

**Why you should read this article:**

- To recognise the unmet needs of homeless people who attend the emergency department
- To increase your awareness of the barriers that homeless people may experience when attempting to access healthcare services, and how these could be addressed
- To count towards revalidation as part of your 35 hours of CPD, or you may wish to write a reflective account (UK readers)
- To contribute towards your professional development and local registration renewal requirements (non-UK readers)

# Meeting the needs of homeless people attending the emergency department

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**Abstract**

Homelessness is on the rise in the UK and, over the past few years, there has been a significant increase in the number of emergency department (ED) attendances and admissions by homeless people. Those attending the ED will often have multiple unmet health, housing and social care needs. While it is not possible to meet all these needs in the ED, emergency nurses should be equipped with the knowledge and skills required to communicate with, refer and signpost patients who are homeless.

Under the Homelessness Reduction Act 2017, ED staff have a duty to refer homeless people, with their consent, to local authorities for assistance. This article details the barriers that homeless people may experience when accessing healthcare services and explains how these can be addressed. It also outlines the actions that emergency nurses can take to improve the care of homeless people in the ED at an individual and a systems level.

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**Keywords**

emergency care, emergency services, ethical issues, health inequalities, homelessness, mental capacity, mental health, professional, public health, substance misuse

**Aims and intended learning outcomes**

The aim of this article is to enable nurses working in the emergency department (ED) to understand the needs of patients who are homeless and know what they can do to address these needs. After reading this article and completing the time out activities you should be able to:

- » Describe the various groups of people who are considered homeless.
- » Discuss the barriers that patients who are homeless may experience when attempting to access healthcare services.

- » Explain the statutory 'duty to refer' patients who are homeless to local authorities under the Homelessness Reduction Act 2017.
- » Understand the importance of assessing mental capacity and safeguarding patients who are homeless.
- » Outline what actions can be taken to improve the care of homeless people attending the ED.

**Introduction**

It has been estimated that 320,000 people in the UK are homeless, including people who

are sleeping rough and those who are living in temporary accommodation such as hostels or bed and breakfasts (Shelter 2018). There are also at least a further 300,000 homeless people who are 'hidden' from statistics, such as people who are 'sofa surfing' (sleeping on various people's sofas) or living in their car (Geraghty 2018).

England, Wales and Northern Ireland have all seen large rises in the number of people sleeping rough in the past ten years. Scotland has seen increases in major cities, but rough sleeping has reduced in other areas (Office for National Statistics (ONS) 2019).

In England, this rise in homelessness has been accompanied by a threefold increase in the number of homeless people attending and admitted to the ED (Iacobucci 2019), and greater use of secondary care services than in the general population (Department of Health (DH) 2010).

Homelessness is associated with suboptimal health outcomes. Between 2013 and 2017, the average age of death of homeless people in England and Wales was 44 years in men and 42 years in women (ONS 2018). This is a reduction from previous research that found the average age of death was 47 years for homeless men and 43 years for homeless women between 2001 and 2009 (Crisis 2011).

Standardised mortality rates in inclusion health groups, which include people experiencing homelessness, are ten times higher than those seen in the general population, with the most common causes of death being preventable and treatable conditions (Aldridge et al 2018).

#### TIME OUT 1

Consider the challenges that a homeless person may have accessing primary care. How do you think this may make them feel? Consider the term 'inappropriate attender'. Do you think this term should be applied to someone who experiences homelessness?

Reasons for suboptimal health outcomes and excess mortality among homeless people include tri-morbidity (co-occurrence of physical health conditions, mental health issues and substance misuse) (Hewett et al 2012), alongside other complex issues including behaviour that challenges, legal and/or immigration issues, and barriers in accessing scheduled care and support services.

Barriers preventing homeless people from accessing primary and preventive care include stigma (Rae and Rees 2015, Gunner et al 2019), low literacy levels,

cognitive deficits, language barriers, mental health issues and substance misuse, as well as practical challenges such as finding someone to care for their pets, transience or being inappropriately asked for identification to register with a GP (Gunner et al 2019). Some people may also be concerned about being charged for care under the NHS visitor and migrant cost recovery programme (British Medical Association 2019); although primary care is not chargeable, this is often not well understood.

These barriers mean that the use of primary and preventive care among homeless people is low, while their use of emergency care is high. However, emergency care focuses primarily on a person's presenting condition and often does not address their broader health and social care needs, resulting in missed opportunities to prevent suboptimal health outcomes and reduce the financial costs to the NHS and other public services.

Homeless people attending the ED often have multiple unmet health, housing and social care needs. While it may not be possible to meet all these needs in the ED, a homeless person's ED attendance should be used as an opportunity to take action. These patients should not be judged to be 'inappropriate attenders' (Ismail et al 2013). Their presenting health conditions should be addressed and ED staff should take the opportunity to 'make every contact count', ensuring they refer and signpost people appropriately.

#### Understanding patients' circumstances and needs

In healthcare settings, staff will often not know if a patient is homeless unless the person is directly asked about their housing status, the person themselves chooses to disclose their housing status, or the person cannot provide an address and needs to register as having 'no fixed abode'.

Many homeless people will have an address, and some will have care-of addresses. This, combined with the fact that some hide their homelessness, means that healthcare staff often miss an opportunity to signpost people to appropriate care and support services. If it is not identified that a patient is homeless when they are admitted to hospital, this can later delay their discharge (Pathway and National Homelessness Advice Service 2019).

#### Access to primary care

The main barrier for homeless people to accessing primary care is with initial

registration. One study by Hodson et al (2019) demonstrated that, out of 100 GP practices in London, 75% asked for an address and/or photo identification to register, which is contrary to national guidance. Many homeless people do not have a form of identification.

Other barriers to accessing primary care include people having insufficient credit on their phone to call the GP surgery and appointments being too short to address their needs in a proactive way (Burrows et al 2016). It may be that, for a homeless person, the ED is the first and only place they can access healthcare. Therefore, where possible, ED staff need to ensure that the patient has access to primary care before they leave the ED.

### Physical health needs

Homeless people experience high levels of morbidity and mortality resulting from long-term treatable conditions, so it is likely that a homeless person attending the ED will have ongoing health conditions requiring treatment, although they may not articulate this as their priority. These conditions often include infectious diseases, which have consequences for public health. Beijer et al's (2012) systematic review found that the prevalence of tuberculosis, hepatitis C infection and human immunodeficiency virus (HIV) infection were significantly higher among homeless people than in the general population.

Aldridge et al's (2019) study found that, in a cohort of 3,882 people identified as homeless who were seen in hospital, 600 died in the following two years, one third of whom died from preventable conditions. Story (2013) identified that homeless people are 2.5 times more likely to have asthma, five times more likely to have a stroke, six times more likely to have heart disease and 12 times more likely to have epilepsy than the general population. They are also more likely to have two or more physical health conditions (Story 2013).

### TIME OUT 2

Among the patients you assess in the ED, do you think you are always able to identify those who are homeless? What issues related to communication and complex trauma might patients who are homeless experience? Are there adequate provisions made in your ED to support effective communication with these patients?

### Communication issues

Communication issues may occur because homeless people are more likely to have low

literacy levels than the general population (ThamesReach 2010, St Mungo's 2014), and they may feel embarrassed or reluctant to admit this, for example when asked to fill in a form.

Cognitive deficits can also cause communication issues. These are common in this population and are often secondary to an acquired brain injury related to physical trauma and/or alcohol abuse. In one study, 45% homeless people were found to have sustained a traumatic brain injury (Topolovec-Vranic et al 2014).

Brain injury can cause cognitive deficits that often go unnoticed and undocumented, particularly if the person is often under the influence of alcohol, because this makes cognitive deficits harder to assess. Cognitive deficits can mean that the person finds it challenging to follow instructions or remember and/or process information.

Another issue is that many people who are homeless do not speak English as a first language and are often not offered interpretation on arrival or during assessment in healthcare services, contrary to official guidance (NHS England 2018).

Mental health issues are common among homeless people, with 80% self-identifying as having a mental health issue (Homeless Link 2014). Even common mental health conditions such as anxiety and depression can lead to considerable communication issues.

### Trauma and its effects on behaviour

Homeless people are more likely than the general population to have experienced adverse childhood events and, as a result, to have complex trauma, post-traumatic stress disorder or personality disorders.

It is estimated that 70% of single homeless people have a personality disorder, compared with 4% of the general population (Maguire et al 2009). This means that a homeless person may find it challenging to trust others, develop relationships, manage stress and wait for treatment. As a result, they may adopt seemingly antagonistic behaviours that they may find hard to modulate.

If a healthcare professional uses an inappropriate choice of words and tone, for example 'you can't speak like that in here!', this may result in a violent reaction, self-discharge or the person being removed from the premises by security, despite the fact that they need care.

A more effective approach might involve the healthcare professional calmly saying 'the

## Key points

- Homeless people experience suboptimal health outcomes and higher rates of mortality compared with the general population
- There are several barriers to accessing healthcare for homeless people, including challenges accessing primary care and communication issues
- Healthcare professionals have a duty to refer homeless people, with their consent, to the local authority for assistance
- It may be necessary for emergency departments to take a systems-level approach to improving the care of patients who are homeless, involving all levels of staff

way you are speaking is difficult for me to deal with, but I want to hear what you are saying. If you could speak a bit more calmly, I will be able to try to help you.'

### TIME OUT 3

Are you aware of the 'duty to refer' under the Homelessness Reduction Act 2017? Do you think your colleagues are aware of it? What could you do to ensure the duty to refer is effectively carried out in your ED? Do you think you would be able to identify a patient who may be experiencing homelessness?

### 'Duty to refer' under the Homelessness Reduction Act 2017

Since April 2018, the Homelessness Reduction Act 2017 has conveyed a 'duty to refer' on various statutory bodies, including healthcare organisations (Ministry of Housing, Communities and Local Government 2018).

This duty requires that homeless people are, with their consent, referred to the local authority for assistance. In healthcare, this duty explicitly applies to EDs and inpatient services, and includes the responsibility to refer people at risk of homelessness within the next 56 days – for example, people likely to be evicted from their home.

The duty to refer provides an additional reason for asking patients about their housing status to identify those who are homeless or at risk of becoming homeless. Most local authorities have an email address for referrals and some have signed up to the Housing Jigsaw system, which enables rapid referral. Guidance on the duty to refer is available from the National Homelessness Advisory Service (nhas.org.uk), which may also be able to provide training for healthcare staff. Hospitals should consider including the duty to refer in their mandatory training.

### Assessing patients who are homeless in the emergency department

#### Identifying patients who are homeless

Homelessness should ideally be identified when a patient arrives at the ED or during initial assessment. Nurses need to understand how to sensitively ask people about their housing status and identify nuances in their responses; for example, a person saying they are 'staying with a friend' may indicate a stable or an unstable housing status, so requires further exploration.

History taking should include an assessment of the person's home circumstances and their discharge destination. Patients may initially be embarrassed about their homelessness or may not see the relevance of their housing

status. Asking routine questions such as 'Do you have any concerns about where you will go on discharge?' or 'Where do you live at the moment? Are you OK to go there on discharge?' may assist in eliciting honest responses.

Identifying homelessness early will enable nurses to gain an understanding of the patient's social context at initial assessment and consider it in the care plan. Housing issues and homelessness should always be considered as a potential cause of a person's frequent or increasing ED attendance. It has been suggested that a person's presentations to healthcare services often increase before they become homeless for the first time. One study found that 59% of homeless women felt that their health had contributed to them becoming homeless (Groundswell 2020).

#### Obtaining accurate contact details

It is essential to check and update the address, contact details and GP details on the hospital records of a patient who reveals that they are homeless. If patients cannot remember who their GP is, staff may find it useful to check the NHS Spine digital database, which contains the Summary Care Records of patients registered in primary care services in the UK who have agreed for their record to be accessible online.

It is also important to obtain next-of-kin and/or emergency contact details if possible. It may be that the patient says they do not have an emergency contact or that it is likely to change, but having such information can be crucial because of the complex health needs of this patient group. If no other contacts are available, the patient can be encouraged to give the details of a key worker or support service.

#### Ensuring triage is effective

When assessing and triaging patients, emergency nurses should start from the perspective that those who are homeless are likely to have a serious health condition that they may not be able to articulate.

Emergency nurses should ensure that they take a thorough medical and medication history, and ask the patient for background information about any mental health issues and substance use. Showing that they care and demonstrating patience is important, even if the patient seems challenging to communicate or engage with. It may be that, in the past, that patient has been triaged in the ED as a minor presentation and redirected to out-of-hours primary care provision.

Nurses need to think carefully and ensure serious health conditions have been ruled out before deciding to do this.

### Assessing mental capacity

Under the Mental Capacity Act 2005, a person assessed as lacking mental capacity is deemed unable to make or communicate a decision about their care because of 'an impairment of, or a disturbance in the functioning of, the mind or brain'.

The impairment or disturbance may be caused by factors such as mental health issues, learning disability, dementia, brain injury or intoxication. Assessing mental capacity may require a considerable amount of time to explore the relevant issues with the patient, and the discussion needs to be fully documented. Box 1 details the two-stage assessment of mental capacity.

In the context of homelessness, mental capacity is often assessed when a person decides not to seek treatment or to leave a healthcare setting before completing treatment. A mental capacity assessment may also be conducted to determine whether a person is able to care for themselves, for example if they are able to take their medicines as prescribed while sleeping rough, particularly if they are unwell. Several factors may affect the assessment of a homeless person's mental capacity, including behavioural issues. For example, some people with complex trauma may be unwilling to engage in a mental capacity assessment because they do not trust others. Guidance on undertaking mental capacity assessments with people who are sleeping rough is available from Pathway (2020).

If the patient refuses to take part in a mental capacity assessment, this should not be recorded as the patient having mental capacity. In such cases, the multidisciplinary team should discuss a plan to obtain external evidence about the patient and gain their trust

so that the assessment can be undertaken. It may also be appropriate to involve a healthcare professional with expertise in mental capacity assessment.

### TIME OUT 4

Think about a patient you have cared for who had been diagnosed with a personality disorder and displayed behaviour that challenges. How did they make you feel? Is there anything you could do to improve the assessment and management of such patients? Ask your colleagues whether they have used any communication strategies that have been effective with such patients, and reflect on how you could implement these in your practice

## Managing patients who are homeless in the emergency department

### Managing behaviour that challenges

When caring for patients who have experienced complex trauma and display associated behaviour that challenges, it is important to empathise with the person and remember that they are presenting to the ED because they have an unmet need. Emergency nurses will need to:

- » Attempt to understand why the behaviour is occurring.
- » Provide clear information and develop trust.
- » Offer practical solutions – for example, signposting patients to day centres, specialist primary care or drug and alcohol treatment services.
- » For patients who frequently attend the ED, put in place clear boundaries that are agreed with the patient, explain these to them gently, and consistently apply these at every attendance. These boundaries need to be agreed collectively by the team and communicated to all staff via the patient's care plan.

To develop skills in establishing therapeutic relationships and de-escalating challenging situations, it may be beneficial for emergency nurses to learn more about trauma-informed

### FURTHER RESOURCES

Homeless Link

[tinyurl.com/HomelessLink-search](https://www.tinyurl.com/HomelessLink-search)

London Network of Nurses and Midwives  
[homelesshealthnetwork.net](https://www.homelesshealthnetwork.net)

Pathway – Faculty for Homeless and Inclusion Health  
[www.pathway.org.uk/faculty](https://www.pathway.org.uk/faculty)

StreetLink  
[streetlink.org.uk](https://www.streetlink.org.uk)

The Queen's Nursing Institute – Homeless Health Programme  
[tinyurl.com/QNI-homeless-health-matters](https://www.tinyurl.com/QNI-homeless-health-matters)

### Box 1. Two-stage assessment of mental capacity

The Mental Capacity Act 2005 contains a two-stage assessment of mental capacity:

1. Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works? It does not matter whether the impairment or disturbance is temporary or permanent
2. If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

The person is regarded as being able to make a decision if they are able to:

- » Understand the decision they need to make and why they need to make it
- » Understand the likely consequences of making, or not making, the decision
- » Understand, retain, use, and weigh up the information relevant to the decision
- » Communicate their decision

(Department for Constitutional Affairs 2007)

care and how to manage personality disorders effectively; for example, by reading *Meeting the Challenge, Making a Difference* (Bolton et al 2014).

After a challenging situation with a patient has occurred, it is important to undertake a team debrief and discuss whether alternative approaches could have been adopted and whether there are community services, for example befriending services, that could support the patient during subsequent ED attendances.

#### Managing substance misuse

Many homeless people attending the ED will misuse alcohol and/or drugs, and may potentially experience withdrawal symptoms. One reason why patients who are homeless may discharge themselves is if they experience or anticipate experiencing withdrawal symptoms.

On their presentation to the ED, nurses need to ask patients who are homeless about their drug and alcohol use and whether they are likely to experience withdrawal symptoms. Developing a plan to manage withdrawal symptoms at an early stage may enable patients to engage with their care and reduce their anxiety. Withdrawal symptoms can be assessed using the Clinical Institute Withdrawal Assessment for Alcohol Scale (CIWA-Ar) (Sullivan et al 1989) or the Clinical Opiate Withdrawal Scale (COWS) (Wesson and Ling 2003). If required, opiate withdrawal regimens using methadone hydrochloride, or alcohol withdrawal regimens using chlorthalidone hydrochloride, need to be initiated as soon as possible.

#### Supporting patients with communication issues

To reduce communication issues, patients with low literacy levels should be routinely offered assistance with forms, instructions and leaflets, on arrival and throughout their ED attendance.

To assist patients with cognitive deficits, it is important to check that they have understood any instruction given and write these down in simplified terms if required. Undertaking a Mini-Mental State Examination (MMSE) or using another cognitive assessment tool at every ED attendance will be useful to identify patients' baseline cognitive functioning and any subsequent deterioration or progress, since cognitive deficits may not be immediately obvious.

It is essential that patients who do not speak English as a first language are offered

interpreting services throughout their ED attendance. Ideally, friends and family should not be used as interpreters unless the patient requests this (NHS England 2018).

#### Signposting patients to community services

A simple but effective intervention is to signpost patients who are homeless to support services in the community. Therefore, nurses need to collect and update information on local services, for use by all ED staff. They could also consider shadowing local services. The types of services to keep information about are:

- » Specialist homeless GPs and/or local GPs.
- » Housing services.
- » Homeless day centres, soup kitchens and night shelters.
- » Homeless charities.
- » Drug and alcohol treatment services.
- » Mental health crisis services.
- » Citizens Advice.
- » Domestic violence associations.
- » Sexual health services.
- » Nurse specialist-led primary care services.

The Homeless Link website ([homeless.org.uk/homeless-england/search-near-me](http://homeless.org.uk/homeless-england/search-near-me)) can be used to source up-to-date information on local services. ED staff can also refer patients directly to their local street outreach service via the StreetLink website ([streetlink.org.uk](http://streetlink.org.uk)) or phone line. StreetLink requires basic information on what someone looks like, where they are sleeping, whether there are any risk factors and ideally the person's name and contact details. It may be useful to inform people who are rough sleeping that they need to remain in one place so that the outreach service can find them.

#### Ensuring there are no safeguarding concerns

The Care Act 2014 requires that vulnerable people are adequately safeguarded from abuse and self-neglect. People with care and support needs, and those with communication issues, are particularly at risk of abuse or self-neglect because they may not be able to alert others to their circumstances. In many cases, people may not be aware that they are being abused or neglected, particularly if they have cognitive deficits.

Safeguarding concerns need to be actively ruled out for any homeless person attending an ED, particularly if the person is to be discharged to the street. If there is evidence that the person will not be able to care for themselves adequately, discharging them could be seen as an act of omission or institutional abuse, and this should be raised

immediately with the charge nurse and safeguarding lead.

The charity Voices (2016) has developed a tool to support people with multiple needs to collect and submit information to social services, so that they can articulate their circumstances in the context of the Care Act 2014.

### Discharging patients from the emergency department

While it is not ideal to discharge a patient from the ED to the street, this does sometimes happen. In some areas, there are specialist step-down facilities, which are an alternative form of intermediate care providing temporary health-led housing placements for people who would otherwise be homeless. Such facilities specialise in managing patients with co-morbid mental health issues and substance misuse (Dorney-Smith et al 2019).

Emergency nurses caring for homeless people need to be experts in assessing mental capacity and understanding safeguarding legislation to ensure that discharge or self-discharge to the street is as safe as possible.

If a patient is assessed as having the mental capacity to self-discharge from the ED and there are no safeguarding issues, they will still need to be signposted or referred for follow-up care wherever possible; for example, by booking appointments for them with specialist primary care or drug and alcohol treatment services. They will also need to be referred, with their consent, to the local authority under the duty to refer.

The Healthy London Partnership (2020) has developed guidance and a checklist to support the safe discharge of patients who are homeless. In some areas, it may be possible to refer patients to homeless health peer advocacy services such as those provided by the charity Groundswell.

### Improving the care in emergency departments of patients who are homeless

It may be necessary for EDs to take a systems-level approach to improving the care of patients who are homeless, involving all levels of staff. This section details some actions that can be taken in the ED to improve the care of patients who are homeless.

#### Nominating a homelessness lead

One method of improving the care of patients who are homeless could be to nominate a homelessness lead within a hospital or ED.

This role would primarily involve making connections with relevant community services and providing useful information in an easily accessible format for staff and patients, for example by producing leaflets and/or a web page.

The homelessness lead could also be tasked with identifying the training needs of staff and sourcing the training required. In a more comprehensive approach, the lead could undertake a full inclusion health review to examine how inclusive forms, leaflets and processes are.

#### Auditing the care of homeless people

In 2015, 22 hospitals in the UK audited the ED care of 294 patients who were homeless, according to 13 standards (Royal College of Emergency Medicine (RCEM) et al 2015).

While the overall care was shown to be effective, the audit revealed several areas for improvement:

- » Around half of patients were not registered with a local GP, and 83% of these patients were not given advice or signposting for GP registration by ED staff.
- » A drug and alcohol history was documented in only 61% of patients.
- » Among patients in whom drug or alcohol use was identified and documented as the direct cause of presentation to the ED, only 25% were referred for specialist drug or alcohol assessment.
- » Of the patients who had an acute mental health issue identified and documented, 27% were not referred to the mental health liaison team.

This audit has led to service improvements in the EDs, and other EDs in the UK could consider auditing the care they provide to patients who are homeless. The RCEM (2020) best practice guideline provides further information about standards of ED care for homeless people.

#### Employing specialist staff or running a specialist service

Many hospitals have chosen to employ nurse specialists, housing workers and/or multidisciplinary teams who work to resolve the issues of homeless people in EDs and inpatient services, and who may use the model recommended by Pathway. It has been demonstrated that the Pathway model: reduces the duration of ED admissions of homeless people and the number of subsequent ED attendances and readmissions (MPath 2013, Dorney-Smith et al 2016, Wyatt 2017); improves housing outcomes

### FURTHER RESOURCES

Public Health England (2019a) Health Matters: Rough Sleeping  
[tinyurl.com/govuk-health-matters](https://tinyurl.com/govuk-health-matters)

Public Health England (2019b) Homelessness: Applying All Our Health  
[tinyurl.com/govuk-homelessness](https://tinyurl.com/govuk-homelessness)

on discharge (Homeless Link 2015, Dorney-Smith et al 2016, Khan et al 2019); and improves health outcomes after discharge (Hewett et al 2016).

The following case study describes how a nurse from the Pathway team supported a homeless person who frequently attended the ED.

Some hospitals have specialist step-down facilities providing intermediate care to patients who are homeless (Dorney-Smith et al 2019). A formal needs assessment is usually undertaken to identify if the patient requires such care. Pathway (2018) offers advice on how to conduct a needs assessment for a medical respite service.

#### Improving the recording of housing status

The Emergency Care Data Set (NHS England 2020) prompts reception staff in EDs to ask patients about their housing status when they initially book in. This is not mandatory but some EDs may routinely implement this. However, even when routinely implemented, it may still be insufficient to identify 'hidden' forms of homelessness such as sofa surfing. Therefore, it may be beneficial to review and extend the housing status fields available on the drop-down menus in the electronic patient systems of EDs.

#### Case study 1. Sally

Sally (a pseudonym) was a 50-year-old woman experiencing homelessness. She was known to 13 hospitals and one primary care provider. She had left-sided weakness from a previous stroke and intermittent urinary incontinence, and was alcohol dependent.

Sally usually appeared unkempt and unsteady on her feet. She had lost her long-term partner eight years ago. It was unclear whether she had the mental capacity to make decisions about her care because she had been unwilling to engage in mental capacity assessments. However, she had sometimes expressed a desire to be cared for.

#### Referral to a nurse from the Pathway team

Sally was referred to a nurse working within the local Pathway team, who found that Sally had had a long history of attendances to the emergency department (ED). In the previous five years, Sally had 508 ED attendances and 59 admissions in nine of the 13 hospitals where she was known – data from the other hospitals were missing.

This pattern of ED attendance had not always been identified by hospital staff for several reasons, including that:

- » Sally had unintentionally given a slightly different name and date of birth every time she had attended an ED.
- » Staff had found it challenging to assess Sally because of her behaviour.

#### Conclusion

The care needs of homeless people attending EDs are frequently misunderstood and, as a result, referral for ongoing care is often insufficient. This means that they may keep returning to the ED, because their health, housing and social care needs have not been adequately addressed by other healthcare services.

Understanding and attempting to address these broader needs of patients who are homeless can have long-term benefits because they may develop confidence and trust in ED staff, who can then assist them in accessing support from other health and social care services.

#### TIME OUT 5

Consider how meeting the needs of homeless people attending the ED relates to The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates (Nursing and Midwifery Council 2018) or, for non-UK readers, the requirements of your regulatory body

#### TIME OUT 6

Now that you have completed the article, reflect on your practice in this area and consider writing a reflective account: [rcni.com/reflective-account](https://rcni.com/reflective-account)

- » Some staff had appeared to adopt a policy of doing what the previous clinician had done.

When staff did identify Sally's attendance pattern, they did not know who they could contact to support her, because she had no settled base and no clear pattern of engagement with community services. Sally tended to self-discharge from the ED but refused to engage in mental capacity assessments about these decisions. Some staff had incorrectly interpreted the Mental Capacity Act 2005 by documenting that they had no reason to assume Sally did not have mental capacity, when there was significant evidence of the contrary.

#### Developing a care plan for Sally

The nurse from the Pathway team developed a care plan that was communicated to all services involved. An initial temporary accommodation placement broke down quickly because Sally needed further support. However, she was eventually taken from an ED directly to a nursing home, where she settled and stayed permanently. Sally stopped attending EDs and her desire to be cared for was satisfied.

Sally's case demonstrates that improvements in communication between teams in EDs are essential to provide effective care for people experiencing homelessness.

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# Meeting the needs of homeless people attending the emergency department

TEST YOUR KNOWLEDGE BY COMPLETING THIS MULTIPLE-CHOICE QUIZ

**1. One of the main barriers to homeless people accessing primary care is:**

- a) Not being allowed into a GP surgery by reception staff
- b) Being asked to provide identification on initial registration at a GP surgery
- c) Attending appointments on time
- d) GPs being unwilling to see homeless people

**2. Which statement is true?**

- a) The use of primary and preventive care among homeless people is low, while their use of emergency care is high
- b) The number of homeless people admitted to emergency departments (EDs) has decreased in England
- c) The use of primary and preventive care among homeless people is high, while their use of emergency care is low
- d) There have been significant declines in the number of homeless people throughout the UK in the past few years

**3. Tri-morbidity is the co-occurrence of:**

- a) Three physical health conditions
- b) Mental health issues, alcohol misuse and drug misuse
- c) Physical health conditions, mental health issues and substance misuse
- d) Three mental health issues

**4. Which of the following groups are considered to be homeless?**

- a) People who sleep on buses
- b) People who are sofa surfing
- c) People who sleep in their car or workplace
- d) All of the above

**5. Which of these tools could be used to assess withdrawal symptoms in patients presenting with alcohol misuse?**

- a) Alcohol Use Disorders Identification Test
- b) Mini-Mental State Examination
- c) Clinical Institute Withdrawal Assessment for Alcohol Scale
- d) Waterlow scale

**6. Under the Homelessness Reduction 2017, the 'duty to refer':**

- a) Requires healthcare organisations to refer homeless people, with their consent, to a local authority
- b) Does not apply to EDs and inpatient services
- c) Requires healthcare organisations to refer homeless people, without consent, to a local authority
- d) Applies only to people who are already homeless

**7. When caring for with patients who display behaviour that challenges emergency nurses need to:**

- a) Attempt to understand why the behaviour is occurring
- b) Provide clear information and develop trust
- c) Put in place clear boundaries
- d) All of the above

**8. Which statement is false?**

- a) Mental capacity is often assessed in homeless people who do not seek or complete treatment
- b) Homeless people who refuse mental capacity assessments should be recorded as having mental capacity
- c) People with complex trauma may not engage in mental capacity assessments because they mistrust others
- d) It may take a long time to explore relevant issues with people being assessed for mental capacity

**9. Patient who want to self-discharge from the ED to the street:**

- a) Must always be prevented from doing so
- b) Should be assessed as having mental capacity to do so and safeguarding concerns should be ruled out
- c) Do not need to be referred with their consent to a local authority for assistance under the duty to refer
- d) Should not be signposted or referred for follow-up care

**10. Which of the following is not a potential role of a lead for homelessness in a hospital or ED?**

- a) Making connections with relevant community services and collate useful information
- b) Identifying staff training needs and sourcing training
- c) Referring homeless people to a mental health liaison team
- d) Undertaking a full inclusion health review

**How to complete this assessment**

This multiple-choice quiz will help you test your knowledge. It comprises ten multiple choice questions broadly linked to the previous article. There is one correct answer to each question.

You can read the article before answering the questions or attempt the questions first, then read the article and see if you would answer them differently.

**You may want to write a reflective account. Visit [rcni.com/reflective-account](http://rcni.com/reflective-account)**

Go online to complete this multiple-choice quiz and you can save it to your RCNi portfolio to help meet your revalidation requirements. Go to [rcni.com/cpd/test-your-knowledge](http://rcni.com/cpd/test-your-knowledge)

This multiple-choice quiz was compiled by **Anne-Claire Bouzanne**

*The answers to this multiple-choice quiz are:*

1 b 2 a 3 c 4 d 5 c 6 a

7 d 8 b 9 c 10 c

This activity has taken me \_\_\_ minutes/hours to complete. Now that I have read this article and completed this assessment, I think my knowledge is:

Excellent  Good  Satisfactory  Unsatisfactory  Poor

As a result of this I intend to: \_\_\_\_\_