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Submitted electronically to: LTCCOP@cms.hhs.gov

RE: Medicare Conditions of Participation, Requirements for Long-term Care Facilities, 42 CFR §483 Subpart B

Dear Director Tavenner and Dr. Conway:

The Coalition of Geriatric Nursing Organizations (CGNO), in conjunction with the American Nurses Association (ANA), responded to the opportunity to provide comments on the Requirements for Participation for Long Term Care Facilities, 42 CFR §483 Subpart B in July 2012. The recommendations addressed: §483.30 Nursing Services, specifically 24 hour RN staffing and a full time RN Director of Nursing without waivers, urging the Center for Medicare and Medicaid Services (CMS) to commence with a review of this section of the Medicare Conditions of Participation through the formal regulatory process. CMS acknowledged the request and responded informally by requesting more evidence supporting these two requests. Three members of the Academy of Nursing, Expert Panel on Aging have concluded their work, the results of which enhance the documentation sent in 2012 (attached).

The CGNO includes eight geriatric nursing organizations whose membership has more than 28,000 nurses primarily working in long term care and is coordinated at the Hartford Institute for Geriatric Nursing (HIGN), New York University, College of Nursing by Sarah Burger. The CGNO mission is to leverage our collective strengths to create a health care environment for older adults that is accessible and reflects person centered care, quality outcomes and evidence based practice across all settings.
Nursing home quality is a priority concern of seven of the eight organizations, including the American Academy of Nursing, Expert Panel on Aging (AAN,EPoA), The American Association of Long Term Care Nursing (AALTCN), The American Association of Nurse Assessment Coordination (AANAC), The Gerontological Advance Practice Nurses Association (GAPNA),The Hartford Institute (HIGN), National Association of Directors of Nursing Administration in Long Term Care (NADONA/LTC) and the National Gerontological Nurses Association (NGNA). Our colleagues at the American Assisted Living Nurses Association (AALNA) devote their energies to other than nursing homes. The diverse memberships include geriatric nurses who are PhD teachers, researchers and clinicians, Masters prepared Advance Practice Nurses, RNs, LPNs, and some nursing assistants.

The American Nurses Association is the leading professional organization representing the interests of the nation’s 3.1 million registered nurses (RNs) and represents registered nurses in all roles and practice settings through our state and constituent member nurses associations and affiliated nursing specialty organizations.

The new evidence examines the complexity of resident care needs requiring RN care, compares research on the positive effects of increased RN staffing in hospitals and long term care, and distinguishes between the competencies of RNs and LPNs in nursing facilities, questioning whether such care meets the ANA recommendations for RN care for residents. For follow up and questions, please contact Sarah Burger, Coordinator of the CGNO (202-319-2611)/sgburger@rcn.com and Cheryl Peterson, Director of Nursing Practice and Policy, ANA at 301-628-5089/cheryl.peterson@ana.org.

Registered Nurse Staffing in Nursing Homes: A Critical Deficit
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Nursing home care quality problems were first comprehensively documented in the 1986 IOM report and repeated in two subsequent IOM reports (1996; 2001). Since that time there have been significant efforts to improve care quality including state and federal legislative initiatives, implementation of several models focusing on person-directed care (nursing home culture change), workforce development programs, and development of professional competencies for nurses employed in nursing homes. Despite these substantial efforts, improvements in quality have been insufficient (US GAO, 2011). While multiple factors have been shown to effect care quality, the staffing numbers and type/mix of nursing staff are clearly important contributors. Significant quality improvements in nursing homes will only be achieved if nurse staffing, particularly RN staffing, is addressed.

Nursing homes are increasingly admitting persons from hospitals, for short term care, with complex, acute care nursing needs. Yet federal staffing requirements do not require 24 hour RN staffing for nursing homes, including those that have sub-acute or transitional care units. The pressure to provide care and services that can only be provided with adequate RN staffing and
skill mix will continue to increase. Changing payment incentives for hospitals (e.g. Readmission Reduction Program) will require partnerships with nursing homes to reduce hospital readmissions. The RN’s role will be pivotal in providing the professional nursing assessments, interventions to prevent complications and inappropriate unwanted advanced illness care, and recognize and respond to change in resident conditions that can often result in avoidable hospitalization and re-hospitalization.

As patients’/residents’ nursing care needs are becoming increasingly more complex in nursing homes, it makes sense to examine the extensive research on nurse staffing and quality care in hospitals. The research literature on RN staffing in acute care hospitals strongly supports that higher RN staffing is associated with lower adverse outcomes (i.e., death and hospital acquired conditions [HACs] and higher quality of care. There have been several comprehensive summaries and systematic reviews of the research on nurse staffing and quality in hospitals (Mitchell, et al, n.d.; Lang, et al, 2004; Kane, et al, 2007). Kane et al (2007) conducted a meta-analysis of 94 studies of nurse staffing and quality in hospitals. These comprehensive examinations of nurse staffing and quality, points to consistent evidence that higher RN staffing impacts a variety of negative patient outcomes. Specifically, higher RN staffing is associated with decreased hospital related mortality, failure to rescue, hospital length of stay, and hospital acquired pneumonia as well as other adverse outcomes (e.g. infections and adverse medication events).

These findings have dramatic implications for RN staffing in nursing homes. RN staffing in hospitals is over 10 hours per patient in a 24 hour period (Welton, 2007). In startling contrast, RN staffing averages 30-38 minutes per resident in a 24 hour period (Harrington, et al, 2011). Castle (2008) synthesized the research on nurse staffing in nursing homes over a 15 year period (1991-2006) resulting in findings consistent with those in acute care settings. Higher nurse staffing levels were positively and significantly correlated with improvements in 40% of the quality indicators studied. While the quality indicators included in the studies were diverse, those most frequently included were pressure ulcers, physical restraints and deficiency citations.

The studies on nurse staffing and quality care in nursing homes have been criticized for their limitations in data sources used and study designs. In response to these methodological problems, Castle (2007) conducted a longitudinal study that included 3941 nursing homes across the U.S., examining the relationship between 4 staffing characteristics (staffing level, use of agency staff, and staff turnover and stability) and 4 quality indicators (physical restraint use, catheter use, pain management and pressure sores). Castle found that high RN staffing levels were associated with higher overall quality. Greater use of agency staff and low staff stability were correlated with worse quality outcomes.

The important role of RNs in nursing homes has recently been examined by exploring nursing practice patterns of RNs and LPNs in nursing homes and how nursing care is enacted. When there are fewer RNs in nursing homes, LPNs find themselves engaged in nursing practice activities that are outside of their legal scope of practice (Mueller, et al, 2012). These include such activities as comprehensive nursing assessments, initiating care plans from those assessments, evaluating the effectiveness of the care plan, and delegating to and supervising unlicensed nursing personnel. LPNs reported that the reasons they find themselves practicing outside their scope of practice is not having enough registered nurses available for providing direct care, RNs that are available are engaged in administrative work, and an inadequate number of licensed nurses in the facility (Mueller et al 2012).
A state’s nurse practice act that specifies RN and LPN roles in regards to nursing assessment, care planning, delegation and supervision can influence the quality of care in nursing homes. Corazzini et al (2011) found state nurse practice acts that were more restrictive regarding LPN scope of practice for delegation and supervision had better state level quality of care in nursing homes.

A comprehensive qualitative study of nursing homes in two states examined the RN and LPN roles related to assessment, care planning, delegation and supervision. Three practice patterns emerged that were associated with quality care for nursing homes residents (Corazzini et al, 2013a; Corazzini, 2013b). The first factor was the quality of connections (e.g. communication, collaboration) between RNs and LPNs in addressing the care needs of residents. The second factor was the degree of interchangeability of RNs and LPNs, that is, the degree to which LPNs are considered equivalent to RNs in assessing, care planning, delegating and supervising. The third factor was RN to LPN staffing ratios, specifically the number of RNs available for assessment, care planning, delegating and supervision. Researchers found that higher RN-LPN connections, low RN-LPN interchangeability, and higher RN-LPN staffing ratios were evident in nursing homes that had fewer deficiencies and low prevalence rates for quality measures such as pressure ulcers, falls with injury, incontinence and physical restraint use. RN assessment and care planning was valued and distinct from LPN contributions in nursing homes with these three practice pattern characteristics, and delegation and supervision by the RN role supported the crucial assessment and care planning contributions to residents’ quality of care.

Optimal RN staffing is essential to enhance the delivery of safe, quality care (ANA, 2012). The compelling evidence that a strong RN presence is needed in nursing homes has led to research studies and expert panels proposing minimum nurse staffing requirements for nursing homes (Abt Associates, 2001; Harrington et al 2000). These proposed staffing requirements were made 13 years ago and the professional nursing care needs of nursing home residents have since become even more demanding. Congruent with the recommendations for RN staffing in nursing homes, the American Nurses Association (ANA) defines appropriate nurse staffing as “a match of registered nurse expertise with the needs of the recipient of nursing care services in the context of the setting and situation” (ANA, 2012, p.8). The ANA outlines a set of core principles for nurse staffing that includes taking into account the needs of the patient population that is matched with appropriate clinical competencies of the nurse, the education and experience of the nurse, and the evaluation of staffing plans based on outcomes, specifically nurse-sensitive indicators (ANA, 2012). These core principles are applicable to all settings where professional nursing is practiced and should be the standard for nurse staffing in nursing homes.

References


