VIEWS AND REVIEWS

ACUTE PERSPECTIVE

David Oliver: Supporting care assistants when clients become ill at home

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In England, personal care and support for dependent older people is largely unpaid, provided by family.¹ For people who have no one to do this, however—and who pass very stringent eligibility criteria for statutory social services² or can afford to pay regardless—it's generally provided by care assistants.³ These carers often earn the national living wage or not much more,⁴ and reports show that many have zero hours contracts⁵ or are not properly reimbursed for time spent travelling between numerous clients' homes each day.⁶

Personal care of older people is hard, highly responsible work. But recruitment and retention of care assistants is collapsing in many parts of the country, along with the provider market.⁷ Without these workers, who could earn more in less demanding jobs, our health and care system would implode.

Care assistants who visit regularly and develop a rapport with the people they help are often the first to notice health deteriorating. Perhaps they find their client on the floor, having fallen; or less mobile, more confused, or drowsier than usual; or with new incontinence. In any event, they generally have 15 to 30 minutes at the property before they must move to the next address.⁸

In such circumstances it's understandable that carers have to make quick decisions about calling for help, such as an ambulance. They may feel more confident if all parties sign up to a clear care plan about a home based response. Most care agencies have protocols for carers to call head office or an out-of-hours number, or 111, or a designated family member or professional. But they aren't clinicians. And a fall or delirium or sudden immobility could result from a serious or life threatening illness, as well as less serious clinical problems. So, a clinical assessment of some kind is often imperative to ensure that treatable illnesses aren't missed.

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Sometimes hospital admission is entirely indicated. In turn, when an ambulance arrives, the crew are under response time

pressures of their own,^{9 10} which can often lead to hospital conveyance as the line of least resistance.

So far as I'm aware, we don't keep figures on numbers of patients admitted to hospital because of care assistants' decisions—but, in my long experience, it's a frequent occurrence. These older patients are often vulnerable and have cognitive impairment, so a sudden trip through a busy emergency department or acute medical unit can be unsettling. In many cases, we in acute care find ourselves asking whether they could have been supported differently.

England has several schemes in which ambulance crews can avoid conveyance by using onsite assessment and referral to community rapid response teams, especially for patients who have fallen.¹¹⁻¹³ Some excellent rapid response intermediate care teams can also support people in crisis.¹⁴ But—even with a response time of two or four hours from the point of referral—this often isn't quick enough for a care assistant who needs to leave the property and move on.

Still, we see some encouraging examples of service models that allow care assistants to refer directly to NHS rapid response teams who can send out practitioners, such as the Newcastle and Gateshead Clinical Commissioning Group's urgent care team.¹⁵ The NHS in north Devon took over the contract for home care services and also offers this rapid at-home response.¹⁶ Norfolk Community Health and Care Trust has a "home ward" multidisciplinary team able to link with social care providers.¹⁷

Such models are encouraging and are surely right for people keen to remain in their home and avoid admission. Sadly, the evidence for savings from such approaches isn't robust, and it's hard to see their use becoming the norm in most localities for most eligible patients, given current workforce and funding pressures.

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