There is a need to standardise policies and procedures in relation to falls of those living under the care of the independent care sector (Scott-Thomas et al, 2017). To highlight this, we carried out research across care homes in the UK, revealing a disparate set of approaches 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.

Falls policy
Our study highlighted the potential fiscal impact on emergency ambulance services in instances where it was commonplace to contact 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 raising of awareness 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. While generic frameworks are available, further consideration of whether falls policies are fit for purpose is urgently required. Here, we present nine key areas for consideration before calling 999.

Use of ambulance services
Our recent research into the operationalisation of policy in response to falls in South Tyneside and 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 to instances of
minor injury. These could have been better treated in the context of basic first aid in the home, in primary care settings or even just by 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 unprecedentedly high level (Jennings and Matheson-Monnet, 2017; Pope et al, 2017).

Existing published literature in the field provides an insight into how the higher likelihood of the inappropriate and frequent use 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 et al, 2016; Scapinello, 2016). More on this can be found in Box 1.

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 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.

Response to patient falls study

In the UK, falls are the most common cause of injury-related deaths in people over the age of 75 (Ferrah et al, 2018) and of those who survive, many face significant mortality over the following months and years (Yardley et al, 2018).

The aim of our original research (Scott-Thomas et al, 2017) was to review the first-line response to patient falls that is operational in the independent care sector in the specific geographical region of North East England. We undertook this via a basic questionnaire survey design, which was implemented online via Survey Monkey.

A convenience sample of 24 of 32 independent care sector homes from South Tyneside participated in the study, representing an overall 75% response rate.

Results

Policies and guidelines for falls in the independent care home sector were investigated, as understood by care home managers. Our findings highlight the disparate responses to falls in the care home settings.

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 those policies that did include direct guidance, there was a great disparity in available information, especially between domiciliary and residential care home settings. The most common recommended action was to ring emergency services in order to move patients, even in the absence of evidence of physical injury.
In the context of residential care home settings, there was a high degree of ambiguity around the assessment of sustained injuries and whose responsibility this was. This was particularly evident in relation to falls with potentially non-visible injuries, which were subsequently not immediately identifiable. There was also reported ambiguity in relation to the management of falls, where there was overlap between accident policies and falls policies. Our research highlights the need for standardisation of policies and procedures in relation to falls of those living under the care of the independent care sector.

At present, there is a disparate set of approaches evident in the contexts of care. Findings of our research were consistent with those outlined in the existing literature, which also highlighted the inappropriate use of A&E services (Chalk et al, 2016), warranting their wider dissemination across diverse health professions and adjunct roles in health and social care settings.

Nine considerations before dialing 999

Care home policies
Regardless of whether residential care settings have established policies, which 96% of residential care settings reported as being operational did, 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 care home staff. Not only can death be an immediate reality of falls in nursing homes, the likelihood of death over the year following a fall also increases radically (Buckinx et al, 2018).

Research to establish these findings incorporated 662 participants from the sample of elderly nursing home individuals (aged 83.2 +/- 8.99 years), of these 484 (72.5%) were women and all were living in nursing homes. Within the identified cohort, 584 and 565 participants, respectively, were monitored over 12 months for mortality assessment and for occurrence of falls via their medical records.

Via stepwise regression analyses, prediction of mortality and falls was undertaken. From the participants included in the study, it was evidenced that 93 (15.9%) died and 211 (37.3%) experienced a further serious fall during the 1-year of follow-up. This research also posited that globally, the frequency of undesirable health outcomes appeared higher in participants with a relative degree of lower limb muscle strength and mobility (Buckinx et al, 2018).

Staff awareness
The five most salient themes from our original research were established as the need for:
- Induction training
- Making staff accountable for reading the falls policy
- In-house training via staff development
- Adjunct association with organisational lifting and handling policies
- 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 methods that are underpinned by appropriate health professions interventions in practice. Consideration of these five key areas is something we posit as a means of addressing these needs at the frontline of care for vulnerable people in practice.

Active and passive mobilisation
The majority of staff think that their immediate response to a fall where a patient has not immediately mobilised ought to be to call an ambulance. In fact, our research into this factor had a response confirming this response in 75% of the organisations that took part in the research.

Staggeringly, and despite the availability and media publicity surrounding paramedic emergency services fiscal constraints, the most common 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 themselves. 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 if a resident had a fall.

However, the purpose of this study was 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 on patient-centred care and service provision.

Integration of 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. Some 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 the 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. These organisations should also be made aware that this behaviour can have a significant negative impact on how patients genuinely in need of expert paramedic intervention can be perceived by those paramedic staff who attend them (Chapman and Turnbull, 2016; Scott-Thomas et al, 2017).

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 to address this, so that in instances where patients fall, there is a clear pathway of management, fully aligned with their individual healthcare needs.

Clarity of the circumstances under which to ring an ambulance

It is relatively easy to be critical of the 4% of the independent care sector we researched that has no specific policy documentation on falls. But if we account for the impossibility of standardising this policy in the context of domiciliary care provision as well as the overlap that often exists between accident policies, it becomes clear where this lack of regulation comes from. 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 to be used to raise awareness of the potential to reduce ambivalence around falls by residential care staff. This was especially apparent in the management of elderly patients, who often live with polypharmacy, limited mobility and an increased predisposition to falls due to gradually limiting proprioception, mobility and eyesight associated with the ageing process (Zia, Kamaruzzaman and Tan, 2017). For these physically vulnerable patients, annual screening is needed as an integral part of a comprehensive care
how to support residents after a fall (NHS, 2018). The NHS offers free one-day courses in the North East and North Cumbria on how to support residents after a fall (NHS, 2018).

(SCIE, 2005; Cooper, 2017; NHS, 2018)

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 needing hospitalisation or emergency admission (McCusker et al, 2012).

Staffing issues

While our research indicated the common use of ambulances as a formalised 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. This happens, for example, during night shifts, where often skeleton staffing is used to cover significant numbers of patients (Bruni et al, 2016). In these situations, the staffing issues may apply for both professional disciplines: paramedic practice and the care home staff.

Ambulance delays

A home should find out 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.

Some 50% of respondents stated that there was no guidance for instances where a resident was on the floor but an ambulance was delayed. This can obviously have a serious impact on the reassurance and support of vulnerable or elderly patients who have fallen, but who may have to remain immobilised 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.

Falls training

We wanted to find out whether respondents and their employees had accessed any formal falls training. Staff in our study reported having accessed formalised 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 were 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 evident.

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.

References


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Key points

- There is a need to standardise policies and procedures in relation to falls in care homes
- Often, care home staff will contact emergency services when a resident falls, even if there is no or minor injury
- The study discussed in this article set out to map the divergences in care home policies on falls and contacting emergency services
- From the study, five themes emerged: the need for induction training; making staff accountable for reading the falls policy; in-house training via staff development; adjunct association with organisational lifting and handling policies; recording and documenting falls correctly and auditing their occurrence
- Specific policy should be in place for situations where a resident falls during the night, when there is less staff present or when the ambulance is facing a long delay