We must tackle unsafe hospital discharge for homeless patients

Nurses need to resist the pressure to discharge homeless patients inappropriately, and must act to ensure better outcomes for them, says Samantha Dorney-Smith

Homeless people experience more health problems and have poorer access to healthcare than the general population. They also have a higher rate of attendance and admission to hospital and, once there, problems continue.

They suffer a higher rate of inadequate inpatient management, and frequently experience unsafe hospital discharge, such as self-discharge, inappropriately early discharge, and/or discharge to inappropriate accommodation.

Hospital admission is often the only time a homeless person is free of substance misuse, well cared for, and in a position to talk coherently with healthcare professionals. It is also a time when there is potential for reflection and making life changes. This opportunity is often missed.

A common reason for self-discharge relates to substance misuse.

Recently, an ambulance crew, when collecting a patient from one of our hostels, drove the patient to the pharmacist for his daily methadone dose on the way to A&E.

This was an example of excellent, patient-centred practice, and demonstrated a clear understanding of that patient’s needs. A client drinking 15L of cider a day or injecting £100 of heroin a day will not stay long in hospital without the addiction problem being treated.

Failed discharges are common. Once in hospital, hostel dwellers often realise their hostel accommodation is unsafe and do not want to return. However, because they are perceived as having a home, their concerns are not heard.

Homeless hostels can be extremely unsafe. Although the voluntary organisations that run them do an excellent job, these hostels are full of clients engaged in substance misuse, with a variety of mental health disorders. Health outcomes are often appalling. In one hostel last year there were seven deaths, at an average age of 38 years.

Clients requesting not to return to their hostel should always be referred immediately to a social worker, and need strong advocacy. Commonly, clients are unable to articulate clear opinions about their future. For example, many homeless patients have cognitive deficits (secondary to alcohol misuse), or are severely depressed and have mental capacity issues. They may not be able to conceptualise the risks of living in a hostel.

Expert psychiatric opinion might be needed. A working knowledge of the Mental Capacity Act is required by all professionals involved in discharging homeless patients.

Some clients may need to be discharged to a homeless persons’ unit. In these cases, patient hotels and/or intermediate care settings should be considered. A welfare rights/benefits worker should also be involved.

Every effort should be made to ensure adequate follow up. Check whether clients have a GP and, if not, try to register them. Refer them to the nearest homeless health team, and check they know how to access services. Ensure you have their addresses for outpatient appointments.

There is often pressure to discharge homeless patients, and a feeling they will quickly become “bed blockers”. There is even sometimes a perception that other patients may be more deserving. Although evidence does suggest that homeless people stay in hospital for twice as long as others, they are generally twice as sick. There is no evidence they become “bed blockers” any more than the general population. If safer discharges do mean clients end up staying longer, the trade off will be less re-admission and much better outcomes for the most vulnerable patients.

So now I encourage you to ask yourself – are you discharging your homeless patients safely?

Hospital admission is potentially a time when life changes can be made. This opportunity is often missed.

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