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Private nursing home care: the middle way

The place of private nursing homes in the care of elderly patients is rousing both emotion and political prejudice. A recent television documentary alleged neglect and even criminal abuse in some nursing homes in Kent.[1] Conversely, a report commissioned for the Registered Nursing Home Association claims that government parsimony and regional variations in interpreting guidelines for nursing homes have caused financial hardship, bankruptcy, and two deaths among the proprietors of residential homes.[2]

The issue was made all the more contentious in 1983, when funds were made available to provide patients on low incomes with a supplementary benefit to pay for care in either residential or nursing homes.[3] Since then private nursing home places in Britain have expanded rapidly, with figures ranging from 34·2 for every 100 000 of the total population in Scotland to 220·2 for every 100 000 in the south east Thames region.[2 4] In England 53 000 old people are in National Health Service geriatric beds but another 28 000 are in private nursing homes.[5] Proponents of the expansion in private institutional care emphasise that it takes pressure off a hard pressed health service.[6] A flourishing private sector also provides patients and relatives with more choice. Critics of the system, however, are concerned about the difficulty of ensuring standards of care.[5]

Current arrangements for monitoring by health authorities are concerned primarily with accommodation or staffing rather than the quality of life. There are no arrangements for the medical assessment of patients before admission, so that people who might survive in the community with rehabilitation and help may be wrongly consigned to long term care.[7] Physically disabled but alert people are likely to be placed with those suffering from severe dementia. Furthermore, the money spent providing supplementary benefit for patients in the private sector might be better spent in expanding the resources for old people within health and local authority services.[8] Conversely, another possibility is that homes can provide less expensive care only by cutting staff levels, equipment, and catering to a minimum acceptable standard.

One response to these difficulties would be to stop providing supplementary benefit for elderly patients to stay in private institutions. But even if there was the political will to do this it would be difficult to dismantle the system without causing great hardship to current patients and proprietors.

If this is not done steps must be taken to assess better the quality of care in nursing homes. The most effective way of doing this might be to look at failures such as the prevalence of patients with pressure areas or under physical restraint.[5] Uniformity of standards for assessing buildings, equipment, and staff would also be useful and these should be equivalent to those in health service units. One approach would be to use a national inspectorate to evaluate local assessment teams.[5] Training staff in both administration and in nursing care of the elderly would also be important.[2] There is also concern about the gap between the cost of implementing the recommendations of health authority reviewers and the social security allowances available to patients.[2] This will have to be closed if high standards are to be maintained.

Medical evaluation of patients before admission to nursing homes would be essential, and a questionnaire might be used to score dependency.[2] This is, however, a blunt instrument that might wrongly categorise people and which would be unlikely to identify patients in need of further assessment or rehabilitation. A better system would be to use geriatricians to make a more detailed evaluation.[9] This has already been used successfully in evaluating clients for admission to local authority residential homes.[10]

Whatever the future of private nursing homes, there must be good communication and coordination with health authorities. Reports from abroad graphically illustrate the dangers of uncoordinated expansion of the private sector[11 12]—not only do many elderly patients experience a low standard of care but also it increases costs.

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Testing time for side room tests

Some side room tests have evolved rapidly in the past few years, and they probably have a bright future.[1] Often their use is mandatory—for instance, in the domiciliary management of diabetes. Yet when a room is used for side room tests it is effectively transformed into a laboratory—so basic microbiological safety principles must be observed. Too often they are not observed, and staff handle specimens of urine, faeces, or blood without following the elementary principles of microbiological practice.

Dipstick tests may produce useful results with urine or blood, but the specimens should not be handled on general work surfaces or discarded into washhand basins that are in general use. Otherwise, the hands and clothing of the staff may be contaminated or contamination of working surfaces may result in transmission to case notes and folders taken directly into the ward or the consulting room. Side room tests should be done in a properly organised room equipped to meet basic safety requirements and by staff who recognise the importance of not transmitting infective agents by hand, contaminated clothing, and other direct or indirect routes. Semmelweiss made the points in 1847, and they were reiterated with reference to infectious diseases units in 1984.[2]

Side room tests should be performed with care and attention to detail and with materials of known reliability backed up by assured quality control; and the results should be interpreted by a trained person. A new or modified test should be resisted until its validity has been proved, and any accepted test should be done strictly according to written instructions. A good case could be made for licensing clinical test kits to provide assurance of quality and consistent reliability (and this does not apply only to side room test kits).

I am not advocating a closed shop. Many such tests are done reliably by doctors, nurses, and paraclinical staff who are not primarily laboratory workers, but many of my clinical colleagues agree with me that side room work merits upgrading and a periodic review of standards. The risks of unreliability or carelessness or uninformed interpretation should be reassessed.

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Editorial freedom: a modest proposal to Dublin

Outsiders who interfere in the internal affairs of others risk rebuke for their presumption and for exacerbating difficulties. Yet many friends of Ireland will be unhappy that the recent unanimous vote by the Irish Medical Organisation to relaunch its journal does not restore the status quo: the publication is to be quarterly rather than monthly and the post of editor has been advertised rather than filled by the previous one, Dr Eoin O'Brien.[1] The latter decision can only add to the rumours that the true reason for closure last December—in the journal's jubilee year—was not its financial difficulties but to dismiss the editor,[2] who in a signed editorial had deplored a recent strike by junior doctors.[3]

In the September issue of the *Irish Medical Journal* O'Brien argued that unilateral industrial action by any group was unacceptable. Should not the profession consider renouncing the right to strike in return for a guarantee of prompt and fair negotiation? A month later, at the annual meeting of the IMO during the treasurer's report, a motion was passed to close the journal because it was losing money; not only was this meeting poorly attended but no notice of the motion had been given and the editor (who is not a member of the IMO but was appointed to his post by invitation) was not present. Significantly, also, at this financial meeting there was strong criticism of the editorial: "Speaker after speaker questioned Dr O'Brien's right to use an IMO publication to express views which were opposed to IMO policy."[4] And in his final editorial O'Brien pointed to ways in which the journal could have been restored to profit.[5]

O'Brien made it clear that he was willing to publish letters opposing his views on the strike, and the last issue of the journal contained two such letters. It also contained 15 letters deploring the closure of the journal, many of them coming from the most prestigious names in Irish medicine. These two sets of correspondence illustrate two of the reasons why medical organisations need independent journals. Firstly, a journal will be a useful forum for debate only if the editor is free to publish all shades of opinion—and politicians more than anybody need to know the mood of their constituents. Secondly, if a medical organisation wants its journal to have international standing and the support of the wider medical community within its own country it must give its editor independence. Nobody wants to publish in a medical journal that is a constrained parish magazine.

Most important medical journals in the world are linked to organisations, and tension inevitably arises when the journal and the organisation take a different view of a sensitive subject. Yet in addition to their committees organisations need editors who will carry out the remit of Bagehot's constitutional monarch—to consult, counsel, and warn. The erosion of the editor's freedom will threaten not only the journal but also the organisation itself and the political health of the wider community. Editors and the press have a duty to raise unpopular issues and say what nobody wants to hear.