

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

Name: Dr Arthur Chesterfield-Evans

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Dr Arthur Chesterfield-Evans M.B.,B.S., F.R.C.S.(Eng.), M.Appl.Sci., M.Pol.Econ.

Submission to Inquiry into Registered Nurses in Nursing Homes

My name is Arthur Chesterfield-Evans and I am currently working in occupational medicine with some general practice. I have had a lot of experience as a GP and after hours doctor visiting nursing homes, though this is not recent. More recently I have been involved as a relative of people in nursing homes and in ED receiving patients from nursing homes. I also have experience in political systems and working in bureaucracies, both Sydney Water and the Dept of Veteran Affairs, in addition to time as an MLC in NSW. I have studied political economy and see public policy both in practical and in a political and economic context.

As a general observation, the health system is not very cost efficient. This is because urgent problems generally take precedence over important ones, which means that cure generally takes precedence over prevention. Prevention is far more cost-effective than cure. Even within the hospital system, intensive care activities tend to take resources from more routine treatments that are more cost-effective. This trend is accentuated by the fact that intensive care medicine is more intellectually challenging to doctors professionally and often more lucrative both to them and to the makers of equipment and support services. Added to this, a failure in an acute situation is more noticed than a failure of preventive strategies and more likely to generate adverse media coverage or legal action. Thus strong action is needed to keep the medical system active in prevention and early intervention to counter this tendency.

The health system is bedevilled also by cost-shifting. This is between Federal and State administrations, but also between the private and public systems. There are many examples of this. State hospitals stopped running clinics where doctors saw patients at a cheaper individual cost, so they went to doctors rooms, which was paid for either by Federal Medicare, the patient or private health insurance. This was a State to Federal cost shift.

As the Federal government makes the Medicare rebate fall against inflation, patients increasing present to Emergency Departments, a shift from the Federal to the State budget. In both these cases above the total cost of the system is increased.

In my experience the Workers Compensation and Motor Vehicle accident insurers deny perfectly legitimate claims and refuse to pay them, shifting the treatments costs to Medicare or the public hospital system, a private to public transfer of costs. (As workers compensation treatment is so expensive, this does not increase total medical costs, but as 'so many doctors are unwilling to do such injury cases because of the legal hassles later the patients re often left stranded and unable to get needed care). This situation is beyond the terms of reference of this Inquiry, but I mention it to alert the Committee members to another example of the effects of this cost-shifting on patient welfare, and the willingness of the private sector to push their costs to the public sector. The idea that the private sector can be left alone to manage their affairs with minimal government intervention is naïve in the extreme. A firm regulatory framework with inspections and enforcement is necessary and desirable especially when the power relationship of the providers and 'consumers' are as different as they are in

the Nursing home sector. .

In Nursing homes there has already been a cost shift from the Federal government to the States. The fall in the Medicare rebate for Nursing Home visits means that GPs often do not go in, or go in infrequently or irregularly. Any serious discussion of whether RNs should be removed should be based on real data of how people in Nursing Homes are monitored medically, how often and by whom. In general it is an axiom of good management that every problem should be dealt with as early as possible, and generally this means that someone very low in the hierarchy of control. If this is not done a problem will become larger and be dealt with later by someone higher up the management chain and take up more time and money. It seems to me that the main driver of the push to get RNs out of nursing home owners who find them expensive and would like people to believe that the RNs are not necessary. Basically RNs find problems earlier than GPs do, so are more cost-effective than GPs. If problems are not discovered in health, they usually get worse. E.g. Minor infections that could be treated by a simple antibiotic progress to pneumonia. It needs to be recognised that many patients are on multiple drug regimes and these are probably not reviewed often enough. Incorrect medications are always a problem and having good staff and protocols are a very important control of iatrogenic diseases. ('Iatrogenic disease' is a polite way of saying disease caused by problems with the treatments).

In short the absence of trained staff in nursing homes leads to treatment errors, a lack of enforcement of good practices such as bedsores prevention and patients become sicker before their problems are recognised. They then go by emergency ambulance to ED at a hugely greater cost than would have been necessary had the problem either been prevented or recognised earlier. The difference is that the costs of the late diagnosis and the ED are borne by someone other than the Nursing Home proprietor. It is a cost-shift. Needless to say, the patient is worse off. It cannot be stressed enough that patients in nursing homes are very vulnerable. Their entire environment is under the control of others and dependant on the competence and goodwill of those who care for them. If they are physically or intellectually impaired, which a considerable proportion are, as they would not go in there otherwise, they may have no advocates, and if the staff cannot recognise problems they are even worse off.

My experience is that the standard of care in nursing homes is generally not high, and they need if anything more rather than less quality control. There needs to be a study of what is offered and what is delivered in the Nursing Home sector and it says a lot that the terms of reference of this inquiry are about whether a significant bastion of trained staff likely to ensure quality can be removed, with no apparent need to look at the larger issue of whether care is adequate or not. Quality of care can be examined, quantified and monitored in a systematic scientific manner, and this should be done by bureaucratic regulation as a matter of course. The results of such monitoring should be available to committees such as this as a matter of course before any attempt to remove what are likely to be sustaining expert service elements in the system.

There is an increased tendency for Management to flatten hierarchies and to rely on protocols to achieve management aims. It is assumed that if there is a good protocol and it is enforced, that less intelligent input into a process is required. In practice, this means that middle management can be dispensed with, people at the bottom can follow the protocol, so all will be well. In practice such a protocol is not much use if there is no way of checking if it is being implemented. In health, it is not much use having a protocol to observe adverse health changes early or to find medication errors if the staff have no training in actually doing either.

In practice, people's health status changes and the changes are subtle. Medicine is both an art and a science. It has sound scientific evidence for many of its phenomenon and treatments and trying to improve this, but there is an art in observing the small changes that indicate disease progression.

My view is the attempt to remove RNs from Nursing homes is a cost saving measure for nursing home owners, that will merely shift the costs to others systems, in particular the State health system, and that it will lower the standard of care of very vulnerable people. As such it is not a good idea and the Committee should reject it.

Another aspect that needs to be mentioned are advanced directives, generally referred to as 'living wills'. My mother had one of these, the staff had been informed and all aspects of the power of attorney had been exhaustively discussed and agreed upon. The directive and other papers were in the patient's folder. She had an episode where she was expected to die but rallied for a few days and deteriorated again. She was about to be evacuated by ambulance and it took considerable effort by my sister, herself an RN of considerable and recognised standing and expertise, to prevent the loading onto the ambulance. She attended at the scene and still had trouble even when she pointed out the patient's wishes and the presence of the directive in the patient's file. There is a societal disinclination to have a sensible discussion about death and dying and added to fear of law suits leads to protocols being followed in terms of the maximising of end-stage treatments that merely prolong unsatisfactory situations. This needs to be addressed.

In short I wish to make 2 points:

1. That taking RNs out of nursing homes is a bad idea for patient care and represents a cost-shifting from nursing home owners to the State health care system, which is a bad idea for the State health system. (The lack of funding for GP or alternative medical services checking patients in nursing homes is another serious problem and cost-shift, but this is beyond the terms of reference of this inquiry).
2. That advance directive and procedures to implement patients expressed wishes regarding their treatments and death be investigated and improved.

Sincerely

Arthur Chesterfield-Evans