Long Term Care Nurse Staffing Study

Staffing 2019

The Long Term Care Nurse Staffing Study (LTCNSS) assesses nurse staffing and related issues in the long term care setting. In 2018, approximately 27% of licensed vocational nurses (LVNs) and 3% of registered nurses (RNs) in Texas worked in the nursing home/extended care setting. Long term care facilities may also employ certified nurse aides (CNAs), certified medication aides (CMAs), and advanced practice registered nurses (APRNs). During the summer of 2019, the Texas Center for Nursing Workforce Studies (TCNWS) administered the LTCNSS to directors of nursing (DONs) or facility administrators of 1,205 Texas nursing facilities. A total of 314 facilities participated for a final response rate of 26.1%.

According to the Census Bureau, Americans over the age of 65 will represent 20% of the population by 2030, and the Department of Health and Human Services anticipates the number of older adults needing long term care services will double by 2050.[1,2] As a result, the demand for nurses in long term care settings is expected to increase. This report provides information on staffing in Texas long term care nursing facilities, including staff mix, future staffing needs, staff characteristics, and temporary staff.

[1]Census Bureau. (2012). 2012 national population projections: summary tables. Retrieved from http://www.census.gov/population/projections/data/national/2012/summarytables.html

[2]U.S. Department of Health and Human Services. (2003). The future supply of long-term care workers in relation to the aging baby boom generation. Retrieved from https://aspe.hhs.gov/basic-report/future-supply-long-term-care-workers-relation-aging-baby-boom-generation

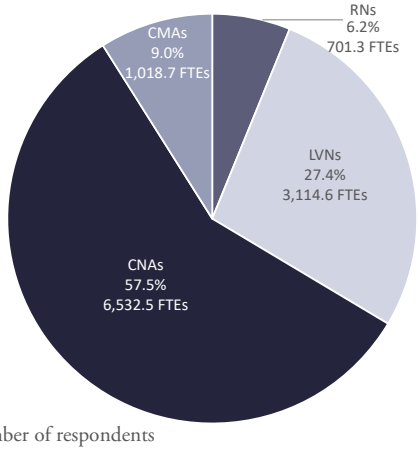
Staff Mix

Direct resident care staff

Figure 1 shows only the composition of staff providing direct resident care in Texas long term care facilities and is derived from the total number of full time equivalent (FTE) positions occupied.

- Over half of direct resident care staff were CNAs (57.5%).
- LVNs accounted for 27.4% of direct care staff.

Figure 1. Direct resident care staff mix (n=289)



Note: n=number of respondents

Administrative staff

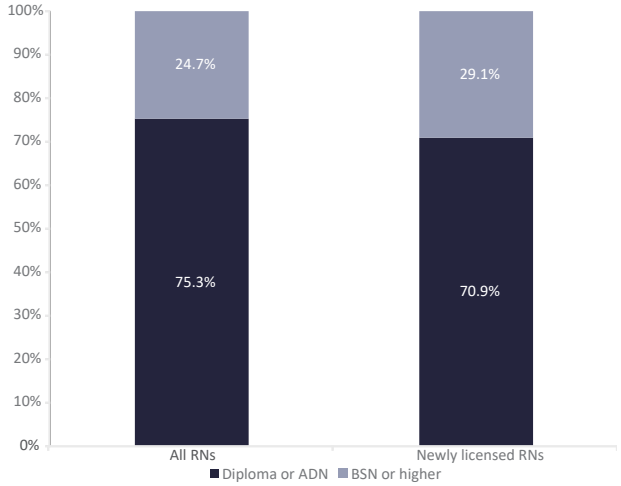
- LVNs comprised the majority of administrative staff, at 56.8%. The remaining 43.2% were RNs.

RN Degree Type

Respondents reported the degrees of newly licensed RNs and of all RNs employed during the facility's last fiscal year (Figure 2).

- 112 out of 385 (29.1%) of newly licensed RNs had a Bachelor of Science in Nursing (BSN) or higher compared to 339 out of 1,371 (24.7%) of all RNs.
- All RNs had a higher proportion of nurses with an ADN or diploma then newly licensed RNs.

Figure 2. Newly licensed RNs and all RNs employed last fiscal year by degree type



Additional Staff Needed

Respondents were asked to indicate whether their facility would need more, fewer, or the same number of staff in the next two years (see Figure 3).

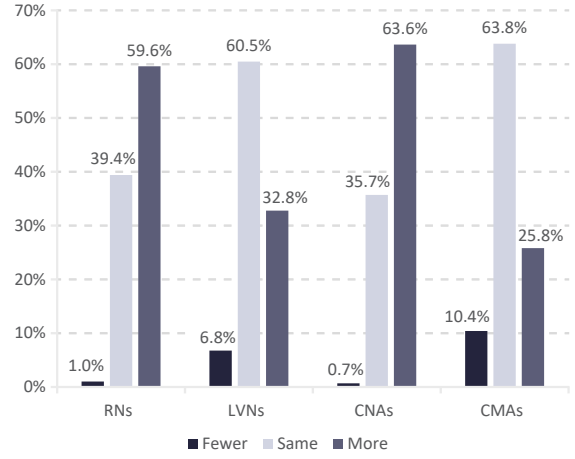
RNs

- 177 out of 297 (59.6%) facilities reported they would need more RNs over the next two years.
- 117 out of 297 (39.4%) facilities indicated that they would need the same number of RNs over the next two years.

LVNs

- 179 out of 296 (60.5%) respondents indicated they would need about the same number of LVNs.

Figure 3. Expectations of staffing needs by staff type



CNAs

- 189 out of 297 (63.6%) respondents reported that their facility would need more CNAs.
- Only 2 facilities (0.7%) reported needing fewer CNAs over the next two years.

CMAs

- 178 out of 279 (63.8%) facilities indicated they would need the same number of CMAs over the next two years.

Respondents were also asked why they would need fewer, more, or about the same number of nursing personnel over the next two years (Table 1).

- The most common reason selected for LVNs, CNAs, and CMAs was patient census. The most common reason selected for RNs was patient acuity.
- "Other" reasons for needing fewer, more, or about the same number of nursing personnel included increasing the facility's state star rating.

Table 1. Reasons facilities need fewer, more, or about the same number of nursing personnel over the next 2 years

Nurse Staff Type	n	Patient Census	Patient Acuity	Budget Concerns
RNs	271	60.9%	70.8%	12.9%
LVNs	257	68.1%	56.0%	16.7%
CNAs	268	77.6%	56.0%	9.3%
CMAs	209	75.1%	45.9%	14.8%

Note: n=number of respondents

Staff Characteristics

Disciplines

Table 2 reports the most common disciplines providing services in Texas long term care facilities.

- Mental health providers and other specialist physicians were the most prevalent (86.9% and 86.6%, respectively).

Table 2. Prevalence of disciplines in responding facilities

Disciplines	% of facilities
Nurse practitioners	79.0%
Clinical nurse specialists	15.6%
Geriatricians (MD/DO)	44.3%
Physician assistants	45.9%
Mental health providers	86.9%
Other primary care physicians (excluding Medical Director)	72.9%
Other specialist physicians (such as podiatrists)	86.6%

RNs with specialty certifications

Table 3 shows the number of RNs with specialty certifications reported by facilities.

- Nursing administration was the most commonly reported nurse specialty, with 14.5% of 282 facilities reporting at least one RN with that specialty.
- Other specialties included wound care (5 facilities) and infection control (3 facilities).

Table 3. RN specialties in responding long term care facilities

Specialties	n	# of RNs
Gerontological	278	7
Rehabilitation	277	5
Certified Dementia Practitioner	278	21
Nursing Administration	282	57
Other	248	40

Note: n=number of respondents

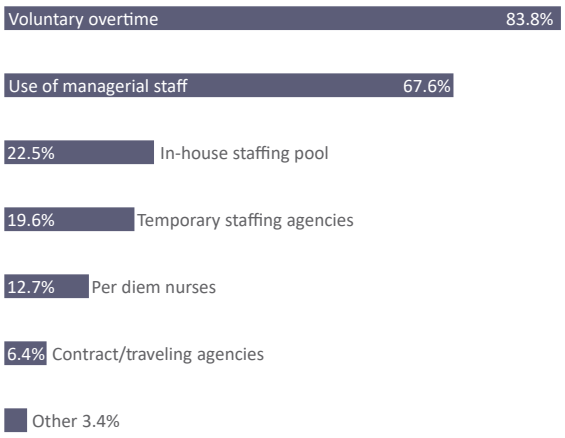
Methods of Interim Staffing

Respondents were asked to indicate which methods of interim staffing their facility used (Figure 4).

- Voluntary overtime was the most frequently used interim staffing method, with 83.8% of facilities reporting the use of this strategy, followed by use of managerial staff by 67.6% of responding facilities.
- Temporary staffing agencies were used by 19.6% of responding facilities.

Respondents were asked to provide the number of contract, agency, traveling, and per diem staff FTEs employed by their facility on 1/25/2019. Responding facilities reported 938.3 direct resident care FTEs and 55 administrative FTEs being utilized in this capacity.

Figure 4. Percentage of facilities using interim staffing methods (n=204)



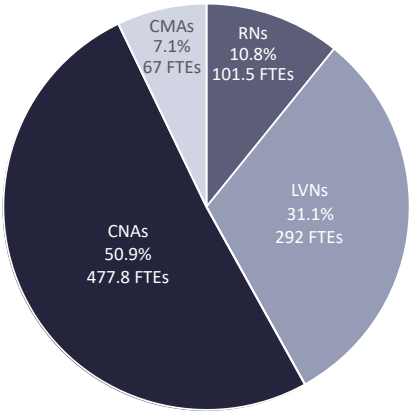
Note: n=number of respondents

Direct resident care staff

Figure 5 displays the direct resident care interim staff mix.

- CNAs comprised just over half of (50.9%) direct resident care interim staff FTEs employed.
- LVNs and RNs made up a larger proportion of interim direct care staff than of regularly employed direct care staff overall (41.9% and 33.6%, respectively).

Figure 5. Interim direct resident care staff mix



Administrative staff

- Of the 993.3 total interim staff FTEs reported, 5.9% were comprised of administrative RNs and LVNs.
- Administrative RNs accounted for 65.5% of the 55 administrative interim staff FTEs reported.

Hours and cost of interim staffing

Facilities were asked to detail the hours and costs of each interim staffing method.[3] Table 4 includes the total hours and cost[4] for each interim staffing method for all licensed direct resident care nursing staff.

- Responding facilities reported a total of 383,281.03 interim staffing hours at a cost of $8,476,257.17, averaging to $22.11 per hour, increasing from $17.64 per hour in 2017.
- 73.3% of expenses for interim staffing were spent on voluntary overtime.
- Voluntary overtime was less costly, on average, than the use of managerial staff, temporary staffing agencies, or contract or traveling nurses.

Table 4. Hours and cost of interim staffing

	n	Hours	Cost	Average cost per hour
Per diem nurses	-	-	-	-
Voluntary overtime	44	273,685.23	$6,215,987.41	$22.71
In-house staffing pool	7	87,956.17	$1,577,936.52	$17.94
Managerial staff	25	12,037.35	$219,772.90	$28.81
Temporary staffing agencies	17	9,405.19	$286,186.55	$28.05
Contract/traveling nurses	5	1,833.5	$123,175.13	$67.18
Other	1	200	$2,000	$10.00
Total		383,281.03	$8,476,257.17	$22.11

Note: No facilities reported hours and costs for per diem nurses; n=number of respondents.

[3]All facilities whose average cost per hour for any interim staffing method that fell below minimum wage were excluded from the analyses.

[4]The analysis on cost of interim staffing is to demonstrate the cost differential between staffing methods, and is not intended for use in estimating nurse wages.

Consequences of Inadequate Staffing

Respondents were asked to select all that apply from a list of consequences their agency experienced in the past year as a result of an inadequate supply of nursing staff. Table 5 displays the results from this question.

- 13.3% of 301 respondents indicated that they experienced no negative impact from a lack of adequate supply of staff, which was similar to the 2017 LTCNSS (13.6%).
- Increased workloads, increase in voluntary overtime, using administrative staff to cover nurse duties, low staffing morale, and increased turnover were all reported by more than half of respondents as consequences of inadequate staffing.

Table 5. Reported consequences of inadequate staffing (n=301)

	# of respondents	% of respondents
Increased workloads	219	72.8%
Increase in voluntary overtime	196	65.1%
Using administrative staff to cover nursing duties	191	63.5%
Low nursing staff morale	186	61.8%
Increased nursing staff turnover	172	57.1%
Difficulty completing required documentation on time	119	39.5%
Increased patient/resident and/or family complaints	114	37.9%
Increased absenteeism	112	37.2%
Wage increases	97	32.2%
Delays in providing care	95	31.6%
Increased number of incident reports	75	24.9%
Using medication aide staff to cover nurse aide duties	68	22.6%
Inability to expand services	58	19.3%
Increased use of temporary/agency nurses	58	19.3%
None - we had an adequate supply of nursing personnel	40	13.3%
Declined referrals	32	10.6%
Delayed admissions	30	10.0%
Other consequences	16	5.3%

Note: n=number of respondents

Consequences of Five-Star Quality Rating System

Respondents were asked to describe any consequences their facilities had experienced as a result of the Five-Star Quality Rating System, which is a nursing home rating system created by Centers for Medicare & Medicaid Services that can be used to compare the quality of nursing homes.

- 34 facilities indicated they had experienced a decline in referrals or admissions, and 14 facilities reported experience an increase in referrals or admissions.
- 26 facilities reported that their star rating had dropped.

Conclusion and Recommendations

Conclusion

CNAs were the most numerous nursing care type employed in long term care settings in Texas followed by direct care LVNs. Direct care RNs only represented of 6.2% of direct care staff. However, 59.6% of participating facilities reported they would need more RNs in the next two years and 63.6% of facilities claimed they would need more CNAs.

Voluntary overtime was the most frequently reported interim staffing method used among responding long term care facilities (83.8%). Interim staffing methods also cost responding facilities nearly $8.5 million. The top three most commonly reported consequences of inadequate staffing were increased workloads, increase in voluntary overtime, and using administrative staff to cover nursing duties.

TCNWS Advisory Committee Recommendations

According to survey respondents, over 50% of long term care facilities reported increased workload, increase in voluntary overtime, low nursing staff morale, using administrative staff to cover nurse duties, and increased nursing staff turnover as consequences of inadequate nurse staffing. Voluntary overtime was the most frequently used interim staffing method, with more than 70% of facilities reporting the use of this strategy. Since CNAs are the most numerous staff type in long term care facilities, comprising 57.5% of staff providing direct resident care, facilities should consider the following:

- Facilities should consider management changes and job redesign to allow CNAs to become essential members of resident care teams and to have increased input in decision making. This approach could include CNA involvement in resident care planning and continuity in CNA assignment to residents.
- Facilities should implement programs that appreciate and value CNAs.
- Facilities should offer programs that provide education beyond that which is mandated.