

## "Staffing in Nursing Facilities"



To address the issue of staffing and quality of care in nursing facilities, a one-day conference of experts was convened by the John A. Hartford Institute for Geriatric Nursing, Division of Nursing, New York University in April, 1998. The expert panel reviewed four sources of information. First, previous studies on staffing and quality of care were reviewed. Second, current nurse staffing levels for all U.S. nursing homes were examined using data from the Federal On-Line Survey Certification and Reporting System. Third, the Health Care Financing Administration time studies on nursing care in nursing homes, 1995-97, were examined using data from the Nursing Home Case-Mix and Quality Demonstration Project.

Fourth, the panel reviewed the minimum standard for nurse staffing adopted by the National Citizens' Coalition for Nursing Home Reform in 1995. Most of the experts recommended minimum staffing standards for nursing administration, 24-hour RN supervision, additional education and training, direct caregiver ratios (1 RN to 5 residents on days, 1:10 on evenings, and 1:15 on nights and additional staff at mealtime), and licensed nurse ratios (1:15 on days, 1:20 on evenings, and 1:30 on nights). The total recommended time is 273 minutes (4.55 hours) per resident day compared with 210 minutes (3.5 hours) on the OSCAR data and 250 minutes (4.17 hours) for the HCFA time studies with adjustments upward to take into account resident case mix. See Table 1 on page 2 for details. Legislative changes in federal and state laws are needed to ensure minimum standards. Julia Carson, a Congresswoman from Indiana, is drafting federal legislation that would increase staffing levels in nursing homes. Staffing levels discussions have occurred in the U.S. Senate Subcommittee on Aging, chaired by Senator Grassley from Iowa. At the initiative of consumer advocates and other organizations, about 21 state legislatures are either considering bills or have drafted bills to increase staffing. Martha Mohler, RN, MN, MHSA, at National Committee to Preserve Social Security and Medicare (202-216-8389) is tracking these state efforts. Consider contacting your state and federal representatives about staffing legislation.

Charlene Harrington, Associate Editor

### FAST FACTS

#### Staff - 1997

- ▶ RNs spent an average of 42 minutes per resident per day in nursing homes. (This includes all time for direct, indirect, and administrative activities.)
- ▶ LVN/LPNs spent an average of 42 minutes per resident day in nursing homes. (This includes all time for direct, indirect, and administrative activities.)
- ▶ Nursing assistants spent an average of 126 minutes per resident per day in nursing homes. (This includes all direct and indirect care time.)
- ▶ The total time for RNs, LVN/LPNs, and nursing assistants was 210 minutes per resident per day (or 3.5 hours) for all nursing care

#### Resident - 1997

- ▶ There were 15,661 certified nursing homes with available data out of 16,500 facilities in the U.S.
- ▶ These facilities reported 1,368,320 residents in 1,626,556 nursing home beds (occupancy rate = 84%).
- ▶ Of the total residents, 7.9% were bedfast, 23% had contractures, 7% had bedsores, 50% had bladder incontinence, 41% had bowel incontinence, and 15% were placed in restraints in nursing homes.

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### Forthcoming...

**Summer 1999:  
Family  
Caregivers**

activities in nursing homes.

**Sources:** On-Line Survey Certification and Reporting Data, Health Care Financing Administration. Harrington, C., Carrillo, H., Thollaug, S.C., and Summers, P.R. (1999) Nursing Facilities, Staffing, Residents, and Facility Deficiencies. 1991 through 1997. San Francisco, CA: University of California. Report can be requested by fax at (415) 476-6552 for \$15.

## Counting Nurses

A variety of health workers provide nursing care: registered nurses (RNs), licensed practical or vocational nurses (LPN/LVN) and unlicensed assistive personnel (UAP) who perform nursing care under the direction of a RN. The UAPs have diverse titles: nurse aide, orderly, nursing attendant, nursing assistant, personal care aide. Licensure, registration requirements or a standard definition does not define the population of UAPs. This makes counting UAPs very difficult.

There are no standards for usual responsibilities or length of training for UAPs, even in categories such as nurse aide. Training and responsibility varies by setting. An exception to this lack of consistency is training is nurse aides who work in long-term care facilities. Those aides who work in facilities that are certified to provide care to Medicare or Medicaid patients must have successfully completed a training program and passed a competency exam, after which they are certified (i.e. CNA).

The Health Care Financing Administration requires that the training program include a 75-hour course of which a minimum of 16 hours are didactic and 16 hours are practical. This amounts to about a two-week course. A high school diploma is not required to take the course. While some nursing homes have state-approved training programs, students often pay for the training at a for-profit technical school.

## PROPOSED MINIMUM STAFFING STANDARDS FOR NURSING HOMES

### ADMINISTRATION STANDARD

- A full-time RN with a Bachelor's Degree would be the Director of Nursing (a provision for grandfathering 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 gerontology training; full time in facilities of 100 beds or more)
- A full-time RN nursing facility supervisor must be on duty at all time

### DIRECT CARE STAFFING STANDARD

- The minimum number of direct care staff must be distributed as follows:

Minimum Level of 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 30 residents	0.53 hours per resident day

- And minimum licensed nurses (RN and LVN/LPNs) 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

The minimum total number of direct nursing care staff would be 4.13 hours per resident day. Staffing must be ADJUSTED UPWARD for residents with higher nursing care needs. Total administrative and direct care nursing staff hours would be 4.55 hours.

### MEALTIME NURSING STAFF

States are required to have a registry of CNAs. CNAs must provide proof of employment and 24 hours of continuing education every two years to maintain their name in the registry. If proof is not provided their name is removed from the list. Although each state includes all CNAs who work in long-term care facilities, it also includes many CNAs who work in hospitals and home care. At least in New York State, there is no way to differentiate those who work in nursing homes from those who work in other settings

Thus, there is no easy way to assess the supply—even for CNAs who are employed in long-term care facilities. Those listed in the state registries include employed nurse aides, those seeking employment, and those who choose not to be employed. We at NYU have used two approaches to assess the supply of nurse aides. First, we have surveyed nursing homes asking how many nurse aides they employ (a body count), and second we have used the

Public Use Microdata Samples of U.S. Census Data. Assessing the demand can be done by surveying facilities that employ nurse aides and asking about the difficulties facilities have in hiring these health workers

-Christine T. Kovner, PhD, RN, FAAN

▶ Direct care staff 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

## Nutrition In Nursing Facilities

Despite federal and state regulations designed to ensure adequate nutrition, nutritional deficiencies are common among nursing home residents. Studies have shown that 30%-85% of nursing home residents are malnourished.

In a 5-year study that investigated the social, cultural, clinical, and environmental factors that influenced nutritional care in nursing homes, the authors found that an inadequate number of staff and lack of supervision of CNAs by professional staff were the major factors that contributed to malnutrition, weight loss, and death.

Nursing home residents are physically and cognitively impaired; many have swallowing disorders. Residents are therefore dependent upon staff for skillful assistance, and they must be fed slowly and carefully. Typically, it takes 30 minutes to one hour to assist or feed a resident. In our study on the day shift, each CNA had 7-9 residents to care for. In the evening, each CNA

was responsible for the care of 12-15 residents. About one hour was allotted for mealtime; the CNAs therefore had about 5-10 minutes to assist or feed each resident. Consequently, residents were fed hurriedly and forcefully; some were not fed at all. We calculated the body mass index (BMI) of the residents in our study. For people over the age of 65, the BMI should range from 24 to 29. Values below 24 indicate that a person may be ill and malnourished. The BMI of the residents in our study ranged from 12 to 30. Their mean BMI was 20; 82% of the residents had a BMI below 24. To improve the nutritional care of residents, it is imperative that the staff/resident ratio at mealtime be increased. CNAs should have no more than 2-3 residents to feed or assist with meals, and professional nurses must supervise them. We have delegated nutritional care, a complex undertaking, to untrained, unsupervised, and often-overburdened CNAs.

- *Jeanie Kayser-Jones, RN, PhD, FAAN*

Source: Kayser-Jones, J. (1997). Inadequate staffing at mealtimes. *Journal of Gerontological Nursing* 23(8), 14-21. and Kayser-Jones, J., and Schell, E. (1997) The effect of staffing on the quality of care at mealtime. *Nursing Outlook* 45(2), 64-72.

## R E S E A R C H B R I E F S

### ***WHILE MORE EXPENSIVE, RN STAFFING IS KEY TO IMPROVING RESIDENT OUTCOMES***

Anderson, Hsieh and Su found that increased RN staffing was associated with improvements in resident outcomes; achieving improvements in resident outcomes requires greater spending. The purpose of this study was to identify resource allocation patterns that relate to resident outcomes in nursing homes. Data were obtained from the Texas Department of Human Services for all nursing homes in the state. Data on staffing levels and financial resource allocation were obtained from the Texas Medicaid Nursing Facility 1990 Cost Reports, and data on case mix and resident outcomes were obtained from the 1990 Client Assessment, Review, and Evaluation Form 3652-A. Study limitations included the lack of psychosocial indicators of resident outcomes, the use of data from one state, limiting generalizability and the limitation of using secondary data where there is a substantial lag time between the actual data collection and when data become available for secondary use. Strengths of the study design include the careful control of case mix influence on outcomes. Other strengths that improved the quality of the study included the use of the configurational approach and the fact that the researchers regrouped the sample in different ways to confirm the veracity of the initial findings.

Anderson, R.A., Hsieh, P.C., & Su, H.F. (1998) Resource allocation and resident outcomes in nursing homes: comparisons between the best and worst. *Research in*

### ***A HIGHER INTENSITY OF NURSING HAS A POSITIVE EFFECT ON RESIDENT FUNCTIONAL OUTCOMES***

RN and LPN nursing hours were significantly related to improved functional ability, increased probability of discharge home and decreased probability of death. The authors of this study advocated a greater use of licensed nurses in the nursing home setting. The study examined the effects of selected nursing home attributes in Minnesota on specific outcomes for residents 65 and older admitted in each of 3 years, 1988 to 1990. The study controlled for residents' age and previous functional ability and illustrated the effect of licensed nursing is as powerful 3 years after admission as it is in the year after admission. Nursing home attributes included size, ownership, noncompliance with a state correction order, and licensed and nonlicensed nursing hours. Information on facility attributes was obtained from the Minnesota Department of Human Services Long-term Care Division. Outcomes included functional ability, discharge home and death. Calculating the resident's Total Dependence Score and the total score on the assessment of eight activities of daily living operationalized the functional outcome. The authors highlighted that if real improvements in nursing home care in the future are to be achieved, a vital first step will be the adoption of a new paradigm for quality, one that emphasizes and expects a reasonable level of benefit.

Bliesmer, M.M., Smayling, M. Kane, R.L., & Shannon, I. (1998) The relationship between

*Karen Gusman Cousin*

*Karen Gusman Cousin*

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The Hartford Institute's primary mission is to identify and develop best practices in nursing care for the elderly. The Institute is committed to disseminating the practices into the knowledge-base and work environment of every practicing professional nurse as well as every nursing student. We seek to inform the public to expect best practice and to assume national leadership in establishing best practice as the standard for geriatric nursing care.

To accomplish this, we are focusing on advancing the competence of nurses and the role that the nursing profession plays within the integrated delivery system of elder care initiatives of The Hartford Institute cluster in four areas: practice, education, research, and policy and consumer education. Additional information about specific initiatives is available on request.

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