Submission No 125

INQUIRY INTO REGISTERED NURSES IN NEW SOUTH WALES NURSING HOMES

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Legislative Council Inquiry into Registered Nurses in New South Wales Nursing Homes

Submission by Dr Yvonne McMaster FRACGP

I write as a retired palliative specialist who has forty years experience of working with dying people in New South Wales. Since retirement, as a volunteer, I have run a weekly support group for patients with advanced cancer. I am now a full time advocate for improvements in access to palliative care in Australia. This information and my recommendations are the result of my experience in palliative care and from input from a large number of stakeholders throughout New South Wales.

23 July 2015

Submission enquiries:

Dr Yvonne McMaster

(a) Population changes and aged care

Enormous changes have taken place in health care over the past fifty years. Now, with the ageing population and chronic disease on the rise, more than one third of Australia's population lives the last part of their lives in an aged care facility[1]. However 16% - 32% of these people actually die in an acute hospital.

Great efforts are rightly being made to assist the elderly to remain in their own homes as long as possible. However this means that by the time that people are admitted to aged care facilities most are very frail and needing a great deal more professional help and support, both medical and nursing.

(b) Changes in the way palliative care units are administered

The residents of aged care facilities are not only the frail elderly. At this time, palliative care units have ceased to be "Homes of Peace" for the dying, and have become "acute palliative care units", reserved for the management of complex symptoms. Now, any patient in a palliative care unit, who does not have complex symptoms needing specialist palliative care, and does not die quickly enough, is now transferred to an aged care facility as soon as possible.

Frequently the family is told within a week or two of the patient being admitted to a palliative care unit that their relief at having their loved one in such a place of blessed peace, where people understand and care and where the care is meticulous yet loving, is about to disappear. This means another transfer to a strange place for a patient and family who are already wrestling with the imminent shattering of the family unit through the death of a loved one. New faces and new ways must be learned and tolerated at this sensitive time. I personally abhor this practice. If this sort of treatment were meted out to people at a time when they were more able to resist there would be banner headlines denouncing it.

But the most serious objection to this unfeeling practice is that the care in nursing homes is so very much more basic than what is offered in palliative care units.

It is bad enough to be sent to a facility with a registered nurse on duty 24/7, where registered nurses are usually stretched to the limit and supported by other staff of variable ability, understanding and training, but without a registered nurse 24/7 there will be no access to "as required" (PRN) medication, no skilled assessment and no appropriate treatment.

What can care staff do except call 000 and send the patient to Emergency?

It is not at all unusual for patients to be transferred from palliative care units to aged care facilities on regular morphine, or other opioids administered either by mouth or by syringe driver. The management of schedule 8 drugs such as morphine cannot be legally left to untrained staff. This results in pain and distress and, usually, transfer to an acute hospital. If there is an unexpected change in the patient's condition, an increase in pain or breathlessness,

or any of the myriad symptoms which can occur as people approach the end of life, there is nothing which an untrained person can do except to transfer the patient to hospital.

(c) Access to medical expertise in aged care facilities

The access which people in nursing homes have to their general practitioner is very much less than they were able to enjoy in their own homes. Although GPs rarely make home visits, people living in the community can readily access their GP through a surgery visit. Most GPs only visit aged care facilities once a month. Compare this with daily visits by specialist doctors in palliative care units.

At this time there is no state-wide provision of specialist palliative physicians to visit aged care facilities. In some areas there are visits by specialist palliative care nurses, and where they are available, these visits are greatly valued but these visits are also not on a regular basis and only when requested by the facility management.

(d) Costs to the NSW Government from withdrawal of registered nurses in RACFs

My colleague, Dr Anthony Ireland and I and presented The Business Case for Palliative Care[2] to Mike Baird, as Treasurer on 20 February 2013. It reviewed, among other things, deaths in hospital using data provided by the entre for Epidemiology and Evidence NSW Health Ministry for 2009-10. It showed that between 16% and 32% of deaths of RACF residents occurred in hospitals. It also showed that 13% of hospital deaths for patients aged 65 years and over are of patients transferred from aged care facilities. Transfer to hospital will occur much more frequently when only untrained care staff are responsible for patients in aged care facilities.

NSW Health has shown that the average terminal admission to hospital is 10 days[3].

10 days at $1000 a day = $10,000.

(e) Conclusion and recommendations

If the NSW requirement to have registered nurses 24/7 in aged care facilities is removed the greatly increased amount of suffering by patients and distress of relatives can't be measured, but the cost to the NSW Government certainly can. There will be a much greater burden placed on the acute hospitals to sort out the issues which could and should be handled in the patient's "own home" (i.e. the nursing home).

I recommend that NSW Health be asked to investigate these possible costs, in the light of what I have said above about the greatly increased need which will arise for aged care facilities to use the services of emergency departments and acute hospitals before any decision to change the rules is made.

If anything, there should be many more registered nurses employed in aged care facilities and

all palliative care services should have the capacity for specialist palliative care doctors and nurses to visit facilities on a regular basis.

References

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Palliative Care in New South Wales
Business Case

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15 February 2013

FOUR POTENTIAL COST BENEFITS FROM ENHANCED PALLIATIVE CARE

BENEFIT 1:

Reduced terminal hospital admissions through increased community-based palliative care services. Will address unmet need and increase proportion of deaths at home. Estimate **3,860** fewer terminal admissions to hospital. Current PC service provides estimated 16,000 registrations with 24% home deaths. Enhanced PC service would provide 22,000 registrations with minimum of 35% home deaths.

Saving: 3,860 admissions @ average cost of $14,700 = **$56.7M**

BENEFIT 2:

Provision of palliative nursing and medical support to residential aged care facilities (RACF) to optimise terminal care in place. Currently between 16% and 32% (2,680 to 5,360) deaths of RACF residents occur in hospitals. Optimised PC service can achieve a two-thirds reduction. Estimate two-thirds reduction in transfers to hospitals being **1,790** fewer terminal admissions. [12]

Saving: 1,790 admissions @ average cost $14,700 = **$26.3M**

BENEFIT 3:

Optimised palliative care service can reduce pre-terminal hospital usage, currently estimated at 224,000 bed-days in last 90 days of life.[13] With enhanced PC, the 22,000 PC patients average 2 days, & the 25,400 non-PC patients average 5.6 days [13 (Box 1, derived)], totalling 186,240 bed-days. Thus Palliative Care support could reduce pre-terminal hospitalisations by **37,760** bed-days (i.e. 224,000 - 186,240), rounded here to 37,500.

Saving: 37,500 bed-days @ average cost $1,040 = **$39.0M**

BENEFIT 4:

Enhanced palliative care in acute hospital units will result in reduced acute care episodes and increased palliative care episodes. We estimate **2,570** transfers of cancer and non-cancer patients from acute care to lower cost palliative care units. (PC for cancer deaths in acute care would increase from the current 33% to 50% and PC for non-cancer deaths from the current 8% to 20%.)

Saving: 2,570 episodes @ average cost differential $6,300 = **$16.2M**

TOTAL POTENTIAL SAVINGS per annum (in 2010 dollars) = **$138.2M**

PLACE OF DEATH IN NSW: COMPARATIVE 2009-10

In NSW a higher proportion of people die in hospitals and a lower proportion potentially die "at home" (i.e. in neither hospital nor aged care) than in other parts of Australia. This difference (14.4 per cent vs 20.6 per cent is highly significant, P<0.0001)

Table I: PLACE OF DEATH 2009-10

DEATHS	NSW	%	Rest of Australia	%	AUST	%
TOTAL [1]	47,400	-	94,720	-	142,120	-
HOSPITAL [2,3]	26,140	55.1	46,890	49.5	73,030	51.4
AGED CARE [4,5 #]	14,470	30.5	28,320	29.9	42,790	30.1
ELSEWHERE	6,790	14.4*	19,510	20.6*	26,300	18.5

* Difference is highly significant P< 0.0001

Reported numbers for aged care adjusted for double counting (13% of hospital deaths aged 65+ have also been counted in aged care [5]).

The relatively low "ceiling" of 14.4 per cent for deaths which may occur at home, is presumptive evidence for less-than-optimal resources to support end-of-life care in community settings.

SUPPORTING CALCULATIONS

BENEFIT 1:
Terminal hospital admissions reduced by enhancing community-based palliative care services

a. Calculation of *Optimal* palliative care *caseload*

- Current estimate of annual PC registrations is 16,000 [7]
- Approximately 78 per cent of which have cancer (n = 12,000).
- Total annual cancer deaths = 14,100 [1] ; not all will accept or need palliative care, hence only limited unmet need for cancer patient *registrations.* However the low home death rate for cancer patients in NSW will be improved by enhancing community palliative care services.
- Non-cancer registrations currently < 3,500- 4,000 per year
- Deaths from *non-cancer, non-acute* disease in NSW = 25,000 [10]
- Palliative care can benefit 35-40 % (8,750-10,000) of these [14]
- Calculated unmet need in range of 5,250 to 7,000 *(say 6,000) registrations per year*, raising the potential PC service registrations to 22,000 , as shown in the penultimate paragraph of the next item (b).

b. Calculation of *Potential* number of *home deaths*

- Some Palliative Care services within NSW currently achieve 24 per cent home deaths [6,9]
- Metropolitan Adelaide describes 30 per cent home deaths in 2012 with planned increase to 50 per cent in 2016 [8]
- Palliative Care Outcomes Collaborative reports Australian home death rates of up to 53 per cent for 2011-12 [9]
- Target value of 35 per cent applied in calculation.

Thus, whilst the *current* position is 16,000 palliative care registrations with 24 per cent home deaths (i.e. 3,840 home deaths), the proposed *enhanced* position would be 22,000 PC registrations with 35 per cent home deaths (i.e. 7,700 home deaths).

Thus there would be 3,860 *additional* home deaths (i.e. 7,700 less 3,840) and the same number fewer hospital deaths. This figure of 3,860 fewer hospital deaths has been used in the calculations for Benefit 1 on page 2.

c. Calculation of costs for terminal hospital admissions 2009-10

(i) Length of stay (LOS) for terminal episode, acute care = 10 days [3]

(ii) LOS for terminal episode, palliative care = 12 days [3]

(iii) Additional LOS continuous with terminal episode = 5 days [16]

(iv) Cost per bed-day, acute care = $1,260 [12]

(v) Cost per bed-day, palliative = $ 840 [12]

Thus,

(vi) Mean cost for end-of-life hospital admission, acute = $18,900
- calculated by multiplying (iv) by [(i) + (iii)]

(vii) Mean cost for end-of-life hospital admission, palliative = $12,600
- calculated by multiplying (v) by 15 days

(viii) Average cost with 25% palliative admissions [6] = $17,300

(ix) Potential cost savings to reflect 85% occupancy rate = $14,700

Explanatory Notes:
- Value of $14,700 (item ix) used in Benefit 1 and Benefit 2
- Value of $18,900 (item vi) - $12,600 (item vii) = $6,300 used in Benefit 4

BENEFIT 2:
Terminal hospital admissions reduced by providing palliative nursing and medical 'in-reach' to residential aged care facilities (RACF)

a. Current estimate is that 13 per cent of hospital deaths for patients aged 65 years and over are from RACF [5] (i.e. 13% x 20,400) = 2,680

b. Enhanced palliative care reduces this by two-thirds [14] i.e it prevents 1790 such admissions (see calculations for Benefit 2 on page 2).

BENEFIT 3:
Optimising Palliative Care service can reduce pre-terminal hospital usage

Study of hospital and health costs in NSW in 2004 identified average 13.0 days in hospital in *last 90 days of life* for each deceased person. [11]

Extrapolating this 13.0-day figure to 47,400 deaths in 2009-10 gives 616,000 bed-days in the *last 90 days of life* (i.e.13.0 x 47,400).

The 'Place of Death' table on page 3 identifies 26,140 deaths in hospital with an average hospital stay of 15 days (see previous entry under Benefit 1 c, i.e 10 + 5 = 15 days) = 392,000 bed-days *for the terminal episode*.

Thus the "pre-terminal" bed-days in the last 90 days of life total **224,000** bed days (calculated as the difference between 616,000 and 392,000).

Currently, 16,000 *palliative* patients are known to have reduced pre-terminal hospital use. Data from Western Australia suggests the average pre-terminal stay (in the last 90 days of life) for patients receiving optimal palliative care is < 3 days. [15]

If the current 16,000 *palliative* patients each use an average of 3 pre-terminal days in hospital, together they spend a total of **48,000** such days in hospital. By subtracting this figure from the 224,000 derived above we arrive at a total of **176,000** pre-terminal bed days for the 31,400 *non-palliative* patients (47,400 total deaths minus the 16,000 palliative deaths). Thus the average pre-terminal admission for *non-palliative* patients is **5.6 days** (176,000 divided by 31,400).

In the enhanced palliative care model, the 22,000 *palliative* patients will use an average of 2 days in hospital with their total pre-terminal usage being **44,000** bed-days.

Use by the 25,400 *non-palliative* patients (i.e. 47,400 total deaths minus the 22,000 deaths in patients receiving palliative care) is 25,400 x 5.6 days = **142,240** bed-days.

Thus, under the enhanced palliative care model, the total pre-terminal hospital bed-days will be 44,000 (palliative) + 142,240 (non-palliative) = **186,240** bed-days.

Thus, enhancing palliative care will save **37,760** bed-days of pre-terminal hospitalisations, calculated as follows: 224,000 (currently, see above) minus 186,240 (after enhancing palliative care).

This 37,760 figure has been rounded down to 37,500 in the calculation on the summary page for Benefit 3 (see page 2).

We have calculated the actual figure saved under Benefit 3 is $45,696,000 which translates into $1,218.56 per bed-day saved. However, since the service description of the non-palliative bed-days saved is unknown, we have used 85% of the latter figure, namely $1,040 per bed-day saved (see page 2).

BENEFIT 4:

Changes in care type by enhancing palliative care access to terminal patients in acute hospital units reduces terminal episode costs through reduced use of intensive care, diagnostics, medical and surgical procedures and pharmaceuticals. [13]

a. Current:

Palliative care for cancer deaths	= 1,589 / 4,754	(= 33.4%)
Palliative care for non-cancer deaths	= 1,064 / 14,189	(= 7.5%)
Total palliative care episodes	= **2,653**.[3]	

b. Estimated from enhanced palliative care:

Cancer deaths = 50 per cent x 4,754	= 2,377
Non-cancer = 20 per cent x 14,189	= 2,838
Total palliative care episodes	= **5,215**

c. Additional palliative care

	Episodes with enhanced palliative care	=	5,215
Less,	Episodes with current Palliative care	=	2,653
Thus,	Additional palliative care episodes	=	**2,562**

d. Palliative episodes have a $6,300 cost reduction
(as shown in calculations for Benefit 1).

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