

Submission
No 137

**INQUIRY INTO REGISTERED NURSES IN NEW SOUTH
WALES NURSING HOMES**

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Partially Confidential

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The Director GPSC3
Inquiry into RNs in Nursing Homes
Parliament House
Macquarie St
Sydney

Attention: Teresa McMichael

Thank you for the opportunity to provide a brief submission to the inquiry into registered nurses in NSW nursing homes.

My name is Dr Con Costa and I work in general practice and as a family GP in the inner west of Sydney for over 30 years. Up until last year I also provided care for patients at the aged peoples home in _____ and I was responsible for the care of up to half of the 32 residents, many of whom were high care patients and some aged in their 80's and 90's.

At the outset let me state my position and my proposals:

1. Medical care for nursing home residents is sub optimal and currently rests essentially on the shoulders of experience and ability of the registered nurse ie deficient GP/ doctor involvement is widespread and systematic and, beneath the veneer, comparable to a “where there is no doctor” scenario in Third world countries.
2. There is widespread dumping of resident medical care on the ambulance service, ED and public hospitals – the default” system.
3. Patient care needs are deficient and will only worsen catastrophically if numbers/ ratio of registered nurses are reduced or removed.
4. The system of medical care needs to be reformed urgently and based around a resident GP (with residents being able to opt out if they have their own GP willing to provide a comprehensive service) , registered nurse and visits from specialist consultants (in person or via video conferencing facility located in larger facilities).

5. The system lacks transparency - and this is a problem for carers, residents and public health system. We need to start collecting meaningful/ reliable statistics on the patients arriving from nursing homes to the ED, properly stratified for risk, and that these be available to carers, ambulance service and public hospitals/ ED administrators - to make system more transparent and allow for better feedback and assistance to residential aged care facilities - as well as cost restitution from owners of nursing homes where dumping of care on the public system is occurring

Narrative

In my experience as a treating GP, the standard of care required and the level of monitoring of those patients is very high and as a local GP I would not consider doing such work without the assistance of registered nurses. The registered nurse is fundamental to GPs being able to provide informed primary care to these residents.

Dr Lyndal Newton of the Australian & New Zealand Society for Geriatric Medicine has put it very well ie “registered nurses are integral in providing skilled, clinical care to nursing home residents with complex, high level needs. This includes assessing and managing changes in condition, providing pain relief, palliation, minimising discomfort or distress, and preventing unnecessary hospital admissions. The roles of a registered nurse and director of nursing in nursing homes with high-care residents are vital to the NSW health system.”

From the primary care/ GP perspective, this includes responsibility for monitoring blood pressures and blood sugar levels of those with ischemic heart disease, hypertension and Diabetes, giving injections, handing out medications and, importantly, screening the frequent and regular day to day symptomatic presentations of these frail and very complicated patients.

It is not an over exaggeration to say that without the registered nurses the system of care for residential aged care facilities would become chaotic, dangerous, inconvenient and very expensive.

My submission is that the standard of Primary Care currently available to most residents in aged care is woefully inadequate under the current fee for service system (see below). The registered nurses role is thus of even increased importance – and any reduction in the presence and the role of the registered nurse would be catastrophic for residential aged care ie the-straw-that-breaks-the-camel’s-back scenario.

GPs and nursing home care – current state of play.

Those relatively few GPs that make house visits to residential aged care, usually schedule only monthly visits. However they may receive tens of calls per week from the aged care homes. These calls need to be from an informed and experienced nurse – otherwise the GP has little option but to visit the facility on each and every occasion, or at least advise the staff to call an ambulance. This is dangerous, inconvenient for the frail elderly and very expensive for the ambulance and hospital systems. Those few GPs involved in residential aged care often drop out as a result.

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Without on site trained nursing staff together with on-call or resident GPs to manage this high demand, the ambulance and the public hospital become the default solution. It is essentially “dumping” of health services for residential aged care, on the ambulance and public hospital system. GPs will attend for these acute episodes, but only if they feel the call is medically warranted and the patients symptoms have been screened by qualified staff.

Naturally if the registered nurse convinces (and supports) the GP to attend the resident it is much better. There is continuity of care, care is not fragmented and it is low cost to the patient and the health system – a GP visit is \$35 approx, whereas an ambulance call out is probably 3 or 4 hundred dollars and the ED visit \$300+ and, if the patient is admitted, it runs into thousands of dollars a day at a tertiary facility. Thus, providing total care for high care patients within the residential aged care facility is not “optional”. It is essential if we are to provide a humane and affordable service to these residents. And this is only manageable if there are registered nurses on a 24 hour basis within the facility.

Residential Aged Care including High care - State of Play:

Few GP's provide house calls: the number of GPs providing house calls dropped to 1/10 of previous numbers between 1990 through to 2000. After hours Locum GP services are usually very experienced in palliative or aged care.

Residential aged care:

- Most are women, majority >80 years, many widowed
- 170,000 in residential aged care as of 30 June 2011, almost all on permanent basis
- 2,760 facilities:

The facilities are becoming bigger - 45% have more than 60 resident places.

Many are high care/ highly dependant, multiple co-morbidities on multiple medications and the population is aging.

My impression is of only a skeleton medical service to many facilities at present ie - doctor attends to write up prescription medication charts once a month with in between care often via ambulance to public ED. The reality is that it is difficult for facilities to get a non salaried resident GP to visit the facility during day for acute episodes. Private GPs could attend during their lunch break at the Medical centre or after work but this is unusual/ far from guaranteed and the walk ins at the Medical Centre will always get priority. Usually staff default to simply calling an ambulance – especially the case for after hour and the first I would hear about it was when they receive the hospital notification that the patient has been admitted.

It cannot be overemphasised that the vital person in the current scenario, often unsupported or under supported medically, is the registered nurse ie often the case that only the registered nurse stands between appropriate timely intervention or simply calling the ambulance. This is on a 24 hour basis but especially at night when the doctor, in my experience, is rarely disturbed. The more inexperienced the nursing staff the more ambulances are called and the higher the cost to residents and the public hospital system.

Pattern of Illness in high care patients

High and constant risk of iatrogenesis – “medicines making the patient sick”.

High care residents inevitably have:

Multiple pathologies including heart disease, high blood pressure, Diabetes, chronic pain, arthritis, depression, dementia etc and often multiple co-morbidities. They are on multiple pharmacotherapy including multiple anti-hypertensives, hypoglycemics, statins, anti-depressants, dementia medications, diuretics, digoxin, heart medications etc - usually a minimum of 5 or 6 different medications in combination. These medications are often toxic individually requiring regular monitoring especially in patients with poor liver and renal function – but in combination can be even more toxic and unpredictable side effects, if not monitored carefully by experienced staff in the aged care facility- especially as most of these patients have poor kidney and liver function.

As above, my experience is that most GP's do not provide community care outside of their Medical Centres – ie do not provide house calls or care to those in residential aged care units, including for high care or palliative care patients (those in residential aged care actively dying from heart failure end stage disease, cancer or frailty of old age).

As above, the few GP's who do provide this service may limit their care to "monthly" visits to the nursing home "to write up the patients drug sheets" – which is the minimum requirement by law? The few GP's currently providing a primary care service to the nursing homes are thus very dependant of the nursing staff in the aged care facility keeping them well informed and assisting them in the care of the residents including when the doctor visits the facility - especially high care residents. The registered nurse is the "eyes and ears" of the GP, including notifying the GP when the resident is unwell or requires an intervention.

Elderly residents including the high care patients are very brittle and their health can change from day to day including need to regularly tailor and adjust their treatment and their kidney and liver function, blood sugar control and electrolytes etc.

Australians deserve better care in old age – especially for those in residential aged care but also for those who elect to stay in the family home.

1. Registered nurses are vital to the current system. The registered nurse is currently all that often stands between life and death of the frail elderly resident – especially after hours. The registered nurse is all that stands between early compassionate and appropriate intervention at the primary care level versus inadequate early response leading to residents being transferred either 1. Unnecessarily at high expense and inconvenience to all involved OR 2. resident being transferred later and sicker and being admitted to a tertiary institution for prolonged periods when an early intervention could have avoided ambulance transfer in the first place. Do we leave all of this in the hands of untrained staff? Who pays and at what cost? Consider.
2. Care of those in residential aged care in Australia is rapidly approaching a “where there is No Doctor” scenario ie health care in the facility being dependant on residential aged care staff almost exclusively would make it comparable to health rationing in Third World countries - were it not for the registered nurses and back up by ambulance and tertiary institutions. The care is thus often, but not always, maintained, albeit dysfunctional and a very costly way to run a care system for residents and the public hospitals and the ambulance service.

3. The situation mirrors a poor state of community primary care outside of the Medical Centres – ie many Australians do not have a primary care GP, significant numbers of those dying at home have no GP or cannot access palliative care in the home - and end up dying in the ICU of a tertiary Public Hospital simply because of a lack of appropriate care at the community level (not ideal for patient or hospitals).

The way forward – “bight-sized” reforms to the system

1. We need more registered nurses in residential aged care and this must be on a 24 hour basis. Reducing registered nurses in residential aged care or in the community is a tremendous loss to humane and efficient, appropriate care but it is also a massive transfer of costs from the primary level and the residential aged care facility onto the public purse – our public hospitals and the public health system. Such costs would be unsustainable in the future and lead to the rationing of health care to the wider community ie user pays. 24 hour availability of registered nurse in residential aged care is not optional – it is a basic minimum in the current situation of inadequate and un reformed small business model of primary care ie based on private fee for service.
2. Any discussion of reforms to end stage care or end of life orders becomes a mockery if people are unable to obtain option of reasonable end of life or palliative care. Euthanasia law reform in such a situation is NOT progressive. The right to choose how to end ones life is seen as important in our society, but it becomes the right to institutionalised killing of the aged and the infirm in a situation where there is no reasonable access to an alternative. Discuss?

High care patients in residential aged care should be seen on the same level as in-patients within a hospital - albeit not needing the acute care or diagnostic work up. Just as with hospital patients they need a **specialist medical team** including 1. GP as diagnostician, 2. registered nurse for monitoring of care between doctor visits and to carry out the instructions of the medical officers, carry out the routine observations accurately, and to understand the significance of the results, liaise with the doctor regularly. 3. Specialist consultants/geriatrician to assist the GP for complex care management including through video conferencing available at the facility*.

Measuring the cost of inadequate residential aged Care

My submission is that any loss of the registered nurses in residential aged care including high care patients will make an already sub standard and rather ad hoc system of primary care in nursing homes even more chaotic and more substandard than at present - and put the lives of these high care patients at even higher risk than at present***.

Reducing or removing registered nurses in nursing homes particularly high care would be to degrade the health service to these patients even further. It would put thousands of lives at risk due to inadequate and non-timely response to their health needs: as well as the enormous problem in residential aged care of iatrogenesis due to the polypharmacy (see above) – which can easily occur without adequate monitoring and supervision by appropriately trained staff – medicines making the patient sick. (Ie many of the frail elderly on multiple medications which can prove toxic when taken alone but even more so in combination and a major cause for hospital admission in Australia – medicines making the patient sick are a major reason for hospitalisation but even more so in residential aged care.)

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Removal or reduction of registered nurses would not only inconvenience patients - resulting in need for hospitalisation for basic health care needs, it would also aggravate what is already - and all too often - a dangerous and improper way to provide health care to the residents. It is also a direct transfer of the health costs to the public hospital (and a significant minority also end up admitted to the hospital after coming to the ED via ambulances only because the resident cannot be sure it is safe to return them to the facility). It is a transferring and amplifying the health costs from cheap basic primary care at the nursing home level, to experience tertiary type care at the hospital level. (A GP visit is \$35 but a ED visit is upwards of \$300 - and much more if admitted) In my opinion the registered nurses are currently standing between these two options. We place lives at risk and costs will only skyrocket if we reduce the Registered nurses in aged care****.

My recommendation would be that the statistics of hospital ED attendance from residential aged care be a focus of review and public transparency (this would be useful for people seeking to place elderly relatives in nursing homes as well) and that this be costed. Administrators and hospital staff of public hospitals should engage in active liaison with nursing homes in their area to better support them and their residents and to estimate frequency of referrals to ED standardised by risk and the end up cost to the hospital service – and that legislators could then look at laws that allow public health system to recoup these costs from nursing home owners - particularly where inadequate practices or staffing ratios are resulting in substandard care and resident care need being inappropriately dumped on the public hospital.

I hope that the above proves useful to your Inquiry. For obvious reasons, and after many years of providing residential aged care, I felt unable to continue to provide such a service. I did so reluctantly as I always felt that the residential aged care residents were the sickest and most needy patients in my practice and in the community, (only one step below hospital in patient residents in terms of their care needs). I also realised that this would then mean that the only other doctor available would have to take on all of the residents ie become the sole GP to over 50 residents, many of them high care. As a society, we ignore these needs at our peril, but also because we will all be old and sick one day.

I would be available to attend before the Inquiry if required - although currently overseas I will be back in Australia from beginning of September.

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Yours Sincerely,

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22/07/2015

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MAA Trained Assessor of Permanent Impairment
Certified Independent Medical Examiner (ABIME)
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* Specialist care needs to be available in the aged care facility. It is very difficult for these patients to access specialists in their private rooms. It is also unfair and bad practice that the GP responsible for residential aged care including high care patients should in effect have no specialist backup due to access issues ie few specialists leave their consulting rooms or provide care in residential aged care facility other than the salaried geriatrician etc. (See reference to “where there is no doctor” and Third World health care above.)

** There should be salaried GPs in the larger residential facilities with the patients having the option to “opt in” - or opt out if they prefer their local GP to visit. My contention would be that most residents would prefer an in house GP on call 24 hours and visiting frequently, to a family GP who finds it difficult to attend regularly.

Alternatively there should be some expectation on those GPs accessing Medicare payments to take some responsibility for residential aged care eg take responsibility for half a dozen or so high care patients together with the registered nurse and specialist support. Further Cuts to Medicare - the four year freeze on the Medicare rebate - will see those few GPs currently providing nursing home care under further pressure or to opt out of bulk billing – and thus the high care patients even more dependant on the registered nurse for their primary care including screening for hospital transfer ie the hospitals even more dependant on the standard of the nursing care in residential aged facility to prevent them being swamped with the elderly complex patients from nursing homes.

***Further cuts to Medicare at the federal level - the four year freeze on the Medicare rebate - will see those few GPs currently providing nursing home care under further pressure or to opt out of bulk billing – and thus the high care patients even more dependant on the registered nurse for their primary care including screening for hospital transfer ie the hospitals even more dependant on the standard of the nursing care in residential aged facility to prevent them being swamped with the elderly complex patients from nursing homes.

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****The basis of low-cost affordable health care is based on prevention ie keep patient well/stable at residential aged care level. My submission is that increasingly scarcity of registered nurses would be paralleled by further voluntary exit from residential aged care by GPs and increase in the cost to the public hospitals as the high care patients seek more of their care at the ambulance/ ED level. This is not only inconvenient for the patient, it is also bad care. It is fragmenting care as the GP knows the patient and can manage them quicker and better because they have a long contact and an accumulated medical record. On the other hand contact with elderly or high care patients for the hospital resident is a nightmare scenario – ie having to assess and manage a new complex elderly patient who then ends up being admitted for “further tests”.