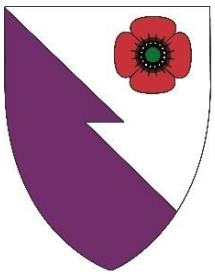
The Royal College of Emergency Medicine

Best Practice Guideline

Inclusion health in the Emergency Department

Caring for patients who are homeless or socially excluded



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Introduction and Summary of recommendations

This guidance has been produced in the light of statutory duties with regards inclusion health but provides good practice for all patients who are socially excluded. It has been produced in a format that identifies standards for Emergency Departments- the rationale for this is discussed.

Hence the summary of recommendations is implied within these standards.

Background and Scope

"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 guideline is designed primarily for use in Type 1 EDs.

Reason for development

Homeless people in England are 60 times more likely to visit the emergency department in a year than the general population [1]. One study suggested that almost a third of homeless people had visited an emergency department at least once in the past year, compared with 0.5% of the general population [2]. This same study showed striking high rates of substance (13.5%) and alcohol dependence (21.3%), hepatitis C (6.3%) and multiple morbidity (21.3%, when compared to the general population. Emergency department attendances made by homeless people have almost trebled in the last 10 years [3].

Chronic homelessness is an associated marker for tri-morbidity, complex health needs and premature death. Tri-morbidity is the combination of physical ill health needs with mental health needs and drug and alcohol misuse. This complexity is often associated with advanced illness at presentation, in the context of a person lacking social support who often feels ambivalent about accessing care and their own self-worth [4].

Attending an emergency department represents an opportunity to provide healthcare advice and offer information regarding accessing social and other support.

Considerations

Production and use of this guidance

This guidance has been produced in a different format than usual for RCEM Best Practice Guidance. RCEM no longer routinely produces standards independent of National audits and standards (see Standards section on RCEM website for details). However, this guideline has been produced in the format which includes standards. This is to enable the production of standards, and audit against these, especially in the light of statutory duties. It is also anticipated that an RCEM National Quality Improvement Project will be undertaken (and based on) these standards.

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.

Miscellaneous

With the socially isolated, presentation at an ED can provide an opportunity to positively intervene. These patients may not (for many reasons) be able to access primary and secondary care as other patients who are not socially isolated- for example for routine preventative health, screening programmes, and for follow up arrangements (e.g. repeat XR, fracture clinics, follow-up clinics).

Hence, an ED attendance is an opportunity, both to consider elements of care that may have not been addressed and ensure that appropriate follow up is in place and accessible to the patient. This requires identification of social isolation, and requires clear documentation of the holistic assessment of the patient needs, and of the decision-making processes and their modification in the light of the patient's social isolation.

In some situations, such as when modern slavery is suspected, an ED attendance may represent a *unique* opportunity to intervene.

Organisational Standards

Standard
Fundamental
1. Emergency Departments fulfil their **statutory duty** to identify those patients who are homeless or at risk of being made homeless in the next 56 days.
1a. Emergency Departments have an auditable method of recording referrals to the relevant Housing Authority of those patients who are homeless or at risk of homelessness.
1b. Emergency Departments gain consent from all patients who are homeless or at risk of homelessness prior to any referral to the relevant Housing Authority.
1c. Emergency Departments have safeguarding processes in place for those patients who are homeless or at risk of homelessness who do not want to share their details with the relevant Housing Authority.
1d. For those patients who are homeless or at risk of homelessness a discharge letter is generated and sent to primary care, including information regarding their housing status. If the patient is not registered with a GP the patient is provided with information regarding accessing primary healthcare services as well as other healthcare services (e.g. dental, mental health).
2. Emergency Departments should obtain and record up to date contact details for all patients who are homeless or at risk of homelessness.
3. The Emergency Department is able to provide information regarding hostels, local hubs, street outreach teams where these services exist for any patient who is homeless or at risk of homelessness.
4. All patients who are homeless or at risk of being homeless have an opportunity to discuss issues related to alcohol or drug misuse and that the emergency department is able to provide written advice regarding local services.
5. Homelessness staff information pack is available and reviewed annually, with details of homeless services, local street outreach, day centres, alcohol, drug and specialist targeted health services, and information on out of hours Services.
6a. All emergency departments have processes in place to ensure staff are aware of how to arrange emergency accommodation for homeless patients both in and out of hours.
6b. The emergency department has processes in place to ensure staff are aware of when the 'Severe Weather Emergency Protocol' (SWEP) is activated.
7. When discharging a patient who is homeless or at risk of homelessness, staff should consider the impact and feasibility of the discharge plan (including follow up, medications, isolation) in the light of homelessness, and document this consideration.
8. All emergency departments have processes in place to ensure staff know who to inform when a homeless patient or a patient at risk of homelessness is admitted through the department into the main hospital.

Developmental
9. Prioritised pathways should be in existence for high risk homeless groups: e.g. Homeless people who inject drugs (PWID) attending with suspected DVT will be unlikely to return for USS next day – they need to be prioritised to prevent DNA and re-attendance.
10. The emergency department should have processes in place to identify those groups at high risk of health inequality, which may be associated with Homelessness e.g. Traveller Communities, Vulnerable Migrants, Sex Workers as well as those at risk of sex trafficking and modern slavery.
11. Emergency department link nurse / lead for homelessness plus/minus vulnerable groups.
12. Emergency department Consultant lead for homelessness plus/minus vulnerable groups.
13. The Emergency Department has access to GP records.
14. Trust has a system of recording alerts and multi-agency care plans for high risk or frequent attenders accessible at point of contact.
15. In department alcohol assessment, brief advice and referral is available according to NICE guidance.
16. Emergency department access to drug assessment, brief advice and referral is available.
17. Multidisciplinary forum organised regularly to discuss homeless frequent attenders with community support services.
18. The emergency department has access to regular educational updates on inclusion health (i.e. specific health conditions, impact of psychological trauma, cultural competence, services available to vulnerable groups, legislation).
19. The emergency department waiting room should have information readily available to inclusion health groups, informing them of their rights and availability of services.
20. The emergency department should have a system in place to identify patients from inclusion health backgrounds.
Aspirational
21. Trust has a Homelessness Officer who liaises directly with the emergency department.
22. The emergency department has access to an Inclusion Health team.

23. The emergency department staff are aware of the services available to patients in the inclusion health categories, and how to access them.
24. The emergency department should make efforts to communicate in the vulnerable patient's language through resources such as language line or a translator.
25. The ED should have processes in place for referral to specialist services tailored to the needs of their local population e.g. HIV testing.

Record keeping (patient notes) 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, the patient should be referred for specialist assessment.
5. If acute mental health problem identified, risk assessment is documented and referral to mental health liaison team.
6. Method of attendance documented (self/ police/ ambulance).
7. Past medical history, drug history and allergies documented.
8a. Patient is only referred for GP follow up if they have a registered GP.
8b. Discharge plans should be documented, including how decision has been affected by homelessness (e.g. follow up as in 8a, isolation requirements etc)
Developmental
9. 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).
10. If brought by ambulance service - patient notes document where collected (essential for reviewing notes for safeguarding / frequent attenders).
11. If attending with alcohol related cause – CIWA score to be documented before leaving department.
12. Homeless patients with alcohol as cause of attendance to have Pabrinex IV administered if indicated.
13. If sleeping rough, referred to an outreach team.
14. Follow up plan for any of the above vulnerable groups (Traveller Communities, Vulnerable Migrants, Sex Workers as well as those at risk of sex trafficking and modern slavery) is documented in the patient notes.

References

1. Homeless people are 60 times more likely to visit A&E, study show. The Guardian 2nd July 2019

2. Bowen M, Marwick S, Marshall T et al. Multimorbidity and emergency department visits by a homeless population: a database study in specialist general practice. British Journal of General Practice 2019; 69 (685): e515-e525. DOI: https://doi.org/10.3399/bjgp19X704609 accessed 26.02.202

3. https://www.bma.org.uk/news/2019/december/no-place-to-recover-the-rocketing-demand-on-the-nhs-from-homeless-patients. Accessed 27.02.2002

4. Homeless and Inclusion Health standards for commissioners and service providers. Faculty for Homeless and Inclusion Health Version 3.1 October 2018.

About this document

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Review
Usually within three years or sooner if important information becomes available.

Conflicts of Interest
None declared

Disclaimers
The College recognises that patients, their situations, Emergency Departments and staff all vary. This guideline cannot cover all possible scenarios. The ultimate responsibility for the interpretation and application of this guideline, the use of current information and a patient's overall care and wellbeing resides with the treating clinician.

Research Recommendations
None

Audit standards
As document above

Key words for search
Emergency Department, Inclusion Health, Homelessness, Social Isolation

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