

A GUIDE FOR RESIDENTS, FAMILIES, FRIENDS, AND CAREGIVERS

NURSING HOME

STAFFING



By the
**NATIONAL CITIZENS' COALITION
FOR NURSING HOME REFORM**

Acknowledgements

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Introduction

Disrespect. Unkindness. Neglect. Abuse. Those are our worst fears when we think about going into a nursing home, or placing our beloved parent or other relative in one. Nursing homes provide nursing care to people whose diseases or disabilities are so great that they need access to 24-hour skilled medical care. They are also homes—places where people need help to live and have their laundry done and take meals and bathe and dress. And the staff who give direct care—nurses and nursing assistants—are the key to both kinds of care. That's why having enough good staff is perhaps the most important thing about a nursing home.

Describing what "good staff" means is easy. Look at what two groups directly affected by "good staff" (or its absence) said when asked, "What does 'good staff' mean to you?"

Resident Point of View:

Residents said good staff means:

- "Helping when needed with personal tasks"
- "Being kind and nice, good to you"
- "Having enough staff"
- "Being polite, courteous, respectful, treating us with dignity"
- "Being friendly, cheerful, pleasant, jolly"
- "Being patient, has time for you"
- "Are well-trained, skilled, knowledgeable"
- "Good staff stays on (works there a long time) providing good care."¹

Nursing Assistant point of view:

Nursing Assistants said good staff are:

- "Helping when needed with personal tasks"
- "Assistants to other nursing and medical staff"
- "Listeners to residents needs and concerns"
- "Hand holders for residents in emotional crises"
- "De-facto family members and friends for residents"
- "Nurturers of a resident's spirit"
- "Advocates for residents"
- "Frontline communicators and information sources to family members and staff"
- "Eyes, ears, and sense of touch for residents"²

You can see that the resident and staff points-of-view are not that different. Professional nurses, who oversee resident care given by nursing assistants, also want good staff: competent, skilled, well-trained nursing assistants who will work with the caregiving team.

You, as consumers, friends, family members, and others, would probably give the same answers to the question: "What does good staff mean to you?" In fact, good staffing is absolutely basic to good nursing home care for residents. But enough good staff is all too rare in today's nursing homes.

The Purpose of this Guide

This Guide will help you define good and adequate staffing. It will help you determine whether you are getting good, adequate staffing in your loved one's facility. And it will help you advocate for good, adequate staff in that facility.

Nursing Care is the Focus of this Guide



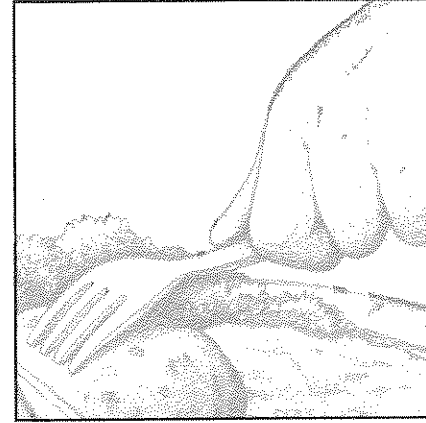
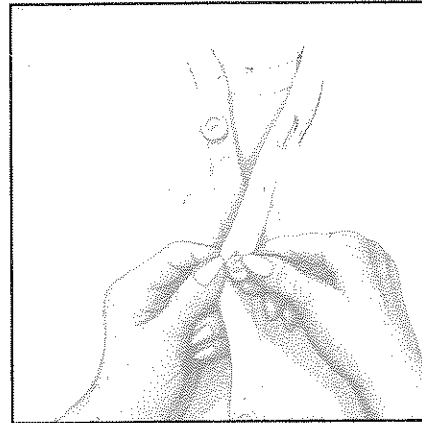
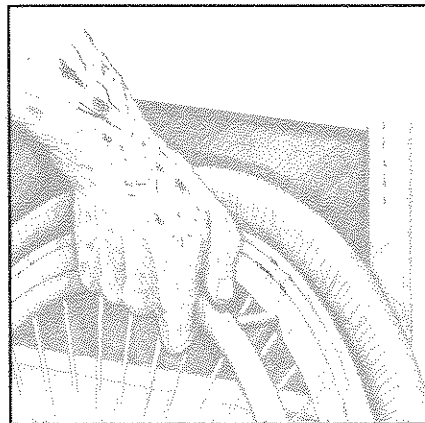
Most of the people who work in nursing homes are nursing staff. Therefore, this guide focuses mostly on nursing staff, by which we mean licensed nurses and certified nursing assistants (CNAs).

Licensed nurses include:

- Registered Professional Nurses (RN with a minimum of two years of education up to and including a masters or PhD in nursing). They supervise and teach Licensed Practical/Vocational Nurses and CNAs. Legally they are responsible for the care given by other nursing staff.
- Licensed Practical or Licensed Vocational Nurses (LPN/LVN with one year of training). They supervise CNAs, give medications, provide treatments, and other direct care.

CNAs are not nurses, but they assist nurses and provide hands-on care to residents. Under the Nursing Home Reform Act, CNAs must have at least 75 hours of training (some states require more). **CNAs provide 70% to 90% of the direct care in nursing homes.**

Staff in nursing homes should wear nametags that clearly identify them as RNs, LPNs, or CNAs.

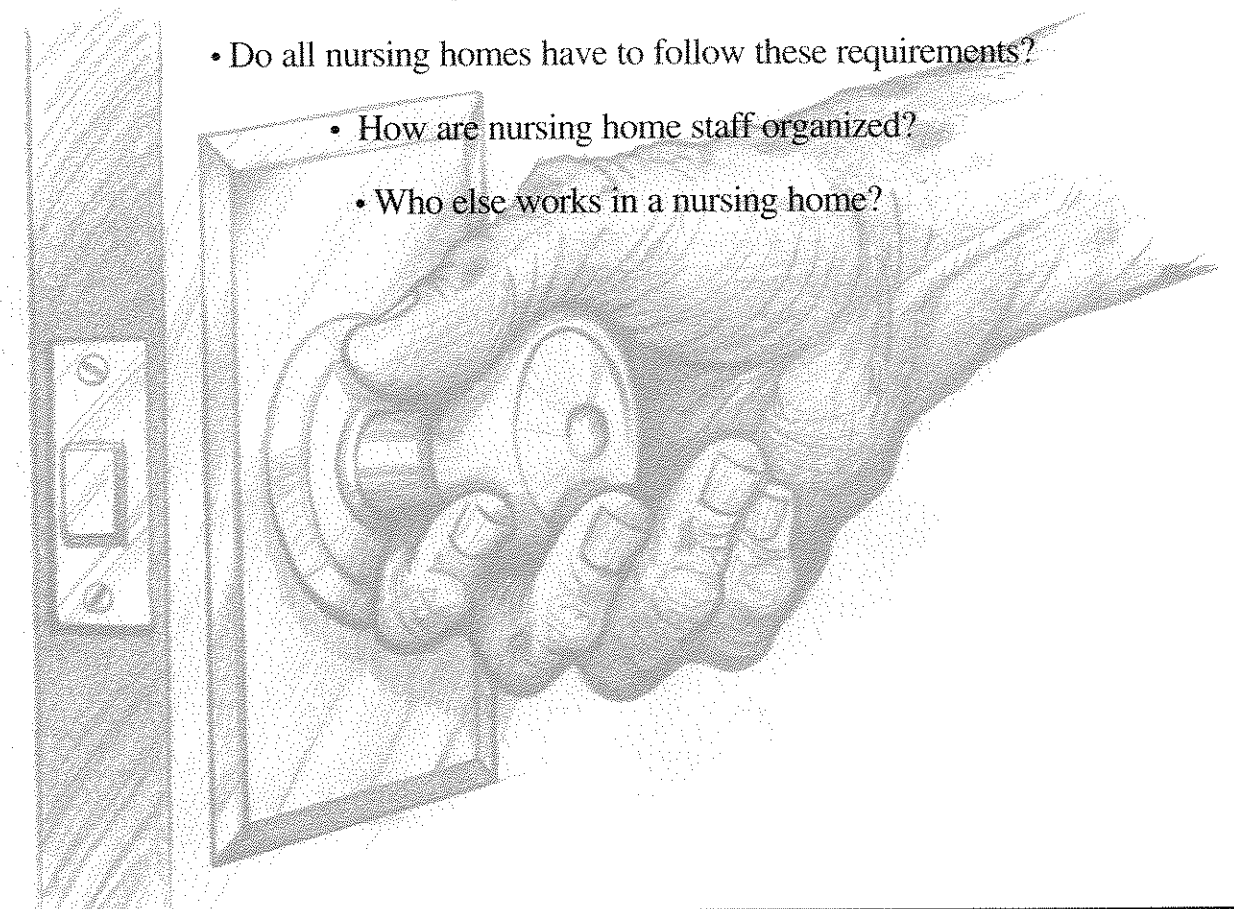


Chapter 1

NURSING CARE: The Foundation of Good Care

This Chapter Answers the Following Questions:

- How much nursing staff does the federal government require?
- Do all nursing homes have to follow these requirements?
 - How are nursing home staff organized?
 - Who else works in a nursing home?



How Much Nursing Staff Does the Federal Government Require?

Protect

The Nursing Home Reform Act (NHRA) of 1987 has strong requirements to protect residents. By law nursing homes must provide care and services so that *each* resident has quality care, quality of life, and his or her rights. Each resident must receive care and services to “reach his or her highest practicable mental, physical, and psychosocial well being.” This is exactly the goal each of us would want as a resident. *Reaching this goal depends on good staff*—yet, the weakest part of the NHRA is the nursing staff requirements. These include:³

- a registered professional nurse (RN) at least 8 consecutive hours a day, 7 days a week;
- 24-hour *licensed* (RN or LPN/LVN) nursing as necessary to meet the licensed nursing needs of residents; and
- Enough *total* nursing staff (RN, LPN, and CNA) to meet the overall nursing needs of residents.⁴

All nursing homes must have a Director of Nursing (DON) who is an RN. In a home smaller than 60 beds, the DON may also be the charge nurse. Most large nursing homes have more licensed nurses, but legally one DON is enough as long as the residents’ needs are met. *Research clearly shows that residents in nursing homes with more RNs have fewer bad outcomes such as pressure sores and infections.*⁵ Thus, homes with more RNs provide better resident care.

Do All Nursing Homes Have to Follow These Nursing Requirements?

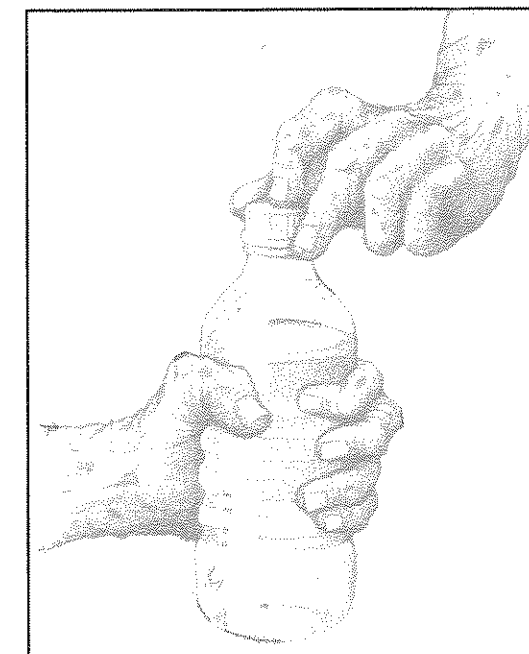
Care

Almost all. The requirements apply to all homes that accept payment for resident care from the Medicare (federal program) and Medicaid (joint state/federal program)—that comprise 94% of our nation’s nursing homes. The three types of nursing homes that accept payment for care from Medicare and Medicaid are:

- Skilled nursing facilities (SNF) that take only Medicare residents;
- Nursing facilities (NF) that take only Medicaid residents; and
- Skilled nursing facilities and nursing facilities (SNF/NF) that take both Medicare and Medicaid residents.

In each state, a State Survey Agency inspects (“surveys”) all homes for good care and adequate staff every nine to fifteen months. The federal Center for Medicare and Medicaid Services (CMS) collects this inspection information for homes certified for Medicare & Medicaid. The results are posted on the CMS website at <http://www.medicare.gov>.

The few homes that only accept residents who pay privately must follow state rather than federal staffing rules. State staffing rules vary greatly. Some are stricter than the federal standard.⁶



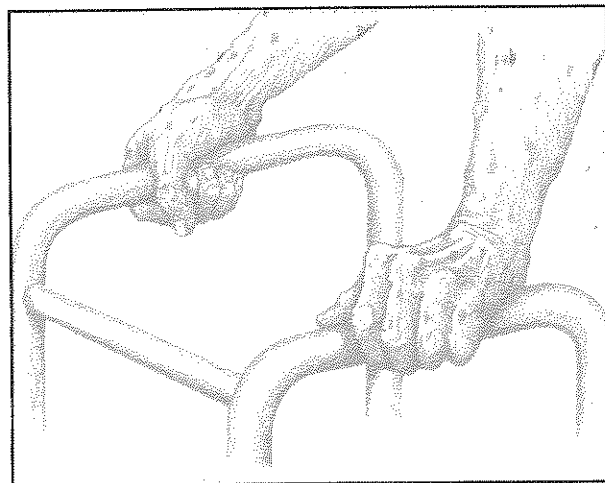
How Are Nursing Staff Organized?

Nurses—The DON is responsible for the quality of nursing care throughout the facility. The DON oversees all of the nursing supervisors and nursing units.

A Charge nurse (an RN/LVN/LPN) organizes and manages the care of residents on each unit. The Charge nurse supervises and supports the CNAs caring for these residents. In a larger home a group of units may have an RN Manager.

In a well-managed home you should see the Charge nurse:

- observing the caregiving process and offering assistance to CNAs giving care;
- making sure CNA assignments balance resident needs with CNA ability and time;
- reporting to CNAs about the medical and emotional condition of the residents;



- interacting with CNAs kindly, pleasantly, and respectfully; and
- modeling cooperative, caring behavior for the CNAs.

Other RN nursing positions may include:

- the In-Service Coordinator who is responsible for training all nursing staff, and
- the Resident Assessment Coordinator, an RN on staff, to do resident assessments. (See Appendix II for Resident Assessment and Care Planning.)

The DON, In-Service Director, and Assessment Nurse rarely give direct care to residents except in a very small home.

Who Else Works in a Nursing Home?

Administration—Each nursing home is run by a Licensed Nursing Home Administrator (LNHA). The LNHA is responsible for everything that happens in the facility—including adequate staffing. More than half of all Administrators must report to corporate headquarters. Corporations may put controls on expenses before care for residents. While being frugal is important, sometimes financial decisions by the corporation prevent the Administrator from providing good care. Other Administrators report to a board of directors. Some Administrators are also owners. Two-thirds of all nursing homes are for profit.⁷

The Administrator sets the philosophy of care in each facility. An Administrator who is humane and caring creates a positive atmosphere for staff and residents. The Director of Nursing is the other important position in setting a tone of caring. In a well-run nursing home the Administrator and the Director of Nursing work closely together and spend a great deal of time in resident care areas.

Others who work in administration are business and medical records personnel, and secretaries.

Caregiving Services—The medical director sets clinical guidelines for the home. Other physicians, nurse practitioners, pharmacists, social workers, dietitian, activities professionals, therapists (including physical, occupational, speech-language), mental health professionals (including clinical social workers, geriatric psychiatrists or psychologists), and dental care providers also provide care. Laboratory, radiology, and other diagnostic services are obtained as needed. (See Appendix IV for a description of these positions.)

Housekeeping and Maintenance—These departments are the largest next to nursing. They include laundry, housekeeping, yard work, and maintenance. Residents often have a special relationship to housekeepers, but they are not usually involved in direct care (and shouldn't be, unless they are trained as CNAs).

Points to Remember

- This guide is primarily about nurse staffing, the foundation of good care.
 - RNs supervise LPNs and CNAs. LPNs also supervise CNAs.
- The Administrator is responsible for everything that happens in the facility, including staffing.
 - Most nursing homes must meet federal staffing requirements.
- Some states have better nurse staffing standards than the federal government.

Chapter 2

GOOD NURSE STAFFING MEANS GOOD CARE

This Chapter Helps You Gather Information to Answer the Following Questions:

- How will I know if there is enough nursing staff?
- How will I know if nursing staff is adequate to provide quality care?
- How will I know if nursing staff is well supervised?

Gathering Information:

This chapter provides checklists to use, but keeping a daily diary of your observations works just as well. Remember to visit at different times of the day and night. Be observant, fair, and accurate. Write down what you see using time, date, place, and names of people involved. Get a simple notebook, copy and use the checklists, or do both!

How Will I Know if There is Enough Nursing Staff?

Trust

Trust your senses—smell, taste, touch, hearing, and sight/observation. Get information from staff, other families, and residents. Note the number of CNAs. Does an RN or LPN supervise them? Some nursing homes provide excellent care.

It was 6 a.m. and some of the residents were awake and ringing their call bells. The night nursing staff was responding. They knew the early risers and were prepared to help them. The others awakened on their own. Simple breakfast foods were available for an extended time for the late risers. Night and day staff agreed that it took less time to help residents when they start the day according to their own habits than on a schedule imposed by the nursing home. This home had enough staff who were well-trained and supervised.

If You Can Answer YES To The Following Questions, There Is A Good Chance There Are Enough Nursing Staff.

Observe On Weekdays and Weekends, Days, Evenings, and Nights.

1. Do staff respond quickly to call lights or calls for help?
2. Have staff worked there long enough to call the residents by name?
3. Is the interaction between staff and residents pleasant and respectful?
4. Are the same staff available every week?

5. Is there enough staff to assist each resident who requires help with eating—without rushing any resident?
6. Are residents helped and encouraged to drink at mealtimes?
7. Are residents offered something to drink between meals?
8. Are residents up and dressed and groomed daily?
9. Are residents helped to move, walk, and use wheelchairs, walkers, and canes?
10. Does the home look and smell clean?
11. Do residents seem relaxed and generally content?
12. Do staff spend time talking to residents?

Ask Nursing Assistants— Do They Answer ‘Yes’?

1. Do you have enough time to provide good care to each of the residents you help?
2. Does your workload remain the same on weekends and holidays?
3. Are you given a choice about working overtime?
4. Is a licensed nurse available to help you when needed?

Ask Other Residents And Family Members— Do They Answer ‘Yes’?

1. Are residents taken to the toilet when they ask or want to go?
2. Can residents bathe as often as they like?
3. Is there enough staff on nights, evenings, weekends, and holidays to help residents with eating, bathing, dressing, toileting, and moving about?
4. Have many of the nursing assistants worked here a long time?

5. Have the Administrator and Director Of Nursing been here over a year?

If the answer to all or most of these questions is “YES” that probably means there are enough well supervised staff.

Every home will have a staff problem now and then. But, you should not experience repeated low staffing on any shift. Keep notes if you start having problems with care. Document what is lacking and when.

How Will I Know if Nursing Staff is Adequate to Provide Quality Care?

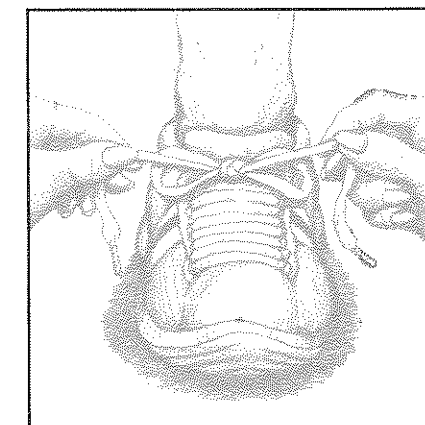
Supervision

Using checklists, decide if inadequate staffing is the cause of poor care.

“Hands-on” care by well-supervised nursing staff is key to good care. Poor staffing leads to neglectful care. Consider one family member’s observations about his mother whose dementia left her unable to ask for help:

... My mother’s hair was not always combed and brushed. Her clothing would have food on it from the last meal. Her fingernails needed cleaning at times....[M]issing clothing was an ongoing and frustrating problem.⁸

Over time, neglectful care leads to poor outcomes for residents. This means pressure sores, incontinence, contractures, malnutrition, dehydration, unnecessary feeding tubes, urinary catheters, accidents, and overuse of chemical and physical restraints. (See Appendix I for definitions of these terms.)



**Noting Poor Care:
The Quality of Care Checklist**

If you see any of the problems on the Checklist below, you are probably witnessing inadequate staffing and poor care. Check any you find, and note the date, day and time it occurs.

Notation example: *Sat/Sun, Nov 2-3—5:00 pm*

Mother still in bed. Supposed to be up from afternoon rest at 3:00 pm. Requested help twice.

Observations	Day	Date	Time
<input type="checkbox"/> Call bell not answered in at least 5 minutes.			
<input type="checkbox"/> Immobile resident is not turned, at least every two hours.			
<input type="checkbox"/> Resident's hands are not clean and nails are dirty or chipped.			
<input type="checkbox"/> Hair smells, is uncombed, and needs to be shampooed.			
<input type="checkbox"/> Resident smells, appears unclean.			
<input type="checkbox"/> Staff is not responding to request to use the bathroom. Resident told: "Just wait, we'll get to you soon. We don't have time to help you."			
<input type="checkbox"/> To avoid asking for help to the bathroom, resident does not drink enough fluids.			
<input type="checkbox"/> Residents told to relieve themselves in their clothing because incontinent brief is on.			
<input type="checkbox"/> Resident's incontinent pad is soaked or ringed with urine/feces.			
<input type="checkbox"/> There is dried feces or urine on clothes or buttocks.			
<input type="checkbox"/> Toenails appear too long.			
<input type="checkbox"/> Food is on clothes several hours after mealtime.			
<input type="checkbox"/> Resident's mouth is dirty and/or dry.			
<input type="checkbox"/> Resident complains of being thirsty.			
<input type="checkbox"/> When given fluid, resident drinks several glasses at one time.			
<input type="checkbox"/> Residents wake early and have to sit for up to several hours before breakfast is served.			
<input type="checkbox"/> There's lack of assistance with eating, food just left in front of resident.			
<input type="checkbox"/> Staff says resident "takes too long to eat" as reason to use tube feeding.			
<input type="checkbox"/> Resident walked when he entered facility, no longer able—not due to progress of disease.			
<input type="checkbox"/> Resident is not bathed regularly.			
<input type="checkbox"/> Bruises: may be due to rough handling by rushed nursing assistants.			
<input type="checkbox"/> Residents appear listless. Question overmedication.			
<input type="checkbox"/> Use of physical restraints.			
<input type="checkbox"/> Resident is not gotten out of bed.			
<input type="checkbox"/> Hearing aid/eyeglasses not worn when resident wants or needs them.			
<input type="checkbox"/> Medications and treatments not given in a timely manner.			

**Noting Poor Quality of Life:
The Quality of Life Checklist**

Quality of life is how the resident is treated as an individual. Residents' emotional well-being should not get worse simply because they are in a nursing home. Residents should be treated with kindness and dignity. They should be able to exercise control and choice in their daily lives. Staff must respect each resident's life-long preferences and habits.

If you see any of the problems on the Checklist below, you are probably witnessing inadequate staffing and poor care. Check any you find, and note the date, day and time it occurs.

Observations	Day	Date	Time
<input type="checkbox"/> Not allowed to wear clothes resident is accustomed to wearing (for example, gentleman who always wore suits made to wear a jumpsuit for convenience of the staff).			
<input type="checkbox"/> Scheduled activities are not held.			
<input type="checkbox"/> There is a secure outside area, but the residents are not assisted in going outside.			
<input type="checkbox"/> Residents lined up in day room facing TV. No stimulating activities.			
<input type="checkbox"/> Residents generally are not allowed to set their own schedule: when to go to bed, when to get up, when to take a bath.			
<input type="checkbox"/> Residents are not allowed choice at mealtime.			
<input type="checkbox"/> The facility often smells of urine, feces, heavy cleaning chemicals.			
<input type="checkbox"/> The interior and/or exterior are not clean.			
<input type="checkbox"/> Hallways are cluttered with linen carts on both sides of the hallway, making it impossible for residents to move down the one side of the hallway using the handrail.			
<input type="checkbox"/> There is not a clean washcloth and towel for each resident.			
<input type="checkbox"/> Almost every day there are new nursing assistants.			
<input type="checkbox"/> Staff are not reporting resident problems to other staff and family members who can help and address them (for example, not eating, unable to swallow, begins to lose weight).			
<input type="checkbox"/> Staff appear harried, harassed—as if short-staffed.			
<input type="checkbox"/> Staff are sitting at nurse's station talking with each other or reading a magazine rather than responding to call bells.			
<input type="checkbox"/> Staff do not knock on doors before entering resident rooms.			

How Will I Know if Nursing Staff is Well Supervised?

Noting Poor Supervision:
The Supervision Checklist

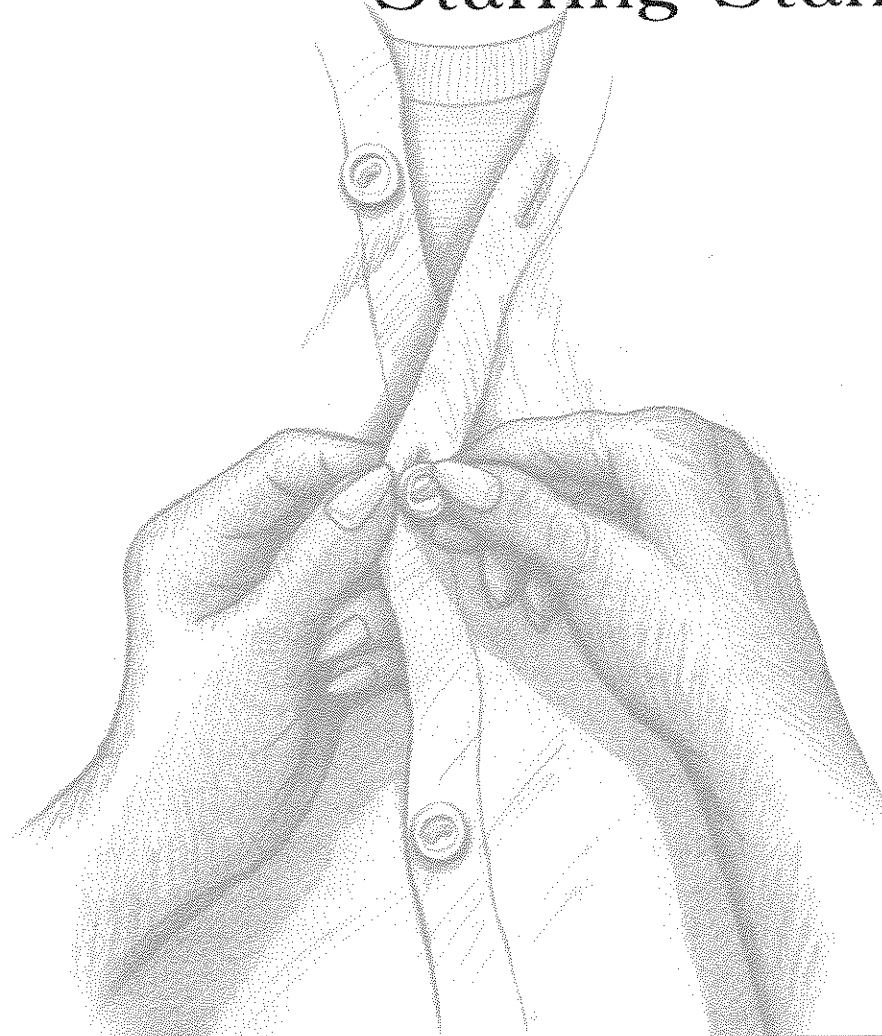
Observations	Day	Date	Time
<input type="checkbox"/> Staff seem plentiful but nursing staff sit in nurses station while resident call lights ring.			
<input type="checkbox"/> Staff are in the dining room but they do not assist residents to eat.			
<input type="checkbox"/> Staff stand up while feeding residents who are sitting down.			
<input type="checkbox"/> Administrator, Director of Nurses not seen in resident care areas.			
<input type="checkbox"/> Staff talk about residents in front of them.			
<input type="checkbox"/> Staff congregate in one resident's room for long periods of time.			
<input type="checkbox"/> Staff take long breaks while resident needs are unmet.			
<input type="checkbox"/> Staff seem to speak sharply or rudely to residents.			
<input type="checkbox"/> Staff do not appear to have the skills to help residents, (for example, can't use scales, take pulse/respiration).			

Points to Remember

- Use your five senses to look, taste, touch, smell, and hear to assess the nursing home.
 - Use the YES question Checklist to assess adequacy of staff.
- Use the Quality of Care and Quality of Life Checklists to record inadequate staffing.
 - Use the Supervision Checklist to record lack of CNA supervision.
- Be objective, be accurate, be fair, and write down your observations and concerns.

Chapter 3

ASSESSING ADEQUACY OF STAFF: Staffing Standards



This Chapter Answers the Following Questions:

- Do nursing homes have enough staff?
- What do consumers and professionals think is enough staff?
- How can you determine the staffing levels in your nursing home?
- How can you use this information to advocate for more staff?

Do Nursing Homes Have Enough Staff?

Neglect

The Checklists in the previous chapter show what kind of care should be provided when a nursing home has both enough staff and adequate supervision. But in July 2000, a shocking government report to the United States Congress found that over half (54%) the U.S. nursing homes did not have enough direct care nursing staff (CNA plus licensed nurse time) even to *prevent harm* to residents. Here is what the government found:

GOVERNMENT REPORT PART I (2000):
STAFFING LEVEL NECESSARY TO PREVENT HARM⁹

Direct care Nursing Staff Type	Hours/minutes of resident care per day required to prevent harm to residents	Percent of nursing homes not having enough staff to prevent harm	Number of residents at risk of harm
Certified Nursing Assistant	2.0 hours 120 minutes	54%	More than 800,000
Licensed Nurse (RN/LPN)	0.75 hours 45 minutes	23%	More than 300,000
Total nursing Hours/minutes	2.75 hours 165 minutes		

The second phase of this government study, released in March 2002, gives us even more evidence that higher staffing patterns improve the quality of care.¹⁰ The study looked at what happens when there are not enough staff providing direct care—such as avoidable hospitalizations for such conditions as electrolyte imbalance and infections; functional decline; pressure sores; and weight loss.

This study found:

- Without at least 2.8 hours a day of nurse aide care and 1.3 hours of licensed nurse care (including at least .75 hours of care by RNs), residents are *much more likely* to experience poor outcomes. This is a total of 4.1 hours of direct care for long-stay residents—close to the 4.13-hour NCCNHR/Hartford Direct Care Staffing Standard.

In other words, the latest study confirms 4.1 nursing hours per resident day is a *threshold staffing ratio* below which quality care simply cannot be provided.

- Worst, the 2002 study estimated that as many as 97% of nursing homes do not have enough nurses and nursing assistants to provide *all* the care required to avoid risk to residents. Over one and one-half million residents live in facilities that don't meet the staffing thresholds!

Another part of this 2002 study analyzed *what it takes for nursing assistants* to provide care—how long it takes to dress and groom residents; help them exercise; assist them with eating; change their wet clothes; and toilet and reposition them.

Other normal events—staff meals, breaks, travel from room to room, housekeeping duties, shower assistance, unexpected interruptions, and social interaction with residents—were also included.

This analysis found that these direct care actions take from 2.8 to 3.2 hours of nursing assistant (licensed nurses were not included in this study) time daily, depending upon residents' needs—and these estimates are low because they were calculated using unrealistically high assumptions about assistants' productivity. In 2000—conservatively—over 91% of nursing homes did not have enough nursing assistants to meet this standard.

The need to advocate for improved nurse staffing is obvious!

What do Consumers and Professionals Think is Enough Nursing Staff?

Standards

How much staff is needed to provide quality care? For child care, we look for staff-to-children ratios, to ensure there are enough staff to care for children of different ages. Is there a staff-to-resident *ratio* as a standard for nursing homes to meet, so that high-quality care can be given?

With much thought and research, residents and their advocates have developed a minimum standard for nursing staff-to-resident ratios (see

Appendix V for the complete standard). The process began in 1995, when the voting members of the National Citizens' Coalition for Nursing Home Reform (NCCNHR) adopted a staffing standard which was then refined by an expert panel of the Hartford Institute for Geriatric Nursing. NCCNHR again adopted it as its consumer staffing standard in 1998. The table on the next page summarizes the direct care part of the NCCNHR/Hartford Direct Care Staffing Standard.

NCCNHR/HARTFORD DIRECT CARE STAFFING STANDARD

	Registered Nurse and Licensed Practical or Vocational Nurse	Certified Nursing Assistant	Total direct care staff (nurse and nursing assistant)
Total hours or minutes of resident care per day	1.20 hours 72 minutes	2.93 hours 176 minutes	4.13 hours 318 minutes

What is Important in the Direct Care Standard?

- This standard is a time ratio—a ratio of staff hours to resident hours. It was derived from, and can be converted into, a person ratio—a ratio of staff numbers to resident numbers. It is equivalent to the following person-staff ratios:

Minimum Direct Care Staff (RN, LVN/LPN, or CNA):		
Day Shift	1 FTE* for each 5 Residents	(1.60 hours per resident day)
Evening Shift	1 FTE for each 10 Residents	(0.80 hours per resident day)
Night Shift	1 FTE for each 15 Residents	(0.53 hours per resident day)
Minimum licensed nurses (RN and LVN/LPN) providing direct care, treatments and medications, planning, coordination, and supervision at the unit level:		
Day Shift	1 FTE for each 15 Residents	(0.53 hours per resident day)
Evening Shift	1 FTE for each 20 Residents	(0.40 hours per resident day)
Night Shift	1 FTE for each 30 Residents	(0.27 hours per resident day)
		(Total 4.13 hours per resident day)

* Full Time Equivalent

Unfortunately—even though, as we’ve just learned, this standard has been *confirmed* by the latest government studies—and even though NCCNHR and almost 100,000 signatories to a Nurse Staffing Petition we presented to Congress in May 2002 have demanded action—the federal government has so far *refused* to require nursing homes to meet the NCCNHR/Hartford Nurse Staffing Standard. NCCNHR continues to advocate for reforms that will make this ratio the minimum staffing standard across the country.

While the federal government is not acting, many states have tried to solve the problem of inadequate nurse staffing in nursing homes, and most states have minimum standards that are higher than the specific federal requirements. Some have even made it a legal requirement for nursing homes to meet certain staffing ratios in their states. Here are the requirements that some states have adopted (shown in relation to other staffing ratios discussed elsewhere in this book):

STANDARDS FOR DIRECT CARE NURSING HOURS PER RESIDENT DAY

Total Nursing Hours Per Resident Day (includes licensed nurses who provide direct care and nurse assistants)	Comparative Standards
2.75	Government Report Part I (Prevents Harm)
3.26	California Standard
3.3	Florida Standard (<i>eff.</i> Jan. 2002)
3.6	2000 Actual National Average ¹¹
3.76	Delaware Standard (<i>eff.</i> Jan. 2002)
4.1	Government Report Part II (Threshold for Providing Quality Care)
4.13	NCCNHR/Hartford Standard
4.55	NCCNHR/Hartford Standard Adjusted Upward for Sicker Residents

How Can You Determine the Staffing Levels in Your Nursing Home?

Compare

In chapter 2 you learned how to know if your friend or family member is getting good or bad care. Now you know that poor care often is the result of not enough or poorly supervised direct care nursing staff. You have also learned about nursing staff standards in hours or minutes per resident day (hprd). But, how can you find out staffing information—hours per resident day—on your own unit or in your own nursing home? Right now there are two ways to find out this information:

- By using information on the government's website, *Nursing Home Compare*; and
- By plain old-fashioned *counting*.

Beginning in January, 2003, there will be a third way to get staffing information in nursing homes. Federal law will require every Medicaid- and Medicare-funded nursing home to *post a sign* daily showing the number of licensed nurses and nursing assistants on duty on each shift. The sign will show those staff who are *directly* responsible for taking care of residents. The law does not require the information to be reported by floor or unit. Once these signs are posted, families should be much better able to tell if enough staff are present. You may also want to check the posted numbers against those reported on *Nursing Home Compare* and do your own count of staff. Medicare facilities will be required to provide this staffing information to any member of the public who requests it.

How do you determine staffing levels by using the government website *Nursing Home Compare*?

The government has a website called '*Nursing Home Compare*,' part of www.medicare.gov. It provides data on every Medicare/Medicaid Nursing certified nursing home in the United States. For each home, it reports on the residents, nursing home owners, and staff.

Nurse staffing is reported in hours per resident day. Follow the instructions on the site to find staffing data for your nursing home. And compare that information to the staffing averages in the United States or in your State.

There is a problem, however. The staffing reported on *Nursing Home Compare* generally appears to be higher than it actually is in the nursing homes. This is because its numbers are self-reported by the nursing homes and are collected at the time of the annual inspection, when residents and families say staffing is the highest. The government rarely checks the accuracy of the data. Sometimes there are transcription errors as well.

- If *Nursing Home Compare* shows more than seven, or less than one, total nursing staff hours per resident day for your nursing home, it is most likely an error and should be disregarded for this home.

- Don't assume that the national and state **average** staffing ratios shown on *Nursing Home Compare* are accurate, because the math includes errors. A better estimate of the average hprd across United States nursing homes for 2000 is 3.6—rather than the 4.1 hprd currently shown on *Nursing Home Compare*.¹²

Another problem with *Nursing Home Compare*'s data is that it may be over one year old. You can find the date of the survey at which it was collected at the bottom of the page.

Even with these problems, checking *Nursing Home Compare* can be a quick-and-dirty way to

get a sense of your nursing home's staffing ratios, and to compare them to those of other nursing homes in your area. You can also compare them to the NCCNHR/Hartford Staffing Standard, to see how far they may fall below the minimum levels that experts agree are required for good care.

- When comparing the data on *Nursing Home Compare* to the Staffing Standard, you should subtract .11 hours per resident day from the *Nursing Home Compare* numbers for licensed nurse time and for total nurse and nurse aide time.¹³

A PAGE FROM NURSING HOME COMPARE¹⁴

<http://www.medicare.gov>—click on *Nursing Homes Compare*

	Number of Residents	RN Hours Per Resident Per Day	LPN/LVN Hours per Resident Per Day	CNA Hours Per Resident Per Day	Total No. of Nursing Staff Hours Per Resident Per Day
Average in The United States	82.1	.9	0.8	2.4	4.1
Average in the State of Vermont	74.4	0.7	0.7	2.4	3.8
Berlin Health & Rehab	119	0.59	0.85	1.65	3.09

This Medicare- and Medicaid-certified nursing home has very low staffing when you compare it to the NCCNHR/Hartford Staffing Standard or to other facilities in its state.

How do you determine staffing levels by counting?

As you can see, *Nursing Home Compare's* data is somewhat flawed. To get a truer picture of your home's staffing, you're going to need to do some old-fashioned arithmetic. Here are the steps you'll need to take:

- count the number of direct care nursing staff, and then
- use the Chart below to convert your staffing ratio to hours per resident day.

Counting direct care staff

Count CNAs and licensed nurses *actually working* on the unit or floor. Usually there are three shifts: day, evening, night. (Some nursing homes use two twelve-hour shifts or some other variation.) Suppose you suspect the night shift is poorly staffed and visit at night. Assume that you find two nursing assistants caring for 50 residents. Divide the number of CNAs by the number of residents:

$$\frac{2 \text{ CNAs}}{50 \text{ residents}} = \frac{1 \text{ CNA}}{25 \text{ residents}} = \frac{1}{25} \text{ or a ratio of } 1:25$$

- This means that each 1 CNA has 25 residents to care for.

Each shift will have a different ratio. Count the aides on the day and evening shifts. Suppose you find 4 CNAs for the 50 residents on these shifts:

$$\frac{4 \text{ CNAs}}{50 \text{ residents}} = 1 \text{ CNA per for each } 12.5 \text{ residents, or a ratio of } 1:12.5$$

- This means 2 CNAs each have 12 residents to care for (ratio 1:12) and 2 CNAs each have 13 residents to care for (ratio 1:13)—for an average ratio of 1:12.5.

A ratio tells you the relationship between two things—in this case the number of staff to residents:

$$\frac{\# \text{ of staff}}{\# \text{ of residents}}$$

You can count the direct care licensed nurses in the same way. You will see these nurses (RN/LPN/LVN) giving medications, treatments, planning care and supervising CNAs. As in the case of CNAs, find the ratios by adding up the total numbers of licensed nurses on duty on a shift and then dividing that total number by the number of residents:

$$\frac{\# \text{ RNs} + \text{LPNs} + \text{LVNs}}{\# \text{ of residents}}$$

Then, you can use the Chart on the next page to change your staffing ratios to hours per resident day (hprd).

This Chart helps in two ways:

- It turns your ratio into hprd.
- It tells how your ratio compares with the different standards you just learned about.

Use it for comparison. In the example above, you found the day ratio for CNAs was 1: 12.5. All the established minimum day ratios on the chart are better than that, including Delaware (1:6) and California (1:7). Your nursing home needs more direct care staff!

Nursing Facility Workload Chart

FOR CERTIFIED NURSING ASSISTANTS (CNAs) AND LICENSED NURSES
prepared for NCCNHR by Christopher Cherney, Licensed Administrator, California¹⁵

This table approximates the number of hours of care per resident day (hprd) (listed in the column on the left) that certified nursing assistants,(CNAs) and direct-care licensed nurses in skilled nursing facilities work if they care for the numbers of residents shown (by shift). Use this table as a guide to determine whether your facility is staffed appropriately.

!!DIRECT CARE NURSES ONLY!!
Equivalent # of Residents per Licensed Nurse (RN or LPN/LVN)

Total Hours per Resident Day (HPRD)	Applicable Minimum Standard	Equivalent # of Residents per Certified Nursing Assistant (CNA)			Equivalent # of Residents per Licensed Nurse (RN or LPN/LVN)		
		Days 7a-3:30p	PMs 3p-11:30p	Nights 11p-7:30a	Days 7a-3:30p	PMs 3p-11:30p	Nights 11p-7:30a
2.00		13	17	24	30	40	59
2.10		13	16	23	29	38	56
2.20		12	16	23	27	37	54
2.30		11	15	22	26	35	52
2.40		11	15	21	25	34	49
2.50		10	14	21	24	32	47
2.60		9	14	20	23	31	46
2.70		9	13	19	22	30	44
2.75	Govt. Report Part I (Prevents Harm)	9	13	19	22	29	43
2.80		9	13	19	21	29	42
2.90		8	13	18	21	28	41
3.00		8	13	18	20	27	40
3.10		8	12	18	19	26	38
3.20	California (3.26 total)	7	12	17	19	25	37
3.30	Florida	7	12	17	18	24	36
3.40		7	12	17	18	24	35
3.50		6	11	16	17	23	34
3.60		6	11	16	17	22	33
3.70	Delaware (3.76 total)	6	11	16	16	22	32
3.80		6	11	16	16	21	31
3.90		5	11	15	15	21	30
4.00		5	11	15	15	20	30
4.13	NCCNHR/Hartford/ Govt. Report Part II (Quality Care Threshold)	5	10	15	15	20	29
4.20		5	10	15	14	19	28
4.30		5	10	15	14	19	28
4.40		5	10	15	14	18	27
4.50		4	10	14	13	18	26
4.55	NCCNHR/Hartford Adjusted Upward for Sicker Residents	4	10	14	13	18	26
5.00		4	10	14	12	16	24
5.50		3	9	14	11	15	22
6.00		3	9	14	10	13	20

Chapter 4

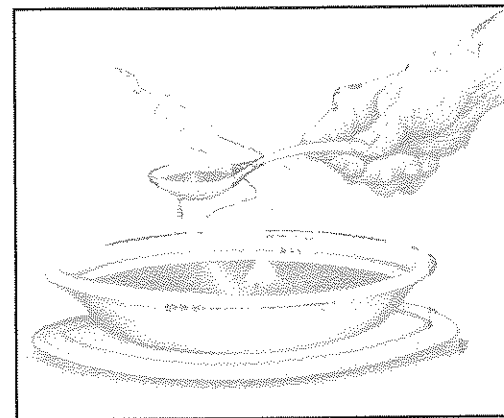
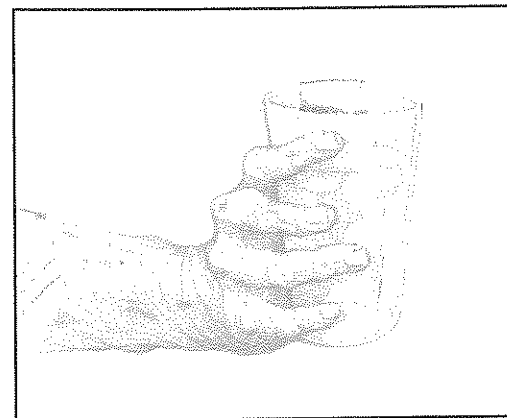
Using your information for change

Once you have found the ratio and the hours per resident day, make an appointment with the DON or Administrator to discuss the staffing. Take your notes and observations about your relative's care.

Point out that poor care and low direct care staffing ratio are linked. Your numbers and observations about your relative's poor care support your position. They are your evidence that lack of staff is related to your relative's unmet needs.

Points to Remember

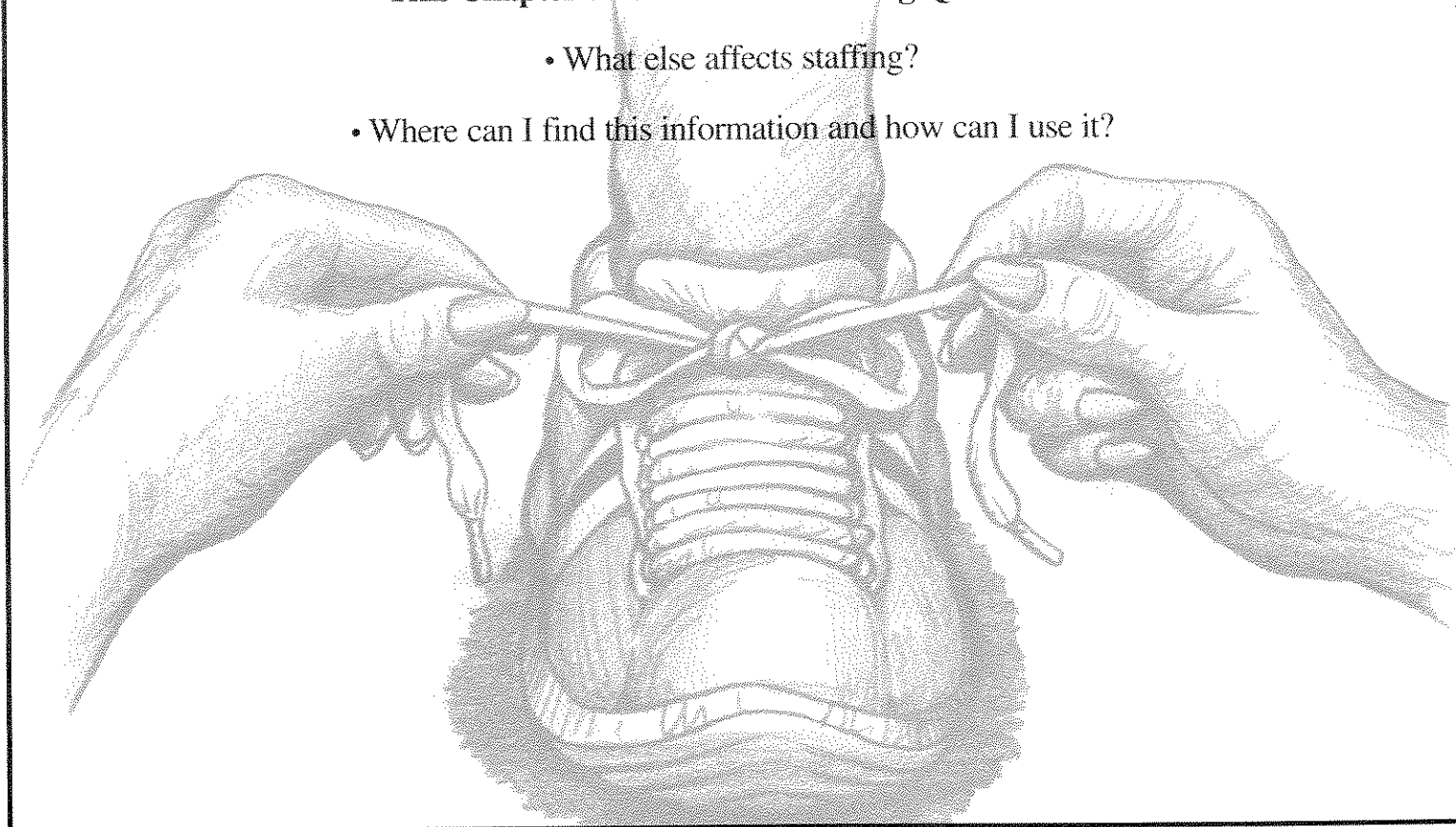
- A United States government report concludes that over 50% of nursing homes do not have enough staff to prevent harm.
- The same government report shows that over 90% of homes do not have enough staff to provide minimally acceptable care.
- The NCCNHR/Hartford Staffing Standard, which has been confirmed by the latest government study, requires **4.13 hours of direct care staff per resident day**. It is adjusted up for sicker residents and for those needing help with eating.
- Use the government website, Nursing Home Compare, for a quick-and-dirty snapshot of your nursing home's staffing ratios. Do your homework and *count* staff on duty for a more complete picture.
 - If you experience poor care, find the staff ratio for CNAs, RNs, and LPN/LVN, combine it with your observations and talk to the DON or Administrator



WHAT ELSE AFFECTS STAFFING?

This Chapter Answers the Following Questions:

- What else affects staffing?
- Where can I find this information and how can I use it?



What Else Affects Staffing?

There are more nursing staff in homes that accept residents paid for by Medicare only.

Medicare is a federal government program that pays for the sickest residents or those that need specialized intensive services such as intravenous drugs, machines to help with breathing, and intensive rehabilitative therapies. This is called skilled care. Staffing is highest in skilled care-only nursing homes or units in nursing homes that serve this high-need population. Medicare units located in hospitals have the highest staffing. Medicare pays less than 10% of all nursing home care. Stays in these units average 21 days.¹⁶

There are fewer nursing staff in homes that accept residents paid for by Medicaid only or by a mixture of Medicare/Medicaid.

Medicaid is a joint federal/state program that pays for “nursing facility care.” Medicaid is the largest payer for nursing home care. The residents are usually quite old and frail with many chronic illnesses requiring many services. In some states Medicaid pays for skilled care similar to that under Medicare—typically when Medicare payment ends. Medicaid only or Medicare/Medicaid homes have lower staffing than Medicare only homes.

The mix of Medicare, Medicaid, and private pay residents affects the quality of care. High numbers of Medicare residents provide more money for staff. Homes with high numbers of residents on Medicaid may mean less money for staff. State Medicaid payments vary greatly. While it is

unknown “how much payment is enough” some Medicaid rates are probably too low to support good care. (See Chapter 7 on advocacy for good payment.)

Private Pay

Research has found that homes with higher rates of private-pay residents provide better care, and those with fewer private-pay residents (that is, higher numbers of Medicaid residents) may provide poorer care. In 2000, 68% of the resident care was paid for by Medicaid, 23% paid privately, and 9% by Medicare.¹⁷

The Connection Between Money and Nurse Staffing

Nursing homes that often have low staff may be trying to save money. One advocate tracked the number of staff who were supposed to be on duty and then compared it to staff actually there. By eliminating one CNA on all shifts for a year, the home could save \$60,000.¹⁸

For-Profit Homes Generally have Lower Nurse Staffing.

There are three types of nursing home ownership: for-profit, non-profit and government-owned (often by a state or county).

- Sixty-five percent of the homes are for-profit. That is, money is set aside from nursing home operations for the owners or investors. They generally have fewer staff.

- Fifty-five percent of nursing homes are owned or leased by nursing home chains. They usually have fewer staff.
- Just over 28% of all nursing homes are non-profit and the rest (six and one-half percent) are government-owned. These homes reinvest profits in the home and generally have more staff.¹⁹

Smaller nursing homes have more nursing staff per resident.

Generally, smaller nursing homes, fewer than 60 beds, have more staff except for skilled nursing facilities. Larger nursing homes (over 120 beds) have less staff. They also are more often found “deficient” in living up to standards of quality care by government inspectors.²⁰

Where Can I Find This Information and How Can I Use It?

Any administrative person in the nursing home can tell you whether they accept residents paid for by Medicare, Medicaid, or private pay.

An independent source for this information is the government’s Nursing Home Compare website, <http://www.medicare.gov>— click on *Nursing Home Compare*. The information under “About the Nursing Home” includes, for each home:

- Medicare Participation
- Medicaid Participation
- Type of ownership
- Whether located within a hospital
- Whether part of a multi-nursing home chain.

You can also click on “About the Nursing Home Inspection Results” to see what the latest survey report says about deficient care or care that does not meet standards.

Caution: these reports may be old; and they only give a snapshot view. Your observations are more important.

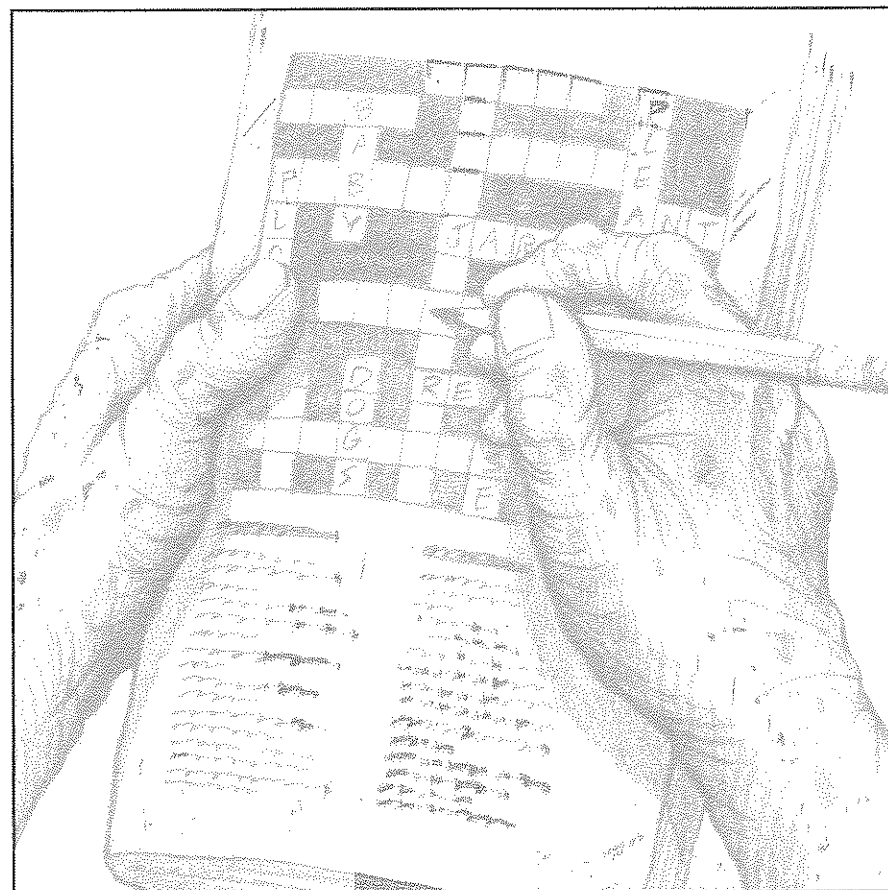
Use this information to:

- Choose a nursing home that has a likelihood of having more staff.
- Make the connection between how the money is being spent and good nurse staffing.
- Use the deficiency information if it is similar to what you are observing.

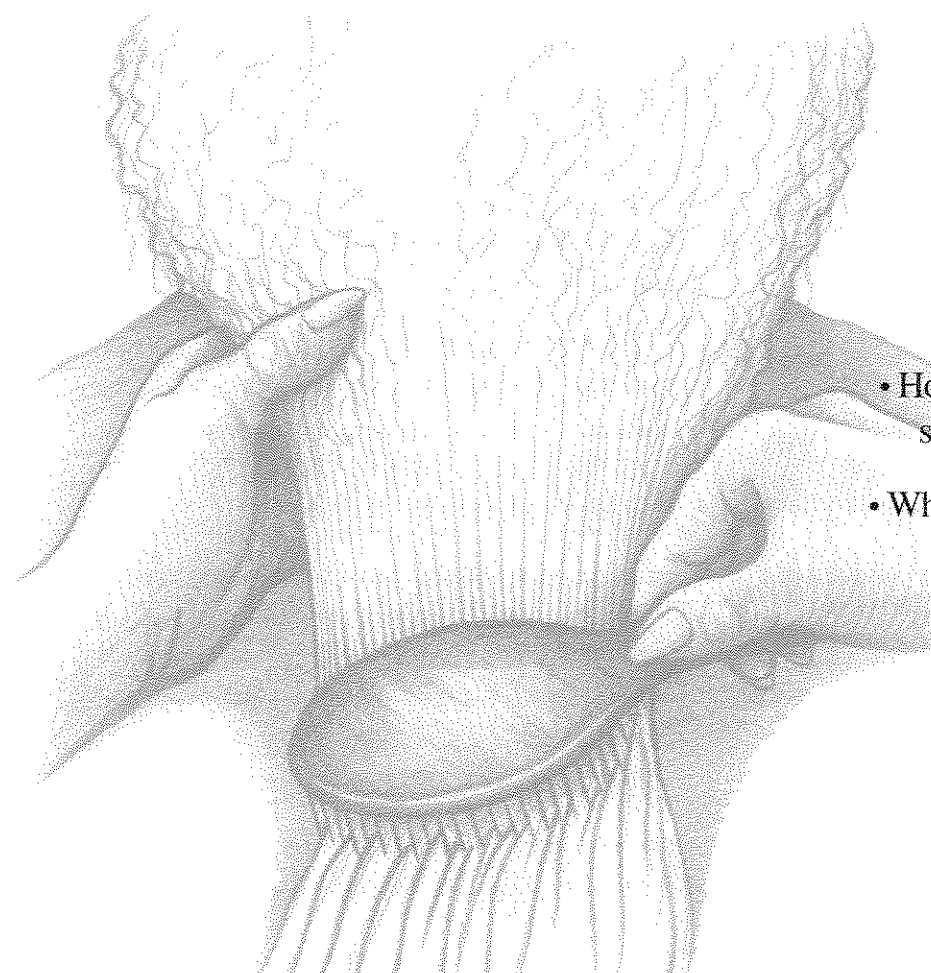
Chapter 5

Points to Remember

- Medicare-only homes generally have the highest nurse staffing.
- Homes with higher numbers of private-pay residents have more nurse staff.
- Non-profit homes generally have more nurse staff than for-profit homes.
- Government-owned homes generally have more staff than for-profit homes.
 - Smaller nursing homes generally have more staff.



ADVOCATING FOR GOOD STAFF WITHIN THE NURSING HOME



This Chapter Answers the Following Questions:

- How can I get enough well supervised staff to care for my relative or friend?
- What can I do to improve staff throughout the nursing home?

How Can I Get Enough Well Supervised Staff to Care for My Relative or Friend?

Advocate

Every resident needs an advocate. Your job is to know the facts and decide when the problem is too few staff and/or unsupervised staff. Always approach staff in non-threatening ways. Go up the chain of command: 1) unit charge nurse, 2) nurse manager in larger homes, 3) the DON, 4) the Administrator. Keep careful notes of each meeting. Use your advocacy skills at care plan meetings (see Appendix II) and at family council meetings (see Appendix III).

The following scenarios illustrate increasingly complex situations. The scenarios also show less and less response from the nursing home until the family must get help from other sources. Remember that raising questions about care and staffing could lead to retaliation against you or your relative. Still, your relative's well-being cannot be ignored. And working with others will make it harder for you or your relatives to be singled out for retaliation.

Use these three steps:

- **Gather the facts**
- **Take action**
- **Follow through**

A Single Disturbing Event: Enough Nursing Staff and the Charge Nurse Works With You

You visit your mom every day on your way home from teaching school. She usually looks forward to your visit and you review the day's events with her while having a Coke together. Today, she is miserable and looks and smells of body odor. What should you do?

1. **Gather the facts and take action:** You ask the charge nurse to come to your mother's room. After the nurse finishes helping your mother, you politely ask her to explain why your mother had such poor care.
2. **Follow through:** The next day, the charge nurse says that there was a new CNA. The DON thought she knew more than she did. With your mother present, the charge nurse explained how she would help this new CNA until she knew her job better. You check on your mother's care over the next weeks, and compliment the nursing assistant as she continues to improve.

A Disturbing Pattern of Poor Care—Informed Consumers Act with Success

Every time you visit your mom, you are on edge because often you find her disheveled and acting distressed. She tugs at her clothes. Other residents on the unit appear the same way. What should you do?

1. **Gather the facts:** Using the Poor Care checklist or your own daily log, you note what you see and when it happens. And you find out what your mother can tell you.
2. **Take action:** With your mom's permission, you share your observations with the charge nurse. She admits they are short-staffed on evenings, nights, and weekends, but says they have enough help during the day. She helps your mother, but nothing really changes.

3. **Gather more facts:** You bring up the poor care at your mother's Care Planning conference. The administrative staff do not deny low staff on nights and weekends. You talk to other family members. They agree that there is low staff on nights and weekends. Together you count the number of staff and residents. Counting licensed nurses and CNAs separately, you find the home is very short of all types of nurses over a 7-day period on each shift: Referring to the Chart on page [25], you know that on evenings, nights and weekends there is not enough staff or supervision of the staff. On weekends the staff is very low.
4. **Take action:** You and another family member ask for an appointment with the Director of

Nurses (DON). She is amazed that you know so much! She states that she has a budget to worry about. You are firm, but very polite. You expect something will be done soon. Before you leave, you make an appointment to check back with her in one week.

5. **Follow through:** You tell your mom what you did and that you will be meeting in a week with the DON. At the next appointment, the DON says she will try to meet the weekday schedule on the weekend. You agree to meet in two weeks to see what progress has been made and discuss your observations in care. You and your mother agree care is becoming more regular. You monitor numbers of staff and your mother's care for the rest of her stay.

What Can I Do To Help Improve Staffing Throughout The Nursing Home?

Action

Sometimes Low Staffing Affects Everyone in the Nursing Home.

elsewhere if you are not pleased with the care here. You know there is not a better choice close by.

A Disturbing Pattern: A Reluctant Administration: An Informed Advocate Gets Change.

Imagine noticing the same poor care for your mom. She is disheveled and agitated, but not all the time. You have gathered all your facts about the staff and observations about your mom. When you speak to your mom about talking with the Director of Nurses (DON), your mom appears concerned and says, "Just don't talk to the Administrator." What should you do?

1. **Take action:** You meet with the DON. You have many facts. Still she says there is nothing she can do. She suggests you take your mother

2. **Take more action:** You bring up the subject at the next family council meeting. Usually the social worker attends, but today the DON attends. Everyone else is recognized to speak but you. You see subtle retaliation. Finally, you simply stand up and present your information. The DON appears furious even as many family members are nodding in agreement with you.
3. **Gather more facts:** Ask other family members to help call a meeting outside the facility. Many of the family members agree to help collect information about the condition of resi-

Chapter 6

dents and staffing patterns. Each person reports similar information. You ask your mother if you may go with other families to see the Administrator. She agrees.

4. **Take action:** You make an appointment with the Administrator, but do not tell him that you will be bringing others with you. Ten family members walk in with the same type of carefully documented information on low nurse staffing and poor care. He says the home is not paid enough by the government to add any more nursing staff. He does agree to take the information to the owners. You make an appointment to see him in three weeks.

5. **Follow through:** Before the meeting, you and other families begin to notice new nursing staff on nights and weekends. You quickly collect information showing the weekend staff hours per resident day have increased from 1.9 hprd to 2.6 hprd. While this staffing is still low, the families decide to check once a month with each other to make sure the new nurse staffing levels stay in place and more are added. They thank the Administrator.

The next chapter will tell you how to get help *outside* the nursing home.

Points to Remember

- Advocacy for improving care can be long, hard work. But it can be rewarding, too. And remember, your family member's life is at stake.
- Be firm. But always be polite to nursing home staff and administration.
- Complain early, before low staff leads to poor outcomes for your relative.
- Use the care planning process in the nursing home to discuss your relative's needs and their connection to low numbers of or poorly supervised staff.
- Resident and family councils can help improve care within the nursing home. Participate and strengthen them.

ADVOCATING FOR ENOUGH NURSING STAFF: ADVOCACY OUTSIDE THE NURSING HOME

This Chapter Answers the Following Questions:

- What can I do if the nursing home doesn't improve nurse staffing?
- How can I help change the system to improve staffing for all nursing homes?



What Can I Do If the Nursing Home Doesn't Improve Nurse Staffing?

Ombudsmen

There are groups outside the nursing home that will help you advocate for better staffing in the nursing home. They are: the ombudsman program, citizen advocacy groups, and state licensing and certification agencies. Although the Nursing Home Reform Act prohibits retaliation, some nursing homes may subtly or blatantly retaliate against you or your relative. Remember that *group activity becomes very important under these circumstances.*

The Long-Term Care Ombudsman Program:

Ombudsmen are consumer advocates responsible for investigating and attempting to resolve complaints made by residents and their families or advocates. Most nursing homes have an ombudsman. The number to call to reach an ombudsman must, by law, be posted in the nursing home. Local ombudsmen provide information and help solve problems for individuals and work with resident and family councils. The state ombudsman also tries to make systemic changes that prevent care problems. Ombudsmen have been working to increase staffing requirements. The state ombudsman program is, in part, federally funded. Call or write NCCNHR for a list of State ombudsmen or visit our website, www.nursinghomeaction.org, for an up-to-date listing.

Citizen Advocacy Groups: Citizen advocates usually are financially independent of government money; they may be freer to take action with less regard for political and financial consequences. They often use the press to get stories of poor care before the public. Not every state has a group. Call or write NCCNHR for a list of citizen advocates or

visit our website, <http://nursinghomeaction.org>, for an up-to-date listing.

State Licensing and Certification Agencies:

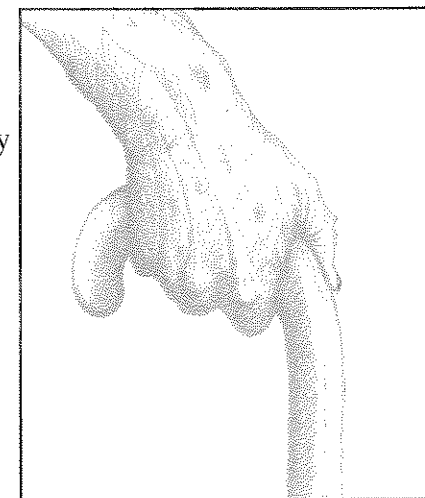
We learned in Chapter 1 that the federal government sets nursing home standards for Medicaid and Medicare certified homes. The federal and state governments together oversee those homes. The responsible federal agency is the Center for Medicare and Medicaid Services (CMS—formerly the Health Care Financing Administration). The responsible state agency is the licensing and certification agency, usually housed in the state health department. The agency inspects each home on average once a year. The state agency also accepts complaints from citizens about staffing and poor care. (The NCCNHR website, <http://www.nursinghomeaction.org>, contains contact information for each state's licensing and certification agency—click on 'Where Can I Go for Help?')

When the state surveyors inspect or follow up on a complaint, they may cite the nursing facility with a "deficiency" on nurse staffing or on a quality of care issue. During the annual inspection, residents and families are asked to participate. Surveyors usually interview the resident council and sometimes the family council members. Ask to speak with surveyors when they are in the nursing home. Share with them copies of your written observations about care and staffing levels.

In 2000, only 5.3% of facilities were cited for low staffing by the survey agency.²¹ Yet we know that 54% of facilities don't provide enough staff to pre-

vent harm to residents.²² Your information will help surveyors understand actual staffing patterns.

Use these outside sources of help to advocate for changes when the facility administration or corporation will not take action. Sometimes you must take this information to state legislators to advocate for good direct care nursing staff with licensed nurse supervisors. Read the next situation and use the information to find a solution.



A Disturbing Pattern and Refusal by the Administration to Act:

GOING OUTSIDE THE NURSING HOME

Respect

Imagine the same poor care and low nursing staff in the situation used in Chapter 5. Even with all the evidence, the administration and corporate owners do not agree to any changes. Your mother and others are at risk for general poor care leading to incontinence, pressure sores, contractures, malnutrition, and dehydration. What should you do?

1. **Gather the facts:** You continue to keep records of resident poor care and numbers of direct care staff.
2. **Take action:** You hold a meeting of family council participants outside the nursing home. You ask the local long-term care ombudsman to attend. You request to be told exactly what action the ombudsman will take on your behalf. The ombudsman tells you that the nursing home is part of a chain and most of the homes in that chain appear to be under-

staffed; the ombudsman program has had similar complaints against this nursing home before, and the nursing home adds staff for a short time after investigations and then they disappear.

The local ombudsman suggests a meeting with the state ombudsman who says that her office is trying to get legislation passed to increase nurse staffing and state funding to support more staff. She is gathering facts to take to the corporation headquarters, and asks you to report your well-documented findings to the state licensing and certification agency. The ombudsman gives you specific information about staffing and care requirements to use in your report to the state. She also gives you the mailing address and tips on writing the letter, and offers to help you track your complaint in the system.

After you have all but given up hope for any action, the licensing and certification agency pays a surprise weekend visit to the nursing home two months later. They give citations for poor quality of care and low nurse staffing. The nursing home is not allowed to admit any new residents until the situation is corrected—90 days later. The nursing home loses money and gets very bad publicity when the citizen advocacy group publishes the information to

the local newspaper. The corporation replaces the Administrator.

3. **Follow through:** The family council continues to meet outside the facility and collect information. This information is shared with the new Administrator. Care begins to improve somewhat, but the residents and families must continue to exert pressure on the corporation to maintain good nurse staffing.

A Disturbing Pattern Of Low Nurse Staffing And Neither The Nursing Home Nor The Licensing And Certification Agency Acts To Increase Staff

Imagine the same poor care and low nursing staff as in the situation above. No public agency will take responsibility even with the excellent evidence you provide. Your mother and others are at risk for general poor care and for incontinence, pressure sores, contractures, malnutrition, and dehydration. What should you do?

1. **Gather the facts:** You keep collecting the resident and staffing data. With written permission of residents or the persons legally responsible for them, you take pictures of some residents who are suffering from the lack of care.
2. **Take action:** While the local and state ombudsmen have been supporting your efforts to get action by the state licensing and certification agency, they also encourage you to take further action. The local citizen advocacy

group also supports your advocacy. From past experience, they are aware that getting timely action within the state is not likely. They suggest the following:

- Visit receptive state legislators
- Report the facts to the Regional Office of the Centers for Medicare and Medicaid Services (CMS) with copies to the central offices in Baltimore and Washington, D.C. (see CMS's website for Regional Office contact information; at the time of publication the web address to get you there was <http://cms.hhs.gov/providers/regions/default.asp>).
- Report to your Senators and Congressional Representative in Washington, D.C.

- Contact the state and local press with a story about the results of inadequate nurse staffing that is harming very sick residents.

The leading local newspaper agrees to write a series of articles on your experiences. In the process of investigating this story, the newspaper finds other residents suffering from neglect due to inadequate staff in other nursing homes. The series, run once a week for four weeks, causes a major response in the state legislature. CMS sends its own team to survey the nursing home. Citing the home for poor staffing and poor care, the home is given 60 days to hire nursing staff and improve care or lose their certification. The nursing home responds,

because they cannot remain open without certification for Medicare and Medicaid.

3. **Follow through:** With the help of the citizen advocacy group, the families in your nursing home are able to affect change. However, the families will always have to monitor care to keep the nursing home does not slip back into poor care practices. The legislature approves a pending bill to increase the staffing ratio in nursing homes. The governor threatens to veto it, but is prevented from doing so because of effective, organized citizen action.

How Can I Help Change The Larger System To Improve Nurse Staffing?

Change

Poor staffing levels in nursing homes is a complicated problem. You can help advocate for change by:

- Insisting that the government provide accurate, timely data on each nursing home's staffing ratios;
- Supporting minimum staffing standards at the state and federal levels;
- Asking legislatures to fund decent levels of direct care and supervisory nurse staffing; and
- Requiring nursing homes to be publicly accountable for spending funds only on staff salaries, benefits, and training.

As you learned in Chapter 3, over half our nursing homes don't have enough staff to prevent harm²³—much less to provide care so that “each

resident [can] reach his or her highest practicable mental, physical and social well-being.”

(Remember, that is what the law requires.) Your efforts will help put enough well-supervised staff in nursing homes to make good care a reality.

What Can I Do?

Each community must pressure its state and federal legislators to change nursing home staffing by letting them know the community supports legislation and/or regulation for good staffing. Originate petitions, fax or mail letters, phone the congressional offices and do it often. Keep the press interested in the issue.

Work with others in your family council and with local community advocacy groups and the state ombudsman to leverage the power of numbers. If

there is no community advocacy group in your area—start one!

How Will The Government Pay For More Staff?

The first question to ask is, “How is the money the industry is already getting being spent?” Right now nursing homes are not required to spend specified monies on nursing staff. Citizen pressure can change that. One way is to support state legislation that requires nursing homes to be accountable publicly for spending funds only on staff salaries, benefits, and training.

The second question is, “How much *more* will it cost?” Nationwide, the price may seem high—adding enough nurses and nursing assistants to provide just 3.45 hours of care per resident day was estimated in a recent government study to cost \$7.6 billion a year. But this would increase current expenditures by only 8%. The study said this price tag is not impossible to afford.²⁴

And this cost estimate ignores the savings that we would reap by preventing the poor medical care caused by insufficient staffing. Right now we spend:

- 2 to 12 billion dollars a year repairing preventable pressure sores.

- 3.26 billion dollars per year on nursing home residents’ incontinence, including the cost of incontinence care and the cost of its consequences, such as urinary tract infections.

The high cost of poor care also causes untold suffering for residents, their families, and the staff who care for them.²⁵ *Your* job is to tell the legislators about the present high cost of poor care—to society, to families, and to the residents themselves.

Be aware that when the states do not prevent poor care (because of low Medicaid payments), residents are hospitalized to treat the consequences. The hospital care is paid for by the federal government’s Medicare program—but the state saves money. Sadly, there is little reason for states to increase Medicaid payments and accountability, since Medicare often picks up the tab. You must graphically illustrate what happens to residents in these conditions. Keep the press on your side!

Are There Other Ways To Improve Staffing?

Yes. The next chapter is on “best practices” in nurse staffing. Some changes are small; others require *culture change* in nursing homes.

Points to Remember

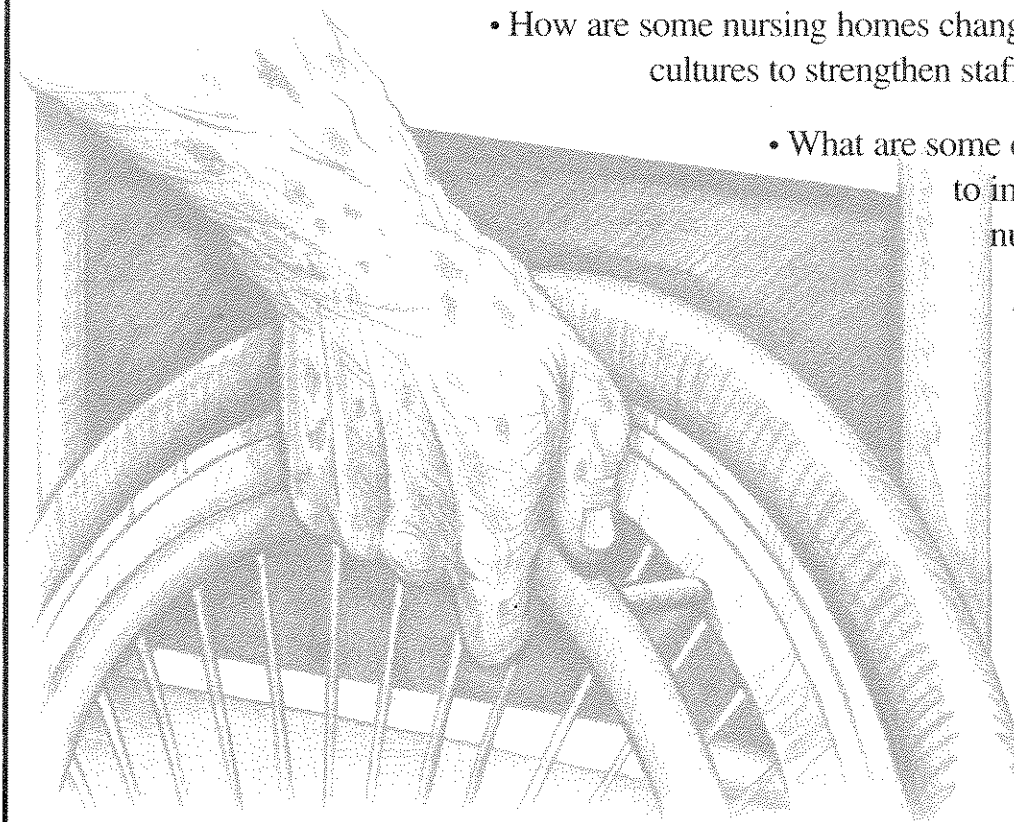
- In nursing homes, the profit motive is not necessarily the best incentive, because it encourages money going to profits before it goes to the care of people.
- Stay involved in nursing home reform after your relative leaves the nursing home. Help others with their advocacy.
- Systems changes take years to accomplish. Work with groups such as citizen advocates and ombudsmen to increase your effectiveness and conserve energy.
- Keep the press on your side.

Chapter 7

BEST PRACTICES IN NURSE STAFFING

This Chapter Answers the Following Questions:

- How are some nursing homes changing their cultures to strengthen staffing and care?
- What are some examples of changes to improve and stabilize nurse staffing?
- Where can I get information about these changes?
- Will I be able to encourage nursing homes to empower and support staff?



In the last chapter you learned how to improve the numbers of staff. This chapter discusses a related topic: good nursing home management practices that improve life for staff, and therefore for residents as well.

Research shows that below certain threshold levels of staffing, no management practices can improve quality. But if a nursing home reaches that threshold level of staffing, its good management practices can and do make a positive difference in the quality of care residents receive.²⁶

How Are Some Nursing Homes Changing the Culture to Strengthen Staffing and Care?

Relationships. We learned in Chapter 1 that residents and nursing assistants define “good care” the same way. Residents talk about nursing assistants as being patient, polite, respectful, caring, and well-trained. Nursing assistants themselves say they are listeners, hand holders, surrogate family members, nurturers, and advocates for residents. Most of these elements depend on building close human relationships. Yet, many nursing homes are managed so poorly that meaningful relationships between staff and resident are impossible.

Poorly managed nursing homes are managed from the top down. Directives for care come from the Administrator and Director of Nursing who control the CNAs at the bottom. The time for work, the order of work, the assignments of residents to staff, and decisions about resident care come from the top. Everyone, staff and residents, must fit into the same structure.

This structure may work in a steel factory. Steel made on an assembly line must meet certain standards. Each piece of steel is identical, each machine finely tuned.

But nursing homes are human institutions and the product, by law, is individualized care. Machines do not deliver individualized care—people do. Top-down structure fails to address individual differences for each staff person and resident.

Top-down management was copied from hospitals, but this traditional medical model has never worked in long-term care institutions. Why? Because it rewards task completion such as bathing and toileting on institutional schedules. But, usually one is only in the hospital a few days and can survive such regimentation. Not so in nursing homes where people stay much longer. There regimentation disregards the important differences between humans and their life-long

habits. The system is set up for nursing assistants to fail and for residents to be stripped of their humanity and individuality.

Individualized care. What if we put the residents’ and staff’s needs at the top? What if we tried to base all decisions on residents’ needs and preferences? CNAs are the ones who can “tune in” to each resident and help design care that is individualized. Let’s see how this works and what it means to resident and staff well-being.

Top-Down Management:

Bathing and bed-making from 8:00 to 9:30 am.

Mrs. Trish Taylor is being cared for by CNA Nattie Jones. Ms. Jones dislikes rotating to care for this group of 8 residents, because Mrs. Taylor and one other woman hate to be bathed. Rushed as she is, Ms. Jones stops by early to be especially nice to Mrs. Taylor, hoping she can get her to bathe after the others are done. Mrs. Taylor is nice enough, but complains that she would rather bathe at night. Ms Jones says that isn’t possible because the home requires bathing in the morning.

Ms. Jones completes her other work and goes back to Mrs. Taylor. Mrs. Taylor tries to be nice, but being hauled off to have a bath when she doesn’t want it makes her furious with Ms. Jones. She screams at Ms. Jones, who walks out of the room. Ms. Jones’s supervisor “writes her up” for not having the baths done and for being rude to Mrs. Taylor. Ms. Jones feels like quitting.

Contrast this with, Bottom-Up Management:

Bathing will be done as often as each resident requires and according to the resident’s “customary daily routine.”

Mrs. Trish Taylor is being cared for by CNA Nattie Jones. Ms. Jones cares for this group of 8 residents most days. Ms. Jones knows their individual schedules very well and has a smooth routine. Mrs. Taylor likes to get up first thing because she sleeps soundly after her bath at night. It relaxes her, and they kid with each other about how she “washes her cares away.” Mrs. Taylor still thanks Ms. Jones for helping her talk this through at a care plan meeting many months ago. “I like to be there for you, Mrs. Taylor. You’ve helped me get a little different perspective on my kids too. Thanks.” Ms. Jones’s supervisor compliments her on how well Mrs. Taylor looks and acts. The supervisor asks Ms. Jones if she has any questions. Ms. Jones answers “Not about Mrs. Taylor, but I’m worried about Mr. Abbott. Remember, he is demented. He is just not himself. Would you see him with me?”

The Important Elements in Ms. Jones’s Bottom-Up Style of Care of Mrs. Taylor Are:

- Residents retain choice and control over their lives.
- Nursing assistants care for the same residents most days.
- Nursing assistants know each resident well and become their advocate.
- Nursing assistants participate in care planning conferences.
- There is a mutual sharing. Problem solving is a two-way street.
- A give-and-take relationship has developed.
- Licensed nurses respect the work nursing assistants do with and for residents.
- Licensed nurses supervise and mentor nursing assistants.

Remember in the top-down scenario, Mrs. Taylor's wishes were not respected, and the nursing assistant wanted to quit. Ms. Jones would either become "hardened" by these repeated injustices or leave. Either way, residents and staff lose.

There is a new ray of hope in nursing homes, because a number of forward-looking facilities are trying to adopt individualized, resident-directed, bottom-up management style and care practices.

The following chart shows the differences between **Top-Down** ("Traditional") and **Bottom-Up** ("Pioneer") management practices:

TRADITIONAL MEDICAL MODEL	PIONEER PRACTICES
Staff provide "treatments"	Nurture the human spirit in addition to meeting medical needs
Residents follow facility routine	Facility follows residents' routines
Staff float	Permanent Assignments
Staff make decisions for residents	Residents make their own decisions
Facility belongs to staff	Facility is residents' own home
Structured activities	Spontaneous activity opportunities around the clock
Departmental focus	TEAM Focus!
Staff know residents by diagnosis	Staff know residents as a person

Many of them belong to the "Pioneer Network," an organization devoted to changing the culture of nursing homes. Current nursing homes literally "kill the human spirit" for both residents and staff. The pioneers show in practice that new ways can decrease staff turnover and increase individualized care. For example, in these homes, nurse assistants are often called "resident assistants"—this new title helps build relationships.

What Are Some Examples of Changes to Improve and Stabilize Nurse Staffing?

Some specific practices that improve and stabilize nurse and nursing assistant staffing:

- Nursing assistant input into the design of their work schedules. Because nursing assistants often have many responsibilities at home, absenteeism declines when they are closely involved in the design of their work schedules.
- Flexible shift hours.
- Good training and supervision of CNAs. Well-trained and well-supervised CNAs know how to help residents remain independent in the activities of daily living—eating, bathing, toileting, dressing, and moving around; and doing well in their jobs makes them feel better about themselves and their jobs and reduces turnover.
- A system for mature and competent nursing assistants to mentor others. Typically, the training CNAs get during the first four months of work does not prepare them to organize and individualize care. Mentoring helps new CNAs stay on the job longer.
- Cross-training staff for jobs such as food handling, nurse assisting, and cleaning. Using universal workers can allow meals to be cooked and served family style on the unit. Laundry and cleaning can be taken care of in the course

of the day. Resident needs are met more quickly, and a home-like, family atmosphere is created.

- Specialized training in individualized care. CNAs who know each resident very well are better able to meet individualized needs. The approach promotes relationships, a key to long-staying CNAs. The approach is also key to effective care planning, and nursing assistants involved in care planning stay on the job longer.

Many of these methods for improving staffing are successful when a facility has a nursing assistant Career Path training program. The career path increases knowledge and skills of CNAs who have worked successfully at a nursing home over 12 months or more. One such program included three eight-week "paths": 1) individualized care, 2) pioneering approaches to quality of life, and 3) leadership. At each level the CNAs are paid a bonus four times a year—a bonus that increases with each of the paths completed, or up to \$1000 per year.²⁷ Since it costs about \$3000 for a facility to hire and train a new nursing assistant,²⁸ the program pays for itself.

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Where Can I Get Information About These Practices?

Many organizations are able to give information about these practices. Here is some background on the major ones (see Appendix VI for addresses):

National Citizens' Coalition for Nursing Home Reform: This book originated because our Board and members believe that best care practices involving CNAs and Licensed nurses are the keys to good care. NCCNHR is the national organization representing consumer interests in policy discussions involving nursing homes and assisted living. NCCNHR advocates for better federal nurse staffing standards. In order to make that possible, NCCNHR advocates for adequate payment to nursing homes in both the Medicare and Medicaid programs tied to strong public accountability for both public and private dollars at the state and federal level.

Pioneer Network: This organization provides training and a clearinghouse of literature, research, and mentors. The Pioneers demonstrate new ways

to decrease staff turnover and increase individualized care, and foster a climate of culture change for long-term caregiving.

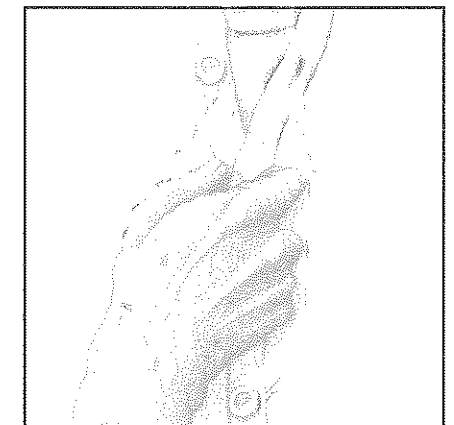
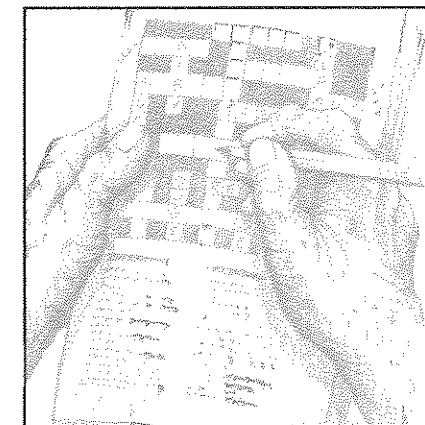
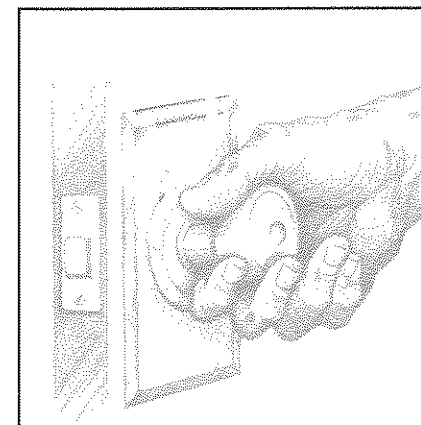
Career Nurse Assistant Programs: This organization believes that Nurse Assisting is a career and that CNAs need professional development within their career track to develop leadership, mentoring skills, and knowledge. Career Nurse Assistant Programs provides leadership training in coordination with the NCCNHR Annual Meeting and in many states.

Direct Care Alliance: This organization developed from a worker-owned home care agency in New York – The Paraprofessional Institute. The Direct Care Alliance provides training and mentoring for workers. DCA also has the excellent statistics on workers. These statistics can be used in advocacy work at the state and national level.

Will I Be Able To Encourage A Nursing Home To Empower And Support All Staff?

This guide began with identifying good care and poor care. Good care requires enough skilled nursing staff. You have learned who works in nursing homes and what they do. You have learned how to count nursing staff and know when staffing levels are too low. And you have learned to advocate for two things: 1) enough staff, and 2) good staffing practices. Use the skills you have learned to improve nurse staffing. While it is easier to change a unit or one nursing home, large and small chains are trying to make changes too. Help them know how to empower the staff and decrease turnover so that residents will have good stable staff to care for them!

*Get more information about how to get good care in nursing homes from NCCNHR's flagship book, **Nursing Homes: Getting Good Care There** (Impact Publishers 2002), by Sarah Burger, Sara Hunt, Virginia Fraser, and Barbara Frank. Order it on-line at <http://www.nursinghomeaction.org> for \$11.95 + shipping and handling.*



APPENDIX I

DEFINITIONS

Chemical Restraint	A psychoactive drug acts on the brain and influences thinking, feeling, and reacting. A psychoactive drug used to treat behavioral symptoms in place of good care is a chemical restraint.
Contracture	Temporary or permanent shortening of muscles; left untreated, can cause a resident's body to curl up, with arms pressed tightly to sides, like an infant in a fetal position. Typically this occurs when resident's joints are not moved.
Dehydration	Too little fluid in the body—a major cause of hospitalization. When there is not enough staff to give fluids residents can become dehydrated.
Feeding Tube	Tube inserted through nose to stomach, or directly into the stomach or intestine, for purpose of administering nutrition. Sometimes used because assisting someone to eat takes staff time.
Incontinence	Inability to control bladder or bowel movements. This may happen when a resident does not get help with toileting.
Malnutrition	Residents do not get enough food and lose weight. A major cause of malnutrition can be poor nurse staffing.
Physical Restraints	Anything near or on your body which restricts movement or your ability to get to a part of your body. Includes: wrist, waist, or ankle restraints, geri chair, and sometimes siderails.
Pressure Sore	Persistent red spot on the skin; can also be a break in the skin, deep sore, or crater-like wound. Found, most commonly, on the end of spine (coccyx); also found on the hips, heels, elbows, shoulders, and, in rare cases the ears. Adequate food, water, turning and cleanliness prevent pressure sores.
Urinary Catheter	Flexible tube inserted into a body cavity or vessel to remove urine, sometimes in place of toileting.

APPENDIX II

CARE PLANNING GUIDE

ASSESSMENT and CARE PLANNING: THE KEY TO GOOD CARE

Each and every person in a nursing home has a right to good care under the 1987 Federal Nursing Home Reform Law. The law, which is part of the Social Security Act, says that a nursing home must help each resident "attain or maintain" his or her highest level of well being—physically, mentally, and emotionally. To give good care, staff must *assess* and *plan* care to support each resident's life-long patterns, current interests, strengths, and needs. Care planning conferences are a valuable forum for residents and families to voice concerns, ask questions, give suggestions, learn nursing home strategies, and give staff information (such as resident background and daily routine). This requirement in the law is vital to making sure residents get good care.

Resident Assessment

Assessments gather information about the health and physical condition of residents and how well residents can take care of themselves. This includes assessing when help may be needed in activities of daily living (ADLs) or "functional abilities" such as walking, eating, dressing, bathing, seeing, hearing, communicating, understanding, and remembering. Assessments also should examine a resident's habits, activities, and relationships in order to help him or her live more comfortably and feel at home in the facility. Assessments help staff to be aware of strengths of

the resident and also to determine the reason for difficulties a resident is having.

An example of where a good assessment helps: A resident begins to have poor balance. This could be the result of medications, sitting too much, weak muscles, poorly fitting shoes, or a urinary or ear infection. Staff must find out the cause of a problem in order to give good treatment. Figuring out the cause is much easier with a good assessment.

Assessments must be done within 14 days of the resident's admission to a nursing home (or seven days for Medicare residents) and at least once a year after that. Reviews are held every three months and when a resident's condition changes.

Plan of Care

After the assessment is completed, the information is analyzed and a care plan is developed to address all the needs and concerns of the resident. The initial care plan must be completed within seven days after the assessment. The care plan is a strategy for how the staff will help a resident every day. This care plan says what each staff person will do and when it will happen (for example, a nursing assistant will help Mrs. Jones walk to each meal to build her strength). Care plans must be reviewed regularly to make sure they work and must be revised as needed. For care plans to work, residents must feel they meet their needs and must be comfortable with them.

Care Planning Conference

An interdisciplinary team—nurse, nurse assistant, activities and dietary staff, and social worker—develops the care plan **with critical input from the resident and/or family members**. All participants discuss the resident's care at a Care Plan Conference to make certain that all medical and non-medical issues, including meals, activities, therapies, personal schedule, medical and nursing care, and emotional needs are agreed upon and addressed. Resident and family member concerns should be listened to by staff and addressed in the care plan. A good Care Plan Conference takes time. It should not be rushed, and could take at least one hour. Every 90 days after development of the initial plan, or whenever there is a big change in a resident's physical or mental health, a Care Plan Conference is held to determine how things are going and if changes need to be made.

Good Care Plans Should:

- Be specific to each resident;
- Be followed as an important guideline for providing good care for the resident;
- Be written so that everyone can understand them and know what to do;
- Reflect the resident's concerns and support his or her well-being;
- Use a team approach involving a wide variety of staff and outside referrals as needed;
- Assign tasks to specific staff members; and
- Be re-evaluated and revised routinely.

Steps for Residents and Family Participation in Care Planning

Residents and family members have the right to be involved in the care plan conference in order to make choices about care, services, daily schedule, and life in the nursing home. Even if a resident has dementia, involve them in care planning as much as possible. Be aware that they may understand and communicate at some level and help the staff to find ways to communicate and work with them. They can express when they hurt or suffer if they are actively listened to. Participating in care plan conferences is a way to be heard, raise questions, and come to a clear agreement with the facility about how the resident will be cared for.

Before the meeting:

- Ask staff to hold the meeting at a convenient time for you and/or your family member;
- Ask for a copy of the current care plan (if one already exists) so that you can examine each aspect thoughtfully;
- Know about or ask the doctor or staff about your loved one's condition, care, and treatment;
- Plan your list of questions, needs, problems, and goals; and
- Think of examples and reasons to support changes you recommend in the care plan.

During the meeting:

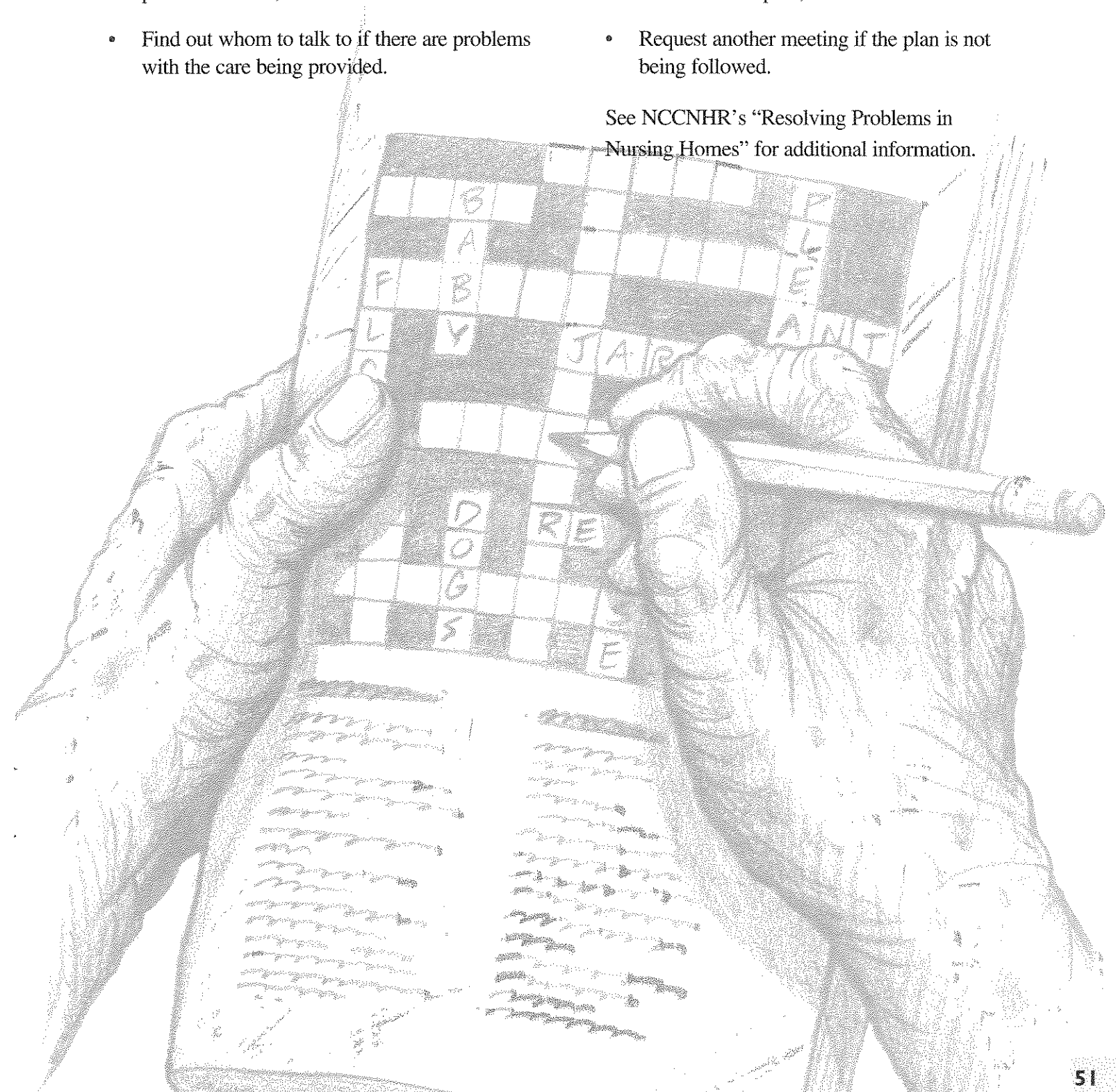
- Make sure the resident is involved and listened to carefully;
- Discuss options for treatment and for meeting the resident's needs and preferences;

- Ask questions if you need terms or procedures explained;
- Be sure you understand and agree with the care plan and feel it meets the resident's needs;
- Ask for a copy of the care plan;
- Find out whom to talk to if changes in the care plan are needed; and
- Find out whom to talk to if there are problems with the care being provided.

After the meeting:

- Monitor whether the care plan is being followed;
- Inform the resident's doctor about the care plan if s/he was not directly involved;
- Talk with nurse aides, staff, and the doctor about the care plan; and
- Request another meeting if the plan is not being followed.

See NCCNHR's "Resolving Problems in Nursing Homes" for additional information.



APPENDIX III

FAMILY COUNCILS

NCCNHR

National Citizens' Coalition for Nursing Home Reform

President Diane Menio
Executive Director Donna R. Lenhoff, Esq.

1424 16th Street, N.W.
Suite 202
Washington D.C. 20036
Phone 202.332.2275
Fax 202.332.2949
www.nursinghomeaction.org

Why Family-Led Family Councils Benefit Families, Residents, and Facility Personnel Open Communication

- Family members feel free to voice concerns without reservation in meetings where staff are not present
- Gives facilities honest feedback to use for continuous quality improvement efforts

Purpose

- Gives family members a place to constructively channel their anger and concern within the nursing home as an alternative to filing complaints with outside agencies such as the ombudsman program or survey agency
- The opportunity to meet privately with other families enables family members to discuss and consolidate common concerns, come up with ideas for how to address issues, and then focus on purposeful goals
- Keeps facility staff from being overwhelmed by a barrage of individual complaints all at once
- Allows families and the facility to focus on common facility-wide concerns and make improvements for all residents

Empowerment

- Families can come up with creative ideas about how concerns can be addressed
- Builds a trusting relationship between families and the facility
- Federal regulations allow families to meet privately with facility staff attending by invitation only

The Nursing Home Reform Act of 1987 Requires:

Facilities certified for Medicare and Medicaid must provide a meeting space, cooperate with the council's activities, and respond to the group's concerns. Nursing facilities must appoint a staff advisor or liaison to the family council, but staff and Administrators have access to council meetings only by invitation. While the federal law specifically references "families" of residents, close friends of residents can and should be encouraged to play an active role in family councils, too.

For more information, please contact NCCNHR at the address above.

Prepared for NCCNHR's Maryland Family Council Project May 2000.

APPENDIX IV

WHO ELSE WORKS IN A NURSING HOME? WHAT DO THEY DO?

Physician—When a resident enters a nursing home, orders for care from a physician must be in place. A physician sees residents every 30 days for the first three months and then every 60 (SNF) or 90 (NF) days. Each nursing home must have a physician medical director. That physician, who oversees medical care, assures each resident is seen regularly. Some residents have the medical director as their physician. Others use their own physician.

Nurse Practitioner—Some states allow a physician's assistant (PA) or a nurse practitioner (NP) to provide some care to residents for a physician. Research shows that the presence of a PA or NP improves care.²⁹

Pharmacist—A licensed pharmacist must review each resident's drugs monthly. Residents often take many drugs. The pharmacist's knowledge can prevent bad outcomes from drugs. The pharmacist reports his/her findings to the physician and the director of nursing.

Social Worker—A nursing home with more than 120 beds must have a full-time social worker with a bachelor's degree. Smaller homes may use a part-time social worker or consultant. A social worker works with residents and families on many quality of life issues including admission adjustment, end-of-life choices, advance directives, and discharge from the nursing home to the community.

Other Mental Health Professionals—such as geriatric psychiatrists or psychologists—are used as needed, generally on a contract basis.

Dietitian—Nursing homes must use a dietitian either full-time, part-time, or as a consultant. If the dietitian is not full-time, a director of food services works with a consultant. Other dietary staff include the cook, dishwashers, and dietary aides who deliver the food to residents. The dietitian assures that all meals meet nutritional and special dietary needs of residents.

Activities Professionals—Those qualified to run this program may be a licensed or registered therapeutic recreation specialist, occupational therapist, occupational therapist assistant, recreation therapist, or activities professional with two years experience in a social or recreational program in a health care setting. The activities professional is responsible for both individual and group activities.

Rehabilitation Therapists—Therapists are licensed by the state. Many nursing homes have a physical therapy department with physical and occupational therapists. Others contract for those services. Speech-language services are usually used according to resident needs.

Dental Services—A nursing facility must assist residents to obtain routine and 24-hour emergency dental services. Residents must pay for this service except in the states where Medicaid pays for it.

Laboratory, Radiology, and other Diagnostic Services—Nursing homes must obtain these services as needed by residents.

APPENDIX V

PROPOSED MINIMUM STAFFING STANDARDS FOR NURSING HOMES*

(Adopted by the NCCNHR Membership, November 1998)

WHEREAS, adequate nursing staff is needed for quality care, and

WHEREAS, the role of the nurse aide and nurse are clearly defined in the delivery of quality of care, and

WHEREAS, nursing home residents need 24 hour care every day, seven days a week, and

WHEREAS, minimum standards not be treated as maximums, and that actual staffing levels be sufficient to enable each resident to achieve the highest practicable quality of care and quality of life,

THEREFORE BE IT RESOLVED, that these standards be adopted by the NCCNHR membership as a model framework for state and federal action:

Direct Care Staffing Standard

- The minimum number of direct care staff must be distributed as follows:
Minimum Direct Care Staff (RN, LVN/LPN, or CNA):

Day Shift	1 FTE for each 5 Residents	(1.60 hours per resident day)
Evening Shift	1 FTE for each 10 Residents	(0.80 hours per resident day)
Night Shift	1 FTE for each 15 Residents	(0.53 hours per resident day)

Minimum licensed nurses (RN and LVN/LPN) providing direct care, treatments and medications, planning, coordination and supervision at the unit level:

Day Shift	1 FTE for each 15 Residents	(0.53 hours per resident day)
Evening Shift	1 FTE for each 20 Residents	(0.40 hours per resident day)
Night Shift	1 FTE for each 30 Residents	(0.27 hours per resident day)

Administration Standard

- A full-time RN with a Bachelor's Degree would be the Director of Nursing (A provision for grand-fathering current RN Directors would be allowed for a specified time period)
- A part-time RN Assistant Director of Nursing (full-time in facilities of 100 beds or more) (This person may also be the MDS coordinator.)
- A part-time RN Director of In-Service Education (preferably with adult education and gerontology training). (Full-time in facilities of 100 or more.)
- A full-time RN nursing facility supervisor must be on duty at all times, 24 hours per day, 7 days per week.

- The minimum total number of direct nursing care staff would be 4.13 hours per resident day.
- These requirements should be in place for all residents, regardless of payment source and no waivers of these standards should be allowed. (Administrative staff would be excluded from the direct care standard except in facilities with 30 or less residents.)
- Nurses and nurse aides must be counted only once in determining the adequacy of staff in skilled nursing facilities and nursing facilities that operate non-nursing units and home agency services.
- Staffing must be ADJUSTED UPWARD for residents with higher nursing care needs. For example, residents classified under the Resource Utilization Groups (RUGs) as being in the category requiring extensive nursing care received an average of 6.2 hours of nursing time per resident day in the 1995-1997 time studies.**

Mealtime Nursing Staff

- Direct care staffing standards will take into account specific needs of residents at mealtimes. At all mealtimes, there will be:
1 nursing FTE for each 2-3 Residents who are entirely dependent on assistance.
1 nursing FTE for each 2-4 Residents who are partially dependent on assistance.
- Residents must be encouraged to remain as independent as possible in feeding themselves, and this may require more staff time than would be required if residents were fed entirely by someone.
- Nursing staff that assist with feeding must be certified nursing assistants who are adequately trained in feeding procedures and licensed nurses must supervise them.

Education and Training

- All licensed nurses in nursing homes must have continuing education in care of the chronically ill and disabled and/or gerontological nursing (at least 30 hours every two years).
- Nursing assistants should have a minimum of 160 hours of training, including training in appropriate feeding techniques (at least 12 hours relevant training every year).

Nurse Practitioners

- Each nursing home is strongly urged (but not required) to have a part-time Geriatric or Adult Nurse Practitioner and/or a Geriatric Clinical Nurse Specialist on staff (full-time for 100 beds or more).

Disclosure: Public Right to Staffing Levels

- A long-term care nursing facility shall post for each wing and/or floor of the facility and for each shift the current number of licensed and unlicensed nursing staff directly responsible for resident care and the current ratios of residents to staff, which show separately the number of residents to licensed nursing staff and the number of residents to (direct caregivers) unlicensed staff. This information shall be displayed on a uniform form supplied by the licensing agency.
- Such information shall be posted for the most recently concluded cost reporting period in the form of average daily staffing ratios for that period.
- This information must be posted in a manner that is visible and accessible to all residents, their families, caregivers, and potential consumers in each facility.

- A poster provided by the licensing agency that will describe the minimum staffing standards and ratios (listed on page 55) shall also be posted in the same vicinity.
- A list, in at least 48 point type, showing the first and last names of nursing staff on duty, shall be posted at the beginning of each shift prominently on each unit.

* Builds on the Nurse Staffing Standards accepted by the National Citizens' Coalition for Nursing Home Reform, 1995.

** 1995-1997 HCFA time studies found about 8% of residents were in the RUGs category that requires extensive nursing care. Approximately 50% of the time for the extensive nursing residents in the HCFA 1995-1997 national time studies were for licensed staff and of that 57% was for RN time. For residents in the rehabilitation RUGs category, the nursing time spent averaged 5 hours per resident day, of which 50% was for licensed staff time and, of that, 50% was RN time. Burke, B., and Cornelius, B. 1995 and 1997 Staff Time Measurement Study. Baltimore, MD: Health Care Financing Administration Multi-state Case Mix Demonstration Project, August 1998.

APPENDIX VI

BEST PRACTICES INFORMATION

National Citizens' Coalition for Nursing Home Reform

1424 16th Street, NW
Suite 202
Washington, DC 20036
Phone: (202) 332-2275
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Website: <http://nursinghomeaction.org>

Career Nurse Assistant Programs

3577 Easton Road
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Phone: (216) 825-4342
Fax: 330-745-8261
Website: www.cna-network.org

Pioneer Network c/o Lifespan—Long-Term Care Ombudsman Program

1900 S. Clinton Avenue
Rochester, NY 14618
Phone: (716) 244-8400 ext. 115
Fax: (716) 244-9114
Website: www.pioneernetwork.org

Direct Care Alliance c/o Paraprofessional Health Care Institute

349 East 149th Street, Suite 401
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ENDNOTES

¹National Citizens' Coalition for Nursing Home Reform, *Consumer Perspective on Quality Care: The Residents' Point of View*, Washington, D.C., 1985.

²Nursing Home Community Coalition of New York State, *Preparing for Quality Caregiving in Nursing Homes: A Major Change is Needed in the Training and Education of Nurse Aides*, March 2000.

³Nursing Home Reform Act, 42 U.S.C. 1302, 1395 et seq., part of the Omnibus Budget Reconciliation Act of 1987 (OBRA, 1987). Public Law 100-203, Subtitle C: Nursing Home Reform. Signed by President, Washington, D.C., December 22, 1987.

⁴The licensed nursing requirements may be waived by the federal government under both the Medicaid and Medicare programs. According to the Health Care Financing Administration Report to Congress, "Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes," (July 2000) [hereafter "Appropriateness of Minimum Nurse Staffing Ratios Part I"], Vol. I, only 27 waivers were granted as of March 11, 2000. Twenty-three came from Minnesota and Oklahoma. When a waiver is in place, the state or the Secretary must notify the Ombudsman and the facility must notify all residents and their immediate families.

⁵Institute of Medicine, *Hospital and Nursing Home Staffing: Is It Adequate?*, Washington, D.C., 1996.

⁶Harrington, C., *Nursing Home Staffing Standards in State Statutes and Regulation*, University of

California, San Francisco, CA, April 2001.

⁷Harrington, C., Woolhandler, S., et al., "Does Investor Ownership of Nursing Homes Compromise Quality of Care?" American Journal of Public Health, September 2001, Vol. 91, No. 9.

⁸From stories collected from residents, families of residents, and nursing home workers in support of the 1999 Massachusetts Nursing Home Reform Act.

⁹*Appropriateness of Minimum Staffing Ratios in Nursing Homes Part I, Vol. I* pp. 4-8.

¹⁰Centers for Medicare and Medicaid Services, *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes* (March 2002) [hereafter "Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes Part II"].

¹¹Harrington, Carrillo, and Wellin, *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1994 Through 2000*, Department of Social and Behavioral Sciences, University of California, San Francisco, CA (2001) [hereafter *Nursing Facilities, Staffing, Residents, and Facility Deficiencies*], p. 75 Table 32.

¹²*Nursing Facilities, Staffing, Residents, and Facility Deficiencies*, p. 75 Table 32.

¹³This is to account for the seven minutes (.11 hprd) of administrative RN and LPN/LVN nursing that *Nursing Home Compare* includes that the NCCNHR/Hartford Standard does not include.

¹⁴<http://www.medicare.gov/NHCompare/Search/AboutStaff.asp>, visited May 4, 2002.

ENDNOTES

¹⁵The assumptions used in creating this chart included:

Length of nursing shift for all CNAs and licensed nurses:	8.0 hours
Percent of direct care hours from CNAs:	70.0%
For 2.0 HPRD, day shift CNA hours as percent of total CNA/hours:	42.9%
Incremental percent of day shift CNAs per increase of 0.1 HPRD, from 2.0 HPRD:	0.057
PM shift CNA hours as percent of PM + Night CNA hours:	59.0%
Night shift CNA hours as percent of PM + Night CNA hours:	41.0%
Percent of direct care hours from licensed nurses:	30.0%
Day shift licensed hours as percent of total licensed nurse hours:	44.4%
PM shift licensed hours as percent of total licensed nurse hours:	33.1%
Night shift licensed hours as percent of total licensed nurse hours:	22.5%

¹⁶September 25 CMS document, *Streamlining the MDS Resident Assessment Process under SNF, PPS*.

¹⁷*Nursing Facilities, Staffing, Residents, and Facility Deficiencies*, p. 19.

¹⁸With permission from Joseph Malloy, family member, from Maryland.

¹⁹*Nursing Facilities, Staffing, Residents, and Facility Deficiencies*, pp. 20-22.

²⁰Harrington et al., "Nursing Home Staffing and its Relationship to Deficiencies," Journal of Gerontology, Social Sciences Section, Vol 55B, No. 5 S278-287.

²¹*Nursing Facilities, Staffing, Residents, and Facility Deficiencies*, p. 108.

²²*Appropriateness of Minimum Nurse Staffing Ratios Part I*, pp. E.S.6.

²³*Appropriateness of Minimum Nurse Staffing Ratios Part I*, pp. E.S.6.

²⁴*Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes Part II*.

²⁵"The High Cost of Poor Care," National Citizens' Coalition for Nursing Home Reform Annual Meeting packet (October 1991).

²⁶*Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes Part II*.

²⁷Apple Health Care, Inc., CNA's Career Path, National Citizens' Coalition for Nursing Home Reform, Annual Meeting 1999, Washington, D.C.

²⁸Robertshaw, Nicky, "Understanding the Needs of Direct Care Staff," Provider, Oct. 1999, pp. 39-53.

²⁹Institute of Medicine, *Hospital and Nursing Home Staffing: Is It Adequate?* Washington, D.C. 1996.

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