Position Statement on Appropriate Staffing Standards
In Post-Acute and Long-Term Care

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

A push to mandate staffing levels at both state and federal levels persists after several decades.

Skilled Nursing Facilities (SNFs) and long-term care (LTC) facilities (also referred to as nursing homes or nursing facilities) are no longer just for aging geriatric residents. Acuity level has increased and entering residents are younger, and/or with far more medically and socially complex needs (including more management of behaviors, tracheostomies, complex wound care, drains/tubes, life vests, and IV medications). In addition, experiences during the COVID-19 pandemic confirmed the importance of having sufficient staffing based on facility 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 addition, it remains inconclusive which staffing elements directly impact the quality of resident care\(^5\).

Further supporting adequate staffing, researchers note the importance of interpersonal trust between staff and residents in post-acute and long-term care (PALTC), stating, “it is a fundamental component of providing ‘quality’ aged care”\(^17\). Trust between staff and residents develops physically and psychologically as residents report increased comfort asking for help, higher quality of life, and less depression symptoms when established trust is present\(^7\). Staff ratios need to incorporate the emotional labor and “facetime” needed to build trust and 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) 8 consecutive hours, 7 days a week and an LPN available 24
hours a day with “sufficient” nursing staff to meet residents’ needs. 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) 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. It is an ongoing challenge to discern what constitutes “sufficient” nursing staff, as there is a high degree of subjectivity.

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, and additional systematic reviews in 2011 by Spilsbury and in JAMDA in 2014 by Backhaus confirmed this relationship. Despite these strong supporting studies, an integrative review published in Nurse Economics found mixed results about the relationship between RN staffing and nursing home quality.

In 2016, the Discrete Event Simulation model was published in JAMDA. 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.

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 (RN and LPN) and quality of care and life of residents in both SNF and LTC facilities, with many studies citing RN hours of at least 4.1 HPRD.

AMDA's Positions

- AMDA recognizes that while having a sufficient number of staff is critical, staffing levels based only on resident-to-worker ratios will not adequately assess or meet resident needs.
  - 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 also recognizes person-centered and evidence-based dementia care requires 24-hour caregiving. As more residents in PALTC are diagnosed with dementia or other cognitively impaired related diagnosis, facilities should have the flexibility and resources to staff adequately based on needs specific to this population.
  - Furthermore, adequate evening/night staff may greatly reduce the inappropriate use of higher risk medications such as anxiolytics, narcotics, and antipsychotic medication regimens.

- 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.

- The development of staffing levels or ratios should be done cautiously, to avoid unintended consequences. For example, a shortage of available workers to achieve compliance with a federal mandate could lead to challenges with access to nursing home care, particularly in rural areas.
AMDA recommends building on existing relevant regulations, such as the F838 Facility Assessment that was included in the 2016-2019 updated OBRA regulations, instead of creating new federal or state mandates.

- AMDA strongly supports increasing PALTC staff compensation (salary and benefits) to match the ongoing competitive market of other health care delivery sites.

- Any decisions about staffing 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;
  - defining and including other categories of caregivers, such as medication aides, feeding assistants, restorative aides, family members, and activities professionals;
  - the quality, competence, and engagement of staff leadership and supervision;
  - addressing adequacy of training and skills development, and
  - the career and educational development of staff (especially among newly licensed nurses).

References


Footnotes

A. Some states have implemented additional nurse staffing requirements, with marginal or inconclusive benefits on limited conditions (i.e., wound healing/pressure sores) but not on management of problematic symptoms such as verbal and physical aggression or on rehospitalization rates. In addition, in Florida, increased CNA staffing was offset by decreased indirect care staff hours, which may negatively impact quality of life.

Between 1995-1997, Staff Time Measurement (STM) studies were completed in 10 states, and thresholds of RN, LPN, and aide time were established, beyond which there were no additional improvements in quality.

B. 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 increasing staffing to these 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%.

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 that “we do not think there is currently sufficient information upon which to base a Federal requirement for all certified nursing homes.” Particular 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, CMS STRIVE Time Study was completed, in an attempt to determine the amount of time actually needed to provide care. Critics of the study express 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 actually 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 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.