When Understaffing Becomes "Rationing"

No factor has a greater impact on the quality of a nursing home or assisted living resident's care and life than staffing levels, whether their outcomes are measured by moments in time (i.e., incidents & condition changes), or periods of time (i.e., physical & cognitive declines). Although physicians, nurses, clinicians, and caregivers design, direct, and deliver resident care, their authority and contributions are confined to staffing budgets they do not control.

Staffing is the allocation of caregiver time to an assigned group of residents during a defined period of the day, but its value is measured by the quality of care that is delivered to the most dependent regardless of time of day, day of week, time of year, holidays, facility profit margins, and management presence. This allocation of staff time is usually defined by staffing budgets, which create "measurable boundaries" that reveal how much resident care and treatment corporate officials and facility administrators are willing and/or able to provide.

Understaffing occurs when the number of caregivers (i.e., floor nurses and/or aides) on a given shift or day is below the mainstream industry, but above state minimum statutory numbers. Of course, some state and federal standards are based on sufficiency regardless of numbers, which measure staffing based on individual resident outcomes and not facility-wide ratios. **Rationing is a dangerous level of understaffing that occurs when tenuous staff-to-resident ratios force nurses and aides to choose which aspects of care and supervision will be left to chance**. Signs and symptoms of "rationing" include the following examples:

1. When most incidents and accidents are avoidable.
2. When most negative outcomes are avoidable.
3. When condition changes are not addressed until several shifts/days have passed.
4. When even a basic level of care is challenging to provide.
5. When high risk residents receive the same care and supervision as any other resident.
6. When an eldercare culture is defined by reactive versus proactive staff practices.
7. When staff rely on "passive" interventions (i.e., devices) versus "active" (i.e., supervision).
8. When families describe their visits with terms like unkempt, foul odors, and no staff.
9. When facilities violate state "minimum" direct care statutory numbers.
10. When facility officials defend ratios based on compliance with state minimum numbers.
11. When caregiver staffing patterns are designed from state minimum numbers.
12. When floor RN staffing patterns are designed from state/federal minimum numbers.
13. When undergoing state surveys is the only exception to rationing practices.
14. When budgets are only driven by profit margins and not resident acuity formulas.
15. When staffing budgets are not increased despite a notable spike in resident acuity.
16. When managerial and clerical nurses are included in direct care staffing budgets.
17. When all caregiver assignments are based on "one-size-fits-all" staffing patterns.
18. When excess caregivers are sent home to comply with rigid staffing budgets.
19. When call-offs are not replaced until minimum staffing levels are reached.
20. When call-offs are not replaced if available caregivers are entitled to overtime.
21. When creating partial shifts to utilize less aides during mid and late afternoon periods.
22. When staffing levels in memory care units are the same as unlocked facility units.
23. When SNF LPN's are substituted for RN's.
24. When SNF medication aides are substituted for nurses.
25. When LPN's serve in management and clerical roles ordinarily occupied by RN's.
26. When SNF's create specialty nurse positions rather than increase staffing patterns.

27. When SNF nurses are not stationed in memory care units throughout their shifts.
28. When (1) SNF nurse is assigned to (2) or more nursing stations on any shift.
29. When only (1) SNF aide is assigned to a standard resident hall on any shift.
30. When staffing conditions are routinely unstable/dysfunctional during weekends.
31. When floor nurses cannot properly supervise aides due to excessive workloads.
32. When shift-to-shift rounds are not scheduled or conducted.
33. When no SNF or ALF caregiver is present or directly supervising a resident unit/hall.
34. When staff is pulled off the floor for in-service education rather attend on their days off.
35. When caregivers are forced to forgo their rest and lunch breaks.
36. When night shift aides perform duties typically assigned to day and afternoon shifts.
37. When ALF aide assignments include housekeeping, laundry, and dietary duties.
38. When understaffing is a frequent topic at staff meetings and in-service education.
39. When terms like "budget" and "corporate" are used to deflect staffing complaints.
40. When facilities rely on hospice, home care, private sitters etc., to supplement aides.
41. When there is high turnover of floor nurses and aides.
42. When "assembly line care" best describes how residents are treated.
43. When aides cannot address high risk/dependent residents every (2) hours or less.
44. When residents who require the assistance of (2) staff face extended wait times.
45. When aides are forced to triage resident requests leaving many for the next shift.
46. When routine ADL's are not performed especially details like oral care and grooming.
47. When the success of feeding at-risk residents is based on how fast they eat and drink.
48. When performing ROM and restorative care is not logistically possible in SNF's.
49. When aides substitute incontinence pads and briefs for toileting assistance.
50. When dependent residents remain sitting for many hours without repositioning.
51. When residents are forced to remain in bed during most of the day.
52. When residents are brought to dining rooms too early and left there too long.
53. When residents are forced to eat in day/dining rooms to ensure proper supervision.
54. When tenuous floor nurse assignments set the stage for clinical errors and omissions.
55. When facilities substitute physical and chemical restraints for bedside supervision.
56. When family members are forced to provide care and serve meals when they visit.
57. When the facility is characterized by a harmful pattern of regulatory violations.
58. When resident supervision is the underlying cause of many regulatory violations.
59. When the facility is characterized by complaint violations.
60. When the facility is characterized by negative consumer ratings.
61. When residents are transferred to another facility due to dissatisfaction.
62. When untimely response to call-lights is a frequent topic at resident/family meetings.
63. When using resident call-lights is considered an exercise in futility.
64. When aides are constantly apologizing to residents and families about short-staffing.
65. When the MDS does not accurately represent a resident's condition.
66. When care and service plan interventions are meaningless paper commitments.
67. When SNF's automatically relax charting when Medicare skilled coverage ends.
68. When SNF's substitute timesaving check-off forms/menus for narrative nurses notes.
69. When SNF's promote cost-saving clinical practices like charting by exception.
70. When SNF aides fail to document ADL's, ROM, intake, turning, and other duties.
71. When caregivers postdate medical records and/or commit false charting.
72. When caregivers are forced to relax or disregard policies, procedures, and training.
73. When nurses are forced to relax or breach professional standards.
74. When staff promote negligent/deflective clichés such as "we can't provide 1:1" etc.
75. When facility officials heavily promote risk agreements.

This list is designed to **identify a pattern of facility practice that is driven by rationing policies**, and not to condemn a facility for experiencing some of these signs and symptoms at times, especially when it provides caregiver staffing levels that are at/above the mainstream industry. Think of this list as a "pass/fail test" to determine whether rationing policies are in place.

The following rationing scenario profiles an "Assisted Living Facility" based on staff-to-resident ratios:

RATIONING SCENARIO

Assisted Living Facility (ALF)

Standard of Measurement: "Staff-to-Resident Ratios"
Mainstream Industry Benchmark: "State Average"

Staffing Pattern:

RATIONING ↓

Afternoon Shift:	Facility 1:	Facility 2:	State Average:	State Minimum:
Aides – General:	1:12 Residents	1:20 Residents	1:15 Residents	1:20 Residents
Aides – Memory Care Unit	1:8	1:15 Residents	1:10 Residents	1:15 Residents
Nurse(s):	Yes	Not scheduled	75% of facilities	N/A
Acuity-based assignments:	Yes	Not available	75% of facilities	N/A

↑----------Same Market----------↑

Variables (i.e., Facility 2 vs. 1:

1. Resident census and acuity are essentially the same.
2. Caregivers at both facilities are well trained, productive, and dedicated.
3. Both facilities have the same quality/quantity of supplies and equipment.
4. Both facilities have a similar floor plan and physical plant.
5. All other operational variables are essentially the same.

Note: This chart is for illustrative purposes only. It does not represent an actual facility or company, or a particular state or year.

The following rationing scenario profiles a "Skilled Nursing Facility" based on staff-to-resident ratios:

RATIONING SCENARIO

Skilled Nursing Facility (SNF)

Standard of Measurement: "Staff-to-Resident Ratios"
Mainstream Industry Benchmark: "State Average"

Staffing Pattern:

RATIONING ↓

Afternoon Shift:	Facility 1:	Facility 2:	State Average:	State Minimum:
CNA's :	1:7 Residents	1:11 Residents	1:8 Residents	1:12 Residents
Floor Nurses:	1:20 Residents	1:40 Residents	1:25 Residents	1:40 Residents
RN's:	30% of floor staff	Rarely scheduled	20% of floor staff	1 floor nurse per day
Nursing Supervisor(s):	Yes	Not scheduled	75% of facilities	N/A
Acuity-based assignments:	Yes	Emergencies only	75% of facilities	N/A

↑----------Same Market----------↑

Variables (i.e., Facility 2 vs. 1:

1. Resident census and acuity are essentially the same.
2. Clinical skills/leadership of RN's and LPN's are essentially the same.
3. Nursing staff at both facilities are well trained, productive, and dedicated.
4. Both facilities have the same quality/quantity of supplies and equipment.
5. Both facilities have a similar floor plan and physical plant.
6. All other operational variables are essentially the same.

Note: This chart is for illustrative purposes only. It does not represent an actual facility or company, or a particular state or year.

The following rationing scenario profiles a "Skilled Nursing Facility" based on hours-per-patient-per-day (HPPD):

RATIONING SCENARIO

Skilled Nursing Facility (SNF)

Standard of Measurement: "Hours-Per-Patient-Day (HPPD)"
Mainstream Industry Benchmark: "State Average"

Staffing Pattern:

RATIONING ↓

	Facility 1:	Facility 2:	State Average:	State Minimum:
CNA 's:	2.14 HPPD	1.80 HPPD	2.08 HPPD	N/A, see total
LPN's:	.86 HPPD	.72 HPPD	.82 HPPD	N/A, see total
RN's:	.45 HPPD	.21 HPPD	.41 HPPD	1 floor nurse per day
Combined Total:	3.45 HPPD	2.73 HPPD	3.31 HPPD	2.50 HPPD
Nursing Supervisor(s):	Yes	Not scheduled	75% of facilities	N/A
Acuity-based assignments:	Yes	Emergencies only	75% of facilities	N/A
	↑----------Same Market----------↑			

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Rationing practices often emerge when the negative variance from industry benchmarks is greater than 20% for ratios and 10% for HPPD values. However, numbers only tell half the story, which is why rationing policies, if any, should be determined using my signs/symptoms test.

The financial success of a facility is a critical factor in delivering quality care and services. However, profit expectations should never require rationing, especially when a modest portion of income can be used to prevent this problem. There is delicate balance between a healthy bottom line and quality resident care that reveals the resolve and mission of facility officials. **Although rationing is practiced at the bedside, these policies are conceived in the boardroom.** It is important to recognize that payroll accounts for 55-70% of operational expenses at most eldercare facilities, and direct care staffing (i.e., caregivers) has the greatest impact on payroll. Therefore, no facility expense has a greater impact on profitability than direct care staff.

Some staff use deflective defenses like "professional judgement" or "every situation is different" to draw attention away from understaffing, and to create the false impression that only they possess the ability and facility insight to determine if caregiver staffing patterns were sufficient. They contend that measuring their facility against industry benchmarks is not realistic and fair. Of course, every facility can be measured against federal, state, and mainstream benchmarks. The question is not whether the following "staffing excuses" are available, but why some facility officials and staff use them:

- Our labor market is too challenging
- Our referral market is too challenging
- Our Medicaid reimbursement rates are too low
- State and federal regulations are unrealistic and too intrusive
- Our contribution margins carve out too much operating income
- Resident independence trumps supervision in assisted living facilities
- Any defensive/deflective statement that begins with "It's not fair"

When I hear these excuses I am reminded of advice that I received as a young administrator: "What one facility can do, another can do."

Always remember:

- Resident neglect results from rationing;
- Rationing results from understaffing;
- Understaffing usually results from lean facility budgets;
- Lean facility budgets usually result from profit expectations; and,
- Profit expectations should never require rationing.

About the author:

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