NURSING HOME STAFFING: IMPROVEMENTS NEEDED

By

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Abstract

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A major concern for advocates, nurses, and families of nursing home residents is the quality of care they receive. Today's nursing home population is older and sicker with more complex care needs. Nursing home staffing needs to keep up with the new demands and changes of the resident population. The purpose of this article is to explore nursing home staffing patterns, describe their impact on quality of care, examine nursing home staffing costs as a barrier to adequate staffing, and suggest an alternate model for the delivery of care in nursing homes.
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Abstract

A major concern for advocates, nurses, and families of nursing home residents is the quality of care they receive. Today's nursing home population is older and sicker with more complex care needs. Nursing home staffing needs to keep up with the new demands and changes of the resident population. The purpose of this article is to explore nursing home staffing patterns, describe their impact on quality of care, examine nursing home staffing costs as a barrier to adequate staffing, and suggest an alternate model for the delivery of care in nursing homes.
**Introduction**

The United States (US) nursing home (NH) population includes 1.5 million persons that reside in 23,000 NHs (Anderson, Hsieh, & Su, 1998). Today, NH staff are caring for an older and sicker population in which sixty percent are over 80 years of age (Foster, 2000a). This shift to an older NH population is due to many factors, for example: 1) the growing demographic trend in the number of elderly persons in the US, which is related to an increase in life expectancy occurring since the 1940s, and the prevalence of more chronic illnesses in the elderly population (Harkness, 1995); 2) younger elderly (less than 80 years old) moving into places such as assisted-living facilities or boarding homes; 3) and to the states directing people to the more reasonably priced assisted-living facilities instead of nursing homes in efforts to reduce state-federal Medicaid costs. In 1999 the state of Washington spent $2,964 a month for a resident’s care in a nursing home compared to $1,129 a month for a person in assisted-living and boarding homes were $828 a month (Foster, 2000a).

There is an increase of sicker patients with more complex care needs being transferred to NHs from hospitals. Patients that in the past would have stayed in the hospital longer to receive acute care to recover from conditions such as joint replacement surgery or from strokes are now discharged to NHs for skilled nursing care (Foster, 2000a). The shorter lengths in hospital stays are mostly due to Medicare changing their method of payment system to diagnosis-related groups, or payment per episode of hospitalization (Young, 2000). NHs may have two different levels of care: skilled and
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Examples of skilled care provided by registered nurses (RNs) [and licensed practical nurses (LPNs)] are: dressing changes, assessing heart and lung sounds, reviewing resident’s medication administration, and providing patient and family education on clinical conditions (e.g., hypertension and diabetes). Physical and occupational therapists provide skilled care when working with patients that are recovering from conditions such as a stroke or a hip fracture to improve their level of functioning. Speech therapists teach stroke patients, that have dysphasia, how to communicate again. Custodial care involves assisting the resident with their activities of daily living (ADL), verses skilled care that focuses on rehabilitation and medical conditions. The custodial or unskilled care, such as helping a resident to the bathroom, helping them at mealtimes, or to get dressed, are usually provided by the nursing assistants (NAs) (Bodenheimer, 1998). Patterns of NH staffing should include an adequate number of RNs and LPNs to meet the skilled or complex care needs of the NH residents along with enough NAs to meet the unskilled care needs (Anderson et al., 1998).

Fifty percent of NH residents continue to receive substandard care a decade after federal mandates were passed in 1987 to improve quality of care (Coccia & Cameron, 1999). These federal mandates covered areas such as increasing professional and unlicensed staffing levels, improving all nursing staffs’ training, limiting the use of chemical and physical restraints, promoting residents’ rights, and providing individual care. The purpose of this article is to explore nursing home staffing patterns, describe their impact on quality of care, examine nursing home staffing costs as a barrier to
adequate staffing, and suggest an alternate model for the delivery of care in nursing homes.

**Literature Review**

Government regulations for NH staffing requirements are general in nature. Government mandates define NH quality of care as staffing levels that provide the highest quality of care they can and to ensure the well-being of the NH residents. The present minimum federal staffing standard for all certified NHs is a RN director of nurses; an RN to work for 8 hours per day, 7 days a week; and an LPN working on the evening and night shift (Harrington, Kovner, Mezey, & Kayser-Jones, 2000). The same minimum requirements apply to all NHs whether they have 50 beds or 150 beds (HCFA, 2000). National experts in long term care (LTC), nurse researchers, nurse educators, LTC administrators, resident advocates, and health care economists, found these mandated staffing requirements/regulations not specific enough to promote quality care. They advocate for a specific NA to resident ratios based on acuity and a higher level of total nurse staffing ratios for NHs with residents who have more complex care needs (Harrington et al., 2000; HCFA, 2000).

According to the director of nurses (DON) at Sunbridge NH in Walla Walla, Washington, there have been no changes in government requirements for staffing of RNs or LPNs and no specific staffing ratios developed for NAs since the 1987 government mandates (B. Zanvanderhastin, personal communication, March 30, 2001). The staffing coordinator at Park Manor NH in Walla Walla, reported that there are no specific nurse to
residents staffing ratios required by Washington State. The Park Manor NH likes their
NA staffing to resident ratios to be at 1:8 for day and evening shifts and 1:17 for night

Improved total nursing staff training to promote quality of NH care was also
included in the 1987 government mandates (Coccia & Cameron, 1999). The current
Washington State NA training requirements are similar to the 1987 mandates. NAs can
work in a NH for up to 120 hours without certification, but need to have their
certification completed by the time the 120 hours are up. In addition, the NAs are not
allowed actual contact with the residents until they have completed 16 hours of
certification training. The total certification training for NAs is 85 hours, which includes
35 hours of classroom training and 50 hours of clinical training (B. Zanvanderhastin,
personal communication, March 30, 2001; M. Locati, personal communication, March
30, 2001).

"One of the major reasons that some nursing homes are still providing inadequate
quality of care is that they provide inadequate levels of staffing" (New York University
News, 2000, p. 1). Forty percent of all certified NHs have continually failed to meet
federal standards resulting in serious patient care issues (Anderson et al., 1998). Fines
for government standards violations have increased 32% since 1996. Many elderly
persons are left lying in urine soaked sheets all night or wait 60 minutes for their call
light to be answered (Foster, 2000a).

Foster (2000a) presented two examples of substandard NH care due to inadequate
staffing. The first example was that of an elderly lady that sustained a fractured ankle after being transferred by one NA instead of two, which was required for her level of care. There were no other NAs available to help with the transfer. The second example was that of a resident that fell off the toilet and fractured her pelvis after being left by a NA who went to answer another call-light and failed to return.

Besides increasing staffing levels, NHs need to improve training for the total nursing staff to better meet the complex care needs of residents (Foster, 2000a). Residents with complex care needs (e.g., persons who have had joint replacement surgery or a stroke) have strict clinical care protocols that need to be followed to prevent complications. Very sick patients are admitted to NHs, today, that do not have properly trained nursing staff to care for them (Foster, 2000a).

In reality, NH staffing levels are driven by government reimbursements. Most NHs worked hard to make changes in the quality of care they delivered after the 1987 government mandates, but the changes placed high demands on the NHs because there was no funding mechanism provided by the government to improve staffing levels. An increase in staffing (both professional and unlicensed) would cause a great financial hardship for Medicare and Medicaid (the government funds approximately 50% of certified NH care costs) because it would drive up their costs for NH care (Coccia & Cameron, 1999). NHs that staff at the minimum government requirements tend to provide less quality of care than NHs that staff at higher levels (Johnson-Pawlson &
Infeld, 1996). A third of NH patients are private paying and the remainder are covered by government programs such as Medicaid (Foner, 1994).

**Caregiving in Nursing Homes**

"Caregiving is the central feature of a NH and needs to be improved in order to ensure high quality of care to residents" (NYU News, 2000, p. 1). NH care is divided into direct care (nursing staff and therapists), indirect care (kitchen staff and housekeeping), ancillary services, and administrative services. The total nursing staff consists of RNs, LPNs, and NAs. The nursing staff makes up 60% of the total NH personnel (Harrington et al., 2000). Eighty-five percent of NHs' direct caregivers are NAs (Schirm, Albanese, Garland, Gipson, & Blackmon, 2000). There are fewer RNs working in NHs as compared to LPNs that make up over half the licensed nurse staffing (Johnson-Pawson & Infeld, 1996). RN staffing requires greater spending by NHs than LPN or NA staff (Anderson et al., 1998). The LPNs perform many nursing and supportive functions required in the care of the NH resident (e.g., supervision, assessments, medication administration, and treatments) (Mikelson, 2001). Yet their education preparation does not support these activities.

Providing quality of care to NH residents involves nurses using the ethics of caring (caregiving). Licensed nurses define caring as a good characteristic of a NA and an ethical component of good caregiving, which incorporates the qualities of compassion, gentleness, patience, and personalized care. NAs base their definition of quality of care
on the ability to be “caring” while delivering residents’ care. Poor NH staffing may affect these caregiving qualities (Schirm et al., 2000). Milner (1993) describes five ethical principles of caregiving (beneficence, nonmalificence, autonomy, justice, and fidelity) to promote quality of care or doing the right thing for the patient (see Table 1).

Inadequate staffing (not enough staff and inadequately trained nursing staff) may make it difficult to follow these principles. Two caregiving examples will follow on how quality of care is jeopardized when these principles are violated. The first example is when there are inadequate numbers of NH staff at mealtime to feed residents sufficiently. Many residents lose weight and become malnourished which may lead to death after large weight losses (Kayser-Jones, 1997). This is a violation of the ethical principle of nonmaleficence, or do no harm (Milner, 1993). The second caregiving example, which is also a violation of nonmaleficence, is when NAs lack appropriate training in feeding residents with dysphagia. Residents with dysphagia need to eat slowly. NAs that are not aware of this dysphagia precaution get frustrated and get in a hurry, in order to meet the hour of time given them to complete mealtime tasks. They mix the resident’s food together and feed them in a hurried and forceful fashion which causes coughing, choking, and in some cases may cause the resident to aspirate the food (Kayser-Jones, 1997).

A qualitative study by Schirm et al. (2000) explored the perspectives of a volunteer sample of 36 licensed nurses (25 RNs and 11 LPNs) and 40 NAs in relation to NH caregiving. Separate focus groups were used to collect data from licensed nurses and NAs. The groups were asked what promotes good care and what are barriers to good
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care. The focus group discussions were tape-recorded and notes were taken for later content analysis to identify content and themes in the data.

Five major themes that emerged from both groups were caring, training and experience, the work environment, relationships among caregivers, and supervision of nursing assistants (Schirm et al., 2000). Caring was found important in providing good care and promoting morale when the quality of care was difficult to maintain. One barrier identified by NAs in providing good care was resentment towards other NAs who were not motivated to help others when needed. Comments from NAs included: “there are a lot of girls on my shift who try hard to get out of doing their jobs, if you ask some of the NAs to help you with something they say it is not in my job description” (Schirm et al., 2000, p. 5).

NAs need both training and on-the-job experience for good care (Schirm et al., 2000). One NA commented on how her training, which used role modeling, was helpful in learning how to feed residents. She reported that you do not just keep spooning the food in to see how many patients can be feed in a certain amount of time. Licensed nurses had stronger views on the importance of technical competence that NAs received from formal training. This formal training provides the basis for learning caregiving tasks such as how to give a bed bath, how to reposition a resident, and how to do peri care. The licensed nurses expressed the importance of providing emotional aspects in NA training for example, being taught to view the residents as a parent.
Comments regarding the work environment theme dealt with feelings of frustration in not having enough staff to provide quality of care (Schirm et al., 2000). The NAs were tired of working short, almost every day, and their quality of work suffered. In a three-hour period they are expected to get 15 residents ready for bed and at the same time promote individualized care. "There is not any time to treat the residents like a person. They are just somebody to get done and then go on to the next person" (Schirm et al., 2000, p. 6).

Some “nurses” (Schirm et al., 2000, p. 9) in this study commented on hating their role of supervising the NAs: they felt inadequately prepared for this job requirement because they were not taught any management skills in nursing school. They reported that supervising NAs requires confrontational skills and produces stress if you are not that type of a person. You are always pleading with them (NAs) to do what they were hired to do. Study findings were used to recommend strategies to promote understanding of each other’s caregiving roles in attempts to improve the NH working environment.

A nonexperimental, descriptive study by Monahan & McCarthy (1992) explored the views of NAs on their employment in a NH. The convenience sample consisted of 76 NAs from 7 NHs in a rural Oregon area. Data were collected at each NH by participants completing a 2-page questionnaire relating to demographic information. The data collector then interviewed the participants and wrote their answers to eight questions relating to their likes and dislikes about caregiving in a NH, what made them choose aide-work, and what helps maintain their morale.
Short staffing, not wages, was a major factor related to poor morale and high turnover rates according to Monahan & McCarthy (1992). Working short also prevented NH aides from having appropriate time to give quality care. The highest percentage of NAs (25%) had been employed for less than a year as a NA and 45% had been employed for less than a year at the current facility. The NAs liked caring for residents and formed relationships with them. They experienced great satisfaction from caring for NH residents. NAs disliked working when staffing levels were inadequate because they were not able to care for their residents properly. The relationships they formed with the residents were the main reason they stayed employed at the NH. The stresses described from working in a NH were both the physical and emotional demands of aide-work; "tired of being tired" (Monahan & McCarthy, 1992, p. 15). Too much was expected from them: not enough time or staff to properly care for residents. The NAs felt that aide-work was not respected by the administration.

**Nursing Home Staffing and Impact on Quality of Care**

A number of authors have indicated that increased total nurse staffing in NHs has shown to be related to positive resident outcomes such as improved functional ability, decreased pressure ulcers, decreased catheter use, and a decrease in urinary tract infections. In addition, lower total nurse staffing has been related to negative resident outcomes, which impacts the quality of care (Harrington et al., 2000; Bowers, Esmond, & Jacobson, 2000; Bleismer, Smayling, Kane, & Shannon, 1998; Johnson-Pawlson & Infeld 1996).
Some negative consequences that can occur to NH residents as a result of unsafe staffing levels are a lack of adequate nutrition and the use of physical restraints (Kayser-Jones, 2000). Kayser-Jone's ongoing, 1998 to 2003, anthropological study is exploring the issue of death and dying among the NH elderly and seeks to identify factors that influence the end-of-life care in a NH. Data from three NHs were collected through participant observation and in-depth interviews with NH staff, residents and their families, and from doctors. Data were gathered on how nursing care is provided, what factors influenced care, who provided care, and what is the outcome of the care provided. Kayser-Jones describes a case study, which is part of her larger ongoing study, in which a terminally ill resident's care is affected by NH factors.

The case study involves a 101 year-old Mrs. Trent (pseudonym) admitted to the NH after a repair of a fractured hip (Kayser-Jones, 2000). It was written in her nursing care plan to encourage eating and that she needed assistance with meals. She was not given assistance with eating her meals, which she needed because of arthritic hands. The NAs had been recording that she had eaten 80-100% of her meals, which was inaccurate because Mrs. Trent was not able to use the eating utensils and most of the food had ended up in her bed or on the floor. Mrs. Trent had requested to eat in her room because she was embarrassed to have others see that she dropped and spilt her food. She sat in a wheelchair for long periods and she was restrained after becoming tired and falling out of her wheelchair. Mrs. Trent developed pressure ulcers, became weak and experienced
more falls, and went from weighting 128 pounds on admission to 98 pounds one year later at the time of her death.

This impact on the quality of NH care, according to Kayser-Jones, (2000), was the result of inadequate NH staffing levels, inadequate staff training, and the lack of licensed nurses’ (RNs or LPNs) supervision of the NAs at mealtime. "While the nursing staff must take some responsibility for the unethical care Mrs. Trent received, her case (this case study) must be placed within the social, cultural, and political context of nursing homes in the United States" (Kayser-Jones, 2000, p. 52). Most nurses (RNs and LPNs) and NAs in NHs take pride in providing a good standard of care. They work hard and become frustrated when inadequate staffing makes it impossible to provide quality care to the residents. NHs that accept Medicare and Medicaid clients and reimbursements are expected to comply with their standards of care: "safe, acceptable, and humane care" (Kayser-Jones, 2000, p. 52).

The current NH staffing standards are not meeting the needs of NH residents (Harrington et al., 2000). The experts in LTC, as mentioned earlier, have developed a proposed minimum RN, LPN, and NA staffing standard (Table 2) that can be used by state and federal agencies to develop new NH staffing regulations which promote quality of care in the US NHs. The proposed minimum staffing standard not only gives specific total nurse staffing to resident ratios, but also gives suggestions for overall staff requirements in nursing administration, for mealtime staffing, for education and training, and for a geriatric nurse specialist or nurse practitioner for NHs with 100 beds or more.
These proposed minimum staffing standards are similar to those of other countries. The US NHs are not staffed as well as NHs in other countries (HCFA, 2000). In Japan the geriatric care centers are considered to be similar to the US skilled NHs. Japan’s nurse staffing regulations are: eight nurses [the report did not specify RNs or LPNs] and 20 NAs for every 100 residents. In Great Britain NH staffing requirements are to employ ample staff with the right skills and experience to meet the needs of the residents. One third of the staff must be RNs. Aide staff-to-resident ratios must be 1:5 during the day, 1:7 during the evening, and 1:10 at night. Besides the concern over costs and staffing levels, other countries are concerned that the staff deliver quality care. In Sweden NHs are to be home-like, patients’ preferences are considered in care delivery, and the patients’ likes and dislikes are taken to heart (HCFA, 2000).

Higher NA staffing levels in NHs were found in the northeastern portion of the US (HCFA, 2000). The range in NA staffing levels across the US in 1998 was from 2.00 hours per resident day (HPRD) in the northeast to 1.94 in the west. The total nursing HPRD staffing ranged from 2.61 in the south to 4 HPRD in the west. The LTC expert’s proposal for 4.55 total nursing HPRD was not considered practical for profit NHs without increased reimbursement rates.

**Main Barriers to Improved Nursing Home Staffing: Reimbursement Rates and Costs for Increased Staffing**

Higher reimbursement rates are needed for improved staffing (Harrington et al., 2000). The nursing home industry accuses the government for not reimbursing them
enough to provide for adequate care of NH residents. This accusation is related to the 1998 Medicare cuts and state-federal Medicaid rates not keeping up with the cost of providing care. NHs are spending twice as much for residents' care then they receive in reimbursements. Eighteen percent of Washington's 278 NHs have closed or filed bankruptcy. The NH industry, in the state of Washington, insists that to pay more for total nursing staff, the state will need to increase its reimbursement rates (Foster, 2000b).

Medicare has a 100-day limit for reimbursement for persons admitted for skilled care. Medicare pays for 100% of the resident's skilled care for the first 20 days of the 100-day limit. The resident is responsible for $89 a day and Medicare picks up the rest for the remaining 80 days. After the initial 100 days the resident is responsible for the costs of NH care (M. Locati, personal communication, March 30, 2001).

Staffing costs are a major expense and the main barrier to adequate total nurse staffing (Francese & Mohler, 1994). Yearly costs of NH care were over $74 billion in 1993 and are estimated to be at $176 billion in 2003 (Vaca, Vaca, & Daake, 1998). The requirements of the federal mandates passed in 1987 called for big changes in delivery of the quality of NH care without providing funding for these changes (Marek, Rantz, Fagin, & Krejci, 1996). The cost increases for the minimum staffing proposed by the LTC experts range from $1.4 billion-$6 billion dollars. Medicaid would be required to pay approximately $938 million-$4 billion of these cost increases (Harrington et al., 2000).

The war over who will pay for the costs of increasing total nurse staffing to
improve quality of NH care is a public policy concern (Coccia & Cameron, 1999). The NH staff must also be resident advocates and push for quality of NH staff and increased staffing levels while balancing cost with quality. Increased staffing levels would cause great financial costs to Medicare and Medicaid. Because government reimbursement is directly related to NH nurse staffing levels, the resident outcomes are affected by the attempts to balance costs and services (Coccia & Cameron, 1999).

Anderson et al. (1998) used Texas state data from 494 NH administrative databases to identify patterns of resource allocation that relate to resident outcomes. Outcomes where defined as affects on residents related to the nursing care they received. The outcomes that were used for comparisons were: verbal or physical aggression; use of geriatric chairs, chest restraint, or wrist mittens; patients with a decubitus, contractures, dehydration, urinary tract infection, or a fracture in the past 3 months. They looked at NHs with good outcomes as compared to those with a higher rate of bad resident outcomes.

Anderson et al. (1998) found that the NHs with best resident outcomes had higher RN (.94 mean) full time employees and fewer licensed vocational nurses (LVNs) (6.03 mean) full time employees and higher costs as compared to NHs with higher levels of bad outcomes that had lower (.86 mean) full time RN employees and more LVN (6.38 mean) full time employees. The mean NA staffing was slightly higher (16.86) at the best outcomes NHs than the worst outcomes NHs with the mean NA staffing at 16.15. According to Anderson et al., the results supported that RN staffing is more expensive
and NH reimbursement needs to increase to meet the costs of providing more RN and NA staffing to promote better resident outcomes.

Improved total nurse staffing may be cost-effective while providing better resident outcomes. Savings that may occur with increased staffing levels are listed in Table 3 (Harrington et al., 2000). Discussions on a few of these overall savings will follow. Better staffing may help lower total nurse staffing turnover, which costs 4 times a monthly salary in costs to train replacements. Poor job satisfaction and high NH aide turnover rates of 100-400% annually result from NA caregiving stressors, with inadequate aide-to-resident staffing ratios being the major stressor (Kettlitz, Zbib, & Motwani, 1997).

Improved NA staffing promotes better resident outcomes, which helps to save on health care costs, by helping to curb NA job stress and corner cutting (Bowers et al., 2000). Bowers et al. (2000) looked at NH staffing levels in relation to quality care and found, in the views of NAs, adequate staffing promotes the development of relationships with residents, which to them (NAs) is a measurement of quality care. For example, without adequate NA staffing levels, time pressures on the NAs make it hard to converse with the residents. Residents are hurried through their cares, rushing interferes with the residents’ routine and “it messes up their whole day... They feel they have been rushed and they have been” (Bowers et al., 2000, p. 6).

Cutting corners, both invisibly and in relation to accountability, were additional
consequences from inadequate NA staffing (Bowers et al., 2000). Fearing a poor evaluation from the nurse supervisor, a NA might not be caught throwing dirty linen on the floor, but might be tempted to cut corners by allowing a resident to lie in a bed full of urine (invisible). The affects of not doing oral care, range of motion, or walking a resident as often as required would be hard to trace to any one NA (accountability). What corners NAs cut during their resident’s care depended on their familiarity with the resident, according to Bowers et al. (2000).

The literature suggests that there are solutions to poor quality of NH care related to inadequate levels of NA staffing. Providing good quality NH aide jobs could be part of the answer to providing cost-effective, good quality NH care (Friedman, Daub, Cresci, & Keyser, 1999). A study by Friedman et al. (1999) approached 397 NAs to complete surveys on demographics and job satisfaction elements with a total of 213 NAs from NHs and 136 NAs from five Programs of All-inclusive Care for the Elderly (PACE) completing the surveys. The purpose was to assess and compare job satisfaction between the 2 groups of NAs.

PACE is an alternative to NH care that is a comprehensive community-based approach that focuses on keeping elderly clients healthy enough to remain in their homes and delay or prevent NH placement (Friedman et al., 1999). Health, medical, and social services are provided to clients in their homes, at day care programs, and at clinics at the PACE sites to promote independent living. The central concept of PACE is a multidisciplinary team approach in decision-making and care that is provided for the
clients. This concept embodies many of the good characteristics of job satisfaction among NAs found by the Friedman et al. study (1999).

The data were rated on a scale of 1-5 points with 1 point being very dissatisfied and 5 points being very satisfied with their job (Friedman et al., 1999). Unpaired t-test to analyze job satisfaction and stepwise forward linear regression analysis to look at independent predictors of job satisfaction were used. Chi-square and unpaired t-test statistics were used to compare the differences between the NH and Pace sites when appropriate. Analyses were completed using the SPSS statistical package. The PACE NAs were more satisfied with their jobs and had a significantly higher chance to develop relationships with their patients. Items important to both groups of NAs relate to their work environment. For example, respect for their suggestions and the chance to organize their workload. This study supports the importance placed on adapting the NH work environment for caregiving (Friedman et al., 1999). The authors did not give the ratio of clients/residents to NAs for either group.

Higher turnover rates, which are related to low job satisfaction and job quality, were found in NHs with higher NA workloads (Anderson, Issel, & McDaniel, 1997). With demanding workloads the NAs are not able to meet the individual needs of their residents, which leads to a decrease in the quality of aide-work. Anderson et al. (1997) used Medicaid Nursing Facility 1989 Cost Reports data from 469 NHs in Texas to look at relationships between organizational variables and NH turnover rates of total nursing staff. The average skill-mix for these NHs was 3% RNs and the rest were LVNs and
NAs. "Turnover averages were all high with NA turnover almost three times that of RN turnover." (Anderson et al., 1997, p. 5). The RNs and LVNs had better quality jobs and higher job satisfaction mainly because of a higher educational background and more autonomy and respect from the administration (Anderson et al., 1997).

Besides being related to higher turnover rates, job satisfaction plays an important part in the nursing shortage and recruitment problems in NHs (Horne, 2000). These issues all amount to inadequate NH staffing. One year ago Mountain Trace Nursing Center (MTNC), in North Carolina, had a high turnover rate and 20 full time certified nursing assistant (CNA) positions open. The reasons they gave for their recruitment and retention problem were: "low pay (we are competing with the fast food market); hard, demanding, distasteful labor (the Department of Labor place CNA’s at a higher risk for on the job injury than steel workers and coal miners); and a poor industry image" (Horne, 2000, p. 2).

The MTNC applied many strategies that were successful in helping to combat their CNA recruitment and retention problem (Horne, 2000). Some of these strategies included: “a $50 recruiting bonus; pay tuition, books, and a salary to CNA students in exchange for a one-year contract; regular staff appreciation activities; use of a bath team; excellent health & dental benefits; and 4 weeks of orientation” (Horne, 2000, p. 3). One year after implementing the strategies MTNC only had 4 full-time open and unfilled CNA positions. The author did not explain how funding was provided for the extra job satisfaction incentives.
This author conducted an informal telephone survey of 6 out of 7 NHs in the Walla Walla, WA area in April of 2001 to determine the number of unfilled total nurse staffing positions at each NH. The open, unfilled positions at the 6 NHs ranged from 0 to 3 with the RN/LPN at a total of 5 unfilled positions and the NAs had a total of 4 positions needing to be filled. These unfilled NH positions do not reflect the nursing shortage crisis as reported by the MTNC in North Carolina. The local newspaper, The Union-Bulletin, has classified ads that have positions open for RNs, LPNs, or NAs on a daily basis and many times the ads include monetary incentives for hiring on with the NH.

**Alternative Model of Nursing Home Care Delivery**

Until a better funding mechanism can be found to improve NH staffing and quality of care, an alternative model for care delivery in NHs is needed. This care delivery model could be called “The Universal Care Team.” The focus behind this change in the delivery of NH care would be that all NH staff, such as administrative staff, housekeeping, therapists, social service staff, and activity staff, not just RNs, LPNs, and NAs, be encouraged to take a part in the residents’ care. The “Universal Duties” task force [in which this author was a member] at St. Mary Medical Center in Walla Walla, WA attempted to improve their patients’ satisfaction level by using this type of an approach to patient care delivery. All non-nursing staff, such as therapists, nutritionists, and social workers that were frequently in the nursing units, were encouraged to help answer phones and call lights during peak busy times on the unit. This gave the nurses more time for actual patient care, and the phone calls and patients’ requests were dealt
with in a timelier manner. The “Universal Duties” efforts fizzled out as time went by possibly because the task force members dwindled and an evaluation component was not built into the program.

Others have also suggested approaches similar to the “Universal Duties” task force in which all NH employees are encouraged to take a part in the residents’ care during mealtime (Kayser-Jones & Schell, 1997; Crogan & Shultz, 2000). In their 1997 study, Kayser-Jones & Schell suggested an “all staff” approach to helping at mealtime in the NH. Other staff members, besides nursing, “could be taught to assist residents with meals, and families could be encouraged to provide assistance during mealtime” (Kayser-Jones & Schell, 1997, p. 71). They also recommended two 1-hour mealtime sessions instead of just one 1-hour mealtime period.

Crogan & Shultz (2000) suggested a similar approach to NH care delivery called “all hands dining.” Their solution included having other NH staff take part in mealtime care. The activity staff could provide a social time before meals by offering the residents juice in the dining room. The social service staff could assist with passing meal trays in the dining room, which would give the nursing staff more time to assist residents in eating. The administrative staff could help by supplying coffee to the residents during mealtime and community volunteers and residents’ families could be asked to help residents at meals.

In using “The Universal Care Team” model of care delivery, the NH staff could be taught to support the residents’ care during busy mealtimes as just mentioned in the
preceding studies and example. Besides passing trays and other mealtime tasks, the staff, from other departments, besides nursing, could take the residents to the dining room and answer call lights and phones at the nurse’s station during mealtime. This would free-up the total nursing staff and give them more time for getting the residents ready for meals instead of running for the phone or call-lights every few minutes. For example, the total nursing staff would have more time to get residents up from naps or take them to the bathroom before meals. Families could also be encouraged to assist NH residents with their meals (Kayser-Jones & Schell, 1997; Crogan & Shultz, 2000).

Short inservices would be needed to inform staff on the changes, to provide teaching sessions, and to get the staff’s feedback on additional ways to help. There would be a need for several staff meetings at the beginning of the implementation of the new care delivery model, then, less frequently as time goes by. At the routine monthly staff meetings there should be a portion of the meeting set aside to discuss caregiving in the NH: what is working and what is not working with the new care delivery model, this would be an ongoing evaluation process component.

Nursing Practice Implications

To promote quality of NH care nurses (RNs and LPNs) need to improve their management and supervisory skills to work more effectively with the NAs. This would aid in promoting teamwork, staff morale, and positive resident outcomes. The required paperwork in NHs can be time consuming for the nurses and take time away from working with the NH aides. Nurses need to take some time, even if the paperwork does
not get finished, and be present at mealtime and at periods during resident cares to supervise, teach, lend a hand, and give positive feedback to the NAs. This will provide an opportunity to assess whether the residents’ cares are being done appropriately and safely. Nursing home administrators may not support this approach, if the nurse’s paper work is not done on time and if the NH does not understand the nurse’s explanation for the importance of overseeing the NAs. The nurse’s supervisory role situation needs to be negotiated with NH administration and policy needs to be changed to support this role.

The supervision of care is the responsibility of the licensed nurse. The NAs need guidance and without supervision the nurse cannot ensure quality of care.

LTC nurses need to advocate for improved staffing in NHs to provide safe, high quality care to residents. More total nurse staffing is needed in NHs. Specific total nursing to resident ratios is needed, not general staffing requirements that were mandated in 1987. LTC nurses need to promote public awareness about the true problems regarding the quality of care conditions in the NHs.

Nursing Research Implications

Current literature shows that there is a relationship between total nurse staffing levels and quality of resident care in NHs. Future research is needed to show if spending more to increase total nurse staffing can reduce the NH’s overall costs for poor resident outcomes and high staff turnover rates. More studies are needed on resident outcome results in relationship to improving the training and increasing the total nurse staffing
levels in NHs. Further studies could evaluate job turnover rates of RNs, LPNs, and NAs in NHs after improvements in staffing are made. Also, studies should examine the effectiveness of total nurse recruitment strategies by NHs. Research is needed to explore alternative models for care delivery in NHs and determine their effectiveness in promoting quality of care.

**Nursing Education Implications**

Improvements in the education of the total nursing staff in a NH should address the complex care needs of today’s NH population. For instance, residents that have undergone joint replacement surgery or persons who have had a stroke require specific clinical-care protocols to prevent complications related to these conditions. The nursing staff should be given adequate training regarding these protocols when first hired and on a biannual basis such as during a skills competency lab. This training session would provide a thorough review of resident care issues, hands on practice, and an opportunity for questions. The goal of these sessions is for the RNs, LPNs, and NAs to learn the safe and proper way to care for residents with complex care needs, which would promote quality of care.

Training protocols to teach the nursing staff about residents that have had joint replacement surgery could include hip or knee precautions, to prevent dislocating the joint, or could include the proper why to use some of the orthopedic equipment such as a polar care unit, an abductor pillow, or on how to turn and position these persons correctly. The polar care unit, which circulates cool water through a pad placed over the
knee to help reduce pain and edema, can cause very severe skin burns if not positioned properly on the new knee joint with a cloth to protect the skin. The most commonly used protocol for the polar care unit is to be turned on at no less than 40 degrees and to be on the resident for only two hours at a time and then off for one hour. The polar care unit must not touch the skin. This author saw a NH resident that suffered severe burns to her knee because the total knee replacement surgery protocol for the polar care unit was not followed. The nursing staff caring for the resident was not trained in the correct way to use the polar care unit. The resident’s healing process was greatly impaired and her NH stay was extended in order to provide the burn treatments required for healing before her skilled orthopedic rehabilitation could be completed.

The NAs should have more than the current requirement of 85 hours of training for certification. Although continuing education hours are not required for all nursing staff, NHs must provide NAs with 12 hours of training per year. The quality of the NH resident’s care can be promoted by the total nursing staff taking classes on caring for persons with dementia and Alzheimer’s Disease and other behavioral education to prevent the use of chemical and physical restraints.

Summary

Substandard NH care must not continue (Coccia & Cameron, 1999). More money needs to be spent on improving NH staffing: higher total nursing staff levels and more training (Harrington et al.). Our most vulnerable population is at great risk residing in NHs because of poor quality of care. Residents should not be allowed to lie in urine
soaked sheets all night or wait for an hour to have their call light answered. Most negative outcomes from poor quality of care, such as bedsores, malnutrition, and injuries from falls, can be prevented (Foster, 2000a). Poor staffing in NHs is a nursing concern because it goes against all the standards of nursing care and the ethical principles of caregiving (Milner, 1993).

Maintaining the quality of NH residents’ care is not just a nursing responsibility; help is also needed from those in all areas of the NH industry, the government, nurse educators, and nurse researchers. Besides improved LTC funding mechanisms to improve NH staffing, better government staffing regulations are needed that speak more to specific staffing ratios. Adequate NH staffing to promote quality care can not be defined only in terms of staffing to promote the well-being of the residents, but defined in terms of total nurse staffing levels to resident ratios and at the same time adjusting for each resident’s level of acuity.
References


Health of residents in nursing homes at risk due to understaffing. (2000, March 9).


Table 1 – *Five ethical principles of caregiving*

<table>
<thead>
<tr>
<th>Ethical Principles</th>
<th>Definitions of Ethical Principles</th>
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<tbody>
<tr>
<td>Beneficence</td>
<td>Do good</td>
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<tr>
<td>Nonmaleficence</td>
<td>Do no harm</td>
</tr>
<tr>
<td>Autonomy</td>
<td>Right to make choices without coercion</td>
</tr>
<tr>
<td>Justice</td>
<td>Fairness, treating persons equally according to their needs</td>
</tr>
<tr>
<td>Fidelity</td>
<td>Faithfulness and trust, also competence in treating the disease or person</td>
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Source: adapted from Milner, 1993
Table 2 – **Proposed minimum staffing standards for nursing homes**

<table>
<thead>
<tr>
<th>Administrative Standard</th>
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<tbody>
<tr>
<td>Full-time registered nurse with a bachelor’s degree as director of nursing</td>
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<tr>
<td>Part-time registered nurse assistant director of nursing (full-time in facilities with 100 beds)</td>
</tr>
<tr>
<td>Part-time registered nurse director of in-service education</td>
</tr>
<tr>
<td>Full-time registered nurse facility supervisor on duty at all times, 24 hr/day, 7 days/week</td>
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**Direct Care Staffing Standard**
Minimum level direct care staff:

- Day shift: 1:5 residents
- Evening shift: 1:10 residents
- Night shift: 1:15 residents

Minimum licensed nurses providing direct care, treatments, and medications, planning, or supervision at the unit level:

- Day shift: 1:15 residents
- Evening shift: 1:20 residents
- Night shift: 1:30 residents

**Mealtime Nursing Staff**
1 nursing staff for each 2-3 residents who are entirely dependent on assistance
1 nursing staff for each 2-4 residents who are partially dependent on assistance

Nursing staff who assist with feeding should be nursing assistants who are adequately trained in feeding procedures and supervised by licensed nurses.

**Education and Training**
All licensed nurses must have continuing education in care of the chronically ill and disabled and gerontological nursing (at least 30 hr. every 2 years).

Nursing assistants should have a minimum of 160 hours of training, including training in appropriate feeding techniques.

**Nurse Practitioners**
Each nursing home is strongly urged to have a part-time geriatric or adult nurse practitioner or clinical nurse specialist on staff.

Source: adapted from Harrington, Kovner, Mezly, & Kayser-Jones, 2000
Table 3 – **Potential savings - improved nursing home staffing**

- May reduce costs of hospitalization
- Improve staff morale and productivity thus reducing costs of supplies and drugs – as residents have more active, satisfying lives with fewer complications and loss of functioning
- Reduction in the use of restraints save money by improving resident outcomes
- Lower staff turnover – costs saved from increased hiring and training replacements (4 times monthly salary is spent in replacement costs)

Source: adapted from Harrington, Kovner, Mezly, & Kayser-Jones, 2000