Caring for older people:

is home care always best?

"At present the mantra seems to be that everyone should be looked after at home, although this is often socially and economically challenging".

In 2007, the famous Swiss actress Lilo Pulver (well-known for the Billy Wilder film *One, Two, Three*) decided to move into a residential home in Bern. At this time, she was neither disabled nor dependent on care, but rather wanted to share her memories and fears with other ageing people. Her decision could be seen as a significant starting point for a broader debate about how we would like to live in old age.

At present the mantra seems to be that everyone should be looked after at home, although this is often socially and economically challenging. However, is the situation in a care home always worse than at home?

Interestingly, Eisele and colleagues in this issue of the *BJGP* show that certain patient groups might profit from moving into an institution.[1] Likewise, Penders and colleagues point out that residents of care homes in the Netherlands actually receive better palliative care from GPs than patients living at home.[2] In addition, they found that people in their home environment face a higher risk of hospitalisation or transfers to other care institutions than older people in care homes.

Such dislocations usually have a negative effect on the quality of life of older people. The question is, therefore, whether living in a home environment is always an advantage for older people and often for patients with multimorbidity with a need for a considerable amount of care.

In order to address this topic, we should look more closely at the group of people who enter nursing or residential homes today, the needs of future residential or nursing home residents, and the GPs' contribution in this context.

WHO ENTERS CARE HOMES TODAY?

The wish to remain independent and autonomous for as long as possible, better health care, a longer disability-free life expectancy, as well as better outpatient care lead to the fact that people enter care institutions later, older, and sicker than before. Mortality statistics in Switzerland show us that, although 30 years ago about 15% of all deaths in Switzerland took place in a care home, it is now more than 50% among those aged ≥75 years. Looking at the population aged >90 years, this figure increases to 75%. This is the case even though three-quarters of the Swiss population want to die at home,[3] and the quality of care delivery in nursing and residential homes has been criticised for years.

Nowadays, slight changes in institutionalised care are taking place. The journal *The Gerontologist* published a supplement last year entitled 'Transforming nursing home culture: evidence for practice and policy'. In it, the authors discussed the aim of improving care quality by de-institutionalising the nursing home culture and focusing on person-centred care. This intended transformation from a conventional nursing home environment into more resident-centred homes with long-term care facilities should take place by changing the physical environment, values, norms, and supporting organisational structure.[4]

WHAT ARE THE NEEDS OF TODAY'S RESIDENTS IN NURSING OR RESIDENTIAL HOMES?

Bradshaw and colleagues point out that the quality of life of residents in a care home depends greatly on accepting the actual living circumstances, together with maximum preservation of independence, the possibility for residents to make their own decisions, the connectedness with others, respect of privacy from care personnel, a home-like environment, and competent care by a preferably consistent group of carers.[5] Additionally, we know that residents of care homes are willing (though this is often disregarded) to talk about end-of-life issues. Unfortunately, this type of conversation does not take place very often.[6]

WHAT CAN GPs CONTRIBUTE IN THIS CONTEXT?

First, GPs often know patients and their needs for many years. Based on research results and their own experience, they should be able to identify patients who could benefit from a stay in a care home and those for whom home care is best.

Minney and colleagues described frail, older, but not cognitively limited patients, who prefer residential care in old age over living in their home environment.[7] However, Nikmat and colleagues show that people with cognitive impairment perceive a better quality of life as long as they can stay in their home environment.[8] Hence, diligent judgement is needed.

Second, dying in an institution usually has negative connotations. It is typically associated with loneliness, isolation, and helplessness in dealing with death and dying. Dying at home, in contrast, is considered positive for reasons such as the proximity of relatives, a familiar environment, and the possibility of better medical control. This is also the point where the role of the GP becomes more important. It has been shown that the more a GP is involved in end-of-life care, the more likely a patient will die in their preferred place[9] and avoid unnecessary hospital transitions.[10]

Hence, it is part of a GP's role to discuss advance care planning with care home residents in good time, to find out if they would accept another hospitalisation if necessary, to learn about their preferred place of death, and to prepare an

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advance directive.[11] For that, GPs require communicative expertise: they need to be skilled in exploring the patient's wishes regarding their end of life; in dealing with disproportionate interventions; and in dealing with wishes to die.[12]

Third, because responsibilities and roles in end-of-life care are often unclear, the quality of care in nursing homes is still particularly dissatisfying. This becomes especially obvious in advanced care planning. Handley and colleagues outlined that, even if care personnel are willing to provide end-of-life care and to help and support residents who will die in a care home, this is complicated due to a lack of roles and responsibilities.[13] Care home personnel and primary care staff have difficulties coordinating their work, and doubt their capacity to work together when residents' trajectories to death are not clear.[13] Here, it is the task of GPs to take a leading role and promote coordination in the caregiver network in order to make the situation for their patients as comfortable as possible.

In the future, the need for care for older people will increase, in both in- and outpatient care. The generation of future care-dependants will look back at an individualised life and patient history, and have high expectations concerning professional care. Integrated care models will provide smoother transitions from care in a home environment to a care home setting.

Those people should receive excellent individualised care according to their needs with their pathways not being defined by institutional deficiencies. It is here where GPs will have to take a crucial part of the responsibility.

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REFERENCES

1. Eisele M, Kaduszkiewicz H, König H-H, *et al.* Determinants of health-related quality of life in older primary care patients: results of the longitudinal observational AgeCoDe study. *Br J Gen Pract* 2015; DOI: 10.3399/bjgp15X687337.
2. Penders YWH, Van den Block L, Donker GA, *et al.* Comparison of end-of-life care for older people living at home and in residential homes: a mortality follow-back study among GPs in the Netherlands. *Br J Gen Pract* 2015; DOI: 10.3399/bjgp15X687349.
3. Vodoz V. *Palliative care 2009.* A study commissioned by the Federal Office of Public Health. GfK Custom Research, 2010. [In German].
4. Zimmerman S, Shier V, Saliba D. Transforming nursing home culture: evidence for practice and policy. *Gerontologist* 2014; **54(Suppl 1):** S1–S5.
5. Bradshaw SA, Playford ED, Riazi A. Living well in care homes: a systematic review of qualitative studies. *Age Ageing* 2012; **41(4):** 429–440.
6. Mathie E, Goodman C, Crang C, *et al.* An uncertain future: the unchanging views of care home residents about living and dying. *Palliat Med* 2012; **26(5):** 734–743.
7. Minney MJ, Hons BA, Ranzijn R. 'We had a beautiful home ... but I think I'm happier here': a good or better life in residential aged care. *Gerontologist* 2015; DOI: 10.1093/geront/gnu169.
8. Nikmat AW, Al-Mashoor SH, Hashim NA. Quality of life in people with cognitive impairment: nursing homes versus home care. *Int Psychogeriatr* 2015; **27(5):** 815–824.
9. Meeussen K, Van Den Block L, Bossuyt N, *et al.* GPs' awareness of patients' preference for place of death. *Br J Gen Pract* 2009; DOI: 10.3399/bjgp09X454124.
10. Barclay S, Froggatt K, Crang C, *et al.* Living in uncertain times: trajectories to death in residential care homes. *Br J Gen Pract* 2014; DOI: 10.3399/bjgp14X681397.
11. Fleming J, Zhao J, Farquhar M, *et al.* and Cambridge City Over-75s Cohort Study. Place of death for the 'oldest old': ≥85-year-olds in the CC75C population-based cohort. *Br J Gen Pract* 2010; **60(573):** 171–179.
12. Deschepper R, Vander Stichele R, Bernheim JL, *et al.* Communication on end-of-life decisions with patients wishing to die at home: the making of a guideline for GPs in Flanders, Belgium. *Br J Gen Pract* 2006; **56(522):** 14–19.
13. Handley M, Goodman C, Froggatt K, *et al.* Living and dying: responsibility for end-of-life care in care homes without on-site nursing provision — a prospective study. *Health Soc Care Community* 2014; **22(1):** 22–29.