The National CONSUMER VOICE for Quality Long-Term Care formerly NCCNHR

# State Nursing Home Staffing Standards

## SUMMARY REPORT

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## Introduction

Chronic understaffing has been a serious problem in nursing homes for decades and has been exacerbated by the COVID-19 pandemic. While there are numerous factors contributing to this problem, one major cause is the lack of adequate minimum staffing standards at both the state and federal levels. Minimum standards ensure that staffing will not fall to a level that would be harmful to residents.

Local, state, and national advocates have pushed for minimum staffing standards for years. Knowledge of the range of state staffing requirements can be very useful in these efforts. To that end, the focus of this summary report is to present staffing requirements from each state and analyze how they compare to each other and to levels recommended by research conducted for the federal government. This information can also be helpful to policymakers, researchers, and the media.

## Relationship Between Staffing and Quality of Nursing Home Care

### Minimum Staffing Levels

The important relationship between nurse and nursing assistant staffing levels and outcomes of care has been well-documented. In fact, a systemic review of 87 research articles and reports from 1975-2003 found that high total staffing levels, especially of licensed staff, were associated with higher quality of care in terms of resident outcomes, particularly functional ability, pressure ulcers, and weight loss.[1]

The federal government itself has acknowledged the relationship between care quality and staffing levels. According to the Centers for Medicare and Medicaid Services (CMS), "There is considerable evidence of a relationship between nursing home staffing levels and resident outcomes. The CMS Staffing Study, among other research, found a clear association between nurse staffing ratios and nursing home quality of care."[2]

The many problems residents can experience as a result of inadequate staffing include higher mortality rates; decreased physical functioning; increased antibiotic use; more pressure ulcers; catheterization; urinary tract infections; higher hospitalization rates; and more weight loss and dehydration.[3]

### Registered Nurse (RN) Time

Studies have shown a relationship between greater RN presence in facilities and higher quality of care. Higher RN staffing levels are associated with fewer pressure ulcers; lower restraint use; decreased infections; lower pain; improved activities of daily living (ADLs); less weight loss, dehydration, and insufficient morning care; less improper and overuse of antipsychotics; and lower mortality rates.[4]

1 Bostick, J.E., Rantz, M.J., Flesner, M.K. and Riggs, C.J. (2006). Systematic review of studies of staffing and quality in nursing homes. *J. Am Med Dir Assoc.* 7:366-376.
2 Design for Nursing Home Compare Five-Star Quality Rating System: Technical Users' Guide. October 2019.
3 Charlene Harrington et al: "Experts Recommend Minimum Nurse Staffing Standards for Nursing Facilities in the U.S." The Gerontologist (2000) 40 (1): 5-16.
4 Harrington C, Dellefield ME, Halifax E, Fleming ML, Bakerjian, D. Appropriate Nurse Staffing Levels for U.S. Nursing Homes. Health Services Insights. 2020; vol. 13.

Increased RN presence is essential for a number of reasons. Over the last several decades, the acuity level of nursing home residents has increased dramatically.[5] This requires expert nursing skills and a high level of knowledge for oversight of care and to anticipate, identify and respond to changes in condition. The higher acuity level of residents requires the presence in the facility at all times of someone who is capable of assessing and responding when residents' medical conditions suddenly change or deteriorate. RNs by training and licensure are the only nursing staff with the skills that are essential for timely assessment, intervention, and treatment.

# Evidence-based Staffing Recommendations

## Minimum Staffing Levels

In 2001, CMS released a landmark report on staffing[6] based on a study mandated by Congress. The report identified specific minimum staffing thresholds below which quality of care would be compromised. It recommended a daily minimum standard of 4.1 hours of total direct care nursing time per resident: 2.8 hours from certified nursing assistants; 0.75 hours from RNs; and 0.55 hours from licensed practical/vocational nurses. Research conducted for the report found that staffing levels falling below this minimum put nursing home residents at risk.

This standard will be referred to as the **"recommended staffing standard"** in this report, the **State Nursing Home Staffing Standards Chart**, and the **Guide to the Chart**.

## Twenty-four Hour Registered Nurse

Three Institute of Medicine studies[7] have recommended that at least one RN be on duty at all times.

# Federal Statute and Regulation

Neither federal statute nor regulation requires a minimum staffing standard or an RN around the clock. The federal requirements are as follows:

- Registered nurse on-site eight hours a day, seven days a week.[8] The regulations do not specify that these hours must be dedicated to direct care only, meaning that facilities are able to meet this requirement by including hours from registered nurses performing administrative duties.
- Licensed nurse—either a registered or licensed practical/vocational nurse—serving as a Charge Nurse on-site twenty-four hours daily.[9]
- Sufficient nursing staff to meet residents' needs. "Sufficient" is not defined.[10]

There is no minimum number of direct care nurse and nursing assistant hours per resident per day required by the federal government; nor is there any requirement for a specific ratio of nursing staff to residents. Because there is no definition of "sufficient," each nursing home can decide for itself how many certified nursing assistants and nurses to assign, leaving open the possibility that a facility can cut staffing levels dangerously low.

5 Mor, V, Caswell, C., Littlehale, S., Niemi, J., Fogel, B. (2009). *Changes in the quality of nursing homes in the U.S.: A review and data update.*
6 Abt Associates for U.S. Centers for Medicare and Medicaid Services, "Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes." December 2001.
7 Institute of Medicine. (2001). *Improving the quality of long term care*. Washington, DC Academy of Medicine. Institute of Medicine. 2004. *Keeping patients safe: transforming the work environment of nurses*. Washington, DC: National Academy of Medicine. National Academy of Medicine. Institute of Medicine 1996, Nursing staff in hospitals and nursing homes: Is it adequate?. Washington, DC National Academy of Medicine
8 42 C.F.R. § 483.35(b)(1).
9 42 C.F.R. § 483.35(a)(2).
10 42 C.F.R. § 483.35(a)(1).

# State Statutes and Regulations

Without federal standards in place, states have addressed staffing through legislation, regulations, or both. State requirements vary enormously. Each state defines and treats factors such as types of nursing personnel, shift schedules, and facility structures (e.g., "units," "stations," "floors")—differently, and sometimes even differently according to facility size.

The chart in Appendix B, **State Nursing Home Staffing Standards Chart**, presents each state's staffing regulations. This information was obtained online. The **Guide to the Chart** (Appendix A) includes a description of the definitions/terminology used and explains how state standards were converted to hours per resident per day. This conversion makes it easier to compare staffing levels between states and to the recommended staffing standard.

A few key abbreviations used in this report are indicated below. For a more comprehensive and detailed listing of terms and definitions, refer to the **Guide to the Chart** in Appendix A.

## Terminology

### CNA/NA

Certified nurse aide/Nurse aide.

### DC

Direct care. Direct care staff refers to RNs, LPNs/LVNs, and CNAs/NAs, but does not include the Director of Nursing (DON) unless otherwise noted. The time worked by direct care staff may or may not include time spent by licensed nurses on administrative or other duties. In the **State Nursing Home Staffing Standards Chart**, a state is considered to have a Direct Care Staff minimum requirement if its staffing standards explicitly mandate a specific number of hours per resident per day for nursing staff or set a specific ratio of nursing staff to residents.

### hprd

Hours per resident per day. This is the number of hours of care provided to each resident each day by nursing staff (RNs, LPNs/LVNs, CNAs/NAs). It is determined by dividing the total number of nursing staff hours worked by the total number of residents.[11]

### LPN/LVN

Licensed practical nurse/licensed vocational nurse.

### RN

Registered nurse.

### Total Nursing Staff

This is the total hprd for all nursing staff—RNs, LPNs/LVNs, and CNAs. It includes the DON's time. This is the total minimum staffing standard for a state when there is a direct care staff minimum requirement or a CNA/NA staff requirement. This is the most useful value for comparing a state staffing standard to the recommended staffing standard of 4.1 hprd (which includes DON time).

11 https://www.medicare.gov/care-compare/resources/nursing-home/staffing

# Analysis of State Staffing Standards

State staffing requirements were reviewed and examined in terms of how they compare to the recommended staffing standard and to each other.

## State Requirements: Total Nursing Staff Time

With one exception, state standards fall far short of the recommended staffing standard. Only the District of Columbia with 4.16 hprd of total nursing staff time meets/exceeds the overall recommended level of 4.1 hprd. The majority of states - 29 - require less than 3.5 hprd, with 15 of those states falling below 2.5 hprd.

*Table 1: Requirements for Total Nursing Staff Time*

| **Total hprd** *Recommended Staffing Standard: 4.1* | **No. of States** | **States** |
|---|---|---|
| 4.10+ | 1 | DC |
| 3.50 – 4.09 | 6 | CA, FL, IL, MA, NY, RI |
| 3.00 – 3.49 | 6 | AR, CT, DE, MD, VT, WA |
| 2.50 – 2.99 | 8 | ME, MS, NJ, NM, OH, OK, PA, WI |
| 2.00 – 2.49 | 13 | CO, GA, IA, ID, KS, LA, MI, MN, OR, SC, TN, WV, WY |
| 1.50 – 1.99 | 1 | MT |
| 1.00 – 1.49 | 0 | |
| < 1.00 | 1 | AZ |

For 18 states, the Total Nursing Staff time cannot be calculated because they do not have a Direct Care hprd or Certified Nurse Aide/Nurse Aide hprd, which are necessary to find the Total. These states are not included in Table 1.

## State Requirements by Type of Nursing Staff

### RN

No state standard meets the recommended staffing standard of .75 hprd for RNs. The District of Columbia comes the closest, with .60 hprd. There are only nine states that have a staffing standard for RNs greater than .30 hprd.

*Table 2: Requirements for RN Time*

| **State** | **RN hprd**, *Recommended Staffing Standard: 0.75* |
|---|---|
| DC | 0.60 |
| MA | 0.51 |
| DE | 0.42 |
| IL, ME | 0.38 |
| MD | 0.36 |
| AK, MT, RI | 0.32 |

### LPN/LVN

Four states—Delaware, Florida, Illinois, and Mississippi—exceed the recommended staffing level of .55 hprd for LPNs/LVNs. Only ten states have an LPN/LVN hprd of .42 or greater (Table 3).

*Table 3: Requirements for LPN/LVN Time*

| State | **LPN/LVN hprd**, *Recommended Staffing Standard: 0.55* |
|---|---|
| FL | 0.94 |
| DE | 0.66 |
| MS | 0.64 |
| IL | 0.57 |
| LA, NY, SC, WY | 0.48 |
| IN, NJ | 0.42 |

### CNA/NA

The vast majority of states do not require a specific hprd for CNA/NAs. While seven states set explicit CNA/NA standards (Table 4), none of these meets the recommended 2.80 hprd for CNA/NAs. Requirements range from 1.20 hprd to 2.50 hprd of CNA/NA time.

*Table 4: States that Set Specific CNA/NA Requirements*

| State | **CNA/NA hprd**, *Recommended Staffing Standard: 2.80* |
|---|---|
| FL | 2.50 |
| CA | 2.40 |
| NY | 2.20 |
| VT | 2.00 |
| OR | 2.05 |
| SC | 1.86 |
| MT | 1.20 |

### Direct Care Staff

The following eighteen states have no direct care minimum requirement: Alaska, Alabama, Hawaii, Indiana, Kentucky, Missouri, Montana, North Carolina, North Dakota, Nebraska, New Hampshire, Nevada, Oregon, South Carolina, South Dakota, Texas, Utah, and Virginia.

Of the states that mandate a direct care minimum, more than half require a minimum of less than 3.0 hprd. The District of Columbia has the highest direct care minimum at 4.1 hprd, while Arizona has the lowest at .48 hprd.

Four states—California, Florida, New York, and Vermont—have a direct care minimum requirement that includes a specific CNA/NA hprd.

### State Requirements by Shift

Seven states also set staffing standards by eight-hour shifts: Delaware, Maine, Michigan, Missouri, Montana, New Mexico, and Oklahoma.[12] These requirements are important because they prevent facilities from front-loading workers on the day shift, leaving the evening and night shifts with too few staff.

## Twenty-four Hour Registered Nurse

Only six states require an RN 24/7 at all facilities, regardless of the number of beds. An additional eight states require an RN 24/7 based on facility size. These fourteen states and the number of beds triggering an RN 24/7 are listed in Table 5. States that allow for on-call RNs are not considered to have an RN around the clock since the RN is not on-site.

*Table 5: State 24/7 RN Care Requirements*

| Requirement | No. of States | States |
|---|---|---|
| 24/7 RN Care | 6 | CO, CT, DC, DE, MD, RI |
| 24/7 RN Care for 60+ Bed Facilities | 1 | PA |
| 24/7 RN Care for 61+ Bed Facilities | 1 | AK |
| 24/7 RN Care for 71+ Bed Facilities | 1 | MT |
| 24/7 RN Care for 90+ Bed Facilities | 1 | ID |
| 24/7 RN Care for 100+ Bed Facilities | 3 | CA, MT, WI |
| 24/7 RN Care for 150+ Bed Facilities | 1 | NJ |

## Recent Developments

Within the past year there have been changes in the staffing standards of a number of states. Four states—Arkansas, Connecticut, New York, and Rhode Island—passed legislation. Both New York and Rhode Island established a direct care minimum, while Connecticut increased its direct care minimum requirement. In Arkansas, the staffing standard changed from a per shift ratio to hprd.

Two states, Arkansas and Rhode Island, define "direct care staff"/"direct caregiver" to include non-nursing staff such as licensed physical or occupational therapists, and licensed speech-language pathologists. Arkansas has further broadened the definition of "direct care staff" to physicians, physician assistants, and "other licensed or certified healthcare professionals."

At the same time, Oregon and South Carolina lowered their staffing standards, stating that the change was for a limited period of time ("temporarily effective 8/24/2021 through 2/19/2022" in Oregon; for the "current fiscal year" in South Carolina).

12 MI and OK set a shift-based minimum as a ratio of direct care staff to residents *or* direct care minimum in hprd.

# Conclusion

Twenty years after the CMS study found that at least 4.1 hprd of direct care nursing staff time are needed just to prevent poor outcomes, state staffing requirements, with a few exceptions, are nowhere near that recommended level. Only the District of Columbia requires this overall level of staffing, and only six states mandate the presence of a registered nurse 24 hours a day regardless of facility size. Despite what is known about the relationship between staffing levels and quality care, staffing standards in almost every state remain severely low.

Residents have waited decades for adequate staffing around the clock. Every day that passes without sufficient staffing jeopardizes their health, safety and welfare. Ongoing and robust advocacy is needed at both the federal and state levels to provide residents with the care to which they are entitled and that they deserve.

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