‘9 Considerations before 999… Falls in Residential Care Home Settings and their Implications to Paramedic Practice’

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Abstract:
Our original research highlighted the need for standardisation of policies and procedures in relation to falls of those living under the care of the independent care sector (Scott-Thomas et al, 2017). We revealed a disparate set of approaches evident in the contexts of residential care, across a specific geographical region, which were largely determined by locally devised and implemented policies. Often these approaches prioritised legalistic and bureaucratic concerns over informed processes of clinical decision making. Our study also highlighted the potential fiscal impact on emergency ambulance services in instances where it was commonplace for contacting emergency services to be the first line response to a patient falling to the floor regardless of whether an injury had occurred. This article seeks to build on this research by raising issues of professional practice for both residential care home managers and their counterparts in paramedic practice. Building interprofessional capacity is of key significance to professional practice and authentic approaches to truly patient centred care. By raising awareness of the impact to paramedic emergency services of first line responses to falls by staff who work in independent residential care homes it is hoped that closer professional liaison between these two professional groups will be advocated across local and regional practice. This awareness raising also has important implications for the training and education of both paramedic and residential care home staff. The article also serves as a means for residential care home managers to reflect on their own locally implemented policies and practices in instances where patient assessments of possible injury and harm are commonplace due to the vulnerability and immobility of their residents. This has important implications for the education of independent care sector workers and the strategic planning of emergency ambulance services. Whilst generic frameworks are available, further consideration of the whether falls policies are suited for purpose is urgently required. ere we present nine key areas for consideration before calling 999.

Keywords:
Interprofessional Capacity Building |Falls |Paramedic Practice |Residential Care Homes| Falls Policies |Education & Training

Anonymised Article

Introduction

Our recent research into the operationalisation of policy in response to falls in South Tyneside North East England revealed the behavioural norms of staff in the independent care sector (Scott-Thomas et al, 2017). In some instances, this practice formed an integral part of independent care sector policy around what residential care home staff are expected to do in the instance of patients falling to the ground and being unable to remobilise. In many cases the reason for requesting emergency ambulances was attributed either due to instances of minor injury, which could be best treated in the context of basic first aid in the home, in primary care settings or even helping patients to maneuver into a position of being able to effectively and safely remobilise themselves.

Evidence from practice reveals that the disproportionate use of emergency ambulance services in relation to falls of patients in the UK independent care sector is at an unprecedented high level (Jennings and Matheson-Monnet, 2017; Pope et al, 2017). Extant published literature in the field provides an insight into how the higher likelihood of the inappropriate and frequent utilisation of unnecessary ambulance services can be demographically predicted. Patterns of this are characterised by an incidence of lower socioeconomic status, chronic disease status and low perceptions of healthcare accessibility in practice (Hudon, Sanche and Haggerty, 2016; Scapinello, 2016). Within this literature there is, notably, minimal mention of the accountability of the independent care sector workforce in requesting emergency services and the situational contexts in which this may happen, but which may subsequently be attributed to people in these groups. Raising awareness and facilitating the reflection of residential care on their current practice is pivotal if these statistics are to improve. A realisation of the fiscal and practical implications of the unnecessary use of emergency services is pivotal if the clinical and professional practice issues outlined in this research are to be prevented in the future. This article presents key areas for consideration in practice.

9 Considerations before Calling 999…

Despite 96% of homes having a policy on falls, only 80% of these included an assessment of possible injury or harm to residents and 13% included no direct guidance for care staff in instances where residents fall and are on the floor. For policies that did include direct guidance, there was a great disparity in available information, especially between domiciliary and residential care home settings. The most commonly recommended and ambivalent action, was to call emergency services in order to move patients, even in the absence of physical injury. Findings were consistent with those outlined in the extant literature, which also highlighted the inappropriate use of Accident and Emergency (A&E) services (Chalk, Black and Pitt, 2016).

1. Considering the Distinction between the Formulation and Practical Execution of Residential Care Home Policies on Falls

Regardless of whether residential care settings have established policies, which 96% of residential care settings reported as being operational, this is no guarantee of effective staff engagement with them in practice with vulnerable patients. On a practical level this raises important questions for care home staff involved in the effective recruitment and retention of new residential care home staff.

2. Considering how Aware Staff are of Operational Falls Policies in Practice

The five most salient themes from our original research were established as the need for:

a) Induction training
b) Making staff accountable for reading the falls policy
c) In house training via staff development
d) Adjunct association with organisational lifting and handling policies
e) Recording and documenting falls correctly and auditing their occurrence.

At the heart of the level of awareness that staff have, lies the need for effective education and training pedagogies that are underpinned by appropriate health professions pedagogical interventions in practice. Consideration of these five key areas is something we posit as a means of addressing these needs at the front line of care for vulnerable people in practice.

3. Consideration of the Concepts of Active and Passive Mobilisation of Patients following a Fall

The majority of staff perceive that their immediate response to a fall where a patient has not immediately mobilized ought to be to call an ambulance, indeed our research into this had a response corresponding to this in 75% of the organisations who took part in the research. Staggeringly, and despite the availability and media

publicity surrounding paramedic emergency services fiscal constraints, the commonest response to questions surrounding this was that staff were operationally required to ring for an ambulance and that they must not, under any circumstances move people who had fallen to the floor. Only a minority of organisations reported that their staff were expected to use hoists to move patients from the floor. Others reported having an individualised care plan for each patient and that carers had to use this in instances where patients fell, regardless of the circumstances. All of these responses demonstrate how a lack of standardised operational responses to falls has a huge impact on the availability of paramedic emergency services in practice. One organisation even reported that there was nothing in their falls policy about what to do in the instance that a client had a fall. The purpose is not to make value judgements on the homes who contributed to this study but to raise awareness of the potential transferability of these findings to other contexts and settings where similar circumstances are likely to prevail with the same impact in patient centred care and service provision.

4. Consideration of Integration of Sustained Injury and Harm into Falls Policies

The ambiguity surrounding whether there were policy inclusions of the assessment of sustained injury or harm to residents following a fall, meant a widening in the disparity of both reporting procedures and actionable outcomes in practice. 79% of organisations reported that they did have an inclusion in their falls policy of assessments that clients ought to be subjected to in order to assess their individual level of sustained injury or harm as a consequence of having fallen. Since 21% of organisations we studied had no specific recommendations in their falls policy of how staff ought to assess the condition of the client who had fallen, this highlights the need to examine individual organisational predictors of the frequent and inappropriate use of emergency ambulance services also impacts significantly in terms of how patients genuinely in need of expert paramedic intervention can potentially be perceived by those paramedic staff who attend them (Chapman and Turnbull, 2016).

5. Consideration of Clarity of Operational Procedures

Just having an operational procedure gives no actual indication of its clarity and subsequent degree of effectiveness in practice. A key issue for residential care home settings ought to be the address of this, so that in instances where patients fall, there is a clear pathway of management, fully aligned with their individual healthcare needs.

6. Consideration and Clarity of the circumstances under which the Residential Care Home would Ring for an Ambulance

It is relatively easy to be critical of 4% of the independent care sector we researched having no specific policy documentation on falls but if we also account for the impossibility of standardising this in the context of domiciliary care provision and also the overlap between accident policies, then this could account for this in practice. It is also arguable that by not having overlapping policies and by choosing to implement only an accident policy, that this permits a less legalistic approach to falls and encourages proactive informed decision-making about individual patients. This is a key area for address.

These issues of professional practice ought also to be used to raise awareness of the potential to reduce the potential for mind-sets of ambivalence around falls by residential care sector staff. This was especially apparent in the management of elderly patients, for whom polypharmacy, limited ambulation and an increased predisposition to fall due to the pathophysiological processes of senescence, which gradually limit proprioception, mobility and the visual senses (Zia, Kamaruzzaman and Tan, 2017). For these physically vulnerable patients, annual screening is needed as an integral part of a comprehensive care package which can provide a means of recognising the need for healthcare interventions which minimise the risk of falls. Such screening can potentially serve as a prognostic indicator of the likelihood of vulnerable patients necessitating hospitalisation or emergency admission (McCusker et al, 2012).

7. Consideration of whether there is any guidance to follow for staff if a resident is on the floor, and an ambulance has been called but is delayed in responding due to high levels of activity?

50% of respondents who stated that they had no availability of guidance instances where a resident was on the floor but an ambulance was delayed. Whilst our research indicated the common use of ambulances as a formalized part of operational policy, the literature indicates that patterns may also exist where there is a correlation between minimal staffing in the independent care sector and inappropriate ambulance use, for example during night shifts where often skeleton staffing is used to cover significant numbers of patients (Bruni, Mammi and Ugolini, 2016). This can have staffing issues for both professional disciplines, whether paramedic practice and the care of residents in care homes.

8. Consideration of whether there is guidance to follow for staff if a resident is on the floor, and an ambulance has been called but is delayed in responding due to high levels of activity?

This can obviously have a serious impact on the reassurance and support of vulnerable or potentially elderly patients who have fallen but who may have to remain immobilized until an available emergency ambulance is available. A mechanism whereby this can be articulated clearly between the interprofessional working of paramedics and residential care home workers is clearly necessary. At present 50% of organisations in our study had no plan to cope with this common scenario.

9. Consideration of whether respondents and their employees had accessed any formal falls training?

Staff in our study reported having accessed formalized staff development sessions, which was clearly divided into 'in house training' and e-learning packages. From an educational perspective, it was notable that the results show a lack of parity between residential, nursing and domiciliary care in relation to how independent care sector staff are directed and made accountable for how they deal with falls. Almost always this involved a focus on the legalistic need for training, with staff signing to say they had gained an insight into falls and that they are aware of how to deal with them. At no point was anyone formally assessed against a competency framework to see whether this training had been effective. As such there was minimum evidence to suggest a robust and transferrable training and development programme for all independent care sector workers in practice. This is of core relevance to the health professions pedagogy of both worker contexts.

Conclusion

Raising awareness of the need to refine and develop existing policies and practice surrounding the interprofessional working of residential and paramedic practice personnel is evidenced by research available in this field. This article provides only nine key areas for consideration where this can be framed in practice. Wider implications for this in the context of both paramedic practice and residential care home settings education and training are evidence. The authors warmly welcome key professional practice and pedagogical debate surrounding how this might be achieved and translated into the everyday practice of interprofessional working.

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