Ensuring safe and appropriate discharge for people who are homeless or in housing need

An outline of the factors nurses need to consider when preparing homeless people for discharge from hospital and why joint working is essential

INTRODUCTION
Homeless people and hospitals are often blighted by inappropriate admission and discharge practice, which creates a “revolving door” situation, where homeless people’s multiple health and other needs are never fully addressed. This can lead to regular readmissions, lengthy hospital stays, and loss of housing or failure to find appropriate accommodation. This problem can happen in both general and mental health facilities and is often due to a lack of communication between services and a lack of appropriate procedures.

Staff working in health and homelessness services can find admission, discharge and joint working challenging. They need more support and information to ensure safe and appropriate discharge for homeless people. Nurses are often the key professionals who can take this work forward.

This article provides information about guidance on improving care for homeless people, including national government guidance and details some Department of Health case studies, highlighting the essential practice points for nurses.

BACKGROUND
Homeless people experience significant health inequalities. For example, the average life expectancy for rough sleepers is 42 (Crisis, 1996). Homeless people are 40 times more likely to not be registered with a GP and four times more likely to use A&E than the general population (Crisis, 2002).

Local homelessness services include day centres, hostels, soup runs and housing advice centres. Specialist homeless health services may sometimes be offered at such venues, but this varies in different areas.

National guidance on homelessness and hospital admission and discharge concludes: “Most homeless people... have poorer health than the general population. People living in temporary or insecure accommodation have difficulty accessing primary care which means that they often do not seek treatment until the problem is at an advanced stage. Once admitted to hospital, they can present a complex medical and social picture” (Department of Communities and Local Government et al, 2006). The guidance states that homeless people often self-discharge due to sometimes unrecognised mental health or substance misuse problems, or anxiety about losing insecure accommodation.

The first key action point when working with patients is identifying their housing status, vulnerabilities and any key working at an early stage. This should ideally be established on admission.

Hospital staff may not be aware when people are homeless. Not all homeless people will be recorded as no fixed abode (NFA) or hostel dwellers. Those staying temporarily with friends may give their friends’ or the hostel’s address as their home. Therefore, it is vital to ask about housing status directly.

Unfortunately, hostels may also be unaware that a resident has been admitted to hospital, so their bed may be given to someone else. On discharge, a lack of notice can mean unnecessary, distressing delays in locating another hostel space.

While homeless patients need somewhere safe and warm to go to ensure full recovery, nurses working with homeless and vulnerably housed people and involved in hospital discharge can take the following steps to improve practice:

- Read the hospital admission and discharge protocol guidance (see Box 1) and consider how to adopt this locally.
- Contact local homelessness services and, where they exist, homeless health services, to build links. This can often be done with the support of the Queen’s Nursing Institute Homeless Health Initiative, which can find relevant contacts (see Box 1).
- Join the QNI Homeless Health Initiative, which is free to join for nurses working with homeless people and offers support.

PRACTICE POINTS

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Inappropriate admission and discharge practice is common for homeless and vulnerably housed people. This article outlines the key points from protocol guidance and details some Department of Health case studies, highlighting the essential practice points for nurses.
discharge can be delayed because a place to stay cannot be found, or they are simply discharged back onto the street. Some hospitals may discharge homeless people and send them to the local housing department, without realising that finding a hostel bed takes notice and planning.

Rough sleepers who are ready for discharge will almost certainly have ongoing health needs requiring follow up.

The relationship between poor health and a lack of housing is significant, yet may not be considered by healthcare professionals preparing a homeless person for discharge.

This may be the case even when considerable time, effort and funding has been invested in that person’s care while they were an inpatient. Discharging to no fixed abode can result in rapid deterioration in health and readmission.

The DCLG, Department of Health, Homeless Link and the London Network for Nurses and Midwives published joint guidance on hospital admission and discharge for homeless people (DCLG et al, 2006). This provides a vital and valuable framework and has been used successfully in some areas. Yet many areas remain unaware or have still not implemented it, causing ongoing problems for hospitals and homeless people.

**KEY ASPECTS OF THE GUIDANCE**

The guidance is intended to enable timely, appropriate and safe discharge, and reduce readmissions, length of hospital stays and self-discharge, by guiding professionals in setting up a local protocol. Partnership working is key to this.

The protocol identifies nine important steps to implement better hospital admission and discharge for homeless people. A summary of these is given below.

**Step one:** identify relevant organisations, such as hospitals, primary care trusts, housing and social services departments, and voluntary sector organisations, including local homelessness hostels and day centres. It is essential that all agencies feel ownership of the protocol. Involving key people and demonstrating to them the good practice and cost-effectiveness of such protocols is crucial. Ideally, champions in each organisation should be found.

**Step two:** set up a steering group. Ensure that all relevant groups are represented, establish roles and responsibilities, set progress review dates, and consider the long term need for such a group.

**Step three:** review existing systems including what happens when homeless people are admitted and discharged, and consider potential gaps and the need for new systems. A larger information gathering meeting involving many partners could be held for this purpose.

**Step four:** identify training and resource needs. This involves identifying key skills and extra resources needed to implement such a protocol. For example, training for hospital staff on understanding homelessness could be considered, and a resource book or other source of information on homelessness and services in the local area set up.

**Step five:** develop a protocol by building on existing systems – it should link to current processes. Identify key people to lead on implementation, and set up a protocol for sharing information.

**Step six:** ensure that the protocol is fit for purpose. Ideally it should include: establishing patients’ housing status on admission; procedures for obtaining consent to information sharing; procedures for ensuring accommodation is not lost (such as communicating with hostels, landlords and so on); identifying key agencies to notify about a homeless person’s hospital admission; developing resources and training needed; and involving key agencies such as NHS, local authority and voluntary sector organisations.

**Step seven:** test and monitor the protocol. Ensure it is piloted and that its impact is monitored, and that the steering group remains in place to oversee implementation. Finally, brief appropriate staff.

**Step eight:** set up audit arrangements. Ensure that an audit procedure is in place to monitor the protocol’s impact on: staff and patient experiences; patterns of admission, readmission and discharge for homeless people; level of self-discharge; and actual date of discharge.

**Step nine:** review and refine the protocol in response to feedback from homeless people, health staff, local authority staff, voluntary sector staff and volunteers, incident reports/complaints and audits.

**RECENT EVIDENCE**

*St Mungo’s Health Report* (Bilton, 2008) showed that 83 per cent of homeless people were discharged without a treatment plan. The charity’s Health Strategy (St Mungo’s, 2008) said: “We have particular concerns about the small number of people who are discharged each year for whom there is no suitable destination in the community and who died without dignity as a result.”

Another recent report, *Discharged to No Fixed Abode* (Shapps, 2008), revealed that, between 2003 and 2007, there was a 36 per cent rise in the number of homeless people being discharged from hospital with no fixed abode. In this report, 67 per cent of hospital trusts responding to a survey were unable to identify “an existing policy addressing homeless patients”.

The QNI Homeless Health Initiative (HHI) began operating in June 2007, providing support to nurses working with people without a secure home. The Big Lottery Fund has provided funding for three years. HHI offers professional development, resources and networking opportunities. We now have around 500 members working across the country with homeless people.

We have discussed hospital admission and discharge with frontline nurses and through our research with 25 homeless people which was commissioned through Groundswell UK (2008), a service user involvement organisation.

One extreme case highlighted in this research was a homeless person who reported: “I was beaten up and I had stitches. Two o’clock in the morning they’re throwing me out. The next day I was vomiting blood.” Even in less severe cases, the majority of experiences were negative, although there were a couple of encouraging examples.
On a positive note, through a recent study of the work of the HHI, we have noted improvements in hospital discharge in some areas. A number of forthcoming HHI case studies, written between May and June 2009 and due to be published in November, have identified achievements in improving hospital admission and discharge for homeless people.

In one of these case studies, a nurse said that her local hospital had often been discharging people who were of NFA to the street, particularly after hours.

The nurse drew up an admission and discharge protocol in partnership with other agencies after seeing all the information through HHI. The nurse reported: “The audit clearly shows an excellent improvement in ensuring discharging [to] NFA isn’t the norm, particularly at night. It also shows how agencies are communicating better regarding risks, etc.”

Another HHI member’s analysis of hospital admissions and discharges in her local hospital identified a number of people making unplanned visits to hospital who had no address and/or GP. She approached HHI for support and was invited to join the initiative and attend a “Growing your homeless health service” workshop.

Her colleague reported: “Practice at how to present information to access money, to improve services, has resulted in my colleague securing funds to be seconded from her current position as community matron, to enable her to shape services for homeless individuals with chronic, complex health issues, with a view to preventing revolving door attendance at A&E and unnecessary hospital admissions.”

These and other HHI case studies that are due to be published in November 2009 demonstrate the important leadership role that nurses can take in improving hospital admission and discharge for homeless people.

NEW CASE STUDIES
In July 2009, the DH published three useful case studies of areas in which protocols or specialist roles had been developed (Housing Learning and Improvement Network, 2009). The publication of these diverse studies focuses fresh attention on how hospital admission and discharge for homeless people can be improved.

The author argues convincingly that hospital admission is an opportunity for homeless people and services: “The rough sleepers’ outreach service describes its work in terms of windows of opportunity, describing how homeless people go through moments when they are really motivated to change their situation. An admission to hospital, when they are alone, out of the madness of life on the street, scared about their health and being detoxed, offers a massive opportunity to services to start working with that individual.”

LESSONS TO LEARN
Another case study was from Newcastle, where no specific new post was created to address the issues, but a multidisciplinary working group was developed with a lead person identified from the local authority.

Improvements were also made in this case, including better joint working, greater clarity for all staff who work with homeless people, a follow up protocol and the feeling of a positive experience for mental health nurses. For further information, see tinyurl.com/newcastle-protocol and tinyurl.com/three-case-studies.

There are many lessons to be learnt from these case studies. The admission of a homeless person to hospital is, rightly seen as a “window of opportunity” to implement improvements while they are off the streets. If this opportunity is missed, their health problems will often fail to be addressed and this can lead to repeat admissions, which is difficult for patients and costly to the system.

The case studies also highlight how the work cuts across several sectors and the only way in which positive outcomes can be achieved is through better joint working.

Local differences are important. In a large urban area with potentially higher numbers of homeless people, it can be worth creating a specialist homelessness discharge coordinator post. In areas with smaller numbers, creating such a post might not be feasible; however, it may be possible to create a post of a discharge coordinator to manage all adults with housing related needs.

Another option is to set up the protocol with overall leadership from one sector such as housing or health, and a steering group with sector leads.

Homeless people’s local health needs – including hospital admission and discharge – should be assessed in all geographical areas as part of joint strategic needs assessments.

One significant aspect to consider is the role of a champion or lead person – all the evidence suggests how important this role is. This person would take responsibility for driving through continuing improvements.
There are also roles for champions/leaders in each sector, such as hospitals or homeless health services.

Nurses are important leaders in this area and are well placed to champion this both on the front line and in strategic roles. This can also be an excellent development opportunity for them.

Therefore, the role of “identified lead nurse”, to coordinate and advise, is extremely important.

Other nurses and all staff – whether health, local authority or voluntary sector – involved in hospital admission and discharge need to develop skills to ensure safe and appropriate discharge for homeless people in the absence of a lead person. No admission and discharge procedure should rely on a single person to work.

CONCLUSION

There are many opportunities for nurses to build their knowledge and understanding of homeless people and their needs.

They can also use the many other people who understand homeless people’s needs for advice and support. Key homeless agencies have already been identified in this article, and their staff can be a rich source of support and guidance, and facilitate practical solutions to problems that arise.

Practitioners can also choose to raise the issue locally and start the process of implementing improvements through the national guidance.

Nurses caring for homeless people and hospital nurses can build robust working relationships with each other and partner agencies, improving everyone’s understanding of roles and responsibilities. This, in turn, creates a collaborative environment to ensure smooth and efficient delivery of services to patients, whether they are going into hospital or coming out. It also supports homeless people to access services and routes out of homelessness, to build new lives and prevent readmissions.

**CASE STUDY 2. WEST SUSSEX**

A post of housing health and social care coordinator was created to take forward the older people’s strategy, and later extended to all adults. Before this post was put in place, a small number of people with complex health, social care and housing needs were occupying hospital beds for long periods. A furnished and disabled-adapted property was needed for people waiting for a housing solution.

Hospital staff were concerned that people were often discharged to the homelessness team, with just a letter stating there was a housing need. The latter said they needed to know from the time of hospital admission about any housing needs.

This led to the creation of the post. Relevant staff were invited to a multidisciplinary meeting and a work plan was drawn up. The plan was taken forward by the coordinator and through homelessness forums. Examples of work carried out included:

- Homelessness was included in a review of the hospital’s discharge process;
- A flow chart was included in the discharge procedure on what staff need to do if someone is homeless;
- Training was offered on housing and homelessness for hospital staff;
- Discharge folders were created with information on local housing/homelessness services;
- Housing staff now fill in housing register applications and carry out any investigations into homelessness while the person is in hospital. This prevents unnecessary bed occupancy. Benefits identified included:
  - A significant reduction in patients being delayed in leaving hospital due to their housing needs – in 2006, 32% of patients were delayed for this reason and remained in hospital beds. By 2008, this reduced to 7%;
  - Better relationships between agencies;
  - More effective and earlier notification about patients who are homeless or who have a housing need;
  - Savings on bed and breakfast accommodation;
  - Preventing the necessity for people who were/are unwell to declare themselves homeless and make a housing application through the local council on discharge from hospital;
  - Massive reduction in last minute telephone calls to the council stating that someone was about to be discharged and requesting it to deal with this and find accommodation at very short notice;
  - A jointly commissioned pilot for a registered social landlord to provide a disabled adapted property for temporary accommodation after discharge, which was reviewed after nine months. This showed it had saved 251 hospital bed days, saving £63,000 of health resources;
  - More linking in at strategic levels regarding homelessness.

**REFERENCES**


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