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Exploring Front Line Ambulance Staff Perspectives of the Hospital Transfer Pathway

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Guidance from the National Institute for Health and Care Excellence in the UK was introduced in 2015 to improve the quality of the care pathway of transfers of care home residents to hospital when needed. The Red Bag scheme was developed by Sutton Clinical Commissioning Group in 2016 as a means of improving communication between organisations involved in the process by ensuring residents' notes and other personal belongings were easily identifiable and kept in one place. The Red Bag was implemented in the North East of England in 2018. The aim of this study was to understand the knowledge of and experiences of front line ambulance staff who had potential to be involved with the transfer of care home residents to hospital. A mixed methods approach was used for the study. Participants were recruited by two research paramedics working in the North East ambulance service and approached to take part in a confidential, on-line survey using Survey Monkey®. Data was analysed through descriptive statistics and a constant comparative analytic framework to develop into concepts found in the free text comments, which were constructed into themes. Two hundred and fifty eight participants were recruited to the study. Six themes were identified in the data that represented the knowledge and experiences of the participants. Findings showed there was variance in the implementation, interpretation and use of the Red Bag in practice. Where effective communication took place, handovers worked well, however perceived organisational processes and avoidable delays prevented the optimal transfer of care. Improved communication between organisations is recommended, along with building capacity and capability within and between professional disciplines working at the front line of patient care were identified as fundamental

mechanisms of streamlining handover processes for the vulnerable and older adults who live in residential care settings.

Keywords: care homes, care home residents, transfers of care, ambulance staff

Introduction

The global ageing population is a testament to the marked improvements in health and care, yet brings economic and social challenges that must be addressed through planning and resource allocation to ensure that older people are afforded optimal quality of life (Department of Health, 2013). Older people have a greater disposition to multiple, long-term conditions, and are likely to require the support of social care, e.g. assessment to determine if they need to move into residential care accommodation in order for their needs to be met. An older person's needs are more than simply medical, assessments should incorporate "psychological, emotional, social, personal, sexual, spiritual and cultural needs; sight, hearing and communication needs; and accommodation and environmental care needs" (National Institute for Health and Care Excellence, 2015a, p. 29).

Social care professionals take a relationship-based approach to the "planning and provision of care, protection, psychosocial support and advocacy in partnership with vulnerable individuals", such as older people, "who experience marginalisation, disadvantage or special needs", rooted in an ethos of social justice and human rights (Social Care Ireland, 2021, n.p.). For social care workers older people living in residential settings are an important population to be considered.

The demographic profile of older adults living in residential care home settings, coupled with natural ageing processes, means that at some stage, residents are likely to require hospital care (Gordon et al., 2014), irrespective of country or healthcare system. In Ireland, it is estimated that 6% of older people live in residential care; this is set to increase in future in line with global ageing trends (Health Information and Quality Authority, 2016).

Dementia is an increasing health concern for older people living in residential care so social care staff, in line with care planning, need to understand and act as an advocate to be able to inform others of non-verbal communication and behaviour of older people living with cognitive impairment, so residents can have their needs and wants articulated to ensure continuity of care and quality of life (Cameron et al., 2020)

Older people living in residential homes who are transferred to hospital may have complex care needs, which are well known to the staff of the home they live in. Ensuring this

information accompanies people when they are transferred to hospital is important to understand people's medical and social needs, e.g. medication dosages, communication issues, so optimal care can be provided whilst the person is in hospital.

In England, The National Institute for Health and Care Excellence (NICE) introduced guidance in 2015 on the transfer of patients with care needs between care homes and other community settings to hospital (National Institute for Health and Care Excellence, 2015b), in order to facilitate communication to improve the quality of the care pathway and experiences of residents requiring these services.

The Red Bag is a concept introduced by Sutton Clinical Commissioning Group in 2016 to improve the handover process between residential care homes and ambulance staff when a resident is transferred to hospital. The aim of the Red Bag is to improve mechanisms of communication between healthcare providers in paramedic practice, residential care home settings and secondary care home settings and also to minimise avoidable delays in the transfer of residents to hospital and back (Sutton Clinical Commissioning Group, 2017). The Red Bag is a means of ensuring important information about a care home resident's health that can be kept accessibly and consistently in one place, for ambulance and hospital healthcare staff. The Red Bag was initially designed to contain standardised information about the resident's past medical history, current health status and any pharmacological management regime they may live with. The Red Bag can be used to provide identification of patients as care home residents to staff working in front line ambulance and hospital settings, to contribute to the provision of person-centred care (Charmaz, 2006). For example, a female resident with cognitive impairment may not be able to articulate a preference for a female carer, which would likely be documented in care home notes, and would prove invaluable if the resident was transferred to hospital. Following discharge from hospital, ward staff would be expected to place the discharge summary and any other notes pertaining to that resident's care in the Red Bag, so that residential care home staff could provide a continuity of care, commensurate with that initiated in secondary care settings.

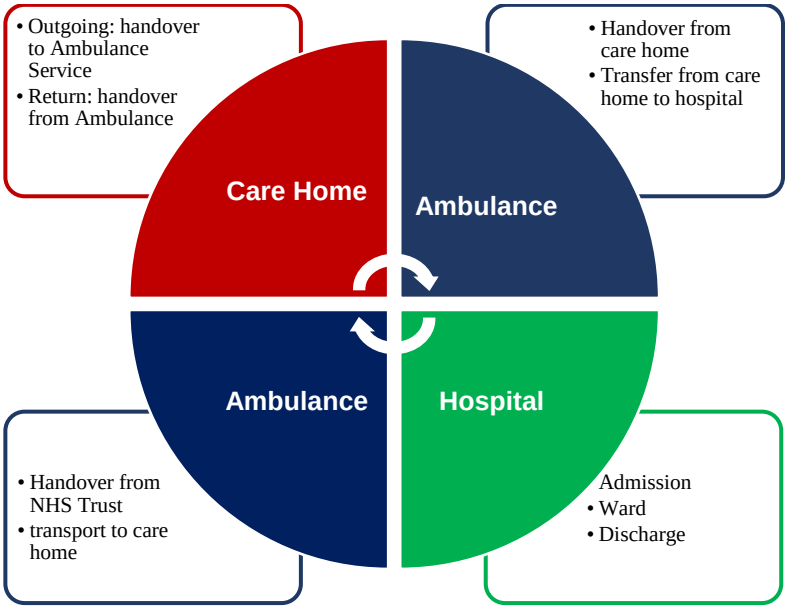
The Red Bag was formally adopted by NHS England and launched across localities in the North East and North Cumbria in early 2018. The process involved multi-agency collaboration across the care continuum, with NHS, local authorities and private care providers working within and between professional disciplines.

There is an acknowledged degree of variance in the size and type of Red Bag used in practice across some localities; some Red Bags are not in fact red. The original Sutton Red Bag was large, incorporating room for personal belongings, e.g. clothing, dentures, and

glasses, in addition to formal documentation and paperwork pertaining to medical history and pharmacology. NHS England produced a smaller size bag suitable for medical and other notes only, these smaller bags were widely distributed across the North East and North Cumbria.

The Hospital Transfer Pathway relies on communications between organisations during handover periods for increased effectiveness and efficiency of process (see Figure 1).

Figure 1: The Hospital Transfer Pathway: Key times for the initiation of communication and transfer of responsibility



Members of the ambulance service are involved at each of these key handover points, and illumination of their perspectives is crucial to understanding current practices of the Hospital Transfer Pathway including uptake and utilisation of the Red Bag.

Aim

The aim of this study was to explore the knowledge and experiences of paramedics with respect to transfers of care home residents to hospital in the North of England.

Methods

The study protocol was designed by the first and fifth author. The protocol was then pilot tested in collaboration with a representative population sample of front-line ambulance staff by two research paramedics. The pilot group were asked to comment on the protocol and study documentation. The feedback was incorporated into the final study design and survey

questions. Following ethical approvals, participants were purposively sampled and were all front-line ambulance staff employed by the North East Ambulance Service. Participants were all recruited by two research paramedics who were not participating in the study to minimise any bias, but acted as facilitators for data collection, raised awareness of the study and answered any questions which arose. The research paramedics were also familiar with the working patterns of front-line paramedic staff so potential participants could be approached in a manner that did not interfere with their working patterns. The pilot group had fed back they would prefer to be approached by a research paramedic than an outside researcher. To facilitate recruitment and maximise participation, the research paramedics visited all ambulance stations across the region and purposively sampled front line ambulance staff at the end of their shifts.

Front line staff were approached and provided with study information and were told that participation was both voluntary and anonymous. Staff who wished to take part in the study provided written consent to, then filled in an on-line survey via Survey Monkey® consisting of thirteen questions asking about their knowledge and experiences of their involvement in the transfer of care home residents to hospital. Data was collected on Ipads®, which were handed to participants after they had consented to take part. Participants completed the survey alone in a private location then returned the Ipad® to the research paramedics. The average time to complete the survey was 4.5 minutes. Basic anonymous demographics were collected, and other questions incorporated free text sections for participants to comment further, so a more comprehensive understanding of the participants' experiences could be gained. Owing to the shift patterns of participants and the recruitment method, it was not possible to accurately determine the number of staff who declined to take part. Participants were recruited across the Northern region between July and September 2019.

A mixed methods approach was used for the study. This allowed the individual experiences of front-line ambulance staff to be captured, and to assess the potential for transferability across similar situated contexts and settings and provided a means of testing the systematic generalisability of findings from across the localities studied. Quantitative methods were used to provide an insight into the metric evaluation of key operational issues in relation to implementing the Red Bag scheme in practice. For this study, constant comparative analysis was used to construct a systematic framework for the researchers to inductively generate abstract concepts from the data (Corbin & Strauss, 2008). Constant comparative analysis involves reading data and concurrently analysing; data is compared

with other data, by reading, re-reading and developing concepts, which are grouped together to become codes, then these are constructed into categories/themes which represent the participant experiences of the phenomenon under investigation Charmaz, 2014). The same authors led the analysis. This was done manually, each one constructing concepts which were discussed and served as active comparators, with a consensus reached for final set of themes, with in-vivo quotes used to illuminate and give context.

Ethical Approval

Ethical approval for the study was given by the Health Research Authority and the University of Sunderland Research Ethics Committee.

Participants

There were 256 participants recruited to the study, with 62% males (n=159), 37% females (n=96) and 5% (n=1) preferring not to say. This figure represented 36% of the total front-line ambulance staff workforce in the North East Ambulance Service (NEAS). The participants were recruited from 53 of the 60 stations across the region. The majority of the participants 85% (n=219) were employed full-time, 11% (n=29) part-time and 3% (n=9) were students or worked a set number of hours. There was a wide representation across ages of the participants, with nearly one third of the participants (32%, n=83) aged between 41-50 years (see Table 1).

Table 1: Participant Ages

Age	*No. of participants*
<20 years	0.5% (n=1)
21-30 years	21% (n=54)
31-40 years	23% (n=59)
41-50 years	32% (n=83)
51-60 years	20% (n=51)
>61 years	3% (n=8)
Skipped question	n=2

Findings

It is noted that participants used the terms 'resident' and 'patient' interchangeably, as the identity of the individual changes with the context of the healthcare setting, i.e. the term 'resident' refers to a care home setting and 'patient' refers to a secondary care (hospital) setting. Both terms refer to people living in residential care homes, irrespective of their location.

Over half the participants had worked for less than 10 years in service (53%n= 134) and just under half of the participants (47%, n=122) had worked for NEAS for over 10 years. When asked how often they had been involved with the transfer of a care home resident to hospital, participants responded as follows (see Table 2):

Table 2: Frequency of involvement with transfer of residents to hospital

Frequency	*No of participants*
More than 10 times per week	9% n=24
3-4 times per week	35% (n=91)
1-2 times per week	27% (n=71)
3-4 times per month	21%, n=54
1-2 times per month	7%, n=18
Less than once per week	5 % n=12
Not involved	1 %, n=2

Participants were asked to comment on the process of transferring residents' notes, medications, and personal items to hospital (see Table 3). There was variance in practice, with many participants reporting more than one method used.

Table 3: Reported current practices in the transfer of residents' note, medications, and personal items from care homes to hospital

Method of transfer	*Response*
Loose notes	40% (n=95)
Plastic or paper envelopes	31% (n=79)
Red Bag	23% (n=60)
Plastic carrier bag	9% (n=24)
Residents' personal bag	4% (n=10)
Skipped question	5% (n=1)
Invalid response	6% (n=15)

> Normally staff place notes into a plastic wallet or stapled together or if available, into the red care folder, medications are given via a MARS chart and personal belongings hastily gathered into a plastic bag or personal bag.
>
> Generally, in a file compiled by the care home on an individual care home basis, more recently the red bag scheme has become more frequently used by care homes.

Participants were asked if they were aware of the principles of the Hospital Transfer Pathway for care home residents; 42% (109) stated they were not aware, 37% (96) said they were aware of the pathway, 19% (49) said they didn't know, and 1% (2) reported little knowledge. Nearly all participants (89%, n= 228) were aware of the NHS England Red Bag Scheme, 9% (24) were not aware, and 1% (4) were not sure. In terms of seeing the Red Bag in practice, there was variance in response from the participants (see Table 4), with over a third of the participants seeing the Red Bag in practice 1-2 times per month.

Table 4: Participant-reported frequency of observing use of the Red Bag in practice

Observing in practice	*Response*
1-2 times per week	22% (n=52)
3-4 times per week	9% (n=21)
1-2 times per month	34% (n=81)
3-4 time per month	10% (n=24)
Other	25% (n=60)
Never	(n=23)
Rarely	(n=13)
Once	(n=24)

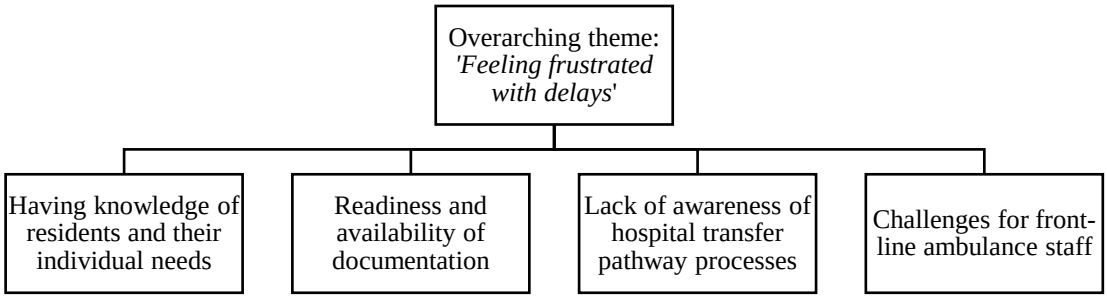
Participants were then asked two open questions: 1) their thoughts on areas of the hospital transfer pathway which were working well (248 responses, eight skipped the question) and 2) their thoughts on aspects on areas of the hospital transfer pathway which were not working well (254 responses, 2 skipped the question). The free text was independently analysed by two researchers who constructed codes that were compared and discussed, with a consensus of themes agreed by the research team. These are presented next.

Themes

There was an overarching theme of 'Feeling frustrated with delays in transfers of care' which are set within the context of two survey question around aspects of transfers of care which worked well and not so well (see Figure 2). It was noted that the most frequent response to this question had to do with issues around waiting, with 120 participants mentioning this in their comments, for example:

> I find great inconsistency in care home handover sometimes vague information from nurses or care staff, lack of knowledge about care needs or past medical history. At times there are adequate handovers as to patient details. Generally, medications do not travel with patients and a MARS [medication administration record sheet] chart is usually provided.

Figure 2: Identified themes



Theme 1: Having knowledge of residents and their individual needs

Participants reported that the transfer of residents was facilitated when staff in the care home knew the resident personally, and were aware of the individual needs of that person:

> If a staff member is familiar with the resident and has a relationship with them.

> When carers who know the patient travel with them to hospital.

> When the staff are aware of the patient and their meds and the paperwork is up to date.

Theme 2: Readiness and availability of documentation

In homes where the Red Bag had been implemented, participants were positive about its use and impact on the transfer of residents:

> Red Bag works well, as all of patient notes, prescriptions, and items to be taken to hospital

> I have seen the Red Bag system being used, which had all the patients' personal and medical information in the bag, which was explained by staff and signed by both staff and crew

> When notes are compiled accurately and kept together including patients' personal information

> When there is a detailed document containing past medical history, medications, allergies, and information about mobility sent with patient, it makes things much easier

Theme 3: Lack of awareness of hospital transfer pathway processes

> [There is] missing paperwork or delays accessing paperwork on-line

> For emergency calls it can often take time for staff to prepare notes, if these were ready in advance the system would be more efficient

> It usually takes time to get patient history, Notes are often spread throughout the care home and paper notes are usually loose piece of paper that are easily mislaid

> Waiting around for information to be photocopied

Theme 4: Challenges for front-line ambulance staff

> Waiting for staff to come with the patient. Not having staff available to come with patients. Always waiting for notes to be photocopied. Some staff do not always know each patient, so you have to wait, sometimes considerably long, to get the right staff for the right information. Also, staff always seem not to have the information handed over from one shift to the next.

> Copying notes and information when you get on scene. Offices being locked so staff can't copy information. Staff members not knowing the patient and then having to collect their personal items.

> Staff trying to find documentation or attempting to speak with a member of staff who witnessed the event.

> When new or agency staff are unable to find paperwork, or do not know where anything else can be found.

Discussion

This study highlighted the perspectives of the front-line ambulance service staff involved in the transfer of care of residents of care homes to hospital in the North of England. There is variance in practice, including communication and use of the red bag in care homes. It was evident that care home staff knowledge of residents, along with detailed and completed paperwork, greatly facilitated the transfer process. Acknowledged delays were attributed to paperwork not being in order or readily available, staff unable to provide information or

accompany residents to hospital and operational issues in care homes. This is the first study to specifically examine the front-line ambulance staffs' experiences in the Hospital Transfer Pathway with many participants.

The communication issues between care home and front-line ambulance staff highlighted in this study are similar to those reported in other studies. The findings of an unpublished review by NHS Institute for Innovation and the Social Care Institute in 2012 found that organisations working together to support care home residents had no common aims, noted lack of communications in sharing both paperwork and other information, a lack of trust and respect, and low levels of understanding roles and responsibilities (Cowley & Ward, 2012).. An evaluation of the Hospital Transfer Pathway in London found similar communication issues and delays in transfers across care home, hospital and paramedic staff (Health Innovation Network South London, 2019), but only 27 paramedics were surveyed for their evaluation, whereas this study had 256.

A German study exploring 18 paramedics' experiences of transfers from nursing homes to hospital reported complexity of issues when transferring residents to hospital including structural (understaffing, lack of physicians) necessitating the call out of emergency paramedic intervention. Handovers of residents were reported as overall poorly organised owing to required information such as medication lists, directives etc were not prepared, with some transfers suggested to be avoidable, such as urinary catheter complications, falls and infections. The study also found that standards of emergency care in residential homes could be improved, along with standards of training and improvement in working conditions may lessen the need for a resident to be transferred (Pulst et al., 2020).

Additionally, the nature of paramedic practice means early response, timely care and avoidance of unnecessary delays as priority, and 'tolerating ambulance handover delays is tolerating significant risk of harm to patients' (NHS Improvement, 2017), this study highlights the frustrations that regional front line ambulance staff experience when there are delays in the Hospital Transfer Pathway.

Many of these findings are similar to a study showing that front line ambulance staff have been called out to care homes to provide care in the absence of on-site nursing and incidents such as falls with care home residents (Robbins et al., 2013; Scott-Thomas et al., 2017). This is often avoidable, and this appears to be a source of contention with front line ambulance staff. In the context of this study, the avoidable issues which occur when dealing with care homes are also a source of frustration.

There is an acknowledged lack of research in care homes (NHS Scotland, 2021), and further studies exploring the social care contribution to care are recommended given the high numbers of older people living in care homes.

Both care home and the ambulance service staff need to have a greater understanding of organisational priorities and each other's' roles in the Hospital Transfer Pathway, including how and why delays occur and how collaboration and communication can be improved.

The findings of the study are limited to the experiences of the participants working within the North East Ambulance Service and may not be reflective of other front-line ambulance staff working in other Ambulance Services in the UK. The study was carried out at a specific time point and captures the practice and experiences which were happening then. The study looked at the experiences of front line ambulance staff liaising with care home staff, who are viewing the care home environment with a specific, external lens based on professional practice, and their views are an interpretation of the situation under investigation and do not necessarily represent the experiences of other health and social care professionals involved in transfers of care. A further limitation is that care home staff were not surveyed, which may have provided a furthermore holistic context to the front-line ambulance staff perspectives.

It is recommended that there are meetings between key staff in ambulance services and different care home providers to identify and discuss issues relating to care, and work collaboratively to establish mutually beneficial processes, and that these processes are piloted and evaluated and are reviewed on a regular basis. The notion of collaborative multi-agency working raises important issues of the need for both capability and capacity building for the safe and personalised care of residents requiring hospital treatment. Belying either is the need for a reciprocally increased knowledge of the professional contributions that all health and social care workers make in their contributions to authentic and compassionate patient centred care. The need for strong and effective communication when transferring older people living in residential care who require treatment in hospital is paramount to ensure safe and personalised care, irrespective of healthcare system or country.

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