staff nurses (9.8%). Educators and staff development employees received the smallest additional compensation relative to base pay (3.3%).

### On-Call Compensation

More than half of the respondents (56%) report that they are on call, compared with 56% in 2014 and 54% in 2013. The median number of hours per week on call is 15, down from 16, which was reported in the past 10 surveys. Among the

---

**Table 7. Mean Pay Raises by Job Title**

<table>
<thead>
<tr>
<th>Job Title</th>
<th>Percentage (%) of Pay Raise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff nurse</td>
<td>3.1</td>
</tr>
<tr>
<td>Hospital/facility administrator</td>
<td>5.3</td>
</tr>
<tr>
<td>Director/vice president/assistant director of nursing</td>
<td>3.8</td>
</tr>
<tr>
<td>Nurse manager/supervisor/coordinator/team leader/business manager</td>
<td>3.4</td>
</tr>
<tr>
<td>Educator/staff development</td>
<td>3.0</td>
</tr>
<tr>
<td>Clinical nurse specialist (master’s degree or higher)</td>
<td>3.0</td>
</tr>
<tr>
<td>RN first assistant</td>
<td>2.8</td>
</tr>
<tr>
<td>Other</td>
<td>3.2</td>
</tr>
</tbody>
</table>

Data are not available for the category indicated by the asterisk. Results are shown only for job titles with 30 or more respondents. Vice presidents and business managers were excluded from the 2015 analysis because of a small sample size.

---

![Figure 4. Mean percentage of additional compensation by job title.](image-url)
on-call respondents, 68% receive a dollar-per-hour amount for being on call (65% in 2014), 7% receive a percentage of their base pay (6% in 2014), and 14% receive no compensation.

Among those who receive dollar-per-hour pay, the median pay is $3.50 per hour. If called in, 60% receive time-and-a-half pay (57% in 2014 and 55% in 2013), 8% receive no additional compensation beyond that for being on call, and 12% get straight-time pay if they worked less than 40 hours that week and time and a half if they worked more than 40 hours. Instead of pay, 3% of the on-call respondents receive compensation time.

Overtime Compensation
A large majority of respondents work overtime (87%), averaging 5.6 hours each week. Approximately 77% of those who work overtime receive time-and-a-half pay (61% last year), but 13% receive no additional compensation. Approximately 93% of those not compensated are salaried employees. As shown in Table 8, directors/assistant directors of nursing average the most overtime at 9.9 hours (8.5 hours in 2014), followed by nurse managers (7.4 hours, compared with 6.0 in 2014), RNFAs (7.0 hours, compared with 6.1 hours in 2014), and hospital/facility administrators (6.2 hours, compared with 6.9 hours in 2014). Educators and staff development employees work the least amount of overtime (3.7 hours per week) and staff nurses rank second in this regard, averaging 4.7 hours of overtime per week. Note that three of the four employee groups with the most overtime hours tend to be salaried employees.

Hiring Bonuses
Relatively few of the respondents received a hiring bonus when they were hired (9%, compared with 10% in 2014). Only 10% of the respondents are certain that their employer now offers a hiring bonus for their position (8% in 2014). For positions with bonuses, 21% were in the $1,000 to $2,499 range (a 6% increase since 2014), 28% were in the $2,500 to $4,999 range (a 2% increase since 2014), and 20% were in the $5,000 to $7,499 range (a 6% decline since 2014).

Staff nurses are the most likely to receive a hiring bonus (12%). Approximately 11% of RNFAs and charge nurses, 9% of nurse managers, 6% of clinical nurse specialists, and 4% of nurse educators received a hiring bonus. Approximately 11% of directors and assistant directors of nursing reported that their facility provides a hiring bonus for their positions.

Shift and Other Differentials
Among the respondents, 90% work the day shift and 5% work afternoons/evenings. Very few respondents work nights, weekend days, or weekend nights (less than 3% for the three categories combined). For those working the afternoon/evening shift, the median differential is $2.50 per hour or 10% of base pay ($2.25 or 10% in 2014). Note that the dollar amounts differ, but the percentages do not; the dollar differences may be due to sampling error.

Benefits
Almost all of the respondents receive benefits as part of their compensation. As shown in Table 9, the most frequently received benefit in 2015 is health insurance (92%), followed by dental insurance (89%), earned time or paid time off (85%), life insurance (83%), and vision insurance (78%). The median number of paid time off days per year was 19, excluding national holidays. This year, we calculated a three-year average of respondents receiving each respective benefit for 2009-2011 and for 2012-2014. This year, several benefits were added to the survey, so historical data are not available for these benefits.
The percentage of recipients in 2015 declined since 2012-2014 in 18 of 24 benefit categories for which there is information across years. Four benefit categories were unchanged in the percentage of recipients. Only two benefit categories (dental insurance and employee referral bonus) experienced an increase in recipients in 2015 compared with the 2012-2014 period.

Compared with the 2012-2014 averages, four benefits experienced double-digit declines in 2015: pharmacy discounts (-11%), tax sheltered annuity plan (-11%), pension plan (-10%), and jury duty compensation (-10%). Since 2009-2011, pension plans have declined 15%, tax sheltered annuity plans have declined 15%, pharmacy discounts have declined 11%, and jury duty compensation has declined 10%. The 21% decline in 401(k) contributions since 2012-2014 was not included as one of the benefits, with double-digit declines because the 403(b) contribution benefit was added to the benefits list this year, and responses in previous years may have included the 403(b) benefit with 401(k) plans. Overall, the conclusion drawn from the analysis is clear: most employers are continuing to reduce the number of benefits provided to study respondents.

**ECONOMIC TRENDS IN THE PERIOPERATIVE NURSING WORK ENVIRONMENT**

In each of the past seven years, we asked respondents whether they had seen any change in the level of activity at their facilities. As shown in Figure 5, in 2015, the perioperative nursing environment continued its comeback since the downturn in activity in 2013. This year, the percentage of respondents reporting an increase in activity grew 8% from 46% in 2014 to 54%, and those reporting a decrease in activity declined 14% from 37% in 2014 to 23%. Over the past two-year period, those reporting increases in overall activity has grown 13% and decline reports have fallen 19%.

To explore changes in perioperative nursing activity, nurses were asked whether they have seen a shift in procedure volumes. As in 2014, two-thirds (67%) reported a shift in procedure volumes away from inpatient treatments to ambulatory or same-day surgery. Approximately one in five respondents (18%) reported a shift from inpatient surgery to hybrid/interventional procedures. At the same time, however, nearly one-third (31%) reported a shift from ambulatory to inpatient treatments.
surgery, and 12% saw a shift from ambulatory to hybrid/interventional procedures. Percentages do not sum to 100 because of multiple responses.

UPDATE ON THE PERIOPERATIVE NURSING SHORTAGE

In the latest survey, the median percentage of vacant full-time nursing positions was low at 4.7% but steadily increasing from 2014 and 2013 (3.6% and 3.1%, respectively). Nurses who work in environments with open positions were asked how much this shortage was affecting their facility and work environment. A zero-to-10 scale was used, in which zero indicated no effect and 10 indicated a critical effect. Of the 932 respondents with open positions (26% of the total sample), the mean rating was 5.5, indicating a moderate effect. These respondents were then asked to indicate the reasons for the nursing shortage at their facilities. Undesirable workload, hours, or shifts was the most frequently cited reason (52%). Insufficient compensation and benefits was cited by 48% of respondents, and job-related stress was the third most common factor (41%). Besides retirement (35%), it appears that some nurses are leaving the facility or the industry (23%), and 15% are leaving the perioperative specialty.

The survey asked respondents whether they were thinking of quitting their job in the next year. Approximately 15% of the sample indicated they probably would or definitely would quit (14% in 2014 and 11% in 2013). We then probed about the nurses’ plans after they quit. Among the nurses who were seriously considering leaving their jobs, 67% said they were thinking of changing employers (61% in 2014) and 12% said they were planning to change careers but remain in health care (18% in 2014). Approximately 12% of those likely to quit plan to retire (2% of the total sample). Approximately 3% of those likely to quit were planning to change careers and leave health care (less than 0.5% of the total sample). Approximately 2% said they were leaving their jobs to attend school full time, and 1% said they might leave for personal reasons, including family, and might return later.

We asked specifically why the nurses were considering leaving their jobs. Of those who were not retiring, 49% indicated dissatisfaction with their work environment (58% in 2014) and 16% mentioned dissatisfaction with compensation (18% in 2014).

OPEN-ENDED COMMENTS ABOUT PERIOPERATIVE NURSE COMPENSATION

Respondents were asked to provide any comments about perioperative nursing that they would like to express. In total, 656 respondents, comprising 18% of the study’s total sample, provided comments containing information or opinions.

Several themes have consistently emerged in comment analysis over the past several years, and they again are present in the 2015 results. Dissatisfaction with compensation again emerged as the predominant theme in the comments, expressed this...
year by a plurality of the commenters. In total, respondents said that their pay does not reflect the amount of responsibility, increasing knowledge requirements, physical and psychological stress, and unique requirements of their jobs. One nurse wrote,

_Nursing needs a global increase in pay. We are required to do so much more work and have so many more responsibilities in and out of the OR. The technology we need to know how to use is immense and growing. We are on most committees in the hospital. Nurses my age are constantly training new nurses._

Another nurse commented,

_Most RNs are performing more than one role—staff RN working cases plus educator or charge nurse or specialty leaders or time and schedule keepers, all for the single pay for one of these roles. We aren’t given even a small stipend for the extra effort._

As has been the case in previous surveys, a large number of nurses who expressed dissatisfaction with pay asserted that OR nurses should be recognized as a specialization and compensated accordingly. A nurse wrote,

_I think we have a unique specialization that no one outside of the perioperative environment understands. We deserve more money since there is so much more to learn, to know, and to retain to care for patients safely. For us, technology is constantly changing, making it a harder place to work, and the job is becoming more physically demanding._

In the view of a number of perioperative nurses, one fact demonstrates that perioperative nursing is indeed a specialization. A nurse explained, “You can take a perioperative nurse and place them almost anywhere in the hospital and they will thrive, but you can’t take a nurse outside of the OR and successfully place them in the OR.” Another nurse agreed, “We are so highly specialized that it’s not conceivable to have ‘float’ nurses provide staffing when the surgery or staffing schedules dictate.” One nurse, however, was skeptical that perioperative nursing would ever be recognized as a specialty. “The view is a nurse is a nurse is a nurse.”

Some nurses asserted that a difficult work environment merited an increase in compensation. Others mentioned concerns separate from the compensation issue. A nurse manager wrote,

_I love the OR and hate to think about leaving it, but the physical and mental toll the job takes makes continuing more difficult each day. We need to make the OR a desirable place to work and not a place where going to the bathroom and getting lunch are major accomplishments. I work hard every day to treat my staff in the manner I’ve always felt nurses should be treated. By doing this, I end up working long hours and helping in the rooms so staff can get a break or leave to pick up kids at daycare. Recognition of the humanness of the nurse and our connection with patients is essential to stop the exit of nurses to other fields within and outside of nursing._

One nurse asserted,

_Money is not and has never been the issue. The total disrespect of nurses by physicians and management is an ongoing battle that becomes more difficult each year. Awesome nurses leave each year because of this, only to be replaced by new hires with no experience. Our nation’s healthcare is at serious risk._

Another nurse agreed,

_Comensation is always a concern. However, if employers would show genuine appreciation to nurses (salaried and hourly) other than mandatory recognition times, fewer employees would look elsewhere for job satisfaction. Too often nurses are given mandates telling us what has to be done but failing to recognize the human factor of nursing. Nurses, for the most part, want to care for the patient, but they get caught up in the must-do’s of documentation and regulatory needs. Five minutes spent in the patient’s room trying to listen to what the patient is saying will have most nurses silently thinking of all the things they should be doing, and not truly listening. For nurses to gain more satisfaction and retention, there must be recognition of the need to spend more time caring and less time dwelling on staff productivity in the face of more complex patients who are quickly in and out to save money._

For some respondents, behavior by some physicians toward perioperative nurses was cited as a particularly vexing aspect of the work environment. “We deserve ‘combat’ compensation as the abuse and inappropriate behaviors by doctors in the OR is omnipresent,” offered one nurse. “The OR is similar to a closed society, and we continue to deal with difficult attitudes.”

_Hospitals can offer all the compensation in the world,” a nurse wrote, “but it means absolutely nothing when they treat nurses poorly._

Concerns about the lack of employer support for certification focused on the inadequate recognition and compensation that nurses receive for certifications they have obtained and the
absence of any financial support to cover certification costs. One nurse wrote,

“I would like to get my bachelor of science in nursing degree and I am working on my CNOR, but all of this is out of my pocket. There is no recognition for these accomplishments or any increase in pay. It is important to have the education and I am doing it to better myself and to give better care to my patients. I just wish the hospital felt the same way, because I know other staff would take these steps if it meant they would be rewarded for it.

Concerns with on-call policies centered on the amount of call required, compensation, and the limits that on-call shifts place on the lives of nurses away from the job. Said one nurse,

“The amount of call that we in the perioperative setting have to take really discourages many people from joining this profession and encourages others to leave. The compensation for only $3.75 an hour to stay on standby, meaning your whole life is put on hold and you can’t plan on doing anything, is not enough to make it worth your time.

Several nurses noted that benefits are declining in the types and amount of support provided. These concerns are consistent with the overall trend of benefit reductions. This was especially a concern for older perioperative nurses. Said one nurse,

“Although my workplace offers benefits, the employee contribution portion rose significantly—over 30% for medical/life insurance/short-term disability. Long-term disability is available with no employer contribution. All of these reductions, and increases in our contribution, are a cut in our income.

Wrote another nurse, “It is shameful that retirement benefits for OR nurses are so poor.”

Respondents also expressed the need to retain nurses with the wisdom and skills that come with many years of experience, but they noted that often retention is difficult for several reasons. At some facilities, more senior perioperative nurses have topped out in compensation and so raises are not forthcoming. Pay compression is a recognized problem. Lower morale is a mentioned frustration among older nurses who do not feel they are respected and valued as much as younger colleagues, although they often serve as mentors to younger team members. On-call requirements are particularly an issue for older nurses, which, in the words of one nurse, “will be a deciding factor when I leave the operating room.” Some potential solutions were offered that include retention bonuses, the development of other forms of compensation for “topped-out” nurses, more part-time positions without penalty, and job sharing.

Although the large majority of commenters stated concerns about compensation and other issues, a number of nurses expressed satisfaction with their jobs and profession and, in some cases, their compensation. “I absolutely love being a perioperative nurse,” wrote one nurse. “It is very rewarding to save lives, or comfort the families of the patients whose lives couldn’t be saved.” Said another, “It has been an amazing adventure all these years from powdering gloves and threading our sutures to robotics. What a ride! It’s been my pleasure and a gift to me to be an operating room nurse.” Another nurse commented, “Perioperative nursing is the best. Each and every day may be challenging and have issues, but it is exciting and we seem to find new solutions as a team.” “I love what I do, the company I work for, and the people I work with,” said a nurse. Another nurse offered, “It’s a great specialty that’s been very good to me.”

Lastly, a number of nurses thanked AORN for its services, the annual article on compensation, and the compensation calculator. “I find the calculator extremely helpful,” one nurse wrote. “It was instrumental in bargaining for my rate of pay in my current position.” Another nurse agreed. “Thank you for sharing your compensation information. So many colleagues are single parents and feel trapped by employers that consistently try to pay the least. This information is so appreciated.” Wrote another nurse, “Thank you for all you do!”

Editor’s note: CNOR and CRNFA are registered trademarks of the Competency & Credentialing Institute, Denver, CO.

Donald R. Bacon, PhD, is a professor of marketing at the University of Denver, CO, and a research associate at Rocky Mountain Market Research, Denver. Dr Bacon has no declared affiliation that could be perceived as posing a potential conflict of interest in the publication of this article.

Kim A. Stewart, PhD, is an independent scholar in Denver, CO. Dr Stewart has no declared affiliation that could be perceived as posing a potential conflict of interest in the publication of this article.