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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.

Artificial inflation of nurse staffing levels appears to be a widespread problem within the aging services industry. According to the Centers for Medicare and Medicaid Services (CMS), more than 80 percent of aging care facilities report higher registered nurse (RN) staffing levels on the public Nursing Home Compare website than are reflected on Medicare cost reports.[1]

Reporting discrepancies serve to mislead residents and family members regarding an organization's capacity to provide basic care, creating the potential for dissatisfaction and complaints. Chronic misreporting also may translate into higher rates of resident injuries and deaths, as well as fraud and abuse claims.

In a healthcare environment with growing resident acuity and ever-increasing expectations concerning transparency and accountability, aging services organizations must be alert to danger signs, including staffing discrepancies, onsite inspection issues, adverse satisfaction surveys, poor accountable care performance measures, and obsolete or nonexistent administrative policies. Facilities that fail to heed the warning signals and take swift action to address problems may experience costly litigation, regulatory sanctions and severe reputational harm.

This edition of *CareFully Speaking*® reviews basic staffing requirements, examines emerging sources of litigation, offers strategies to help diminish staffing-related exposures, and lists a range of relevant resources and initiatives.

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1 See Lowenstein, J. "Analysis Shows Widespread Discrepancies in Staffing Levels Reported by Nursing Homes." The Center for Public Integrity, November 12, 2014.

Initiatives to Strengthen Staffing Requirements

The following initiatives aim to make aging care environments safer for both residents and workers by educating consumers and lawmakers about the perils of chronic understaffing:

- ***Better Staffing: The Key to Better Care** is a campaign launched in 2014 by the National Consumer Voice for Quality Long-Term Care to educate residents, families and legislators about the need for increased aging care staffing. The campaign advocates for a federal law mandating that every resident receive at least 4.1 hours of nursing care per day.*
- ***Nursing Home 411**, a website operated by the Long Term Care Community Coalition, provides news, research reports and resources relating to quality of care and resident rights issues, including ways to improve the working conditions of direct care staff.*
- ***Nursing Home Report Cards**, an initiative of Families for Better Care, ranks the quality of resident care on a state-by-state basis. Annual report cards include nurse hours per resident per day, among other performance indicators.*
- ***Safe Staffing for Quality Care Act** is a proposal under consideration by the New York state legislature that would require nursing homes to increase nurse staffing levels. If the law is enacted, New York would join 36 other states that regulate aging services staffing.*

STAFFING BASICS

The federal Nursing Home Reform Act establishes minimum nurse staffing levels for certified aging services organizations that provide Medicare and Medicaid services.[2] Specifically, *42 CFR 483.30* 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 nurse assistants, 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."

Within the aging services industry, government guidelines are often perceived as less than satisfactory because they fail to specify thresholds below which residents are at risk of harm. In their current form, federal laws require 30 hours per day in a setting with 100 residents, which translates to 0.30 hours per resident day (HPRD), or approximately 20 minutes of nursing attention per resident per day.[3] However, as early as 2001 CMS reported that, for safety's sake, residents staying 90 days or longer should receive a minimum of 4.1 HPRD. Despite these findings, as well as a long-term effort by consumer advocacy groups to raise staffing quotas (see the sidebar to the left), federal requirements remain vague in terms of defining adequate staffing numbers and have not been updated to reflect changing resident acuity profiles.

In addition to the federal guidelines, the vast majority of states have enacted 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, with HPRD mandates ranging from as much as 4.2 to as little as 0.44.

EMERGING SOURCES OF LITIGATION

Aging services settings confront the daily challenge of satisfying safety and quality standards while maintaining costs at a manageable level. Many facilities have attempted to remain competitive by aligning with an accountable care organization (ACO) – i.e., local medical practices, hospitals, aging services settings and other healthcare providers that voluntarily join forces to increase coordination and quality of care for Medicare patients. In some cases, however, aging services organizations have misrepresented staffing capacity and inflated performance data in order to attract potential ACO partners. 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 face allegations of misrepresentation and Medicare/Medicaid fraud. For example, in the ongoing class action lawsuit *State of New Mexico ex rel. King v. Preferred Care Inc. et al.*,[4] the state attorney general alleges that a corporate aging services entity maintained dangerously low staffing levels in nearly a dozen facilities and misrepresented service capabilities to Medicaid and Medicare

2 The Nursing Home Reform Act is part of H.R.3545 – Omnibus Budget Reconciliation Act of 1987.

3 See Howe, C. "Staffing Ratios in Nursing Homes," *Arizona Geriatrics Society Journal*, October 2010, volume 15:2.

4 Case number D-101-CV-2014-02535 (First Judicial District Court, Santa Fe County, New Mexico, Dec. 5, 2014).

programs, as well as to consumers.[5] The complaint asserts that the organization earned $229 million over a four-year period – three-quarters of which was paid by state and federal agencies – while neglecting the safety and well-being of residents.

The *King* case represents the first time prosecutors have compared industrial engineering simulation findings (i.e., measuring how long it takes to complete various tasks) with a defendant organization's self-reported data on resident assessment and staffing, in order to demonstrate that reported staffing levels could not meet basic resident needs. If their suit is successful, New Mexico prosecutors will have established a legal precedent.

Aging services organizations also may be vulnerable to private litigation in states that set a minimum staffing ratio and provide statutory damages for violations. For example, in *Lavender v. Skilled Healthcare Group*, a California jury awarded $619 million to private plaintiffs after finding that the defendant facilities were inadequately staffed for 13,118 days.[6] The determination of liability was based upon review of internal staffing records, emails and witness testimony.[7]

The *King* and *Lavender* cases shed light upon the potential gap between resident services represented and billed by facilities and what is actually provided. The *Lavender* case demonstrates that aging services organizations found liable for Medicare/Medicaid violations or consumer fraud may be subject to very substantial monetary penalties and consequent negative publicity.

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. Tools such as the AMDA Universal Transfer Form encourage facilities to plan ahead and optimize staffing resources at the precise time of resident arrival.

For additional recommendations on how to create a safer and more effective admissions process, see the box below.

BENCHMARKS FOR SAFER ADMISSIONS

The Pioneer ACO Model from 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 by telephone*, and residents are assessed within two to three days to determine if they need a behavorial 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 ACO partners.
- *Regular team meetings with ACO leadership are held concerning specific residents*, in order to prevent unnecessary hospital readmissions.

5 See Horwitz , J. and Bryan, S. "New Mexico Sues Nursing Home Chain on Care, Staff." *Santa Fe New Mexican*, December 5, 2014.

6 Case number DR060264 (Calif. Super. Ct., Humboldt Co.), 2010 WL 4926747.

7 California law allows a maximum penalty of $500 per violation under the state Health & Safety Code §1430(b). The award was determined by multiplying the number of deficient days by the number of residents per day, totaling 1,237,539 deficient patient days.

Substandard performance measures. As aging services settings increasingly align with ACOs to obtain maximum reimbursement levels under the Medicare Shared Savings Program, maintaining recommended staffing levels and achieving other quality of care benchmarks becomes an even higher priority. ACOs are unlikely to partner with a facility embroiled in federal and state compliance actions due to chronic and deliberate understaffing, or one that reports high hospital readmission rates and prolonged rehabilitation stays. The checklist of performance benchmarks on pages 6-7 is designed to help aging services providers assess their overall readiness for ACO alignment.

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.

QUICK LINKS

- "ACOs and Long-Term Care: Don't Get Left Behind." Update posted by the Duane Morris law firm on December 28, 2012.
- Haciski, R. "Legality Reality: Litigation on the Rise for LTC Industry." Posted online by the Graham Company® on June 18, 2014.
- LaPorte, M. "ACOs: A Look at What Works for Nursing Home Providers." *Provider*, September 2013.
- The Long Term Care Community Coalition's Safe Nursing Home Staffing Standards Toolkit, which includes issue briefs, sample letters to elected officials and news media, petition forms and other resources.

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 persistent 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:

- *Invest in electronic documentation formats and other information technologies* designed to improve workflow, lessen the burden of paperwork and permit staff to focus on patient care.
- *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.
- *Align staff education and training with current clinical realities*, focusing on topics that help caregivers meet changing demands, such as care of behaviorally challenged residents, interpersonal communication, computer skills and time management.
- *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.

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. In fact, disparities between these two datasets are so common that, as part of the Patient Protection and Affordable Care Act, CMS is now working to implement an electronic data collection system designed to facilitate the submission of payroll-based, verifiable staffing information about registered nurses, licensed practical nurses and certified nursing assistants.[8]

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. Additionally, findings and corrective actions taken should be thoroughly 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.

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8 See "Implementation of Affordable Care Act Provisions to Improve Nursing Home Transparency, Care Quality, and Abuse Prevention." An issue paper from the Kaiser Commission on Medicaid and the Uninsured, January 2013.

Meeting ACO Performance Demands: A Self-assessment Checklist

READINESS CRITERIA	STATUS	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. **Before deciding whether to align with an accountable care organization (ACO), 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 that participate in the ACO, in order to ensure cultural compatibility. - Effectiveness of current measures to reduce costs. - Annual marketing and strategic goals, in order to ensure that they align with ACO expectations regarding increased admission and discharge volume, reduced length of stay and hospital admissions, enhanced rehabilitation services, and improved access to geriatric nurse practitioners and physicians. - The ACO'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 performance improvement (PI) process is established** to monitor the following quality of care measures, among others: - Outcomes. - Average length of stay. - Rehospitalization rates. - Functional rehabilitation progress. - Adverse occurrences during care transitions, including shifts between levels of care. - Resident/family satisfaction rates.		
2. **The PI process also monitors incidents and warning signs,** including: - Falls. - Pressure sores. - Infections. - Restraint use. - Pain. - Psychotropic medication mismanagement. - Pharmacy errors. - Survey noncompliance.		
3. **To facilitate reporting of both case-specific and aggregate outcomes data to the ACO, residents are categorized by pertinent risk factors**, such as: - Clinical complexity. - Rehabilitation potential. - Discharge readiness. - Hospitalization risk.		
4. **The ACO's proposed quality performance measures are reviewed and compared with current quality review processes,** which are 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.		

READINESS CRITERIA	STATUS	COMMENTS
PREPARE ACO ALIGNMENT INFRASTRUCTURE		
1. **An electronic health record system has been adopted** and tested for compatibility with ACO recordkeeping systems.		
2. **The medical director is assigned responsibility for actively communicating with ACO leaders** and partner hospitals about quality of care, and this duty is included in the job description.		
3. **A system is created to respond to inquiries from ACO peers**, involving designated physicians and nurses.		
4. **Space is made available in the facility for ACO clinicians**, who are also given access to private telephones and computers, resident records and nursing assistance.		
5. **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.		
DEVELOP JOINT PROGRAMS		
1. **A forum is established to facilitate dialogue between the aging services setting and its ACO partners** with respect to forging mutual goals and measuring outcomes.		
2. **The medical director is in regular communication with ACO peers** via joint operating committees, weekly clinical meetings, quarterly case management reviews and other similar forums.		
3. **There is a written strategy to increase the presence of ACO physicians in the aging services facility** and to improve care by promoting physician involvement in: - Nursing staff rounds. - Facility leadership meetings. - Performance improvement meetings. - Education programs and in-service training. - New admission assessments. - Family conferences. - Utilization review.		

CNA Risk Control Services

ONGOING SUPPORT FOR YOUR RISK MANAGEMENT PROGRAM

CNA provides a broad array of resources to help aging services organizations remain current on the latest risk management insights and trends. Bulletins, worksheets and archived webinars, as well as past issues of this newsletter, are available at **www.cna.com/riskcontrol**.

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