

The new meaning of “residential care”

There was a time when residential care served as a place where elders with disability received basic, low-intensity medical and nursing care. Physicians did not need to visit more than once a month, as the patients were stable and change didn't occur overnight. However, this is no longer the case in British Columbia.

According to BC Vital Statistics, between 2000 and 2004 the number of deaths in residential care increased from 21.9% to 28.2% while the number of deaths that occurred in hospital decreased from 61.5% to 53.6% and the number of home deaths remained stable. These figures show it is clear that residential care has become essentially the new hospice for British Columbians.

Today we are living longer and experiencing more disability-free years of life. In 1986, 137 British Columbians died at an age greater than 100. By 2004 this number rose to 236. The fastest-growing segment of our population is now the over-100 age group.

However, when an elder suffers from chronic illness it reduces his or her functioning and causes a multitude of diseases that require management. When the burden of chronic illness begins to reduce day-to-day function of the individual, it usually means that he or she is coping with several chronic illnesses. Sixty-five percent of Canadians over age 65 have two or more chronic medical conditions, and 25% have four or more medical conditions. One of the more common medical conditions—cognitive impairment—is seen in 8% to 10% of people over age 65 and 35% to 40% of people over age 85.

Symptoms of cognitive impairment are hard to assess and can manifest in behavioral changes that are completely unrelated. For example,

chronic pain can manifest as agitation, worsening cognitive impairment, calling out, aggression toward staff, or withdrawal—all of which could equally be attributed to dementia. Controlling these symptoms and improving the quality of life for these elders takes a team approach and takes time.

When cognitive impairment limits the ability to live independently, residential care is often the only option, resulting in facilities with very high rates of cognitive impairment.

Many residential care facilities have adopted the Eden philosophy of care that aims to eliminate the loneliness, helplessness, and boredom that plague residents. It aims to create communities where people can live full and meaningful lives. It is a call to our society to resist warehousing elders who can no longer perform in a way that society associates with worthiness. Achieving this will take change over time in our processes of care, but it is essential that we continue to value these members of society by endeavoring to provide them with good quality of physical, psychosocial, and spiritual life.

Common causes of deaths in residents include advanced organ failure such as CHF, CVA, COPD, neurodegenerative conditions, and ESRD. These conditions follow a course of prolonged decline punctuated with episodes of severe exacerbations of illness—or, from the patient's point of view, near-death experiences. The final exacerbation leading to death is unpredictable. With unpredictable dying patterns, the complexity of the medical care, and the need for care of the whole person, including the living environment, it seems logical that a palliative approach to residential care would work well. Thus, rather than identifying a resident as “palliative,”

we apply a palliative approach to everyone in the facility from the time they move in until they die.

A palliative approach uses a symptom-based approach to care rather than a disease approach to care. Most residents will have multiple chronic conditions (i.e., diabetes with CHF, ESRD, and CVA) for which guidelines exist for the individual disease rather than multiple co-morbidities. We may not be sure of what disease is causing what symptom. Thus our measure of a good outcome in patient care would be whether we controlled the symptom as opposed to whether we were able to keep blood glucose and cholesterol below a defined level. This doesn't mean we cease to use diagnostic services but that we balance the benefit vs burden before we order them. This means understanding the life goals of our patients and families in addition to understanding their medical conditions. The need for care of the body, mind, and spirit is nowhere more evident than in residential care, where people are trying to find enjoyment, comfort, and meaning in the midst of declining function, cognitive impairment, and complex medical conditions.

This is not simple care. To provide quality care requires knowledge and skills in chronic disease management, palliative care, geriatrics, and psychiatry, as well as working as a member of a team. It is well suited to family physicians who enjoy the challenges of a puzzle without benefit of the whole picture. More physicians are needed to provide this quality of care and they should be paid fairly for what they do and recognized for the complex and diligent medical care they provide.

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