The Case for Minimum Nurse Staffing Standards in Nursing Homes: A Review of the Literature

By Janet C. Wells, AB

Since the late 1960s, consumer advocates have urged government implementation of mandatory minimum nurse staffing standards in nursing homes to overcome chronic understaffing, high staff turnover, and consequent neglect of residents. The debate over the efficacy and affordability of mandatory staffing standards has continued for more than 35 years. This report reviews the growing body of research verifying the connection between identified nursing staff-to-resident ratios and quality care; the prevalence of avoidable medical conditions and

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hospitalizations below certain hours per resident day of direct care; and inadequate enforcement by state and federal regulators. While the nursing home industry, federal health officials, and US Congress remain resistant to mandatory staffing standards, a few state legislatures have adopted legislation requiring the minimum ratios or hours of direct care per resident day recommended by experts. A larger number of states have implemented standards below the recommended minimums.

**Key words:** minimum staffing standards, nursing homes, nurse staffing, staffing ratios

Advocates have long known that poor care—both neglect and outright abuse—are directly tied to poor staffing. When one CNA (Certified Nursing Assistant) is responsible for 25 residents during a shift, it stands to reason that many people may not be given fluids, toileted, or turned during those 8 hours. Even the most well-meaning and caring CNA cannot attend to the needs of residents when taking care of too many people. As the needs of nursing home residents have become more and more complex, nursing homes have continued to be staffed at low levels.¹

Inadequate staffing in nursing homes causes unnecessary pain and suffering to nursing home residents. Throughout our nation’s nursing homes, an erratic staffing situation exists where residents receive anywhere from 8 minutes of direct care (per resident day)² to 3.5 hours of direct care daily.³ The primary caregivers for nursing home residents are aides or nursing assistants (NAs)—called certified nursing assistants (CNAs) if they completed the minimal required training. In a typical facility, a NA who works the 7:00 a.m. to 3:00 p.m. shift will spend, on average, a total of 42 to 44 minutes with each resident.⁴ A NA on the night shift will ordinarily spend much less time with each resident. Resident advocates including the family members and friends of residents, concerned citizens, and health professionals have begged for even modest increases in staff time to little avail. Despite exorbitant nursing home fees, nursing home residents are too often neglected because of inadequate staff. The examples in this report demonstrate the personal cost of this policy failure and illustrate the inhumanity of the current situation.

Since the late 1960s, consumer advocates have urged the implementation of minimum staffing standards in nursing homes. Advocates urge legislators to establish a minimum standard to serve as a foundation on which to build quality care. When the first Senate Special Committee on Aging convened in the late 1960s, long-term care experts had already drawn the link between staffing and quality of care. The nursing home industry also acknowledged the necessity of staffing ratios. In July 1969, a representative for the American Association of Homes and Services for the Aging (AAHSA), today known as the American Association of Homes and Services for Aging (AAHSA), testified before the Senate Moss Subcommitte and maintained that the adoption of staffing ratios for nursing homes was "...urgent and wholly possible."⁵ The Senate Subcommittee on Long-Term Care recognized the link between staffing levels and quality of care in its assertion that "the inadequacy of one RN [Registered Nurse] in charge of a nursing home with 150, 200, 300, or 400 beds is obvious."⁶ Despite the agreement between the Senate Subcommittee and industry representatives, the US Department of Health, Education and Welfare (HEW) refused to set staffing standards and maintained that ratios were nothing more than a crude index of total time dedicated to patient care.⁷

Over the past 35 years, various studies have verified the logical connection between staffing and quality of care, yet only modest progress has been made in the implementation and enforcement of existing federal staffing standards. Long-term care experts and consumer advocates, including the National Citizens' Coalition for Nursing Home Reform (NCCNHR), continue to urge the government to adopt a national minimum staffing standard. On the industry side, provider associations continue to acknowledge the importance of adequate staffing in providing important services to residents. In a report to the US Senate Special Committee on Aging, AAHSA voiced support and encouragement for minimum staffing requirements provided that they are based on sound research and supplemented with reimbursement rates that reflect staffing requirements.⁸ In the last decade, a wealth of research and information has accumulated demonstrating the need for adequate staffing.
standards and the effects of different staffing levels on quality of care.

The Centers for Medicare and Medicaid Services (CMS) has released studies identifying a threshold staffing level below which quality of care is compromised. Other researchers have used data collected through the On-Line Survey & Certification Assessment Reporting System (OSCAR) to establish a direct relationship between inadequate care and staffing levels. (OSCAR data report individual facility deficiencies and staffing levels). Despite convincing studies and detailed proposals, federal consideration of staffing ratios and adequate nursing home staffing levels remains slow. Bureaucratically, HEW has become Health and Human Services (HHS), a more focused agency, while demographically the population that is aging has continued to grow. Nevertheless, the same rationales asserted over 30 years ago are advanced today to justify government’s failure to adopt a more stringent staffing standard. These rationalizations include a nursing workforce shortage, a fear of bankrupting facilities in a time when more facilities may be needed, and the alleged lack of sound, methodological research demonstrating the need for a particular staffing ratio.

**PRESENT STAFFING REQUIREMENTS**

**The current federal standard**

The current federal staffing standard requires that all Medicaid or Medicare certified nursing facilities provide “sufficient nursing staff to attain or maintain the highest practicable...well being of each resident.” The language makes this regulation less of a standard than a goal. Aside from a specific requirement that facilities employ a registered nurse for at least 8 consecutive hours a day, 7 days a week, and both a director of nursing and licensed nurse, the federal standard about direct care and staffing remains vague. Although some states have further defined the meaning of sufficient staffing by implementing legislation that mandates increased hours of nursing care per resident day, in many states the standard remains vague and open to interpretation (and abuse) by nursing home providers.

**State staffing standards**

As of 2002, at least 36 states and the District of Columbia had supplemented the minimum federal staffing standard with increased staffing requirements. In Delaware, for instance, direct caregivers must provide 3.67 hours of direct care per resident day. In many jurisdictions, state staffing standards remain lower than actual staffing levels and HHS’s recommended minimum standards necessary for safety. However, recent efforts have been made to improve the situation. Between 1999 and 2000 one quarter of the states set higher staffing standards for nursing homes. Nonetheless, a more stringent standard remains inadequate.

Although many states have made efforts to increase staffing standards and some have been successful, average nurse staffing levels did not improve between 1997 and 1999. Though state staffing standards varied greatly in 2000, the lowest reported standard amounted to a disgraceful 8 minutes of care per resident per day in Virginia and Alabama.

**Enforcement of the present federal and state standards**

The federal government contracts with the states to investigate complaints regarding violations of quality of care standards and to conduct annual inspections of all Medicaid and Medicare facilities. A group of state surveyors visits the facility for a few days every 9 to 15 months to evaluate whether residents need is being met by the facility. If a Medicare or dual Medicare-Medicaid facility is found to violate a federal quality of care standard (including staffing), the surveyors refer the deficiency to CMS. CMS imposes a sanction based on the recommendation of the state. The imposition of sanctions is usually precluded by a 30- to 60-day grace period for facilities to rectify the deficiency without sanction.

Because of the predictability of surveys, quality of care problems or deficiencies that exist regularly in the facility may not be apparent during the surveyors’ visit. In 1999, the Healthcare Financing Administration (HCFA), now CMS, instructed states to schedule surveys of facilities during different months each year. Despite HCFA’s mandate, such surveys of facilities remain predictable and in over one third of facilities. Since facilities can estimate when surveys are going to visit, they are able to increase staffing levels for the survey. This usually sufices given that surveyors are only required to check staffing during extended surveys and do not monitor staffing levels regularly.

Even if facilities are inadequately staffed, state surveyors rarely issue deficiencies for staffing violations. An analysis of 1999 OSCAR data found that only 5.7% of all nursing home facilities were cited for inadequate staffing. This percentage varied considerably among states, with some states issuing no staffing deficiencies during the entire year. Yet sound research detailed throughout this article suggests that many nursing facilities are consistently understaffed.
Regardless, surveyors are more likely to issue citations related to quality of care than staffing because the federal staffing standard is so vague and difficult to understand.6

**ACTUAL STAFFING LEVELS: ARE THEY SUFFICIENT?**

**Actual staffing levels: The national average**

An analysis of OSCAR data and staffing levels reported from state surveys revealed that the 2001 average total nurse staffing level was 3.5 hours of care per resident day.3 A data book of OSCAR data compiled by researchers in 2002 detailed the existence of a negligible 0.2 increase in average nursing hours per resident day from 1995 to 2001.3 The average 3.5 hours of care falls well below the 4.1 hours recommended by HHS as necessary to avoid harm and jeopardy to residents.12,13

** Sufficiency of the national average staffing level**

I have no time to speak to the residents. They cling to you. One resident called me in one night. She grabbed my arm and asked me to hold her. I gently removed her hand and explained that I had 16 residents to care for and could not stay. She died the next day. All she wanted was someone to be with her. I felt terrible.14

To put the amount of time spent with each resident into perspective, 3.51 nursing care hours per resident day equates to 70 minutes per 8 hour shift.3 This means 14 RN minutes per resident, 14 LPN minutes per resident, and 42 NA minutes per resident per shift in a 100-bed facility.15 Thus, in an average facility, a NA working the 7:00 a.m. to 3:00 p.m. shift is limited to an average of 42 minutes with each resident. Although some residents may require less than 42 minutes of care, many will need far more daily care. Typical tasks that the NA might be required to perform within that 8-hour shift to provide basic care to each resident include bathing, toileting, incontinence care, feeding, grooming, dressing, and transporting. The level of assistance needed and time required to complete each task varies from resident to resident. However, government data indicate that dependence in these areas is high, with approximately 50% of residents requiring bathing assistance, 90% needing toileting assistance, 55% needing incontinence care, 80% needing feeding assistance, and 45% needing wheelchair assistance or assistance in getting out of bed or a chair.16

Table 1 below, available on the NCCNHR Web site at http://nursinghomeaction.org, provides approximations of all the time required to complete many of the direct care tasks performed by CNAs. In addition to providing consistent basic care to residents, the NA must also allocate time to answer call lights, keep water pitchers full, handle emergency situations, and in theory form relationships with residents.

**The implication of actual staffing in facilities for quality of care provided to residents**

It is anticipated that the number of people older than 85—those most likely in need of nursing home care—will more than double between 2000 and 2050.17 Although there has been a recent decline in nursing home occupancy, this trend will likely cease as the number of people older than 85 increases dramatically. If current practices continue, it will be hard to meet this challenge and provide any semblance of quality care because studies indicate that, even with today’s more manageable numbers, 25% to 33% of all nursing homes currently operate below the minimum federal staffing standard.5,18,19

**Staffing is related to quality of general nursing care**

Research has documented the connection between staffing levels and the comfort and well-being of residents. Spector and Takada20 found that higher staffing levels were related to improvements in resident functioning and that lower staffing levels were associated with negative outcomes including high catheter use, low rates of skin care, and low resident participation in activities. Cherry21 found that increased RN staffing levels were associated with fewer pressure sores, fewer urinary tract infections, less antibiotic use, and reduced catheter use. Cohen and Spector22 found that higher staffing levels reduce the likelihood of death and increase the likelihood of improved function among residents. A study of homes in Minnesota found that licensed nurse staffing levels had a significant impact on the well-being of first-year residents. Higher licensed staffing levels in nursing homes were associated with improved functioning and a heightened probability of rehabilitation to the point of discharge from the facility.23 A California study found that NAs working in facilities that report staffing levels at 3.9 hours per resident day maintain significantly lower case loads and provide better care than do NAs working in facilities with less staff.24 Unfortunately, very few facilities staff at that high level. Overall, inadequate staffing levels have been found to relate to poor resident outcomes, including preventable hospitalizations.25
Table 1.

<table>
<thead>
<tr>
<th>Duties</th>
<th>Time(min)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The following are examples of resident care responsibilities a CNA may have on a single daily shift:</td>
<td></td>
</tr>
<tr>
<td>Shower</td>
<td>10-30</td>
</tr>
<tr>
<td>Bed bath</td>
<td>10-15</td>
</tr>
<tr>
<td>Personal hygiene care (each time incontinent)</td>
<td>5-10</td>
</tr>
<tr>
<td>Partial baths (face, oral care, hands, peri-care) on each resident</td>
<td>10</td>
</tr>
<tr>
<td>Foley catheter care</td>
<td>5-10</td>
</tr>
<tr>
<td>Empty and measure catheter bag at end of shift</td>
<td>5</td>
</tr>
<tr>
<td>Oral care/dentures</td>
<td>5-10</td>
</tr>
<tr>
<td>Groom/shave resident</td>
<td>5-10</td>
</tr>
<tr>
<td>Dress resident</td>
<td>5-10</td>
</tr>
<tr>
<td>Nail care to resident</td>
<td>5-10</td>
</tr>
<tr>
<td>Body/hand lotion to skin</td>
<td>5</td>
</tr>
<tr>
<td>Toilet resident</td>
<td>10-15</td>
</tr>
<tr>
<td>Vital signs (temperature, pulse, respiration's, &amp; blood pressure)</td>
<td>10</td>
</tr>
<tr>
<td>Set up meal tray, document food/fluid intake each meal</td>
<td>5-10</td>
</tr>
<tr>
<td>Total feed the meal to a resident</td>
<td>20-60</td>
</tr>
<tr>
<td>Each CNA may have a minimum of 2 residents to feed</td>
<td>40</td>
</tr>
<tr>
<td>Serve and feed nutritional supplements during the shift</td>
<td>1-10</td>
</tr>
<tr>
<td>Handwashing between each resident</td>
<td>1</td>
</tr>
<tr>
<td>Bed making, unoccupied</td>
<td>5</td>
</tr>
<tr>
<td>Bed making, resident in the bed</td>
<td>10-15</td>
</tr>
<tr>
<td>Resident unit organization</td>
<td>5-10</td>
</tr>
<tr>
<td>Documentation &amp; observations on the resident care records</td>
<td>3-5</td>
</tr>
<tr>
<td>Passive range of motion (5-10 repeats) to resident</td>
<td>15</td>
</tr>
<tr>
<td>Ambulating resident to dining room or other areas</td>
<td>10-15</td>
</tr>
<tr>
<td>Assessment of pain, depression, and behavior</td>
<td>5-10</td>
</tr>
</tbody>
</table>

*The Nursing Service Group Inc, PO Box 32, Barrington, IL 10011; available on the NCCNHR Web site: [http://www.nccnhr.org/govpolicy](http://www.nccnhr.org/govpolicy).*

There is also a connection between staffing levels and facility compliance with government requirements. A nursing home's likelihood of being cited for facility deficiencies was found to decrease as nursing staffing levels increased.26 A study of the OSCAR data conducted in 2000 found a direct correlation between the number of cited deficiencies in nursing homes and registered nursing hours.26 Specifically, the findings of this study indicate that fewer RN hours were associated with more quality of care deficiencies and fewer NA hours were associated with both quality of care and quality of life deficiencies.26

There is a connection between staffing levels and actual harm to vulnerable residents. On average, in 2001, nursing homes provided 3.5 hours of care per resident day. That same year, state agencies found that one fifth of all nursing homes surveyed caused actual harm or placed their residents at risk of death or serious injury. Deficiencies issued that year identified that 32% of all nursing homes had poor food sanitation, 24% had inadequate quality of care, 22% had environments susceptible to accidents, and 18% provided improper treatment for pressure sores. Additionally, the data indicated that the percentage of facilities cited for lack of activities of daily living services increased approximately 40% from 1995 to 2001.27 A 1999 study identified over 25% of all nursing homes as having serious deficiencies that cause actual harm or place residents at risk of death or serious injury annually.28

*A recent report issued in 2003 found that the number of nursing homes cited for actual harm dropped in 2002 to 20% (GAO-03-561). However, federal comparative surveys cited in this case revealed that state surveyor's underestimation of actual harm deficiencies is a significant problem (US GAO-03-561). Based on a federal review of 76 surveys, the study found that 39% of the surveys contained low-level citations for deficiencies that actually qualified as actual harm deficiencies because the deficient practice was connected to actual harm suffered by at least 1 resident (GAO-03-561).*
Staffing is related to end-of-life care of residents

... Mr. Larkin was dependent on the staff for his care... Despite his need for help, the staff seldom assisted him at mealtime. Because of the bone metastases, it was difficult for Mr. Larkin to find a comfortable position. When he asked to be repositioned, sometimes the staff refused to help him. Shortly before he died, the RN on the unit said: "Oh, I don't think Mr. Larkin's going anywhere yet. I think he'll hang on for at least a month. Yesterday, I borderline lost it with him. He called me in four times in forty-five minutes... I told him that I had other patients with more critical problems who need my attention." Mr. Larkin died 4 days later. At the time of his death, he had five pressure ulcers on his back.27

A 30-month study of 117 terminally ill residents in 2 proprietary nursing homes found that inadequate staffing contributed significantly to the quality of end-of-life care. Staffing levels and workloads heavily influenced whether or not a resident received bathing/showering, oral health care, and repositioning/turning.27 Because of inadequate staffing, many residents were left in bed to develop pressure sores and contractures (an abnormal shortening or shrinkage of muscles, tendons). The study found that 54% of the 117 terminally ill residents had pressure sores at some point within the 30-month period and 82% of the residents died with pressure ulcers. An aggregate of 167 pressure sores were found on 63 residents. In this study, staff acknowledged their own failure to turn and reposition bed-ridden residents every 2 hours and admitted that they were able to turn residents only every 3 to 4 hours.27

Nursing assistants who must race from 1 resident to the next do not take the time they should to communicate with incoming NAs to coordinate care between shifts. A dying resident who has not eaten in days may be force fed by an aide who is oblivious to the resident's status. Sometimes the mouth of a dying resident is packed with uncottoned food because everyone is too busy to observe or check.

Staffing is related to pressure sores or bed sores

In general, Lunnie C. is very wasted, very cachectic. She is in horrible condition, there is a stench in the room, to the point of gagging me as well as the hospital staff that has been present in the room. (Hospital Physician, Reference 28)

In 1995 when Lunnie C., a 93-year-old woman, was admitted into a Texas nursing home she was well nourished, well hydrated, reported no pain, no pressure sores, and no terminal illness. This was not the case when she was transferred to the hospital in 1997 after being in the care of the nursing home for over 2 years. Upon admission into the hospital in 1997, Lunnie C. suffered from multiple stage intravenous pressure sores down to the bone, severe malnutrition, dehydration, sepsis, and unmanaged pain. An investigation by the Texas Department of Health Services revealed that "... the staff waited too long to turn the resident, to the point that Lunnie became uncomfortable, especially on the day and night shifts; any length of time past two hours is intolerable to the resident."28 Nursing home caregivers admitted, "When Lunnie would yell out for help or out of pain the nurses and aids would just shut her door; the facility was short of staff all the time."28 Severe pressure sores cause excruciating and unnecessary pain to the resident and can result in amputation or even premature death. Most pressure sores are preventable if a resident is given proper skin inspection, incontinence care, repositioning, and adequate nourishment. However, due in large part to inadequate staffing, these basic needs are often left unmet.

Staffing is related to nutrition and hydration of residents

Frequently it's difficult to get everyone fed. especially on the floor where they have a lot of 'feeders.' Some of the new CNAs have a hard time feeding people on time. They don't know the people. Some try and take shortcuts to rush things. I've seen some of them walk out of a room with a resident's tray that still has most of the food on it, and I know that resident usually eats everything... They just didn't take enough time to feed them.29

Mrs. S., a 93-year-old woman with severe cognitive impairment and mild dysphagia, was admitted to the nursing home weighing 103 lb. When intubated into the study, she weighed only 79 lb. We had never heard her speak. One evening as she was being fed too quickly, she said, speaking clearly. "Take it easy on this old woman! Don't choke me! Don't choke me!"29

Numerous studies have attributed inadequate nutritional intake, malnutrition, dehydration, and starvation to low staffing levels within nursing homes.29, 32 During a typical evening meal, a CNA is responsible for assisting 12 to 15 residents.33 Often, meals are served during a 1-hour period. Because of time constraints placed on staff to feed residents and return the trays to the food carts, some CNAs are compelled to cut corners. In a study conducted in 2 proprietary nursing homes, researchers found that some
residents were forced to eat quickly and slow independent eaters were spoon-fed, which eventually caused them to become more dependent. Other residents, requiring complete or partial assistance with feeding, were not fed at all.33

In some instances, CNAs would mix the entrée, sides, and dessert together with milk so that the residents could drink their entire meals.35 Because CNAs were responsible for feeding a certain number of residents, and sometimes answering call lights at the same time, meals were often cold by the time residents received assistance from CNAs.

Many residents have choking problems and require special diets such as thickened liquids. Lack of staff means that the correct drink or food is not obtained from the refrigerator and the residents are fed inappropriate food putting them at significant risk of choking.

RECOMMENDED MINIMUM STAFFING STANDARDS

The current federal staffing standard in nursing homes is so inadequate that it fails to ensure quality of care and safety of residents.36–38 As a result of family dissatisfaction and their own commitment to social justice, advocates have recommended various federal staffing standards that articulate a minimum requirement for sufficient staffing. Expert studies and calls for improvement will be discussed below in chronological order.

Required government study, Centers for Medicare and Medicaid Services

The Secretary shall conduct a study and report to Congress no later than January 1, 1992, on the appropriateness of establishing minimum caregiver to resident ratios ... and shall include in such study recommendations regarding appropriate minimum ratios.39

Pursuant to the mandate of the Omnibus Budget and Reconciliation Act, 1990, and despite its 1992 deadline, CMS released its final report on the appropriateness of minimum staffing standards in 2001. This was an important study for residents and their advocates. On the basis of its findings, CMS noted that the staffing levels of many nursing homes compromise the safety of residents and the quality of care. One of the studies included in the report found that a minimum of 4.1 direct care hours per resident day are necessary to avoid quality of care problems. A second study found that essential nursing assistant functions such as dressing, grooming, exercising, feeding, toileting, changing wet clothes, and repositioning requires at least 2.8 to 3.2 nursing assistant hours per resident day.12 Both findings support the need for a national staffing standard for long-term care facilities.

Institute of Medicine recommendation

The respected Institute of Medicine (IOM), part of the National Academy of Sciences, released its study on nursing home staffing in 1996.40 IOM recommended a federal staffing standard consisting of 24 hour per day RN coverage and increased levels of total nursing staffing that take into account resident casemix.41 In a later study, "Improving the Quality of Long-Term Care," the IOM recommended the development and implementation of minimum staffing levels based on casemix.42

Hartford Institute for Geriatric Nursing Expert Panel

In 2000, an expert panel sponsored by the Hartford Institute for Geriatric Nursing convened and recommended a minimum federal standard that closely reflected a previous standard proposed by NCCNHR in 1998.43 The standard recommended by the panel called for the implementation of the following policies:

- A requirement that all facilities have at least 1 RN nursing supervisor on duty at all times;
- A requirement that all facilities with 100 beds or more employ a full-time RN, Director of Nursing, a full-time assistant director of nursing, and a full-time RN director of in-service education;
- A requirement that all facilities with 100 beds or fewer employ a part-time RN, Director of Nursing, a part-time assistant director of nursing, and a part-time RN director of in-service education;
- A minimum staffing standard for all nursing homes consisting of 4.13 hours of direct nursing care per resident day to be adjusted upward based on resident casemix;
- Minimum day shift ratios of 1 LPN/RN for every 15 residents and 1 NA for every 5 residents;
- Minimum evening shift ratios of 1 LPN/RN for every 20 residents and 1 NA for every 10 residents;
- Minimum night shift ratios of 1 LPN/RN for every 30 residents and 1 NA for every 15 residents.44

House Committee on Government Reform Reports: Making the case for the CMS report’s minimum standard

Two recent studies conducted by the Committee on Government Reform further verify the relationship that exists...
between staffing levels and quality of care. Following the release of the 2001 CMS report, which recommended a minimum standard of 4.1 total nursing hours per resident day, the Congressional committee issued reports on nursing homes in Texas and Los Angeles County. In each study, the researchers found a close correlation between the number of serious deficiencies issued to a facility and the facility’s staffing levels. Although the degree of the relationship varied, each study reiterated that nursing homes failing to meet the CMS report’s minimum staffing standards were more likely to be cited for violations that caused actual harm than did facilities that were in full compliance with that standard.

A study of Texas nursing homes conducted from March 2001 to August 2002 found that on average Texas nursing homes provided 3.19 hours of care per resident day. According to the study, 94% of the nursing homes did not fully meet the CMS report’s recommended staffing standard. Of the 64 (6%) facilities that did meet the recommended minimum standard, only 8 (3%) were cited for deficiencies that caused actual harm to residents. On the other hand, 41% of the 1060 facilities that did not meet the recommended standard were cited for a violation that caused actual harm. Based on its findings, the study concluded that Texas facilities that do not meet the elements of the CMS report’s recommended minimum staffing level are over 3 times more likely to have serious violations of federal standards than do their nursing home counterparts that do meet the standard. The study conducted in Los Angeles County produced similar results. In Los Angeles County, nursing homes that met the requirements of the CMS report’s minimum staffing standard were over 50% more likely to be in full or substantial compliance with federal guidelines.

Taken together, these Congressional reports are strong evidence of the need for a stricter staffing standard that is at least as stringent as the 4.1 total hours per resident day minimum standard recommended by the CMS report. By directly comparing the number of actual deficiencies among facilities within a geographic region that met the standard against those who did not, the researchers established a definite threshold below which quality of care is consistently and significantly compromised. It is important to note that 91% of the nations’ nursing homes maintain NA staffing below the minimum standard recommended by the 2001 CMS report. Furthermore, over 40% of all nursing homes would have to increase their NA staffing levels by at least 50% to meet these standards. The aforementioned studies illustrate the need for change to guarantee quality care and to help facilities operate within the law.

**IMPLEMENTING A NEW STAFFING STANDARD: COSTS/BENEFITS**

How are nursing homes funded?

Long-term care is primarily funded by federal and state financing through Medicaid and Medicare reimbursements. In 2002, Medicare and Medicaid reimbursements accounted for approximately 60% of all nursing home expenditures. Medicaid is the largest source of financing for nursing home care, accounting for roughly 45% of the revenue of an average facility. Medicaid is a federal match program; the reimbursement rate provided for a Medicaid recipient varies from state to state and is determined by the state’s contribution. In most states, reimbursement rates are calculated based upon a facility’s past expenditures adjusted for inflation. In 1980, the Boren Amendment required states to provide nursing home Medicaid payments that were “reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality standards.” The Boren Amendment was repealed in 1997 and states are now able to set reimbursement levels lower than the requirement of that policy. In 2002, the average Medicaid reimbursement rate was $124.26 per day and state rates varied from $323.05 per day of care to $82.92 per day of care.

Medicare reimbursements for nursing homes used to be based on their total expenditures. In 1998, Congress enacted a prospective payment system (PPS) that calculated reimbursement rates based on the amount of care expected to be given to residents. To facilitate transition into the new system, Congress authorized temporary payments in addition to the prospective payments. The authorization for these increased payments has since expired and Medicare reimbursement rates decreased to calculations equivalent to expected care to be provided. In 2001, the average Medicare reimbursement rate reached $268 per covered day. Because of the disparity between Medicaid and Medicare reimbursements and Medicaid’s alleged failure to cover all costs, nursing homes have relied on Medicare funds to supplement payments for costs incurred by Medicaid residents.

**Estimated costs of implementation of a recommended standard**

CMS admits that increasing staffing up to the levels recommended by its report would improve quality.
yet it asserts that no action can be taken until there is further analysis of the "tradeoff" between cost and quality improvement. Nursing home residents and their families live with those tradeoffs every day—tradeoffs that cause pain, suffering, and death, as well as expensive medical treatment for problems that could have been avoided with good nursing care. (Donna Lenhoff, Executive Director, NCCNHR, Reference 28)

There is ongoing debate regarding the costs of higher staffing and who should bear them. Would more staff simply mean less profits for provider corporations or a huge burden for government funders? According to the expert panel that convened at the John A. Hartford Institute, implementation of the 4.55 hours per resident day minimum staffing standard may require a 2% to 7% increase in total nursing home expenditures. A 2001 study shows that implementing the new proposed staffing standard would require over $11 billion in additional funding to pay the benefits and wages of increased staff. Furthermore, the study finds that increasing the minimum standard of care to 2.9 CNA hours per resident day would require over $8 billion in additional funds. Six billion dollars may be a mistaken or highly exaggerated estimate; however, to put money amounts in perspective: if the $6 billion figure is accurate, that would still be less than what Americans spend on pet food annually.

**Does the implementation of an increased staffing standard require an increase in reimbursement rates?**

Most advocates for increased staffing standards acknowledge that an increased staffing standard may require some increase in federal funding for nursing home payment programs. However, advocates also maintain that costs incurred by the implementation of a more stringent staffing standard could be at least partially offset by ancillary Medicaid and Medicare cost savings. Increased levels of professional nurse staffing may reduce the incidence of preventable hospitalizations. Adequate staffing levels could alleviate many of the conditions that cause residents needless suffering such as improper incontinence care, bed sores, and falls. Increased staffing levels would decrease worker caseloads, which in turn may reduce work-related injuries and increase productivity. According to a California study, higher staffing levels were clearly associated with lower turnover rates. High turnover of direct care workers who quit because they are overworked, underpaid, and underappreciated is extremely costly. For every worker that leaves a facility, the facility must pay between $1400 and $4300 for replacement and training costs. This replacement cost potentially exceeds 4 times the monthly salary paid to that worker. Furthermore, high turnover rates cause quality of care concerns due to a lack of continuity with the residents and a lack of sufficient experience as a long-term care worker. These factors must be taken into consideration when weighing the costs and benefits of implementing staffing ratios.

Although ancillary savings will not completely offset the costs of implementing a new standard, an increase in Medicare reimbursement rates may still not be necessary. The Medicare PPS already pays facilities to staff at levels beyond federal and state requirements. Under the PPS, reimbursement rates are determined based on the average staff time expected to be given to each resident multiplied by the average staff salary required for each resident. Although Medicare-certified facilities are reimbursed based on the expectation that they will provide staff and salary at the calculated level, they are not required to meet these levels. Therefore, many advocates and long-term care experts believe that funding should not be increased for Medicare-certified facilities to the extent that expected staffing levels paid for exceed required staffing levels.

Instead, the implementation of a minimum standard equivalent to the standard already paid for in Medicare rates should be accomplished without an increase in reimbursement rates.

Furthermore, the sufficiency of Medicare rates has already been established by the fact that facilities are using excess profits from Medicare to supplement low Medicaid payments for Medicaid recipients requiring greater levels of care. An increase in Medicare rates would not benefit facilities with few Medicare patients and many Medicaid patients. However, facilities with many Medicare patients and few or no Medicaid patients would be unjustly enriched by such an increase.

Importantly, some long-term care experts maintain that even existing Medicaid rates may not preclude nursing homes from meeting a minimum staffing standard. Although states with higher Medicaid rates tend to provide higher staffing levels, the median LN staffing hours in some states with the highest reimbursement rates was equivalent to the median levels found in states with the lowest reimbursement rates.

Will an increase in reimbursement rates improve staffing?

If nursing homes are getting more money, I expect them to use that money to improve patient care...
That means not using the money to increase profits or double the administrator's salary. Nursing homes already get billions of tax dollars. They also get a lot of the residents' own dollars. Unfortunately, quality of care is too often poor. More money should result in better care. It's as simple as that. (Senator Chuck Grassley, Chairman, U.S. Senate Committee on Finance, Closing Statement, July 17, 2003, Hearing, Reference 47)

Will throwing money at providers help? Several studies have established a positive relationship between Medicaid reimbursement rates and staffing levels in nursing homes. However, recent studies conducted during the fluctuation of Medicare reimbursement rates suggest that higher reimbursement rates do not enhance staffing levels. Following the implementation of the PPS, Medicare-certified facilities temporarily received an increase in Medicare reimbursement rates. As federal funding temporarily increased, staffing levels decreased in those facilities.

A GAO analysis of nursing homes’ expenditures in Mississippi, Washington, and Ohio provides an idea of where the increased funding may have been allocated. That GAO study found that the average share of expenditures devoted to resident care activities, including nursing care and medical supplies, was slightly greater than half of the total expenditures. The study also showed that homes with higher total expenditures generally spend disproportionately less on staffing and more on capital and administrative expenses than do homes with lower expenditures. Additionally, a US News and World Report investigation found that 1 out of every 5 nursing homes spends over 20% of the revenue on administrative expenditures. These studies support the notion that any funding increases intended to raise staffing levels should be allocated solely for the purpose of direct care staffing. Rather than an outright increase in reimbursement to all Medicare-certified facilities, additional funding should be made available to only those who use it exclusively for direct care.

Reconciling the implementation of a more stringent staffing standard with the national nursing staff shortage: Learning from state standards and state proposals

All nursing homes face the daunting task of recruiting enough staff because the work is hard and the pay is low. A more stringent staffing standard will by necessity involve recruiting and retaining the necessary staff to attain compliance. In 2002, there were approximately 96,000 vacancies for full-time CNAs, LPNs, and RNs in nursing homes throughout the nation. Additionally, annual turnover rates in nursing homes average approximately 50% for nurses and 70% for nursing assistants. Two thirds of nursing facilities throughout the nation reported that recruitment was more difficult in 2002 than in 2001. Because of the current staff shortage and high turnover rates, many facility or nursing home industry advocates contend that implementing a more stringent standard that requires increased nurse staffing is not feasible at this time.

The adoption of staffing standards may well alleviate some of the retention and recruitment difficulties facing nursing homes. Various factors contribute to high turnover rates and high vacancy rates including low wages and benefits, lack of an upward career ladder, risk of injury, and high workloads. Although these factors all contribute to high turnover and low retention, recent studies suggest that the workload caused by understaffing is the primary cause of dissatisfaction among direct care workers in nursing homes. In other studies, long-term care workers identified the lack of adequate staff within a facility as one of the most significant barriers to retaining long-term care workers.

Implementation of staffing standards in the states*

Recent state efforts indicate that the nursing home workforce shortage does not preclude establishment of more stringent staffing standards. Many states have recently implemented staffing ratios for nursing homes in spite of the staffing shortage. The approaches taken by the various states differ in leniency, phase-in period, and strategy. These state examples, taken together, may provide a model for implementing a successful and adequate staffing standard federally or in other states.

Some states, including Oklahoma, Arkansas, and Florida, have adopted incremental implementation of staffing ratios. Oklahoma's Phase I, implemented in 2000, required 1 direct care worker for every 8 residents during the day shift (1:8), 1 direct care worker per 12 residents during the evening shift (1:12), and 1 direct care worker per 17 residents during the night shift (1:17). Phase II, implemented in 2001, increased staff ratios to 1:7 during the day shift; 1:10 during the evening shift; and 1:17 during the night shift. As of February 2003, Oklahoma's Phase III had not yet been implemented. Following implementation of Phase III, nursing homes in full compliance with the aforementioned staff to resident ratios shall be permitted to

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*This section was compiled from www.cga.state.ct.us/2005/olddata/phy/rpt/2005-R-0204.htm; retrieved July 7, 2005.
implement "flexible staffing." Flexible staffing means that as
long as the staff-resident ratio is not greater than 1:16 at
all times and direct care hours are maintained at 2.86 per
resident day, the facility will not have to maintain the exact
ratios for each shift as detailed above. Ultimately, the 2.86
minimum hours will be incrementally increased to 4.1
hours for facilities given reimbursements that cover the
costs of care and additional staffing. Oklahoma facilities
not in compliance with the strict staffing ratios will be re-
quired to maintain full compliance for at least 3 months
prior to being permitted to implement flexible staffing ac-
cording to Oklahoma House Bill (HB) 2218.

In 2001, Florida also adopted a 3-stage staffing standard.
According to the 2001 legislation, staffing levels for CNAs
will increase from 2.3 hours to 2.9 hours between 2002
and 2004. The legislation also mandates minimum staffing
of licensed nurses at 1 hour per resident day. Additionally,
Florida nursing homes must maintain a strict CNA-to-
patient ratio of 1:20 and a nurse-to-resident ratio of 1:40.
Minimum CNA hours per resident day may be performed
by nurses, so long as they are performing CNA duties
throughout their entire shift and are not counted toward
fulfilling the nurse-to-resident ratio or minimum nursing
services (FSAL § 400.25, as amended by Ch.2001-45).

Arkansas has also adopted a phased-in staffing ratio for di-
crect care staff. During FY 2001–2002, direct care must be
provided at a ratio of 1:7 on the day shift, 1:10 on the even-
ing shift, and 1:16 on the night shift. The direct care staff
ratios were improved in FY 2002–2003 to 1.7:1 on the day
shift, 1:9 on the evening shift, and 1:14 on the night shift.

According to the legislation, the day shift ratio will de-

Other states have implemented strict ratios and staffing
standards without an incremental delay. In 2001, Maine
implemented staff-to-patient ratios consisting of 1:5 on the
day shift, 1:10 on the evening shift, and 1:15 on the night
shift (Code Me. Rules 0-144, Ch. 110, 9-A). Massachusetts
has implemented 3 different staffing standards based on
facility characteristics and care provided. These standards
range from 2.6 to 1.4 hours of nursing care per resident
day depending upon the level of care provided by the fac-
cility (105 CMR 150.007).4

Using secondary research, this report has summarized
key issues related to staffing standards. These highlights are
meant to inform the policy debate about solutions to the
dire consequences suffered by residents who do not re-
ceive proper care in the nursing home setting.

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*Too late to be included in this article, the Assistant Secretary for Planning
and Evaluation (ASPE) of the US Department of Health and Human
Services published State Experiences With Minimum Nursing Staff
Ratios for Nursing Facilities: Findings From the Research to Date
and a Case Study Proposal by Jane Tilly, Kirsten Black, and Barbara
Ormond, of the Urban Institute, Washington, DC (February 2003).

The ASPE research updates some of the state data in this article, finding
that 19 states have implemented increased staffing requirements
since 1997, although several delayed, reduced, or eliminated their
requirements. Of 11 states ASPE identified that had introduced new staff
ratio legislation in the past 3 years, none had yet enacted a new minimum
staffing law.

Minimum Nurse Staffing Standards in Nursing Homes


47. Effects of the Medicare Prospective Payment System on the Quality of Care in Nursing Facilities. Department of Health Policy and Administration, University of North Carolina at Chapel Hill; 2002.


