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Expert nurse response to workforce recommendations made by The Coronavirus Commission For Safety And Quality In Nursing Homes

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ABSTRACT

COVID-19 has exposed the longstanding internal problems in nursing homes and the weak structures and policies that are meant to protect residents. The Centers for Medicare and Medicaid Services convened the Coronavirus Commission for Safety and Quality in NHs in April, 2020 to address this situation by recommending steps to improve infection prevention and control, safety procedures, and the quality of life of residents in nursing homes. The authors of this paper respond to the Final Report of the Commission and put forth additional recommendations to federal policymakers for meaningful nursing home reform: 1) ensuring 24/7 registered nurse (RN) coverage and adequate compensation to maintain total staffing levels that are based on residents' care needs; 2) ensuring RNs have geriatric nursing and leadership competencies; 3) increasing efforts to recruit and retain the NH workforce, particularly RNs; and 4) supporting care delivery models that strengthen the role of the RN for quality resident-centered care.

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Introduction

Our nation's 15,600 nursing homes (NH) are prime hotspots for outbreaks of the Severe Acute Respiratory Coronavirus 2 (COVID-19) in what is now becoming an unremitting pandemic. Individual states report that up to 50% of cases and deaths attributed to the virus have occurred in these facilities (Belanger, 2020). Beyond enormous morbidity and mortality, residents are experiencing significant harms due to restricted visitation policies and isolation procedures that are

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intended to mitigate the spread of the virus (Abbasi, 2020). The evidence is clear: COVID-19 has exposed the longstanding internal problems in NHs and the weak structures and policies that are meant to protect the most vulnerable among us. They have fallen short in preventing and containing community spread of the virus.

The Centers for Medicare and Medicaid Services (CMS) recognized the urgency of this health crisis and convened the Coronavirus Commission for Safety and Quality in NHs in April, 2020 (https://www.cms.gov/files/document/coronavirus-commission-safety-and-quality-nursing-homes.pdf). The 25-member commission was composed of academicians, clinicians, NH administrators, family members, residents, industry professionals, and scientific experts. The members were charged with making recommendations to improve infection prevention and control, safety procedures, and the quality of life of residents in NHs. The final report of the Commission contained 27 recommendations and was released in September 2020 (https://sites.mitre.org/nhcovidcomm/).

As expert geriatric nurses, we have been monitoring the COVID-19 situation in NHs across the U.S. for several months. Our observations confirm many of the Commission's observations and include other fundamental issues that plague the industry: chronic understaffing overall, particularly of professional nurses [i.e., registered nurses (RN)], lack of geriatric expertise and leadership for managing complex care problems, and an environment focused on regulatory compliance, to the exclusion of quality improvement (QI).

The purpose of this paper is to respond to the Final Report of the Commission by putting forth recommendations to federal policy makers. The recommendations build on those of the Commission so that meaningful NH reform becomes a reality. We recognize the necessity of ensuring compliance with recommendations, particularly those around staffing levels because of their association with safe, quality care. In addition to regulatory compliance, recommendations for NH reform must also speak to QI, a defining feature of high-quality resident-centered care. Policies that will make it possible to improve NH care include: 1) ensuring 24/7 RN coverage and adequate compensation to maintain total staffing levels that are based on residents' care needs and acuity; 2) ensuring RNs have geriatric nursing and leadership competencies; 3) increasing efforts to recruit and retain the NH workforce, particularly RNs; and 4) supporting care delivery models that strengthen the role of the RN for quality resident-centered care (Berlowitz et al., 2003; Coleman & Whitelaw, 2020; Rantz et al., 2018).

There is wide public support for regulatory compliance and aggressive QI in NHs (Brown, 2020). Federal policy makers are proposing legislation to that effect. There is also consensus among leaders in the industry that clinical services must take precedence over the emphasis given to NH operations and profits, and there is a call for greater transparency in how federal monies are appropriated (National Academies of Science, Engineering and Medicine, 2021). We believe our recommendations for strengthening the workforce should be added to those of the Commission so that national efforts for NH reform become a reality.

CMS Recommendations for Workforce Ecosystem

Two sections of the Commission Report are devoted to the Workforce Ecosystem. Recommendation 6 addresses measures to immediately improve resident safety while Recommendation 7 includes steps to be taken to improve quality and safety in the future.

Recommendation 6. While many of the 27 recommendations made by the Commission impact RNs working in NHs in some way, recommendations 6A-6 E have the greatest impact on their direct roles and responsibilities. Unfortunately, only one recommendation in that section, indeed in the entire Report, directly addresses RN staffing. Recommendation 6C states: Support 24/7 RN staffing resources at NHs *in the event of a positive SARS-CoV-2 test within that facility*.

We believe the Commission's recommendation falls short of what is needed to improve quality care of residents as it pertains to RN staffing. By focusing on the short term and only in COVID-19 positive NHs, the recommendation fails to appreciate the historical context that led to this point, it ignores issues that impact how well NHs are able to respond to crises by enacting many recommendations in the Report which are the responsibility of RNs, and it impedes the sustained improvement of NH quality, a primary goal of the Commission.

Recommendation 7. We strongly support the Commission's recommendations 7A and 7C for expanding the certified nursing assistant (CNA) workforce. Recommendation 7A states: Catalyze interest in the CNA profession through diverse recruitment vehicles; issue guidance for on-the job CNA training, testing and certification: and create a national CNA registry. Recommendation 7C states: Catalyze the overhaul of the workforce ecosystem in partnership with federal, state, local, territorial and tribal (SLTT), and other public, private, and academic partners.

We believe the Commission's recommendation falls short by not requiring CNA staffing based on resident needs and by not recommending increased wages and benefits for CNAs. Many CNAs work two jobs because they cannot make a living wage working full time in NHs (U.S. Bureau of Labor Statistics, 2019). A recent Leading Age report indicates that CNA wages need to be increased by 15% to stabilize the workforce (Weller et al., 2020). Adequate wages could preclude the need for CNAs to work in multiple NHs, allowing for better cross coverage of CNA within one NH, reducing the risk for cross contamination between NHs, allowing for CNA handoff communication within NHs, ultimately improving resident safety, and likely improving retention.

Background

Characteristics of Residents

Approximately 1.2 million people reside in U.S. NHs where they receive skilled nursing care, rehabilitation, and related services (Harris-Kojetin et al., 2019). The care needs of NH residents are complex due to their functional limitations and higher disease burden. Almost half of all people who live in NHs are 85 years or older and over 80% need help with three or more activities of daily living (ADLs) (American Geriatric Society [AGS], 2020). Most have incontinence and more than a third have difficulty with hearing or vision.

The mental health and medical complexity of NHs residents is growing at an unprecedented rate. Between 50-70% of NH residents have dementia (Kaiser Family Foundation, 2019). The deinstitutionalization of persons with serious mental illness (SMI) has resulted in NHs acting as de facto mental health facilities (Grabowski et al., 2009). There is evidence that NHs with a high proportion of residents with SMI have a higher probability of catheter use, hospitalization, and feeding tube use (McGarry et al., 2019). In addition to managing complex residents who require chronic care, NHs increasingly offer post-acute care services and provide complicated wound care, enteral therapy, and cardiac monitoring (AGS, 2020). Because older adults with lower acuity and higher function are more likely to receive care in community settings, NH residents have higher needs today than they did in the past. In today's NH, residents require a professional nursing (RN) workforce with gerontological nursing knowledge, advanced assessment and decision-making skills, technical expertise, and leadership ability.

Current Staffing Requirements and Their Adequacy

The staffing model for providing nursing care to residents was passed in 1987 and has not been adjusted in more than 30 years to account for the medical complexity of residents now served by NHs (https://aspe.hhs.gov/pdf-report/covid-19-intensifies-nursing-home-workforce-challenges). Federal regulations currently mandate that NHs provide RN, licensed practical/vocation nurses (LPN/LVN), and CNAs, adequate in number, skills, and competencies to the meet the residents' care needs (Centers for Medicare and Medicaid Services [CMS a,b], n.d.). These needs are to be determined by an analysis of resident assessments and individual plans of care, and must consider the number, acuity, dependency, and diagnoses of the facility's resident population (Centers for Medicare and Medicaid Services [CMSa], n.d.). The analysis must be updated annually, and surveyors may issue a deficiency if the assessment is not based on actual care needs.

At a minimum, every facility must have a licensed nurse (RN/LPN/LVN) to act as charge nurse on each shift. For at least 8 consecutive hours a day, 7 days a week, an RN is required on site. Additionally, a designated RN is to serve as the director of nursing (DON) on a full-time basis unless the facility has a CMS waiver. The DON may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

A CMS study in 2001 established the importance of having a minimum of 0.75 RN hours per resident day (hprd), 0.55 LPN/LVN hprd, and 2.8 (to 3.0) CNA hprd, for a total of 4.1 nursing hprd to prevent harm or jeopardy to residents (Harrington et al., 2016). Several organizations have endorsed this minimum and have suggested that facilities should have 24-hour RN coverage (ANA, 2014; Coalition of Geriatric Nursing Organizations, 2013; Institute of Medicine, 2004). Because average resident acuity has grown over the past 20 years (Medicare Payment Advisory Commission (2016); Tyler et al., 2013), some experts have recommended even higher staffing standards to improve the quality of NH care, with higher adjustments for greater resident acuity and functional needs (Harrington et al., 2016).

A recent study by the Office of Inspector General (2020) found that for substantial periods of time many NHs' staffing levels are below one or more of the required federal levels. When staffing levels account for resident acuity, the situation is even more dismal: about 75% of NHs almost never meet the CMS expected RN staffing level based on resident acuity (Geng et al., 2019). Low staffing levels are a major contributor to NH safety violations (Castle et al., 2011). Current staffing levels are substantially lower than those recommended to prevent harm or jeopardy, much less to provide quality care.

Recommendations for Quality NH Care

As expert geriatric nurses we make four recommendations to federal policymakers that build on Commission recommendations so that they are more than a temporary solution. These recommendations are made to help ensure that quality care becomes a reality. NHs have long labored under an institutional approach to care which undermines the ability to implement quality resident-centered improvement initiatives at the local level (Kapp, 2012; McGlinton et al., 2016). To ensure that quality care is sustainable will require strong professional nurse (RN) leadership and adequate staffing, critical resources that have been repeatedly called for in national reports but have been ignored in NH policy and practice (Harvath et al., 2008; Institute of Medicine, 2011; Wunderlich & Kohler, 2001).

Recommendation 1: Ensure 24/7 RN Coverageand Adequate Compensation to Maintain Total Staffing Levels That Are Based on Residents' Acuity and Care Needs

Over the past 25 years, numerous research studies have documented a strong positive impact of nurse

staffing on both care processes and outcome measures (Harrington et al., 2016). Research studies have found a strong association between higher total staffing levels (RNs, LPN/LVNs and CNAs) and better outcomes as defined by lower survey deficiencies and improved resident quality measures (Castle et al., 2011; Castle, 2008). Some of the strongest positive relationships, however, are found between RN staffing and quality (Dellefield et al., 2015). Other studies confirm the findings that lower nursing staffing levels are linked with poor resident outcomes, including higher rates of infection control violations, higher mortality and hospitalization rates, and diminished physical functioning (Castle & Anderson, 2011; Schnelle et al., 2004). The pandemic has only accentuated the urgency of adequate RN staffing in NHs prompting Recommendation 6C as a temporary stopgap measure.

Recent research out of California and other states has shown the strong relationship between higher RN staffing and a lower likelihood of any COVID-19 infection, lower infection rates, and/or lower death rates, controlling for other factors (Figueroa , et al., 2020; Gorges & Konetzka, 2020; Harrington et al., 2020; He et al., 2020; Li et al., 2020; Rau & Almendrala, 2020). A recent study also demonstrated the positive impact CNA retention has on quality indicators, with the suggestion that retention has substantial policy relevance (Castle et al., 2020). The evidence is consistent, and it is robust. Staffing levels directly affect a NH's ability to not only prevent and contain infections, but to provide safe, quality care for residents. NH reform must mandate and enforce adequate RN and overall staffing levels that meet residents' needs. Harrington et al. (2020) have developed a detailed system for determining adequate staffing levels based on resident acuity and care needs. This method can be used by NHs to guide staffing decisions.

Integral to maintaining appropriate staffing levels is adequate compensation for the NH workforce. As noted above, a recent Leading Age report indicated the need to increase CNA salaries by 15% to stabilize the workforce and prevent the continued erosion of quality care (Weller et al., 2020). Front-line workers deserve salary and benefits commensurate with their essential functions.

Recommendation 2: Ensure That RNs Have Geriatric Nursing and Leadership Competencies

An adequate number of RNs and overall staff are needed to deliver quality care, and the recommendation must be accompanied by policies that strengthen the role of RNs in NHs. RNs play a critical role in NH QI and require competencies for the role of: 1) care role model; 2) gerontological nurse; 3) care team leader; and 4) mentor and teacher (Mueller et al., 2016). They serve as planners, coordinators, supervisors, and direct providers of care (Dellefield, 2006). Yet many RNs lack the specialized knowledge needed to provide competent care to older NH residents. Most RNs in NHs hold an associate degree and receive little or no geriatric training during their basic nursing education (Dwyer, 2011). Clearly RNs are accountable for the nursing care provided by LPN/LVNs and CNAs, thus, the role modeling, supervision, direction, and coaching role of the RN is especially critical in the NH setting. RNs in NHs have significant professional development needs to provide this clinical leadership and be accountable to ensure that complex nursing needs of older residents are met (Institute of Medicine, 2008; Silvestre, et al., 2015).

The QI process is uniquely linked to the RN's role as leader, coordinator, and provider of clinical care. RNs in administrative roles are vital in supporting the changes necessary to improve patient/resident outcomes (Rantz et al., 2001). When RNs are accountable for the care provided in a NH, they are actively engaged in quality monitoring and improvement activities, especially those that are associated with nurse sensitive quality measures such as falls, pressure injuries, and immobility.

Even though RNs are increasingly responsible for the supervision and delegation of complex care tasks to LPN/LVNs and CNAs, they often lack critical leadership skills and experience (Institute of Medicine, 1986; Institute of Medicine, 2001; Mueller et al., 2012). Few basic RN nursing programs prepare graduates in leadership, management, or organizational skills (Siegel et al., 2010). Most nurse managers and supervisors are selected based on their performance in nonsupervisory roles, and few opportunities exist for them to learn essential competencies. These competencies may include motivating staff, budgeting, problem solving and decision making, and/or use of best practices (Sullivan-Marx et al., 2008). Leadership skills of RNs in NHs are generally learned through trial and error (Institute of Medicine, 2008; Siegel et al., 2010).

When RNs lack leadership skills, the impact on NHs is costly in terms of productivity, turnover and quality. Strong RN leadership skills have been shown to contribute to staff productivity, retention and resident and family satisfaction rates (Harvath et al., 2008; McGilton et al., 2007). Further, research points to lack of RN leadership development as a significant barrier to NH productivity, while enhancement of RN leadership skills results in improvements in quality of care (Harvath et al., 2008).

There are several ways to improve RN leadership skills in the NH. Currently, nursing home administrators are required to have considerable training/education/ and a national certification. CMS could institute similar requirements for RNs in leadership positions. Competencies in leadership and geriatric nursing have already been developed by professional organizations and do not need to be duplicated (American Association of Directors of Nursing Services Certification (https://

www.aadns-ltc.org); American Nurses Credentialing Center Gerontological Nursing Certification (https://www.nursingworld.org/our-certifications/gerontological-nurse)). The Bureau of Health Professionals could prioritize the development of grant programs that provide educational support for graduate nursing students, giving preference to nurses currently in leadership positions in NHs who plan a career in these settings. Funding for these programs should not supplant current funding at the Bureau.

The most important factor, however, is the need for nursing homes to compensate RNs with higher wages for increased competencies, comparable to hospital settings. This would include RNs with specialty training, bachelor degrees, certified nurse specialists, and nurse practitioners. Higher wages would stabilize the RN leadership which has historically had high turnover rates (Castle & Engberg, 2005).

Recommendation 3: Increase Efforts to Recruit and Retain the RN Workforce

The above recommendations depend on the availability of adequate numbers of RNs who desire to work in NHs. The Commission Report outlines methods for expanding the CNA workforce but does not mention the RN workforce. Only 4.8% of RNs in the U.S. work in NHs (Smiley et al., 2018). The chronic shortage of RNs is a critical and ongoing problem that has intensified during the pandemic (Abbasi, 2020; Cox, P, 2020; Graham, 2020; Weaver & Mathews, 2020; Xu et al., 2020).

The RN shortage in nursing homes is directly related to low wages. RNs in nursing homes receive much lower wages than RNs in hospitals (Bureau of Labor Statistics, 2019). RN turnover rates in all U.S. nursing homes averaged 141 in 2017 and 2018 (Gandi et al., 2021). Although high turnover rates are associated with inconsistent and poor quality care (Castle & Engberg, 2005), high turnover rates have persisted for years because they result in a net savings to nursing homes (Mukamel et al., 2009). An added problem is staff turnover, which approaches rates as high as 100% in many NHs. Staffing shortages contribute to high staff turnover and, together, have a profound impact on the ability to provide quality care (Kramer et al., 2012; Maxwell, 2010).

The key action step put forth to address Recommendation 6C is to use federal relief funds and regional health system resources to augment RN staff during a COVID event. Relief funds, however, do not alleviate the chronic shortage of RNs. A 2015 study from Georgetown University Center on Education and the Workforce, found there were 1.6 million job openings for nurses and predicted that RN shortages will worsen through 2030 (Juraschek et al., 2019). There are several strategies that can be implemented to recruit and retain an adequate number of RNs for NHs. These include implementing career ladders for those who already work in NHs, expanding Title VIII funding to prime the pipeline, and instituting nurse residency programs to improve retention.

An untapped source for expanding the RN workforce in NHs are the unlicensed staff who already work there. CNAs provide upwards of 90% of direct care delivery to older residents (Manatt Analysis Report, 2020) and are typically women of color (Harris-Kojetin, 2019). The average CNA obtains basic certification to work in a NH facility, and then maintains that same position, on average, for between 11 and 20 years (CDC 2004-2005). CNAs report that they stay in their jobs because they "like helping other people" (CDC, 2004-2005). Currently there are few opportunities for CNA advancement. This is unfortunate as CNAs have already demonstrated their interest, dedication, and attractiveness to care of older adults in LTC. Inclusion of minority CNAs in the RN pipeline would also enhance the much-needed racial and ethnic diversity of the workforce and may help to lessen disparities in care (Meghani et al., 2009). Opportunity for advancement within their jobs as well as upward mobility with a competitive wage directly addresses CNAs most cited reason for leaving their job in the first place: "poor pay and need to find a better job" (CDC, 2008).

Funding a career ladder for CNAs could be provided using federal resources, i.e., CMS or through state sponsored Civil Monetary Penalty (CMP) funds. Massachusetts, for example, has received funds from the federal government to create educational programs involving 15 community colleges. This model began as a statewide grant initiative and now trains students in the health services professions to care for older adults (https://masscc.org/programs/).

Schools of nursing could increase their capacity for educating RNs if Title VIII funding were expanded to provide funding to increase the number of faculty, enhance geriatric education in nursing programs, support NHs as clinical sites to place students, provide student scholarships, and expand transition to care programs in NHs (https://ana.aristotle.com/SitePages/nursingworkforcedevelopment.aspx). A federal loan forgiveness program would also help attract RNs to these settings.

Nurse residency programs have consistently led to improved nurse retention as well as improved quality of care (Goode et al., 2013; Medas et al., 2015; Trepanier et al., 2012.) Nurse residency programs have been recommended by the Joint Commission on Accreditation (2002), the American Association of Colleges of Nursing (2008), the National Council of State Boards of Nursing (2020), and the Future of Nursing Report jointly sponsored by the Institute of Medicine and the Robert Wood Johnson Foundation (2011). All organizations cited their impact on both improved care and retention of RNs. Nurse residency programs have proliferated in acute care settings but are rarely found in NHs. Concerns about cost and insufficient staffing have been major obstacles to implementing nurse residency programs in these settings. One

strategy for financing NH RN residency programs would be to obtain CMS educational funding, as is the case for medical residencies.

Recommendation 4: Support Care Delivery Models That Strengthen the Role of the RN

It is imperative that the limited number of RNs in NHs engage in QI and provide crucial assessment and care management of residents, as well as safe supervision to the large number of unlicensed staff providing most of the direct care. In addition to geriatric nursing and leadership competencies, this requires attention to the care delivery systems that guide the organization and delivery of professional nursing care (Lyons et al., 2008; Mueller & Savik, 2010).

Currently in most NHs, RNs are accountable for the completion of specific tasks. Since their performance is judged based on this task-oriented approach, RNs are not motivated to look at the big picture of the quality of care of individual residents or the quality of care delivered by the NH. They are no longer held responsible nor do they have the authority for the quality of care of residents. Further, there is evidence that RNs and LPN/LVNs are used interchangeably in NHs (Mueller et al., 2018) and it results in the LPN/LVN performing tasks outside their scope of practice. The pervasiveness of interchangeability minimizes the residents' access to professional nursing care. Since care is delivered in an environment that does not hold any role responsible for ensuring that residents—individually and collectively—receive optimal quality of care, the well-being of residents suffers.

The need to adhere to strict CMS regulations has also influenced NH cultures. Since NHs could be fined or shut down if they violate regulations, NH managers are extremely concerned about adhering to the regulations, and this traditionally has resulted in an authoritarian, top-down management approach. This approach creates job dissatisfaction and is not supportive of a professional practice environment for RNs. Further, RNs who take on management roles do not often have education in the intricacies of these regulations or how to ensure compliance with them. As a result, they may be more focused on meeting regulatory requirements than on addressing residents' needs, and lose sight of the accountability inherent in their scope of practice. Evidence suggests that an authoritative management style is an ineffective way to produce positive patient outcomes (Anderson et al., 2003).

Professional nursing practice (PNP) models are defined as systems that support RNs' control over the delivery of nursing care and the environment in which that care is delivered (Hoffart & Woods, 1996). The American Nurses Credentialing Center defines professional nursing practice models as a "schematic description of a system, theory, or phenomenon that depicts how nurses practice, collaborate, communicate, and develop professionally to provide the highest quality care for those served by the organization" (Silverstein et al., 2017, p.78). PNP models are operationalized in health care delivery settings through the implementation of evidence-based nursing practices, RN involvement in decision making regarding resident care, staffing, and work environment policies and practices, and extensive support for professional development for RNs (Lyons et al., 2008).

PNP models are supported and recognized through the American Nurses Credentialing Center (ANCC) Pathway to Excellence™ program in organizations that demonstrate a commitment to creating a work environment where nurses flourish because they experience, among other things, job satisfaction, professional growth and development, respect, and appreciation (http://www.nursecredentialing.org/Pathway.aspx).

Focusing on the care delivery system, as well as the professional development and practice environment needs of RNs, has the potential to address other issues plaguing NHs—specifically recruitment and retention of RNs. When RNs can practice in an environment that supports professional nursing practice, turnover decreases and retention increases (Laschinger, 2008; Rondeau et al., 2006; Stone et al., 2006). The literature also notes that when RN turnover is high, quality of care for NH residents is lower (Castle et al., 2006). Thus, if the quality of NH care is to be improved, it is imperative to strengthen the RN practice environment in NHs.

Summary

The COVID-19 pandemic has exposed the vulnerability of our nation's NHs and the residents who live there. The current crisis reflects a historical lack of investment in professional nursing (RN) practice and adequate staffing that could have prevented many of the catastrophic outcomes of the past year. Now is a time for reflection on how we got here, but more importantly, how we can move to a future where safe quality NH care is a reality. We have identified fundamental and essential elements for nursing home reform by calling attention to the need for adequate staffing and well-prepared professional nurses who are supported by an environment that goes beyond regulatory compliance and emphasizes QI.

Author Contribution

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