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Jun 29 2022
Independent Regulatory Review Commission

From: dkwnyny@aol.com
To: DH, LTCRegs
Subject: [External] Rule-making 10-224, Long Term Care Nursing Facilities, Proposed Rule-making 4
Date: Monday, June 27, 2022 6:53:48 AM

CNA Workload: A Neglected Factor in Long-Term-Care Staffing Discussions

This comment addresses the proposed regulations for Long-Term Care nursing facilities. Specifically it addresses, from the viewpoint of a Certified Nursing Assistant, the proposal requiring only one nurse aide per 10 residents during the day and evening, one nurse aide per 15 residents overnight. If the state is serious about ensuring each resident four hours of nursing attention each cay, this would require five, not ten, nursing assistants per day and afternoon/evening shifts.

If the pandemic has served any purpose, it's highlighted the disastrous consequences of substandard staffing levels. Often in workshops and zoom meetings I listen to respected leaders from the LTC world discount the importance of increased staffing, soft-pedaling the urgency of this crisis. To me this seems incomprehensible. I can only guess that they may not know the situation in a concrete way. I write as a former CNA to illuminate what a CNA's work-shift time constraints are and strengthen the argument for increased staffing.

Aides work an 8-hour shift which includes, in Pennsylvania, a mandatory one-half hour meal break. (In some facilities employees are also permitted a second 15-minute break.) The first and last ten or so minutes of a shift are spent getting and giving shift updates to the previous or next shift of aides. Thus each aide has about 7.25 hours left for care tasks. Assume that an aide may need a bathroom break or two during a shift and maybe a few moments for a calming 'time-out,' for a helpful conversation with another aide or a supervisor, for an urgent phone call from home. Factor in time spent walking from one room to another, one task to another, one resident to another. An aide might have 420 minutes, to dedicate directly to resident care.

An aide will ordinarily be responsible for the care of six to ten residents on a shift which has plus or minus 420 minutes of available work time. (Would you believe the number of residents might be higher?) If we do the math, we see that aides may have 42 to 70 minutes for each resident on each shift. Over two shifts, this is a total of 85 to 140 minutes to help an elderly, frail resident with toileting, washing (on certain days showering), grooming, dressing and undressing, moving to the dining room, eating, returning to the day room, using the toilet during the day. If a resident has even a moderate degree of cognitive impairment, this has an added impact on the time an aide will need for each step of care-giving.* We expect —and CMS requires— that aides do all these tasks in a person-centered way.

These tasks mentioned are just the essential ADLs. We also expect aides to engage with residents to give them 'moments of joy,' in the words of one dementia-care author. Other tasks aides are responsible for during a shift:

- for safety purposes, keeping alert to where each resident is;
  distributing drinks to ensure hydration;
- serving snacks;
- checking toileting needs and assisting residents with this as needed;
- repositioning immobile residents every two hours;
- helping with transfers of wheelchair-bound residents (from bed to wheelchair, wheelchair to lounge chair, lounge chair to wheelchair, wheelchair to toilet and back several times in a day, wheelchair to bed);
- helping with transfers of residents who though ambulatory are unsteady or weak;
- helping other aides with two-person-assist transfers;
- responding to resident questions throughout the shift ("When can I eat?" "When will my son be here?" "I'm cold, where is my jacket?" "What time is it?" "Don't I have a doctor's appointment today?" "Where is my mother?");
- accompanying residents to other areas of the building as needed for medical care, hairdressing appointments, other events;
- engaging with residents through conversation;
- in between ADLs, assisting the Activities Staff with projects;
- throughout the day there are spills to clean up, phones to answer, paperwork to be done, visitors' questions to be answered;

- in some communities aides are also responsible for making beds, doing laundry and putting it away. refilling supplies of towels and toiletries.

How much time, pray tell, is left for hand-washing and infection control?

If an aide comes to work with a bad back, or sore knees, or is pregnant, these things will mean she has a lower energy level or slower response time. When an aide is tired from working a second job, or a double shift, this will slow him down. If an aide should call out at the last minute and the shift is short- staffed, this further impacts care. All these factors take a toll on resident care and on aides' job satisfaction and physical and emotional well-being. Even if seventy minutes of care per resident per shift were sufficient—and really, it's not—at the current staffing levels in most LTC homes, residents don't get even this. I challenge administrators to refute this with data. Is it really acceptable to pare staff levels so thin that we impair not only the quality of care but the safety of residents and aides alike? Is it acceptable that the owners of long-term care homes sustain their organizations by controlling their costs with sub-par staffing levels (and, *ahem*, substandard wages)?

Owners of LTC homes will say, "We don't need more staff, we need better training; our CNAs need to work smarter." Yes, we do need to look at aides' training, especially related to dementia care. (Aides are often well-trained; they jut don't have the time to put that training into practice.) But tell me how all this will change the fact that over two work shifts a resident may, on a good day under ideal conditions, receive two hours of personal-care or skilled-care assistance. (A resident who may be paying $4,000 to $12,000 or more a month for care.) Owners will also claim there is no money for more staff. Before we accept this claim we should demand disclosure of the income, assets and expenses of LTC homes. Financial transparency is a part of culture change whose time, alas, has not yet come.

Costs notwithstanding, can those setting care standards justify the substandard staffing they've tolerated, thanks to lobbying efforts of the long-term care industry? Would we entrust our dog to a kennel that gives our pet only seventy minutes of attention a day? Long-term-care homes care for the people we love. Tell me please, how can we who care about residents continue to close our eyes to staffing imperatives? How can we sit still and stay quiet about this appalling reality one minute longer?

*Cognitive acuity of long-term-care home residents must play a much greater role in determining resident needs and staffing levels.

The Impact of Dementia on Residents' Needs, CNA Workload, and Staffing

How are staffing needs in healthcare settings determined? In hospitals, to plan patient care administrators use a Patient Classification System. This is a method for determining how serious the patient's medical condition is, what level of nursing care the patient needs, and how many nurses must be on duty to ensure that patients get the care they need. The severity of a patient's medical condition and needs is referred to as acuity. When our loved elders become too frail to remain at home, we move them not to a hospital but to a long-term-care home. Still, residents of these homes are there because of declining health. They need care. Perhaps not the kind of care that calls for medical specialists and hi- tech equipment to be on hand. But they do need attention paid to their declining physical and cognitive health. Long-term-care homes use census as the basis for staffing. Acuity doesn't have the same imperative in these homes that it does in hospitals. It should. It must. My hope is that thisc omment will help persuade all who are concerned about the quality of life of those living and working in long-term care homes to advocate for staffing based on the cognitive acuity of residents.

The list below gives a picture of what the care challenges are in long-term-care homes when residents show symptoms of memory loss or other cognitive problems. (According to the CDC, this is nearly half the residents of nursing homes. The Alzheimer's Association has put this at two-thirds.) The ramifications of these symptoms for aides' workloads should be evident. These symptoms and their impact on workload serve as a rationale for using residents' cognitive acuity, rather than census alone, as the basis for staffing in long-term care homes.

One reason legislators don't pay more attention to staffing levels might be that they don't appreciate, in a visceral way, the symptoms of progressive dementia and how these symptoms affect aides' workload. Do administrators really comprehend what an aide's work day is like? Do state regulators realize how much time it takes just to assist with ADLs when a person shows symptoms of dementia? Or are they 'cognitively impaired' when it comes to understanding a workload impacted by cognitive loss. For example: CNAs are expected to encourage persons with dementia to function at their highest level, to do as much for themselves as the can and want to do. But a resident living with dementia who wants to dress herself might take twenty minutes to do this, needing an aide nearby to cue or assist as required. A Cognitive Acuity Assessment tool could, I believe, help administrators, families and legislators understand staffing needs in a concrete way.

A Cognitive Acuity Assessment tool is a descriptive list of the symptoms of dementia. This list isn't meant to be a

discouraging forecast for those who, thanks to the support they have, may not show severe symptoms. The better the care a person has, the more a person diagnosed with dementia can retain functionality, with fewer and less severe behavioral symptoms. But insofar as persons do experience serious consequences of dementia, those who regulate care homes need to appreciate residents' needs, and staff accordingly. Below is what I think this tool might look like. If you are an aide working in a memory-care community, or a home care aide, or someone caring for a family member at home, these symptoms are familiar to you. They are your constant companions. I'm not sure they're as familiar to those who set long-term care staffing standards. If they were, we would have better staffing. These symptoms create behavioral challenges aides must and want to respond to effectively and compassionately, so our residents will feel secure, content, at home.

Those living with dementia may not exhibit every symptom mentioned; frequency and severity may vary greatly among persons and even in an individual from day to day or over months. these symptoms are present at all, they have a substantial impact a CNA's workload.

1. Independent in ADLs but needs extended time to toilet, wash, dress and groom, eat.
2. Needs verbal or visual cues for washing, dressing, eating, toileting, grooming.
3. Needs assistance to complete the above tasks.
4. May have impaired hearing.
5. May have impaired vision.
6. May have gait or balance problems.
7. Uses cane, walker or wheelchair.
8. Forgets to use cane or walker.
9. Is at risk for falls. Has fallen numerous times.
10. One-person assist. Can't stand unaided for toileting, grooming, transferring.
11. Two-person assist. Cannot support self standing, cannot assist in transfers.
12. Difficulty using or comprehending speech.
13. Is losing words, including recall of names.
14. No longer uses words. Doesn't respond to words.
15. Has difficulty communicating needs and emotional states either verbally or by gestures.
16. Has significant short-term memory loss.
17. Asks for absent or long-dead family members.
18. Is repetitive in asking questions or expressing wishes.
19. Is incontinent, unaware of toileting needs.
20. Handles feces.
21. Becomes easily agitated, may yell.
22. Is argumentative.
23. Loses 'filters.' May use uncharacteristic profanity or insults.
24. May undress in public.
25. Is impatient when it's necessary to wait.
26. Can become physically combative.
27. Paces, wanders.
28. Attempts elopement.
29. Has sleep problems, insomnia.
30. Rummages (through drawers, etc.).
31. "Shops," i.e. takes things belonging to others.
32. Hoards or hides food, other possessions.
33. May crave food after eating a meal, denies having eaten.
34. Unable to follow multi-step instructions.
35. Can become 'stuck' in repetitive behavior.
36. Has difficulty initiating, sequencing or ceasing actions.
37. Has difficulty way-finding.
38. Has poor sense of time.
39. Sundowns.
40. Recognizes changes in cognitive abilities yet denies any change.
41. No longer initiates conversation.
42. Unable to participate in games, crafts.
43. No longer comprehends what he//she reads.
44. Cannot participate in physical exercises.
45. Resists socializing, is more withdrawn.
46. Is subject to depression.
47. Is prone to anxiety.

48. Is subject to manic episodes.
49. Has delusions or hallucinations.
50. Seeks sexual or intimate physical contact with others against their wishes.

As dementia progresses in an individual and in the long-term care community, the amount of time a CNA needs to spend with residents increases. The number of CNAs needed on a shift increases accordingly.

As a former CNA I beg you: please ensure that long-term care communities will have the staffing they need to ensure the well-being of residents and staff alike. If the state is serious about ensuring each resident four hours of nursing attention per day, this calls for five, not ten, nursing assistants during the 7am to 11pm shifts.

(submitted by Donna K. Woodward, Havertown PA, former CNA)