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A Risk Management Resource for Aging Services | Republished 2021

Insufficient Staffing: A Major Source of Aging Services Liability

In both negligence and wrongful death lawsuits, plaintiff attorneys often include allegations of inadequate staffing as an underlying cause of resident harm. However, a growing number of claims now assert low nurse staffing levels as the *sole* source of liability. Relying upon an array of quality- and performance-related information, plaintiff attorneys contend that some organizations are cutting costs and imperiling residents by deliberately understaffing facilities and over-reporting caregiver numbers to the government.

Staffing levels are one of the most tangible measures of quality care, but often fall well below the expectations of the Centers for Medicare & Medicaid Services (CMS).[1] In 2018, CMS began to utilize payroll-based staffing data to more accurately gauge staffing levels and calculate federal quality ratings of aging services organizations. Payroll-based data are linked to daily payroll information and reflect staffing measures from several categories captured over the course of an entire year, as compared to static point-in-time estimates previously reported by facilities during their annual recertification surveys. Known as the Payroll-Based Journal (PBJ), the CMS resource tool has revealed large daily staffing fluctuations. One study, in particular, analyzed PBJ data for more than 15,000 aging services organizations and revealed the following key findings:

- 55 percent of surveyed facilities met the expected level of staffing less than 20 percent of the time.
- 91 percent met the expected registered nurse (RN) staffing level less than 60 percent of the time.

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- Weekend staffing time per resident amounted to 17 minutes for RNs, 9 minutes for licensed practical nurses (LPNs) and 12 minutes for nurse aides (NAs).
- For-profit facilities were more likely to report higher staffing numbers than not-for-profits.
- Staffing levels increased before and during the time of annual surveys, but subsequently diminished.[2]

In an environment with growing resident acuity and ever-increasing expectations concerning transparency and accountability, aging services organizations must identify staffing discrepancies, as they can translate into higher rates of resident injuries and deaths, as well as fraud and abuse claims for misreporting levels. Facilities that fail to take swift action to address problems of staffing deficiencies may experience costly litigation, regulatory sanctions and severe reputational harm. This edition of *CareFully Speaking*® reviews basic staffing requirements, examines sources of staffing-related litigation, offers strategies to help diminish exposures, and presents a range of relevant resources.

1 According to a new survey by the American Health Care Association, in conjunction with its National Center for Assisted Living, just 1 percent of U.S. nursing homes currently report being fully staffed.

2 For a one-year period, researchers compared facility-reported staffing and resident census data to PBJ-generated data. The study's comprehensive findings were published in *Health Affairs*, Volume 38:7, July 2019 which is available by subscription or for purchase.

Staffing Requirements

The federal Nursing Home Reform Act, enacted in 1987 as part of the Omnibus Budget Reconciliation Act, establishes minimum nurse staffing levels for certified aging services organizations that provide Medicare and Medicaid services. Specifically, 42 CFR § 483.35 requires:

- One RN for eight consecutive hours per day, seven days a week.
- One RN or licensed vocational/practical nurse for each of the two remaining shifts, seven days a week.
- One full-time RN director of nursing, who may serve as charge nurse for facilities with 60 or fewer residents.

While there is no minimum staffing threshold for NAs, staffing as a whole must be sufficient to "maintain the highest practicable levels of physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care."

Appropriate staffing has long been debated in the aging care industry. In 2001, a landmark CMS study recommended a minimum of 4.1 hours per resident day (HPRD) to prevent harm to residents who are admitted longer than 90 days. However, the ability to sustain this level of staffing long term is adversely affected by high facility turnover rates and poor recruitment efforts. The catastrophic impact of COVID-19 on aging services organizations has renewed interest in promulgating federal minimum staffing regulations. Until such national standards are mandated, organizations such as the American Nurses Association, the Coalition of Geriatric Nursing Organizations and the National Consumer Voice for Quality Long-Term Care have endorsed the 4.1 HPRD guideline, and have further recommended that RNs be on duty for 24 hours per day and licensed nurses provide at least 30 percent of total nursing care hours.

In addition, the vast majority of states have issued staffing regulations, which are generally considered more stringent than the national benchmarks. Most states have established specific thresholds in terms of either nursing HPRD or staff-to-resident or staff-to-bed ratios. State-imposed direct care staffing requirements vary widely. However, organizations are encouraged to review statutory HPRD mandates and/or established staffing ratios. For state-specific information on nursing home staffing, visit the website of the Long Term Care Community Coalition or its Nursing Home 411 Data Center.

Safe staffing levels do not involve simply complying with numbers. They also require skilled and experienced staff members, and an organization's ability to retain those professionals. For recommendations on how to safely staff aging services facilities, see "Five Essential Tips for Safe and Appropriate Staffing" below.

Five Essential Tips for Safe and Appropriate Staffing

1. Attract and select the right people.

To identify desirable traits in potential recruits, profile the personnel that remain within the organization, as well as those who leave. High retention levels among unlicensed assistive personnel in aging services settings point to the following staff characteristics:

Personnel who tend to stay…

- have a history of longer tenure with fewer employers.
- have friends who are aides or assistants.
- possess decision-making power.
- work with a maximum resident ratio of 1:10 and have more permanent assignments.

Personnel who tend to leave…

- are unemployed at the time of application.
- lack relevant experience beyond caring for family or friends.
- feel misplaced and unappreciated within the organization's culture.
- have entry-level, multi-task job descriptions.

2. Embrace innovative staffing models.

A realistic staffing model with balanced and safe workloads ultimately decreases the risk of unsafe care due to excessive overtime shifts. The following staffing concepts may potentially improve staff efficiency:

- **Resident neighborhoods,** where the facility is divided into nursing "districts," with 12 or fewer residents per employee.
- **Job sharing,** where NAs are assigned to rotate within the organization, focusing on those units where help is most needed.
- **Permanent assignment,** where staff members are assigned to certain residents for the duration of their stay, encouraging a primary care approach to resident nursing.

(continued)

Five Essential Tips for Safe and Appropriate Staffing (continued)

3. Draft contingency plans in the event staffing level vulnerability arises.

Staffing deficiencies are inevitable, but planning can help avoid sustained periods of unsafe levels. Contingency plans should include the following features:

- **Staff floaters,** where certain employees are appointed to fill gaps in staffing schedules, rather than changing assignments frequently. Extra staff members are assigned to "float" during high-demand times and work partial shifts if needed.
- **Alternative workers,** where non-clinical and time-consuming tasks such as completing paperwork are delegated to ward clerks and hospitality aides, thereby permitting direct care workers to focus on patient care.
- **Federal and state employees,** where, for example, a national crisis or pandemic requires deployment of the National Guard to aging services facilities.
- **Temporary staff,** whenever employed staff is unavailable in sufficient numbers, such as high-census periods and in times of crisis. When selecting agency professionals, exercise vigilance in the following areas:
  - **Contracts,** ensuring a temporary staffing agency has adequate insurance coverage for negligent acts of its employees.
  - **Credentialing,** verifying that the staffing agency performed the initial licensure and competence evaluation of prospective candidates under the terms of the contract.
  - **Criminal background checks,** screening temporary hires for prior convictions that may or may not affect potential employment.
  - **Health and drug screening,** primarily focusing on a candidate's immunization history and exposure to infectious pathogens, as well as drug screening that conforms to applicable legal requirements under state law.
  - **Orientation,** requiring agency personnel to review organization policies and procedures, as well as sign a confidentiality agreement to secure sensitive information and prohibit the release of unauthorized resident care data.

4. Recognize the warning signs of inadequate staffing.

While insufficient staffing may manifest somewhat differently across various types of aging services organizations, most occurrences include some forewarning of the following signs:

- High turnover of staff or little consistency in staffing patterns.
- Over-reliance on temporary workers.
- High staff illness rates that are stress-related.
- Complaints regarding disorganized and time-consuming clinical systems and processes.
- Staff reports of inadequate time to communicate with residents, families and other caregivers.
- Limited and/or rushed staff orientations.
- Staff development that is restricted to mandatory training only.
- Limited support for staff, such as supervisors and support groups.

5. Use technology to support safe staffing.

An increasing number of organizations are considering how assistive technology can improve administrative and clinical efficiencies. For example, by incorporating online technology into educational and professional development programs, organizations can enhance and diversify their on-site training and specialty topics. In addition, web-based educational opportunities appeal to younger current and prospective employees.

Electronic documentation formats and other information technologies are designed to improve workflow, diminish the burden of paperwork and permit staff to focus on resident care. Other interventions to consider include handheld computers and monitoring devices, which promote autonomy and facilitate highly accurate, keystroke documentation.

Sources of Staffing-related Litigation

Aging services settings confront the daily challenge of complying with safety and quality standards while maintaining costs at a manageable level. In some cases, however, aging services organizations have misrepresented staffing capacity and inflated performance data in order to remain competitive on the CMS Care Compare website (previously the Nursing Home Compare site). Such deceptive practices, as well as other imprudent cost-cutting policies, can create significant risk for both facilities and residents, as described below:

Intentional understaffing. Organizations that fail to employ sufficient caregivers to safely manage residents at a time of rising acuity may encounter allegations of misrepresentation and Medicare/Medicaid fraud. A determination of liability is often based upon a review of internal staffing records, corroborated by emails and witness testimony. In addition, a review of billing records can reveal a gap between resident services provided by staff and those actually billed by a facility. Discrepancies can lead to Medicare/Medicaid violations or liability for consumer fraud, both of which may subject organizations to substantial monetary penalties and consequent negative publicity. (See Quick Links for a resource summarizing two landmark cases that alleged intentional understaffing as the direct cause of liability.)

Unsafe "24/7" admission policies. Due to intense competition for residents, many aging services organizations have implemented around-the-clock admission policies. However, by permitting residents to be admitted after hours, when nurse staffing levels tend to be at their lowest, a facility is more likely to initiate a pattern of delayed and/or inadequate care.

To minimize problems, aging services settings should admit residents only during regular daytime hours of operation, when caregivers are available to oversee the process, perform necessary assessments and exchange critical information. For additional recommendations on how to create a safer and more effective admissions process, see "Benchmarks for Safer Admission," to the right.

Benchmarks for Safer Admissions

The Pioneer ACO Model presented by CMS helps establish a framework for the aging services admissions process. It focuses on the following quality criteria:

- **Residents are accepted from their home,** as well as directly from emergency departments and clinicians' offices.
- **Same-day admission screens are available,** with residents being accepted until 9:00 p.m., seven days a week.
- **Assessment and initial evaluations are completed and documented on the day of admission** for resident arrivals that occur before 2:00 p.m.
- **A nursing supervisor is present at all times,** including evening and night shifts.
- **Mental health coverage is available seven days a week via in-person, virtual or telephonic consultation,** and residents are assessed within two to three days to determine if they need a behavioral health consultation.
- **Therapeutic needs are assessed upon admission,** and treatment is available at least six days per week.
- **Urgent radiology and laboratory tests are obtained and reported within five hours of order time,** and prescriptions are delivered within six hours.
- **Resident needs are determined during the admissions process,** and necessary equipment is placed in rooms prior to arrival.
- ***INTERACT,*® or a comparable quality improvement tool, is utilized by the organization,** and findings are reported quarterly to administrators.
- **Regular team meetings with leadership are scheduled concerning specific residents,** in order to prevent unnecessary hospital readmissions.

Organizations that **fail to employ sufficient caregivers** to safely **manage residents** at a time of **rising acuity** may encounter **allegations of misrepresentation** and Medicare/Medicaid fraud.

Substandard performance measures. Facilities are unlikely to attract residents in a competitive market if they are embroiled in federal and state compliance matters due to chronic and deliberate understaffing, or if they report high hospital readmission rates and prolonged rehabilitation stays. Suboptimal performance data also can result in more direct harm to aging services settings. In the event of litigation, self-reported data that suggest a harmful and possibly deliberate pattern of understaffing may subject facilities to punitive damage awards for intentional and malicious acts resulting in resident injury. The checklist of performance benchmarks on pages 7 to 8 is designed to help aging services providers assess their overall readiness to deliver a high level of care and minimize exposure to costly litigation related to sub-standard performance.

Failure to properly monitor residents. Liability claims asserting falls, pressure injuries and other sources of preventable harm frequently allege a lack of monitoring due to low staffing levels. Other common allegations that highlight the appropriateness of staffing levels include, but are not limited to, inadequate staff interaction with a resident, delayed response to a decline in the resident's physical condition, failure to instruct the resident to call for assistance, and/or untimely family and physician notification regarding adverse incidents or changes in the resident's condition. By ensuring safe staffing levels and proper supervision of residents, organizations may prevent injury and infection, while improving health outcomes.

Risk Mitigation Strategies

Staffing levels frequently serve as a fundamental measure of nursing home quality. The following strategies can help aging services providers enhance their overall rating, reputation and competitive position by addressing staffing-related safety and compliance issues:

Utilize pre-employment assessment tools. Screening questionnaires help narrow the field of candidates by offering insights into applicants' attitudes, values and inherent competencies, such as compassion, conscientiousness and customer service skills. These tests should not be viewed as a definitive guide to prospective employees' future success. However, they can indicate strengths and weaknesses in such essential areas as team orientation and communication abilities.

Address the root causes of perpetual staff turnover. At a time of chronic nursing shortages, staff retention has emerged as a key competitive factor for aging services settings. Poor working conditions and low wages are the most common reasons that nurses seek employment elsewhere. The following interventions can help bolster morale and enhance staff retention:

- **Reduce burnout** by limiting mandatory overtime to emergency situations.
- **Utilize ergonomic designs and techniques,** such as those recommended by OSHA to reduce the threat of injury to aging services staff and residents.
- **Help employees manage job pressures** by offering wellness, fitness and stress reduction programs.
- **Offer fair and competitive compensation and benefit packages** commensurate with education and experience.
- **Give entry level staff the opportunity to augment their skills and grow with the organization,** in order to increase employee loyalty, reduce turnover and improve quality of care.
- **Implement employee recognition programs designed to offer staff members positive feedback,** as well as a sense that they are respected and appreciated.

Quantify the labor time necessary for basic care, and staff accordingly. Organizations should know on a day-to-day basis whether available nursing staff can safely meet resident needs. To calculate the requisite labor supply, multiply the total number of residents currently in the setting by the state-imposed HPRD, then divide that figure by the daily number of hours worked by an employee. Thus, a 100-resident facility in a state mandating a 2.9 HPRD with eight-hour shifts would require 37 nursing staff members. For settings that experience higher resident acuity levels, staffing requirements may need upward adjustment.

Align training with job demands. Staff educational requirements may fail to comprehensively address current clinical realities. Thus, a periodic re-examination of entry level and ongoing training programs represents a sound practice. To better align training with changing demands, consider expanding curriculum offerings to include computer skills, effective teamwork, interpersonal communication and time management skills.

In addition, career pathways for certified NAs help reduce the gap between entry-level assistants and LPNs by encouraging skill development beyond the required core tasks. Training programs that address the following knowledge and clinical competencies can further enhance staffing capabilities:

- Care of behaviorally challenged residents.
- Catheter and ostomy care.
- Mobility-related complications.
- Signs of circulatory insufficiency.
- Skin and foot care concerns.
- Providing diabetic care.
- Symptoms of hypoglycemia and hyperglycemia, and blood glucose level monitoring.
- Identifying and reporting signs of infection.
- Mastering oxygen safety and oxygen-saturation monitoring.
- Understanding scope of practice and limitations in caring for acutely ill residents.

Traditional instruction methods may preclude meaningful assessment or skill mastery for first-time NAs. Consider implementing a format that includes presentations, as well as return demonstration and evaluation. The following instructional tips may be helpful:

- Deliver classes in short modules, 30 to 45 minutes in length.
- Provide practicum exams that closely emulate real-world scenarios.
- Offer "shadow training" under a buddy or mentor.
- Consider instituting a no-rotation policy for 30 days.

Reconcile discrepancies between state-reported staffing numbers and payroll records. Organizations are strongly encouraged to continuously monitor their staffing data input practices and reconcile any inaccuracies. By comparing state-filed staffing reports with institutional payroll records, regulators and plaintiff attorneys can easily determine whether care promised to residents and paid for by a state or federal program was actually rendered by nursing staff.

Swiftly rectify any staffing-related compliance violations. A corrective action plan in response to low nurse staffing levels should do more than simply note the deficiency and describe the changes necessary to address it. Plans also should answer the following inquiries regarding the organization's commitment to permanently maintain safe levels of nursing care:

- **How will staffing levels be monitored,** and at what intervals?
- **How will compliance be documented** and reported internally and externally?
- **Who will hold management accountable** for implementing corrective action plans?

Failure to adequately address any of these issues may lead to recurring noncompliance and/or the rejection of corrective plans by regulatory authorities.

Continuously monitor satisfaction data and respond swiftly to complaints. Consumer complaints filed with the state and interviews with residents, family members and former employees can be used to substantiate allegations of chronic understaffing. Eyewitness accounts of residents being left alone for long periods of time, or being denied assistance with basic activities of daily living, serve as credible evidence of neglect.

Quality issues noted in satisfaction surveys, as well as complaints of neglect or abuse from residents, family members or employees, should be promptly investigated and addressed. In addition, findings and corrective actions taken should be comprehensively documented. Otherwise, problems can intensify, leading to allegations of deliberate understaffing.

In today's competitive and litigious aging services environment, chronic understaffing can have serious consequences for an organization. In order to ensure a safe, legally compliant level of staffing and attend adequately to resident needs, leaders must periodically examine staffing numbers and other quality indicators, review personnel practices and be willing to implement indicated changes.

Meeting Performance Demands: A Self-assessment Checklist

Readiness criteria	Present Yes/No	Comments
Convene a performance team		
1. A diversified team, co-chaired by the medical director and director of nursing, is charged with monitoring federal/state regulations and analyzing their actual and potential impact on the organization.		
2. The team examines a wide range of issues, including the following:		
• Services to be provided, e.g., rehabilitation, skilled nursing, assisted living, memory care.		
• Existing relationships with local hospitals and physician groups, in order to ensure cultural compatibility.		
• Effectiveness of current measures to reduce costs.		
• Annual marketing and strategic goals regarding admission and discharge volume, reduced length of stay and hospital admissions, enhanced rehabilitation services, and improved access to geriatric nurse practitioners and physicians.		
• The organization's commitment to improve quality and reduce costs, and its willingness to establish performance measures designed to help achieve these goals.		
Identify performance measures		
1. A robust quality assurance and performance improvement (QAPI) process is established to monitor the following quality of care measures, among others:		
• Outcomes.		
• Average length of stay.		
• Re-hospitalization rates.		
• Functional rehabilitation progress.		
• Adverse occurrences during care transitions, including shifts between levels of care.		
• Resident/family satisfaction rates.		
2. The QAPI process also monitors incidents and warning signs, including:		
• Falls.		
• Pressure injuries.		
• Infections.		
• Restraint use.		
• Pain.		
• Psychotropic medication mismanagement.		
• Pharmacy errors.		
• Survey noncompliance.		
3. To facilitate internal and external reporting of both case-specific and aggregate outcomes data, residents are categorized by pertinent risk factors, such as:		
• Clinical complexity.		
• Rehabilitation potential.		
• Discharge readiness.		
• Hospitalization risk.		

Readiness criteria	Present Yes/No	Comments
Identify performance measures (continued)		
4. QAPI measures are reviewed on a regular basis, compared with strategic goals and upgraded as needed.		
5. High-profile quality processes – including admissions from acute care facilities, transition readiness and discharge planning – are monitored by a designated individual who reports to the performance team on a regular basis.		
Medical direction		
1. A forum is established to facilitate dialogue between the aging services setting and its medical staff with respect to forging mutual goals and measuring outcomes.		
2. The medical director is in regular communication with administration via weekly clinical meetings, quarterly case management reviews and other similar forums.		
3. There is a written strategy to increase the presence of the medical director and other physicians and advanced practice providers in the aging services facility, and to improve care by promoting physician involvement in:		
• Nursing staff rounds.		
• Facility leadership meetings.		
• Performance improvement meetings.		
• Educational programs and in-service training.		
• New admission assessments.		
• Family conferences.		
• Utilization review.		
Communication infrastructure		
1. An electronic health record system has been adopted and tested for compatibility with existing recordkeeping systems.		
2. The medical director is assigned responsibility for actively communicating with partner hospitals and facilities about quality of care, and this duty is included in the job description.		
3. A system is created to respond to inquiries from regulatory agencies at the state and federal level, involving designated physicians and nurses.		
4. Written clinical guidelines and pathways are adopted to assist staff at critical points, including creating and managing care plans, setting rehabilitation goals, evaluating transfer readiness and preparing residents for early discharge.		

Quick Links

- Alert: Latest Staffing Reports Indicate Most Nursing Homes Fail to Meet Federal Staffing Threshold, issued by the Long Term Care Coalition, Quarter 1, 2021.
- Assisted Living Fact Sheet: Staffing Ratios, issued by the Long Term Care Coalition.
- Gaivin, K. S. "Nursing Homes See Higher Caregiver Turnover Than CCRCs." *McKnights Senior Living*, September 22, 2021.
- "Insufficient Staffing – Litigation," issued by the Center for Medicare Advocacy, January 23, 2015.
- Nursing Home Staff Competency Assessment, which includes an interactive competency assessment tool, issued by the Centers for Medicare & Medicaid Services.

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