The Royal College of Emergency Medicine

Clinical Audits

FACULTY FOR HOMELESS AND INCLUSION HEALTH

Royal College of Physicians

EXCELLENCE IN EMERGENCY MEDICINE

Faculty Standards for A&E work with Homeless Patients

This document details the draft Faculty for Homelessness and Inclusion Health standards V3.0, for use in the November 2015 RCEM pilot clinical audit.

"Inclusion Health" addresses the health care needs of the socially excluded, who experience the extremes of health inequalities. Needs are characterised by complexity, often involving the combination of physical ill health with mental illness and drug or alcohol dependency in the context of a lack of social support and personal resilience. Individuals may be homeless, sex workers, vulnerable migrants or Gypsies and Travellers.

This pilot audit focuses on the needs of homeless people, including rough sleepers and members of the street community (squats, sofa surfers, hostel dwellers and others in insecure accommodation).

An effective response to this complexity requires multi-agency coordination and links to appropriate services and support.

The Faculty for Homeless and Inclusion Health is a multi-disciplinary network of clinicians and service users, supported by Pathway Charity, with the aim of improving the quality of health care for homeless people and other excluded groups. The Faculty publishes Standards for Commissioners and Providers

V2.0 was commissioned by DH and endorsed by the Royal College of Physicians.

V3.0 of the Standards is in preparation, and will include more recommendations for secondary care and emergency departments. As part of this process the Royal College of Emergency Medicine has offered to support a pilot homeless health audit, to be carried out in selected Emergency departments in preparation for Christmas period 2015.

Understanding the different types of standards:

- **Fundamental standards**: need to be applied by all those who work and serve in the healthcare system. Behaviour at all levels and service provision need to be in accordance with at least these fundamental standards. No provider should provide any service that does not comply with these fundamental standards, in relation to which there should be zero tolerance of breaches.

- **Developmental standards**: set requirements over and above the fundamental standards.

- **Aspirational standards**: setting longer term goals.

Organisational Standards

Standard
Fundamental
1. Homeless patients are identified and recorded by ED staff
2. Discharge letter is generated and sent to primary care, if the patient is registered with a GP
3. Drug use as direct cause for presentation is identified and recorded
4. Alcohol use as direct cause for presentation is identified and recorded
Developmental
5. ED has access to NHS spine to identify registered GP
6. Homelessness staff information pack is available and reviewed annually, with details of Streetlink, local street outreach, day centres, alcohol, drug and specialist targeted health services, and information on out of hours services
7. Homeless patient leaflets are available in the ED, with details of day centres, alcohol, drug and specialist targeted health services, and information on out of hours services
8. Designated link nurse for homelessness in the department
9. Follow up plan is documented in the patient notes
10. Trust has a policy for safeguarding vulnerable adults in A&E (including homeless)
11. Trust has a system of recording alerts and multi-agency care plans for high risk or frequent attenders accessible at point of contact
12. In department alcohol assessment, brief advice and referral is available according to NICE guidance
13. In department drug assessment, brief advice and referral is available
14. Multidisciplinary forum organised regularly to discuss homeless frequent attenders with community support services
Aspirational
15. Lead consultant for homelessness and/or vulnerable groups
16. ED has access to GP records
17. Prioritised pathways for high risk homeless groups: e.g. Homeless IVDU attending with suspected DVT will be unlikely to return for USS next day - need to be prioritised to prevent DNA and re-attendance
18. Identified process to locate homeless persons with abnormalities on results after leaving department (e.g. check previous records for addresses / contact numbers; Check CHAIN (if in London); Check Spine; Check psych system. If all no leads add alert in case of next attendance, contact police if urgent)
19. Homeless patients further defined and recorded as "rough sleepers" (actually sleeping outside) or "street community"(includes all short term or insecure accommodation such as sofa surfing, squatting or living in hostels and shelters)

20. Process to facilitate GP registration where necessary (e.g. GP Service that has an open policy to homeless patients & agreement to temp register for follow-up or continued primary care
21. Shared list of high risk/vulnerable patients across health and social care and street outreach services
22. Method of obtaining feedback on how patients felt they were treated and if their problems were addressed e.g. friends and family test
23. Robust and regular contact to provide link to community support organisations for rough sleepers and other vulnerable groups
24. Designated worker or team to support follow up from A&E
25. Process to record people using waiting room for shelter without booking in
26. Care for staff: Training to provide alcohol brief intervention for homelessness, including quick risk assessment and signposting
27. Care for staff: Support or clinical supervision available for staff dealing with homeless patients.
28. Training for staff on homelessness and helping homeless patients
29. Bookable slots with a specialist local homeless nurse (linked with GP) service 3 times weekly to manage primary care (chronic illness, wounds etc).
30. Specialist homelessness practitioner or team on site

Patient Note Standards

Standard
Fundamental
1. Number of homeless ED attendances in the last 3 months recorded
2. Number of homeless patients leaving department without being seen by a clinician in the last 3 months recorded
3. Drug and alcohol history documented
4. If drug or alcohol use is direct cause for presentation, referred for specialist assessment
5. If acute mental health problem identified, risk assessment/ MMSE/MOCA documented and referred to mental health liaison team
6. Method of attendance documented (self/ police/ ambulance)
7. Past medical history documented
8. Medication history documented
Developmental
9. Patient is only referred for GP follow up if they have a registered GP
10. If patient is not registered with a GP, advice or signposting for registration is given
11. Discharge letter to GP includes homeless status
12. Written information on homeless services offered to patient.
13. Replacement clothing offered if necessary
Aspirational
14. Social history documented by assessing clinician to include sleep site, length of time homeless, homeless services frequented, key worker (may be street outreach, hostel worker, probation)
15. If brought by ambulance service - patient notes document where collected (essential for reviewing notes for safeguarding / frequent attenders)
16. If attending with alcohol related cause - CIWA score to be documented before leaving department
17. Homeless patients with alcohol as cause of attendance to have Pabrinex IV administered if indicated
18. If sleeping rough, referred to an outreach team