Position On Staffing Standards In Long Term Care

August 10, 2022

This updates HOD Resolution of 2000 and AMDA Staffing Statement of 2002

Abbreviations: Centers for Medicare and Medicaid (CMS), Practitioners, Certified Nursing Assistant (CNA), Licensed Practical Nurse (LPN), Allied Health Professionals, Nurse Practitioner (NP), Physician's Assistant (PA), Physician

Summary

The primary focus of this statement is to:

- Expand upon AMDA's 2000 position on minimum staffing standards in nursing homes (AMDA House of Delegates Resolution A00) and AMDA's 2002 position on direct care staffing in nursing homes (Statement H02)
- Encourage a systems approach to establishing appropriate staffing standards
- Encourage ongoing active engagement with both medical directors and adjunct provider teams in establishing appropriate staffing recommendations

Background

Despite intense interest over several decades from clinical professionals, resident advocates, and state and federal regulators, a systematic, evidence-based approach to determine the appropriate level of staffing to meet the needs of residents remains frustratingly elusive.

Skilled nursing facilities (SNFs) and long-term care (LTC) facilities (also referred to as nursing homes or nursing facilities) are no longer settings just for aging geriatric residents. Acuity has increased among the older adult population, and entering residents are younger and/or with far more medically and socially complex needs (including more intensive management of behaviors, tracheostomies, complex wound care, drains/tubes, life vests, and IV as well as oral medications). In addition, experiences during the COVID-19 pandemic confirmed the importance of having adequate staffing based on facility/resident need and of hiring high-quality, well-trained staff.

The Institute of Medicine (IOM) defines quality in health care as the "degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge"[7]. Staffing is presumed to affect the quality of care and life of nursing home residents[8], yet standardizing staff and patient ratios remains a challenge, as staffing varies greatly by facility type and resident profile[6].

In further support of adequate staffing, researchers note the importance of interpersonal trust between staff and residents in post-acute and long-term care (PALTC), stating, "[trust] is a fundamental component of providing 'quality' aged care" [16]. Trust between staff and residents develops physically and psychologically as residents report increased comfort in asking for help, higher quality of life, and less depression symptoms when established trust is present[16]. Staff ratios, therefore, need to incorporate the emotional labor and "face time" needed to build trust and to offer more opportunities to decrease the task-driven care occurring in PALTC settings.

In this context, adequate nursing staff is defined, per AMDA's 2002 position on direct care staffing, as an appropriate number of well trained, properly supervised individuals who meet the personal [direct] care

needs of nursing home residents. Direct patient care is further defined to include assisting the patient with feeding, drinking, ambulating, grooming, toileting, dressing, and socializing[1].

Current federal law at 42 CFR §483 requires facilities to have an adequate number of licensed and qualified staff to provide care and services to residents. The Nursing Home Reform Law of 1987 required facilities to have a registered nurse (RN) in the home 8 consecutive hours, 7 days a week and an LPN available 24 hours a day with "sufficient" nursing staff to meet residents' needs[4]. When the federal nursing home regulations were updated in 2016, the decision was made to continue the longstanding requirement of sufficiently meeting the needs of the residents and not instituting specific staffing minimums. The introduction of the Payroll Based Journal (PBJ) reporting system in 2016 has also provided additional insights into nursing home staffing, including variability between weekdays, nights, and weekends. The level of care must be sufficient for each resident to attain or maintain their highest practicable physical, mental, and psychosocial well-being[2]. Given the current federal and state nurse staffing requirements, researchers have created and continue to refine evidence-based guidelines to improve both process and outcome measures of nursing home quality[14].

Research has been ongoing to collect clinical and scientific data to try to determine staffing levels that will best achieve desired outcomes as well as to develop recommendations that are sensitive to changes in case-mix and acuity. In 2008, Grabowski found that low nurse staffing levels are a predictor of hospitalizations[5], and additional systematic reviews in 2011 by Spilsbury[12] and in JAMDA in 2014 by Backhaus[3] confirmed this relationship. An editorial published in Nurse Economics in 2015 generally found positive results about the relationship between RN staffing and nursing home quality[9]. There has been a significant rise in evidence-based supportive research of higher RN staffing levels and associations with better resident care and quality; improved activities of daily living, reduced emergency room use and rehospitalizations; and fewer violations of federal regulations that have resulted in deficiencies for facilities [14, 18, 19]. In addition, studies also support stronger links between both LPN and CNA staffing (and decreased turnover) and improved resident outcomes [14].

In 2016, the Discrete Event Simulation model was published in JAMDA[11]. This type of approach may provide a better estimate of nurse aide staff time, recognizing that earlier models were not accurate in estimating the amount of time required for activities of daily living (ADL) care, especially for residents with behavioral health needs. The aide hours recommended within this model vary from 2.8 hours per resident day (HPRD) for the lowest acuity, up to 3.6 HPRD for the highest acuity.[i]

Further studies completed during the coronavirus pandemic in 2020 also supported having adequate staffing levels in PALTC settings. There was a strong positive correlation between higher nursing staff hours (CNA, LPN, and RN) and quality of care and life of residents in both SNF and LTC facilities, with many studies citing total care hours between each nursing discipline of at least 4.1 HPRD[14, 17, 18].

AMDA's Positions

- AMDA recognizes that while having adequate staffing is critically important, minimum staffing levels should not become a fixed ceiling, as staffing levels based only on resident-to-worker ratios or assumptions that staff availability is an easily fixable variable will not adequately or safely address and meet resident needs.
    - Any decisions about staffing levels need to consider the broader issues, including:
        - the complexity and acuity of a facility's population;
        - the functional level of residents and services required;

  - creating consistent work schedules[10] that are flexible, to accommodate the changing needs of the residents along with improving consistent communication and documentation regarding the care needs of residents;
  - the existence of staffing shortages for some types of staff in some geographic locations, and temporary staffing shortages due to such events as employee illness or termination;
  - staffing other categories of caregivers, such as medication aides, feeding assistants, restorative aides, family members, and activity professionals to meet the acuity and need of each facility;
  - appropriate training and ongoing skills development according to facility resident populations and acuities;
  - the career and educational development of staff (especially among newly certified aides and licensed nurses);
  - The management skill and quality of supervision of front-line staff; and
  - the leadership, quality, competence, and engagement of medical directors and adjunct attending teams of MDs, NPs, and PAs, and staff leadership.
- AMDA recognizes that person-centered, evidence-based dementia care, care of individuals with other neurological disorders, and care of residents with mental health diagnoses, requires 24-hour caregiving. As more residents in PALTC are diagnosed with these health conditions, facilities should be supported to staff adequately based on care needs specific to these populations;
  - Furthermore, adequate evening/night staff may greatly reduce the inappropriate use of higher risk medications such as anxiolytics, narcotics, and antipsychotic medication regimens.
- AMDA strongly supports increasing PALTC staff compensation (salary and benefits) to match the ongoing competitive market of other health care delivery sites.
- AMDA supports continued research regarding staffing levels (number and skill mix) that will optimally meet the individual needs of residents in nursing homes.
- AMDA supports all options to recruit and train staff and continues to work with other stakeholders to address the current staffing crisis.
- AMDA highly values direct caregivers in PALTC. Their continued involvement supports a resident achieving his/her highest goal of optimizing functional levels. The quality of a resident's life is significantly affected by care that is competent, compassionate, and responsible.

In conclusion, AMDA reminds our community partners and supporters of the positive impact the above changes can have on safe care and the maintenance of high-quality care of our residents. Promoting this honorable and important work with pride and integrity will help to support and expand our workforce. In addition, as we consider funding, education, and skills training, we must find means to recruit, retain, and support our certified nursing assistants, licensed nurses, and other members of the care team who deliver and maintain the high-quality care of our residents.

** Special Note – this position statement addresses direct-care staffing. To learn more about AMDA' s position on medical director requirements please visit https://paltc.org/?q=amda-white-papers-and-resolution-position-statements/nursing-home-medical-director-leader-manager. To learn more about AMDA's position on attending physician role in the nursing facility please visit https://paltc.org/amda-white-papers-and-resolution-position-statements/role-attending-physician-nursing-home

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Endnote

[i] The first data to suggest specific ratios at which quality is either compromised or significantly enhanced was provided in the 2001 CMS Report to Congress on Appropriateness of Minimum Staffing Ratios in Nursing Homes Phase II final report. It was estimated that increasing staffing to the reported ratios would increase RN wages by 2.5-7% and nurse aide wages by 10-22%, with an overall increase in nursing home costs of 8%[15]. It was also noted in this report that management practices, training, and turnover were additional significant contributors to quality outcomes above and beyond the hours per resident day. The final report stated, "We do not think there is currently sufficient information upon which to base a Federal requirement for all certified nursing homes." Concerns included details of the cost analysis and the inability to enforce staffing ratios, due to inaccurate collection of data on nurse staffing. In 2006-2007, the CMS STRIVE Time Study was completed, to determine the amount of time needed to provide care. Critics of the study have expressed concern that this was evaluating "actual practice," not the amount of time to provide "high quality" care, and that it was under-representing the amount of time staff need. It was also noted that large, high-volume facilities were over-represented in the sample. The data was incongruent with the times recommended by the earlier staff time measurement (STM) studies completed in the late 1990s, with an overall recommendation of only 83% of the total nursing hours recommended by the STM studies. Because of these concerns, the CMS Medicare Nursing Home Compare Technical Expert Panel in 2008 rejected the use of these data[14].