# Checklist for staff

A simple checklist for hospital staff on the practical steps they can currently take to support effective discharge of patients experiencing homelessness and those at risk of homelessness is provided below, which can be adapted and aligned to local admission and discharge policies.

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| Has this person been identified as experiencing homeless or at risk of homelessness on admission or within 24 hours?  *This should be done by asking ‘do you have somewhere safe to stay when you leave hospital and/or Are you worried about where you will stay after your discharge?’* | ☐ |
| If they answer ‘no’ to the first question and ‘yes’ to the second question seek consent to make a referral to the local authority/CPS.  If consent is given, the individual’s contact details and the reason for the referral (that they are homeless or threatened with homelessness) should be shared with the local authority/CPS.  Designated contact for homeless discharges is: homelesshd@dublincity.ie  Details for every local authority can be found here:  <https://www.gov.ie/en/publication/942f74-local-authorities/> | ☐ |
| If consent to refer to the local authority is not given, discuss and identify the support they need to maintain their stay in hospital and to avoid early self- discharge.  *For example, are they concerned about losing their accommodation due to being in the hospital? Do they have any drug or alcohol needs that need to be addressed? Would peer support be beneficial for them* (for peer support details see stakeholder registar). | ☐ |
| Have you explored relevant partners to involve in coordinating safe and effective discharge arrangements?  In discussion with the patient, identify any key workers/case managers or other people who may have been involved with them and can support them and help with discharge coordination. Check with local authority/CPS if key worker/case manager’s details can be obtained from PASS system.  Involve the patient and where relevant their ongoing discharge destination and support staff in making decisions about their discharge arrangements. | ☐ |

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| For people sleeping rough – have links been made with the local outreach team?  The Street Outreach Service engages with adults experiencing rough sleeping, helping them transition into short-term homeless accommodation and connecting them to permanent housing options. The service also links individuals to housing and health services to support stability and prevent further rough sleeping. Contact with outreach team can be made through:  This will help to understand the background and support offers that may be available in making discharge arrangements. | ☐ |
| Have you assessed whether ongoing care, support and assessment can be carried out safely at the discharge destination by providing clear information on the level of support needs to the local authority/CPS? | ☐ |
| Have you notified both the patient, local authority/CPS and, where relevant, their ongoing destination in advance of the planned discharge, so that the necessary arrangements can be put in place?  Discharge arrangements such as timing, transportation and support should be agreed with the individual and the ongoing destination. (Discharge Summary and prescription to be given to patient prior to discharge) – ensure PHN referral has been sent if relevant. | ☐ |
| Have you sent discharge summary to relevant service providers and receiving facility before patient leaves the hospital (such as GP, StepUp-Step Down, homeless service provider, etc.). | ☐ |
| The local champion / link person / team for homeless patients to contact for support are **[to be completed locally]** | ☐ |
| Local homelessness services and partners to consider involving in discharge coordination are **[to be completed locally]** | ☐ |