

THE NATIONAL IMPERATIVE TO IMPROVE NURSING HOME QUALITY

Honoring Our Commitment to Residents, Families, and Staff

Committee on the Quality of Care in Nursing Homes

Board on Health Care Services

Health and Medicine Division

A Consensus Study Report of

The National Academies of

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(AARC, 2016). Respiratory therapists are educated and trained in all aspects of pulmonary medicine and can help residents manage all respiratory diseases and conditions. Under current regulations, respiratory therapy is considered a nontherapy ancillary service (AARC, 2017).

Speech–Language Pathologists and Speech Therapists

Speech–language pathologists help evaluate and treat a range of conditions that lead to communication, cognition, memory, problem-solving, language expression, or swallowing disorders in long-term care residents (Casper, 2013). Approximately 5 percent of all speech–language pathologists work in nursing and residential care facilities (BLS, 2021a). Among speech–language pathologists working in nursing homes, 83.4 percent are employed full-time, and 82.8 percent are paid on an hourly basis; 61.7 percent work for one employer, 24.7 percent work for two employers, and 9.4 percent work for three or more employers (ASHA, 2021). More than 1 in 5 nursing homes have funded, unfilled positions (ASHA, 2021).

DIRECT-CARE WORKERS

Direct-care workers—nursing assistants (also called nurse aides), personal care aides, and home health aides—provide the majority of hands-on care to residents in nursing homes (Campbell et al., 2021). Direct-care workers provide care that includes everyday tasks such as assistance with eating, bathing, toileting, and dressing as well as more advanced tasks such as infection control and taking care of cognitively impaired residents (BLS, 2021b; PHI, 2021; McMullen et al., 2015). Taken together, these tasks are critical to maintaining the function, well-being, and quality of life of the resident. CNAs—nursing assistants who have met specific federal and state educational and training requirements—make up the largest proportion of direct-care workers in nursing homes.

Demographics

More than 527,000 nursing assistants were employed or contracted by nursing homes across the United States in 2020 (12 percent of the total direct-care workforce) (BLS, 2021c). Among these workers, the median age was 38, and 91 percent were women; 58 percent were people of color (38 percent Black/African-American, 13 percent Hispanic/Latino, 5 percent Asian or Pacific-Islanders, 2 percent other), and 21 percent were born outside of the United States (PHI, 2021). More than 90 percent had completed at least high school, and 13 percent had an associate’s degree or higher (PHI, 2021).

As the demand for direct-care workers increases, nursing homes in the United States will need to fill approximately 561,800 nursing assistant jobs between 2019 and 2029 (Campbell et al., 2021; PHI, 2021). This effort will not come without challenges which have plagued the ability for nursing homes to recruit and retain an adequate supply of direct-care workers for decades, however. Many of these challenges are rooted in structural and systemic factors that play out in the form of low wages, minimal training requirements, and lack of respect and recognition which to a significant degree represent the legacy of longstanding institutional racism, sexism, and ageism (Drake, 2020; Ryosho, 2011; Sloane et al., 2021; Squillace, 2009; Travers et al., 2020; Truitt and Snyder, 2020). Because of the crucial role of this position in nursing homes, significantly improving the quality of care requires investment in quality jobs for direct-care workers.

Immigrant workers, both documented and undocumented, fill critical gaps in the direct-care workforce, especially in nursing homes that serve a high share of Black and Latino residents (Lee et al., 2020; Zallman et al., 2019). As such, this group may be a primary target for recruitment efforts. However, when entering the workforce immigrant workers face additional barriers, such as language, health literacy, and uninsured rates, compared with native-born individuals (Campbell, 2018; Lee et al., 2020). One strategy to support immigrant workers and attract them to direct-care worker positions includes a pathway to citizenship (Katz, 2019; White House, 2021).

Wages

The mean hourly wage in 2020 for nursing assistants in nursing homes was \$15.41, and the mean annual wage was \$32,050 (BLS, 2021c). The bottom quartile of nursing assistants earns less than \$26,650 annually, and the bottom 10 percent earn less than \$22,750 (BLS, 2021c). The level of pay for direct-care workers in nursing homes has drawn stark attention to comparable wages for other types of work that might be considered to be more desirable. For example, while nursing assistants provide increasingly complex care and face persistent challenges with inadequate training and risk of on-the-job injury, they may earn little more than cashiers (\$25,020 per year), food service workers (\$24,130 per year), or retail sales workers (\$27,320 per year) (BLS, 2021d,e,f). A 2021 story found that many nursing home workers were leaving for jobs at Amazon:

The average starting pay for an entry-level position at Amazon warehouses and cargo hubs is more than \$18 an hour, with the possibility of as much as \$22.50 an hour and a \$3,000 signing bonus, depending on location and shift. Full-time jobs with the company come with health benefits, 401(k)s and parental leave. (Varney, 2021)

Direct-care workers often have to work multiple jobs, forego important necessities such as health insurance and retirement benefits because of an inability to afford premiums, and live in congregate housing (Morris, 2009). Because of their low wages, 34 percent of direct-care workers require some form of public assistance, and many live in poverty; direct-care workers who are also women of color are more likely than white women and men to require public assistance, live in poverty, or live in low-income households (PHI, 2019, 2021). This could in part be a result of the fact that Black female direct-care workers make 20 cents per hour less than White female direct-care workers and 70 cents per hour less than White male direct-care workers (Scales et al., 2020). For family member perspectives on the compensation of nursing home workers, particularly CNAs, see Box 5-5.

BOX 5-5 **Family Member Perspectives**

“I would improve the wages and benefits for nursing home staff so they would be fairly compensated for their work and so the best and brightest worker would be attracted to the profession.”

— Family Member, Schenectady, New York

“I believe the greatest improvement to care would be addressing nurse aide issues comprehensively; pay a living wage of at least \$15 per hour, support fixing employability barriers like adequate childcare and public transportation availability. The reality is that the staff is underpaid, overworked, under supported, and insufficiently trained to care for residents.”

— Family Member, Wilmington, North Carolina

“Staff on front lines are not paid well, are not trained well regarding person-centered care, do not have skills to succeed.”

— K.S.

“Staff are incredibly caring people who need to be paid a living wage.”

— Family Member, Berkeley, California

“If they paid workers more, maybe there would be more and better care and at the prices being charged per month, I don’t see why they can’t.”

— Wendy

“I wonder if the pay should be higher for people in the trenches and not corporate level.”

— Family Member, Sioux Falls, South Dakota

These quotes were collected from the committee’s online call for resident, family, and nursing home staff perspectives.

Education and Training

CNAs are required²⁰ to have a minimum of 75 hours of training plus at least 12 hours of continuing education annually, including 16 hours of “supervised practical training,” that covers basic nursing services, personal care services, basic restorative services, mental health and social services, care of cognitively impaired residents, residents’ rights, and other topics (Hernández-Medina et al., 2006). The minimum number of hours and topics covered by CNA trainings have been a cause for concern as these requirements have not changed since the passing of the Nursing Home Reform Act, part of the Omnibus Budget Reconciliation Act of 1987. Given the marked increase in nursing home resident acuity, complexity, and care needs, current requirements are inadequate (Hernández-Medina, et al., 2006). For example, one small study found that CNAs in nursing homes had inadequate knowledge related to aging, cognition, and mental health (Kusmaul, 2016). Some states and facilities have implemented more robust training efforts, with many states requiring additional hours and topics of training beyond federal minimum requirements. CNAs themselves have expressed interest in including education on dementia and infection control (Lerner et al., 2010).

Additional training of CNAs has been associated with improved nursing home quality indicators (Hernández-Medina et al., 2006; PHI, 2011; Trinkoff et al., 2013; Zheng and Temkin-Greener, 2010). As a result, various bodies have suggested that the number of required hours for training be increased to between 100 and 120 hours, with 50 to 60 of those hours going toward clinical training (Hernández-Medina, et al., 2006). Specifically, the 2008 IOM report *Retooling for an Aging America* recommended that “Federal requirements for the minimum training of [CNAs] and home health aides should be raised to at least 120 hours and should include demonstration of competence in the care of older adults as a criterion for certification” (IOM, 2008, p. 218). While many states have increased their requirements since 2007, only the District of Columbia and 13 states (up from 12 states in 2007) require at least 120 hours (IOM 2008; PHI, 2020).

CNAs reporting high-quality training are more likely to work in states requiring additional initial training hours and were more satisfied with their jobs than those with low-quality training (Han et al., 2014). Training focuses specifically on work-life skills, such as problem solving, task organization, and working with others, helped to increase satisfaction (Han et al., 2014). Additionally, the implementation of orientation programs for newly hired staff in all states and facilities is needed (IOM, 2004).

Florida is one of the states that requires 120 hours of training for CNAs. R. 64B9-15.006, Fla. Admin. Code.

²⁰ CMS Requirements for Long-Term Care Facilities—Requirements for Approval of a Nurse Aide Training and Competency Evaluation Program, 42 CFR § 483.152 (2016).

Because the care needs of the resident are complex, dynamic, and growing, CNAs need ongoing professional development to adapt to the changing needs of the resident population. The current federal requirement for professional development is that CNAs must receive 12 hours of in-service or continuing education each year.²¹ The inclusion of topics such as infection control, care of the cognitively impaired, behavioral health, resident rights, skin care, communication techniques, safety and disaster training, and resident confidentiality may help ensure the competency of CNAs in carrying out their responsibilities. The National Institute of CNA Excellence, a project seeking to recruit and train CNAs, is expected to launch in 2022 (NICE, 2021). Created by the National Association of Health Care Assistants, the project provide virtual training that goes beyond traditional training in clinical skills to include topics like team building, leadership skills, conflict resolution, resident advocacy, and communication. The project further plans to support the CNA candidate through certification and job placement. For family member perspectives on the training of nursing home staff, particularly CNAs, see Box 5-6.

BOX 5-6 **Family Member Perspectives**

On behalf of my mother, there is inadequate amount of properly trained staff. They barely know the rudimentary basics of personal care. There is no medical, transfer, aging, or infection control training.

— **Concerned Citizen**

Improvements to care include mandating staffing ratios for aides and increasing competency with more skill lab time during initial training, and require annual skill demonstration.

— **Family Member, Wilmington, North Carolina**

Need to provide much better training in areas including feeding of memory care residents, infection control, communicating with memory care residents, interacting with residents from cultures/ethnicities different from their own, and treating residents with dignity, compassion, and respect.

— **M.K.**

These quotes were collected from the committee's online call for resident, family, and nursing home staff perspectives.

²¹ CMS Requirements for Long-Term Care Facilities – Training Requirements, 42 CFR § 483.95(g) (2016).

Job Requirements and Characteristics

Unlike licensed personnel such as RNs, direct-care workers do not have an official scope of practice. Instead, nine authorized duties are listed by the Code of Federal Regulations to be allowable by each state : (1) personal care, (2) safety/emergency procedures, (3) basic nursing, (4) infection control, (5) communication and interpersonal activities, (6) care of cognitively impaired residents, (7) basic restorative care, (8) mental health and social service activities, and (9) residents' rights (McMullen et al., 2015). While these are duties that direct-care workers are authorized to perform, depending on the state they may not be tasked to do so. Moreover, there are a number of additional duties that direct-care workers have been permitted to carry out, such as medication management, wound care, catheter care tasks, and the management of medical information, because they benefit residents and alleviate pressure from other members of the workforce (McMullen et al., 2015).

Medication aides are most often CNAs who have received training to administer medications in some capacity based on the regulations provided by the state. There are variations in the requirements of the medication aides related to supervision, hours of training, continuing education, and length of time working as a CNA and in the facility. For example, in Iowa medication aides can only administer medications under the supervision of an RN (ANA Enterprise, 2015). As of March 2020, certified medication technicians (as defined in the 2020–2021 Nursing Home Salary and Benefits Report by the Hospital and Healthcare Compensation Service and the American Health Care Association), had a median hourly wage of \$15.66 in nursing homes (HHCS, 2020).

Staffing Levels

As noted earlier in this Chapter, a 2001 study by CMS proposed that minimum staffing standards for nursing assistants (thresholds below which residents were at risk for serious quality-of-care issues) should be 2.4 hours per resident day for short-stay residents and 2.8 hours per resident day for long-stay residents (Feuerberg, 2001). However, these levels are rarely achieved in all nursing homes. Furthermore, these minimum staffing standards may not reflect the acuity of the residents' needs, and lead to excessive workloads or the inability of CNAs to provide high-quality care. For example, one simulation estimated that nurse aides needed between 2.8 and 3.6 hours per resident per day in order to meet resident needs for assistance with activities of daily living (depending on resident acuity); however, reported staffing levels averaged only between 2.3 and 2.5 hours per resident per day (Schnelle et al., 2016). On average, one nursing assistant supports

12 residents per shift, and one in 10 nursing assistants support 16 or more residents (PHI, 2019).

Turnover and Burnout

Adequate staffing in nursing homes has been difficult to achieve because of high turnover, stigmatized perception of the CNA role, and poor working conditions (Manchha et al., 2021). One recent analysis using data from the Payroll Based Journal found the average turnover rate among CNAs to be 129.1 percent; in comparison, turnover rates were 140.7 percent for RNs and 114.1 percent for LPNs, with some individual facilities found to have nursing staff turnover rates over 300 percent (Gandhi et al., 2021). High turnover is expensive for nursing homes and negatively affects the quality of the services delivered and the quality of life in nursing homes (Feuerberg, 2001; IOM, 2004; Seavey, 2004). Contributors to these high turnover rates among direct-care workers in nursing homes include characteristics related to the nature of the job itself and the working environment found in nursing homes, including factors that result in injury. One analysis, for example, found that more than half of CNAs had incurred at least one work-related injury within the past year and almost one-quarter of CNAs were unable to work for at least 1 day as a result of being injured (Squillace et al., 2009).

The top reasons for direct-care workers leaving their jobs include lack of respect, low salary, staff shortages, personal health concerns, lack of appreciation by the facility, lack of teamwork among the staff, lack of trusting relationships with residents and families, lack of tools to do the job, lack of good relationships with supervisors, and not being informed of changes before they are made (Bryant, 2017; Mickus et al., 2004; U.S. Congress, 2001; Zhang et al., 2016). For example, one study of nearly 400 nursing homes in Iowa found that higher wages were associated with lower CNA turnover (Sharma and Xu, 2022). Moreover, CNAs are also often undervalued for their skills, mistreated, and disrespected and experience workplace violence in the form of physical and verbal abuse (Tak et al., 2010). While the work of the direct-care workforce has commonly been referred to as physically demanding, in 2020 during the midst of the COVID-19 pandemic, nursing home workers saw one of the highest death rates among all occupations (Lewis, 2021). The direct-care workforce is likely to experience even higher rates of burnout, though most of the literature on the topic focuses on the rate of burnout among licensed nurses and physicians (Cooper et al., 2016). For a family member perspective on staff burnout, see Box 5-7.

Greater retention of CNAs has been found to be associated with improved functional status and fewer pressure ulcers, electrolyte imbalances, and urinary tract infections among nursing home residents (Kimmey and

BOX 5-7
Family Member Perspective

“Unfortunately, many well intended staff end up frustrated, burnt-out, and numbed by lacking support of management.”

— K.S.

This quote was collected from the committee’s online call for resident, family, and nursing home staff perspectives.

Stearns, 2015; Trinkoff et al., 2017). Many approaches to support the retention of this direct-care workforce have been proposed, including:

- Pay a wage reflective of the risks and physical demand that direct care workers assume daily.
- Provide a separate payment that can go toward wages, benefits (e.g., sick leave, health insurance), or both, similar to New York’s Home Care Worker Parity Law.²²
- Enhance work relationships by improving communication and supervision so that CNAs feel appreciated, listened to, and treated with respect.
- Improve management systems by increasing and improving staffing and scheduling along with increasing the availability of more robust training and better career ladders.
- Improve work system factors, including helping CNAs with directions, providing resources and supplies, and preventing injury and exposure to hazards or violence (Kemper et al., 2008; Morris, 2009).
- Create formal promotion programs, peer mentoring programs, and tuition reimbursement programs and proactively engage nursing assistants in efforts to enact such programs (Kemper et al., 2008; Stone and Dawson, 2008).

Tailored and ongoing training programs improve job satisfaction and reduce turnover (Ejaz and Noelker, 2006; Han et al., 2014). For example, an approach based on the occupational adaptation framework (Schkade and McClung, 2001) has been found to show greater gains in skills mastery and more cooperative approaches to solving complex problems such as dementia care needs than traditional skills training approaches (McKay et al., 2021).

²² Additional information available at <https://dol.ny.gov/home-health-care-aides-and-wage-parity> (accessed November 3, 2021).

There is also a need for opportunities for job advancement and upgrading the skill of CNAs (Campbell, 2021; IOM, 2004; PHI, 2016; Wiener et al., 2009). Career advancement opportunities include attaining a specialized skill or expertise area (e.g., medication aide) or advancing to a higher level of licensing (e.g., LPN/LVN, RN). One older study demonstrated that empowering CNAs led to reductions in health deficiency citations, reduced staff turnover, and a decline in urinary incontinence rates among residents (Stone et al., 2002). Strategies specific to empowerment were mostly focused on having CNAs participate in care planning and care plan implementation.

Supervision and Support

The immediate supervision of direct-care workers is carried out by both LPN/LVNs and RNs. These relationships are often challenging as a result of power dynamics arising from the hierarchical structure of most nursing homes, incivility, bullying, and undue time demands (Cooke and Baumbusch, 2021; Lundin et al., 2021). When these groups work together to communicate and support one another, it makes for a better relationship, so decentralization of hierarchical systems can promote better teamwork across disciplines and roles (Kemper et al., 2008), and encourage supervisors to demonstrate supportive behaviors (McGilton et al., 2004). Relationships among personnel can also be improved by leadership training for all levels of supervisors and managers, developing self-managed work teams, improving information sharing between nurses and direct-care staff, enhancing responsibilities for direct-care workers, team building, peer mentoring, and involving direct-care workers in care management decisions (Eaton, 2000; Eaton et al., 2001; Rantz et al., 2013; Stone and Dawson, 2008). Furthermore, nursing homes need to create a culture of values that fosters respect, trust, collaboration, and interprofessional health care team building (Kemper et al., 2008). Ultimately, nursing home leadership is responsible for creating a desirable working environment in the nursing home. For nursing home workers' perspectives on supervision, support, and the workplace environment, see Box 5-8.

Expanded Roles for CNAs

One notable example of expanding recognition of the role and importance of the CNA is the Green House model for nursing home care (see Chapter 6). Green House nursing homes employ modified staff roles to split work, empower staff, and have staff members work together. Direct-care workers in Green Houses, referred to as “shahbazim” (singular, “shahbaz”), “work in self-managed teams and are responsible for direct resident care, cleaning, laundry, meal preparation, staff scheduling, and activities, and simulating how families might organize work” (Bowers and Nolet, 2014).