London Network of Nurses and Midwives Homelessness Group

5th conference – 2018

‘Still discharging to the streets’

Focus Group Write Up and Analysis

Focus groups write ups and notes

Aim:

To critically examine the patient journey from admission to discharge identifying realistic solutions and providing practical recommendations on improving the safety of homeless patients discharge from hospital. Through working with people who have first-hand experience of being homeless (groundswell peers) and being discharged unsafely to the streets, we identified some main points within the pathway from admission to discharge which directly contribute to unsafe discharges.

Methodology:

We used an off ramp/on ramp model as follows:

Initial Contact → Admission → Care Delivery → Discharge Planning → Point of **SAFE DISCHARGE**

Off ramps are exit points along this pathway that prevent a person reaching the final destination of safe discharge - these are identified problems.
On ramps are actions or interventions that enable continuation of the progressive journey towards safe discharge - these are proposed solutions.

Factors that could lead to an unsafe discharge (**off ramps**) were identified through qualitative working groups collating peer advocates experiences of supporting people who are homeless to access health services. Re-occurring issues they encountered as barriers to achieving safe discharge were discussed & consistent themes across stories were chosen as thematic off ramps. This was a detailed and emotive piece of work undertaken prior to the conference and we would like to thank our partners at Groundswell for their participation and willingness to share those stories in order to direct this piece of work.

Conference delegates (n=253) working in the homelessness sector were randomly allocated into 10 discussion groups consisting of a mixture of healthcare professionals, peer advocates and volunteers were then asked to work together to identify solutions to these issues (**on ramps**). Randomisation ensured a wide variety of experiences and opinions were represented in each group and ground rules were set to enable participation by all group members.

This was a 55-minute exercise, and each group held approximately 20 people (not all delegates participated). Each group was further split into 2 sub groups focused on either **Initial Contact/Admission/Care Delivery** or **Care Delivery/Discharge Planning/Point** steps of the patient journey**.** Facilitators helped to focus attention when needed and keep tasks to time with an aim of generating at least 2 solutions per identified off ramp to improve clinical practice.

Please see appendix 1 for Off Ramp pathway

Findings:

As you can imagine with so many participants and the huge amounts of discussion generated, there were many issues raised and even more solutions suggested.

We recorded all suggestions and then summarised recurring themes to generate a set of practice recommendations. Although this was done in a timeline format many of the proposed solutions cross over all stages of the patient journey.

Off Ramp 1 @ Initial contact

Inaccurate accommodation information gathered & recorded on NHS systems (e.g. care of address, old address or an address patient is collected from but can't return to)

Proposed Solutions (On Ramps enabling patient to reach desired destination of safe discharge):

- Increased use of interpreting services including telephone interpreting, use of photos/picture cards for patients with literacy issues to ensure accurate recording
- Training of A+E reception to improve communication, change perceptions and accurate recording of homelessness status. Non-judgemental attitude training– suggestion of Royal College of Emergency medicine audit
- A+E staff having access to a list of homeless day centres so reception staff can ask if the patient is supported by any of them
- Establishing routine questions to be asked in A+E (i.e.: have you got somewhere safe to go when you leave? Do you have support where you live? Do you have access to a bathroom/kitchen) Could consider a pilot project of data collection at A+E for homeless patients?
- Regular A+E attenders to have named link nurse/consultant
- Hospital staff to have 'view only' access on CHAIN to see if presenting patient is a known rough sleeper
- Have a system of 'flagging' certain addresses given by patients that are known day centres to help identify homeless status
- All healthcare workers to assess capacity to make specific decisions around health & treatment at multiple points in care pathway as this may fluctuate
- Prioritising patient in triage if likely to self-discharge/not wait for assessment

Off Ramp 2 @ Admission

Keyworkers/support workers aren't identified or contacted by clinical staff so unaware of health needs and unable to offer support post-discharge

Proposed Solutions (On Ramps):

- An alert or 'homeless flag' to be put on patients record with consent to trigger processes for assessment of housing need, contacting keyworker/specialist services & prompt early discharge planning & rapid referral to specialists in hospital
- Shared electronic care plans that can be accessed across secondary/primary care ie: 'co-ordinate my care'
- Paper passport – can be carried by patient with basic information to support when they attend hospitals
- Information available in clinical areas regarding local resources of specialist homeless services for signposting & referral
- Finding out where there last GP is registered and when they last saw them to improve communication & integration of hospital & primary care
- A named nurse or person who works with the patient from admission to discharge and acts as a link person to community-based healthcare & support services
- Having Pathway teams (or equivalent) in hospitals that link with primary health care and homeless keyworkers at the point of admission to facilitate advance discharge planning.
- Improved information sharing guidance & governance that facilitates interagency sharing for clients with complex needs
- Provision of storage/care solutions for patients valued items (e.g. dogs, tents, bags) when being admitted that can lead to early self-discharge
- Ask about any prison history/probation workers – how can we support?

Off Ramp 3 @ Care Delivery

Absent or sub-optimal treatment for drug/alcohol addiction (if not well managed likely to lead to self-discharge)

Proposed Solutions (On Ramps):

- Judgemental attitudes of staff highlighted as requiring training (ie: trauma informed thinking) for all professions including reception & clinical teams
- Creating a homeless 'champion' in inpatient areas to raise awareness & link to specialist teams including drug & alcohol services

- Peer advocates to be linked to hospitals & providing support on wards for patients with drug and alcohol dependencies
- Case studies for staff in training to be able to see impact of poor linking with drug/alcohol services and longer-term consequences of failure to treat adequately
- Review of current methadone titrating protocols in hospitals and include need to personalise for each patients' specific needs
- Follow up via ward staff for those who self-discharge – this is often because difficulties with coping with drug and alcohol addiction and puts the blame on the patient rather than the system failures. If unable to complete treatment in hospital primary care need to be informed as part of follow up
- Improved pain management which will impact on methadone use
- Asking the patient questions about methadone prescribing i.e. which pharmacy do you use, how will you collect after discharge?
- Ward pharmacists to link with MDT more for co-ordinating drug replacement therapy and logistics
- Activities to get involved in whilst in hospital to avoid boredom/withdrawal symptoms worsening

Off Ramp 4 @ Discharge Planning

Planning left too late and unable to get appropriate support in place in time to facilitate safe discharge

Proposed Solutions (On Ramps):

- Inclusion health principles to be taught in pre-registration training for nurses and medics.
- No recourse to public funds specialists in hospitals to advise on complex discharges (Praxis has funding for this in some hospitals)
- Resource folders on wards to support discharge planning for homeless patients
- Specialist homeless discharge teams in every hospital and routine referral at admission
- Routine MDT meetings for homeless patients admitted to the ward at point of admission
- Asking about getting to outpatient appointments for follow up, providing bus tickets
- Giving outpatient appointment to patient BEFORE they leave the hospital so not lost to follow up
- Protected clinical time for staff on wards for complex discharge planning
- Improved links with social services and pan-London safeguarding alerts for patients that are vulnerable/at risk
- Commissioning step down/intermediate care beds
- Involving OT and physio at early stages to assess issues - same standards of care as housed population

- A simple 'algorithm' or clinical flow chart for staff/nurses/doctors to use when discharge planning for homeless patients

Off Ramp 5 @ Point of Discharge

Discharging at evenings and weekends when no support is available

Proposed Solutions (On Ramps):

- Weekend/late evening discharge should be avoided in this group due to high risk of unsafe discharge
- Bed managers/hospital to incorporate this principle into operational policies
- Best practice guidance could be linked to 'Duty to refer' under Homelessness Reduction Act 2017
- Assistance with GP registration on discharge
- Expediting discharge summaries to GPs and 'link person or support worker' & contacting them at discharge to support primary care follow up
- If discharge on a weekend is inevitable, to be highlighted to outreach teams (similar to severe weather emergency protocols) as high priority for night shelter
- Better safety netting offering advice/leaflets (ie: out of hours GP, 111)

Overall Themes:

- A knowledge gap exists amongst secondary care staff around homelessness - this was highlighted throughout all discussion groups.
- There would be benefit in increasing reflective practice, case studies and clinical supervision focusing on homelessness for staff to learn from previous cases as consequences of poor discharge planning are rarely seen in the discharging clinical area.
- Primary/secondary/voluntary sector need to work together more & be aware of each other's limitations to avoid frustrations and improve communication & operational working practices.
- Lack of funding is always a barrier as capacity in health services to manage individual complexity is reduced.
- Lack of joint commissioning between acute trusts, primary care and local authority contributes to difficulty integrating secondary & primary care
- Infrastructure is needed within hospitals to support any changes, i.e.: IT systems, service level data sharing agreements, safe staffing levels
- Complex discharges of people experiencing homelessness take time & resource to plan safely & effectively, this needs to be planned & actioned from admission

Recommendations:

1. **Training on the needs of homeless patients** which must be succinct, easy to access and available to all professions (reception staff, drug and alcohol workers, nurses, doctors, discharge teams). Ideas included online training or for specialist homeless services to in reach and deliver short training sessions. Focus should be on dignity, respect, non-judgemental attitudes and services being more flexible & accessible for homeless people.
2. **Better quality data collection is needed at point of contact/admission**. Specifically this should include key workers contact details, services the person uses, their housing status, address/care of address, recent GP, NOK etc. This could utilise a simple pro-form assisted by interpreting services or literacy support where indicated. Potentially this could be a pilot study trialling data collection tools - these need to be brief, include the right questions and be developed conjunction with peer advocates & specialist homeless teams.
3. **A 'database' or resource of local homeless services** to be available to all staff (i.e.: folders on wards/intranet) with details/phone number/leaflets in different languages for signposting homeless people. This would require regular updating to reflect changes n voluntary sector projects
4. **An alert or 'flagging' system that highlights when someone has complex housing** needs to trigger early discharge planning at point of admission
5. **Patient Passpo**rts which highlight that they are homeless, describing specific additional needs & providing key worker & other important contact details
6. **Having a homeless link person** on each ward/within each department who has increased knowledge, good links with community and is able to advise staff & signpost patients as part of discharge planning
7. **Identifying those who attend frequently and providing a named nurse/doctor** who they can build a relationship with and have some continuity of care under.
8. **Multi-Disciplinary Team Meetings to be planned for all complex homeless patients at point of admission**
9. **Guidance/flow charts for ward staff** of things to consider with homeless patients on admission
10. **Policies in hospitals to consider NO WEEKEND/EVENING discharge for high risk homeless patients**
11. **Better links with peer advocates for support on wards** (specifically with addiction issues) Potential to commission 1 peer advocate per hospital??
12. **Inclusion health to be part of standard nurse/medic training curricula** to improve awareness & reduce knowledge gap in future

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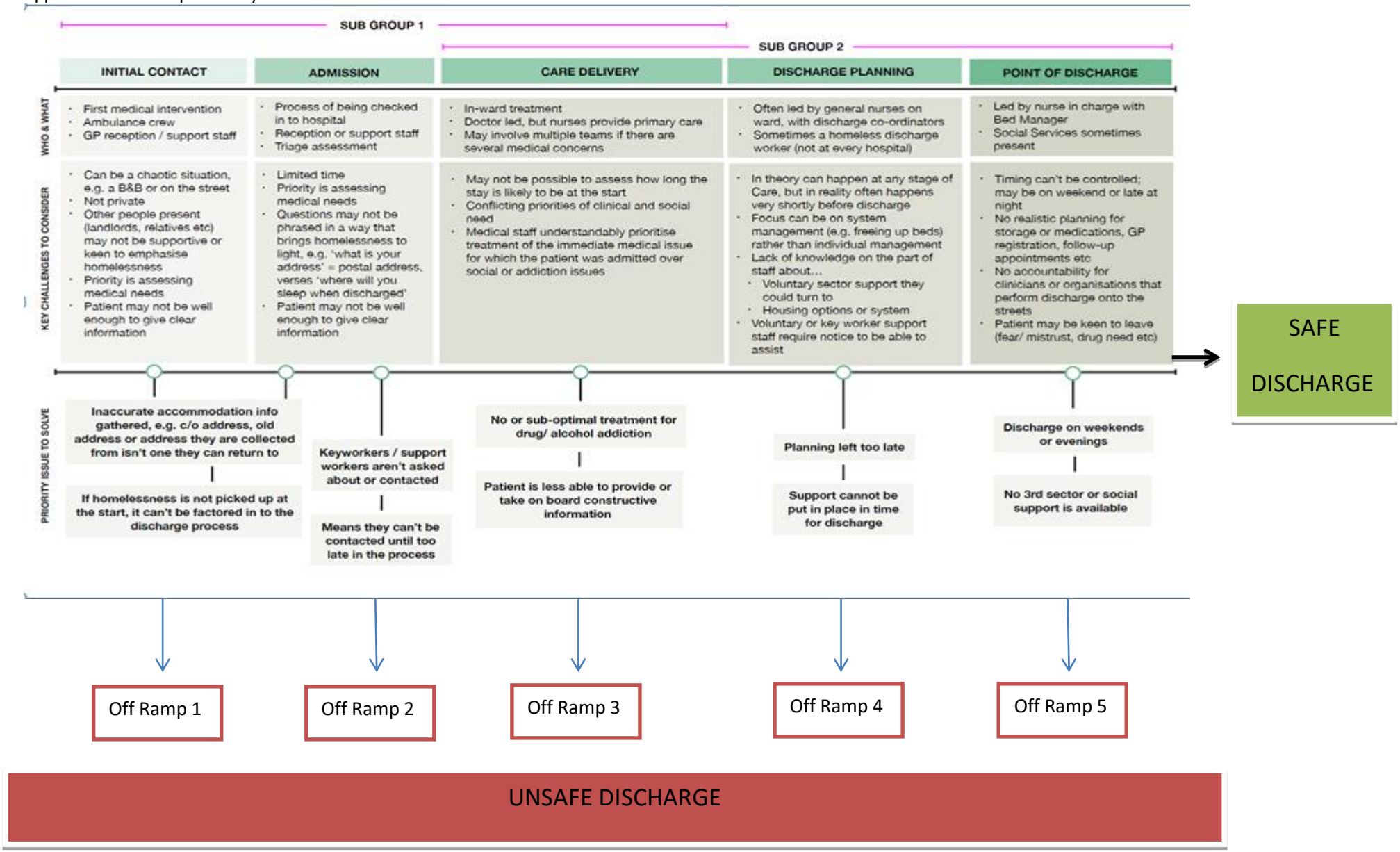
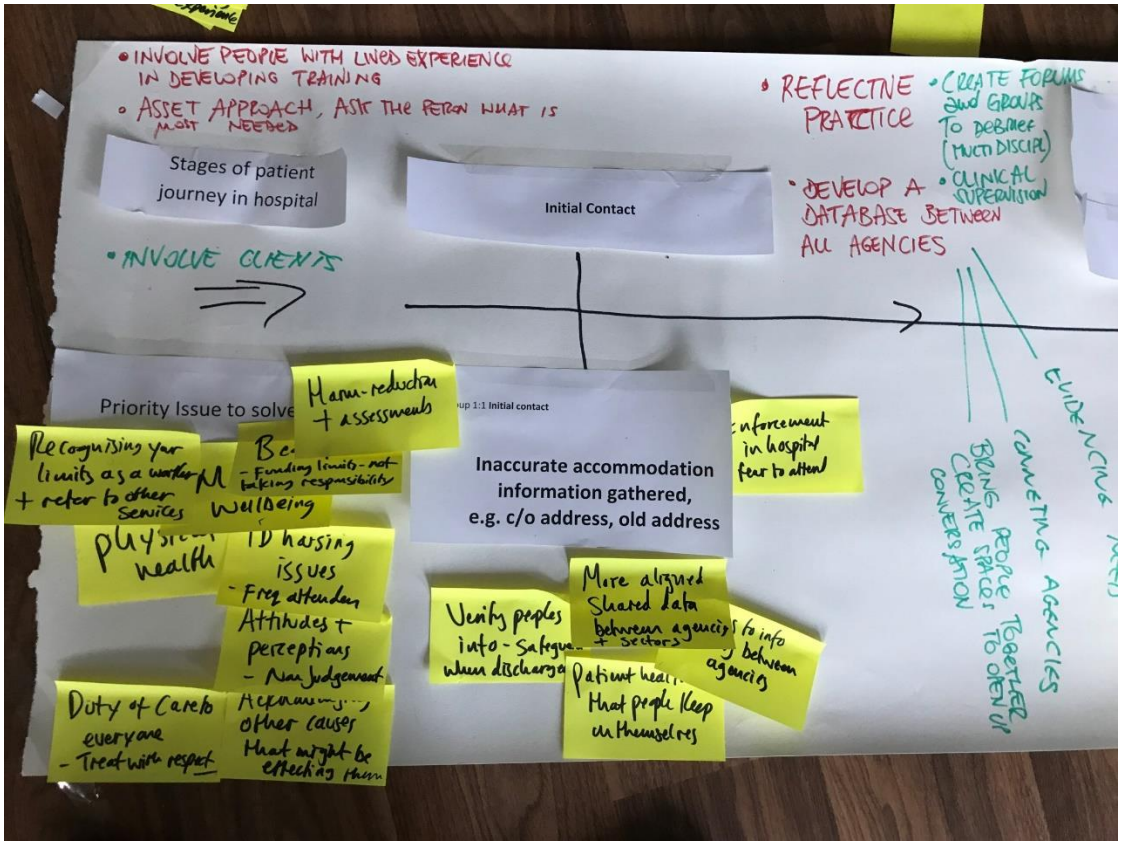
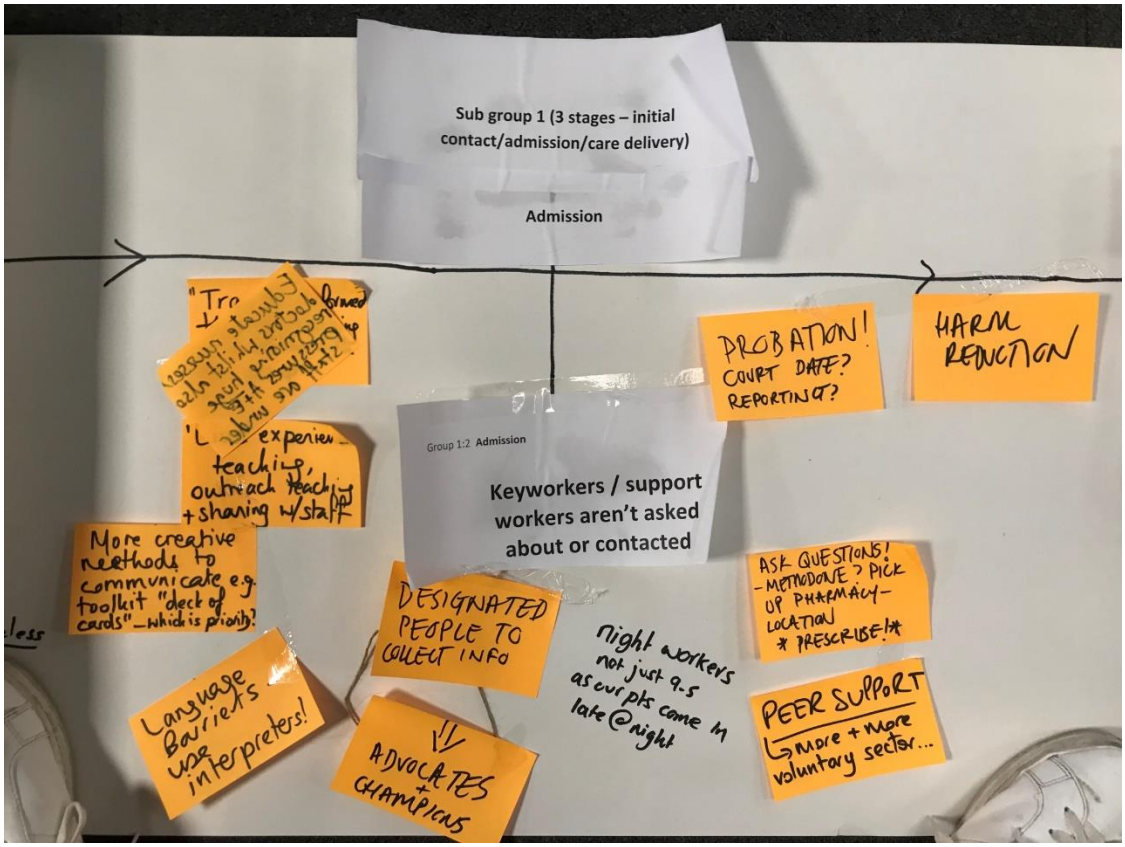
Many thanks to all those who contributed.

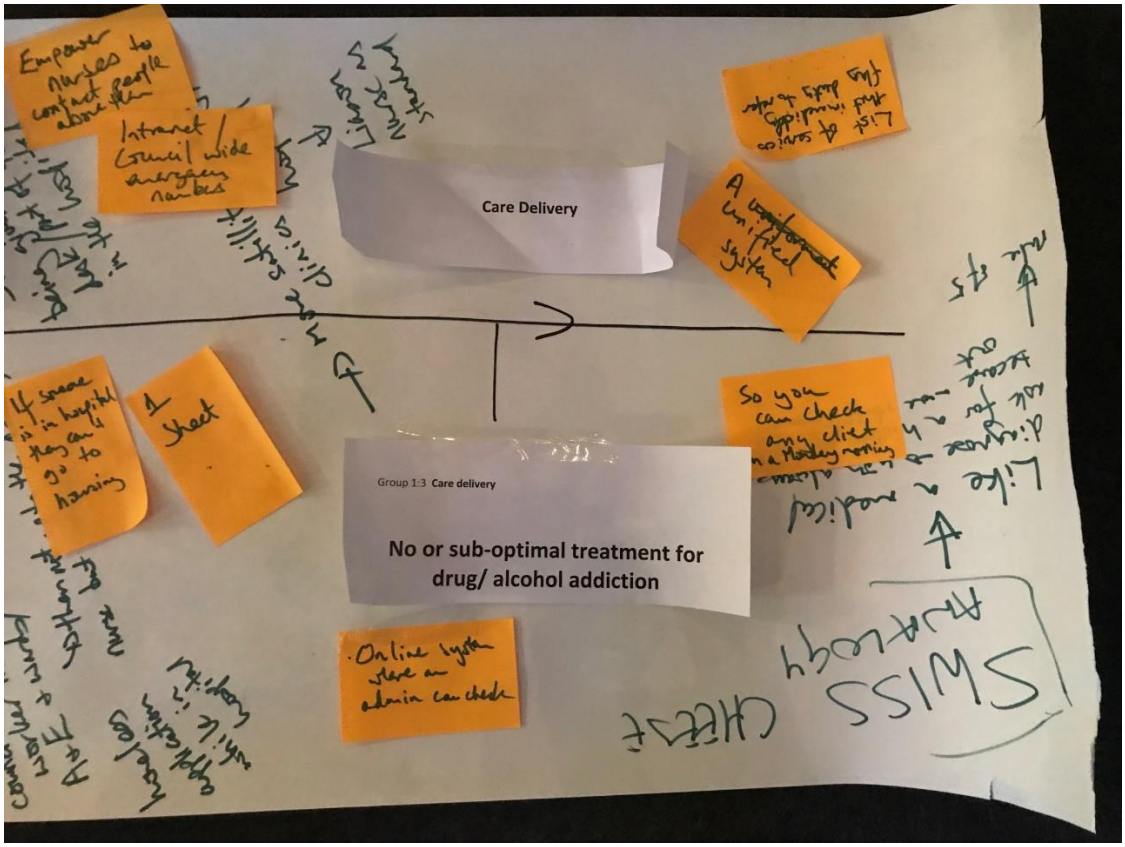
Appendix 1: Off Ramp Pathway

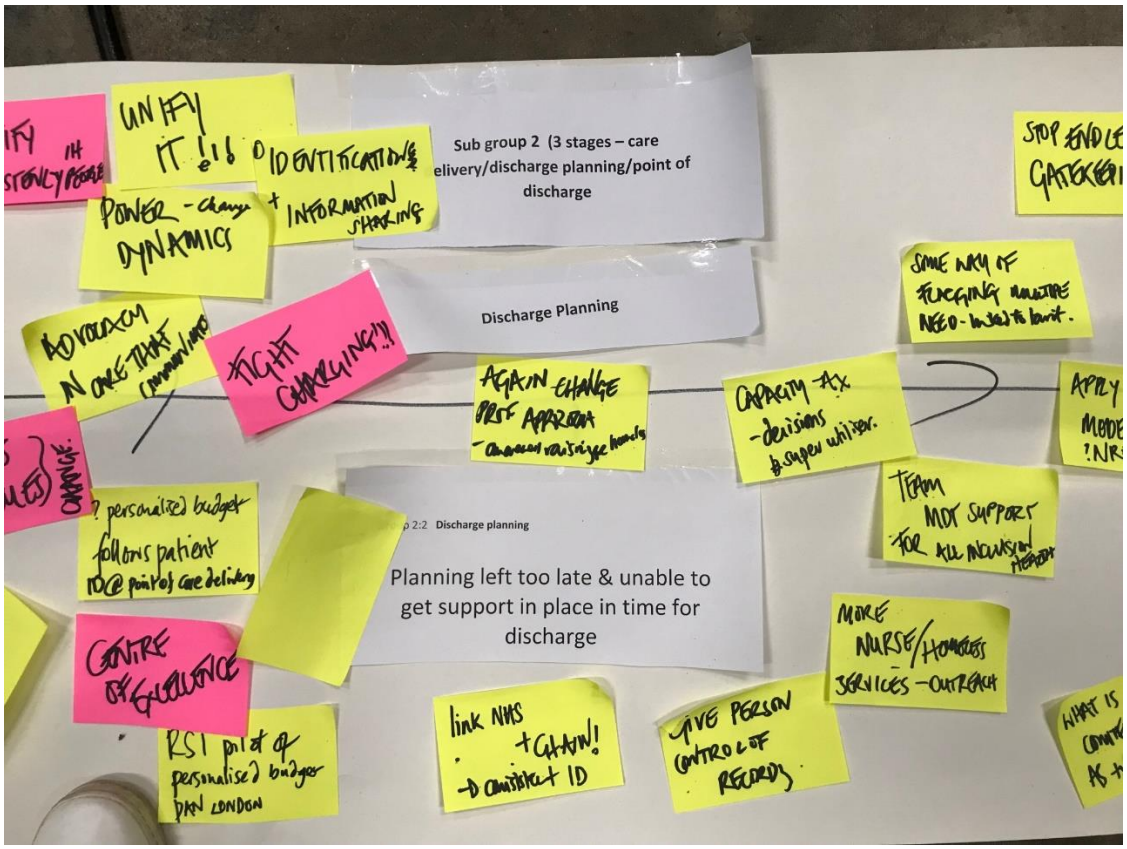


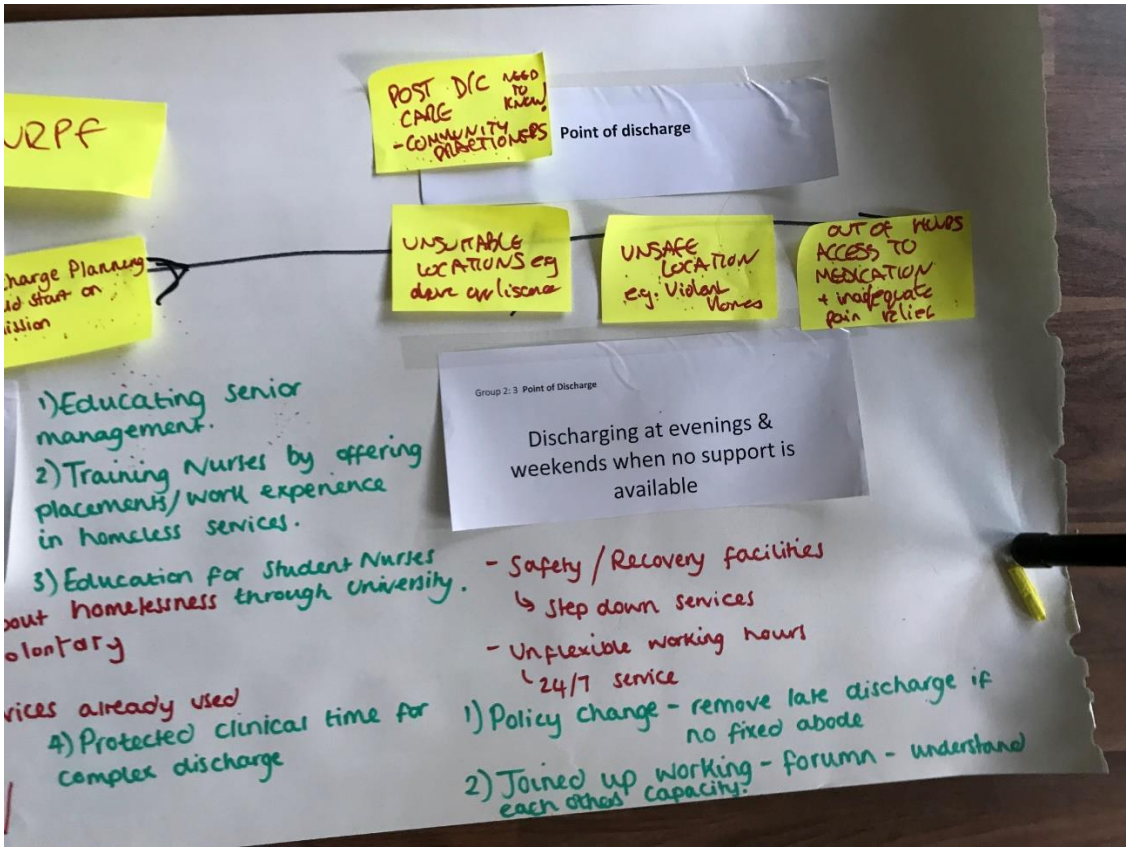
Appendix 2: Examples of Focus Group output






Care Delivery
Group 1:3 Care delivery
No or sub-optimal treatment for drug/ alcohol addiction
Empower Nurses to contact people about them
Intranet / Council wide emergency numbers
A unified system
1 sheet
So you can check any client
Online system where an admin can check
SWISS Analogy


Sub group 2 (3 stages – care delivery/discharge planning/point of discharge
Discharge Planning
Group 2:2 Discharge planning
Planning left too late & unable to get support in place in time for discharge
UNIFY IT
IDENTIFICATION + INFORMATION SHARING
POWER - change DYNAMICS
FIGHT CHALLENGE!!
AGAIN EXCHANGE PROF APPROVAL
CAPACITY TX - decisions
SOME WAY OF FLAGGING
TEAM MDT SUPPORT FOR ALL
? personalised budget follows patient
CENTRE OF EXCELLENCE
RSI pilot of personalised budget DAN LONDON
link NHS + CHAW! - consistent ID
GIVE PERSON CONTROL OF RECORDS
MORE NURSE/HOMELESS SERVICES - OUTREACH
STOP ENDLESS GATEKEEP


URPf
POST D/C CARE NEED TO KNOW
- COMMUNITY PHARMACIST
Point of discharge
UNSUITABLE LOCATIONS eg
UNSAFE LOCATION eg. Violent
OUT OF HOURS ACCESS TO MEDICATION + inadequate pain relief
Group 2: 3 Point of Discharge
Discharging at evenings & weekends when no support is available
1) Educating senior management.
2) Training Nurses by offering placements/ work experience in homeless services.
3) Education for Student Nurses
homelessness through University.
- Safety / Recovery facilities
↳ Step down services
- Unflexible working hours
↳ 24/7 service
4) Protected clinical time for complex discharge
1) Policy change - remove late discharge if no fixed abode
2) Joined up working - forumn - understand each others capacity.