Misunderstood and Overlooked: Piloting tissue viability wound care and nurse outreach with people experiencing homelessness and multiple disadvantage

Partner working between:

Fulfilling Lives in Islington and Camden
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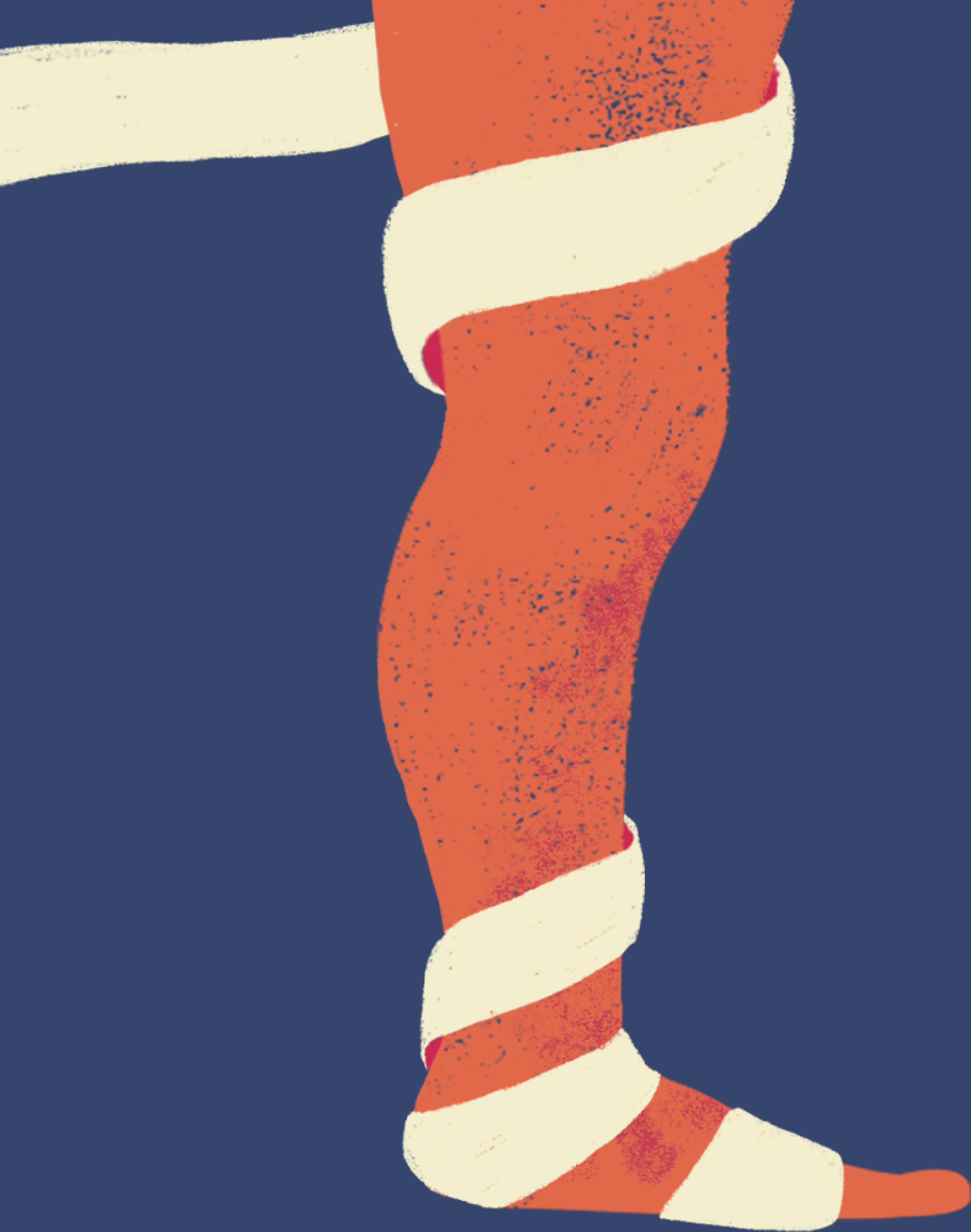
Public Health – Camden
London Borough of Camden Council – Adult Pathway Services

Authors:

Dr Jasmin Malik
Dr Jemell Geraghty

Fulfilling Lives in Islington & Camden



Authors:

Dr Jasmin Sakhina Tzortzakakis Malik
MBChB BSc MSc MRCGP DFFP DRCOG
GP Homeless and Inclusion Health
Clinical Lead Homeless Health and Mental Health
NHS North Central London

Dr Jemell Geraghty DHRes, MSc, BN, RGN
Nurse Consultant Tissue Viability & Lecturer King's College London
Email: jemell@vascularwoundcare.com
Twitter: @woundnurseUK

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Introduction

Homelessness and poor health is intrinsically linked with the poorest health outcomes seen within society[1]. People experiencing homelessness are among the most vulnerable and isolated. Subsequently, death at a young age is commonly seen, with the average age of death being 45 for men and 43 for women[2].

When seeking help and treatment, there are multiple barriers that continue to exist. The format of traditional health and care systems struggle to meet a homeless person's needs and as such, it directly impacts on the ability to engage with mainstream services. Consequently, due to finding barriers in accessing primary health care, there is an increased usage of secondary care and the additional expense of repeat visits to A&E and hospital admissions. These visits don't provide long-term condition management with appropriate continuity of care, and may be avoidable [1]. The result is a revolving hospital door, with at times the stark reality of 'discharge to the streets' still taking place.

> ***I've lost count of how many times I've been admitted to hospital with my leg ulcers, the last time I was in for five weeks.***
>
> James

This report focuses on two pilot projects that took place in Camden in relation to addressing the health inequalities and provision for the homeless population. Project 1, was an Outreach Nursing service and Project 2, a Tissue Viability Nurse-led wound clinic.

Pilot project 1: Nurse Outreach into hostel pathways

In view that multiple morbidity is common among people facing homelessness, accessible and available primary care is a pre-requisite for effective health care interventions [3]. Acknowledging that there are barriers affecting the level of engagement for this population group, outreach nursing has been linked to meeting the healthcare needs of people experiencing homelessness [1, 4].

Pilot project 2: Wound care pilot

There are a number of reasons a person experiencing homelessness can develop a wound, frequently this relates to their past or current medical or surgical history and their psychosocial environment and wellbeing.

In particular homeless people often develop wounds to the lower limbs and feet. For persons who have a history of injecting drug use one of the most common and debilitating wounds is chronic venous leg ulceration. These are wounds, more commonly known as ulcers that can develop spontaneously or as a result of trauma or injury and do not heal easily or at all because of the underlying vascular complaint related to the veins that have been damaged and/or are incompetent from injecting.

It is not uncommon for people to live with these ulcers on one or both legs for many months, even years. The ulcers cause great distress, isolation, embarrassment and depression not to mention pain, malodour and weeping from the wounds. People with a history of injecting can also have recurrent abscesses to the groin or other areas of the body, which often become infected and need surgical intervention and antibiotic treatment. Recent studies from a local London hospital raised particular concern for the increase in skin, soft tissue, and vascular infections (SSTVI) and demonstrated that 58% of hospital admissions in people who inject drugs were related to SSTVIs. The study called for a more proactive monitoring of SSTVIs and work to improve access to services that would provide wound care and support concordance was also highlighted [5].

> ***I don't want to go to my family because I don't want them to see me like this. I'm embarrassed for them to see me like that.***
>
> Rob

Coull et al. (2014) collected data from 200 participants in needle exchange and methadone clinics across Glasgow, Scotland, establishing the prevalence of skin problems and leg ulceration in a sample of young injecting drug users (age range 21- 44 years; mean 35 years): 60% had experienced a skin problem and 15% of all the participants reported having a leg ulcer. The study highlighted a concerning growth in the prevalence of leg ulceration in the young injecting drug user population compared to 1% of the adult Western population [6].

Complications and serious sequelae as a result of chronic SSTVI include local as well as systemic infection, sepsis, endocarditis and amyloid amyloidosis resulting in renal failure. The London School of Hygiene and Tropical Medicine 'Care and Prevent' study is currently further investigating skin and soft tissue infections and AA amyloidosis among people who inject drugs in London.

Early data from the 311 participants indicates that 84% have been homeless over the past year.

The good news is that for purely venous ulceration there is good evidence to suggest that these are treatable, healable and for the majority preventable with the gold standard treatment of compression therapy. The Cochrane Library, recognised as the epitome in the hierarchy of evidence, endorsed the importance of compression therapy as the gold standard in the treatment and prevention of venous leg ulceration [7, 8].

> ***I'd been in the emergency in hospital and the nurse didn't even want to touch my leg and that make you feel not good, you know what I mean? Like you can feel that, you can see that.***
>
> Rob

Engaging with people when they are suffering from these debilitating wounds can be increasingly difficult as they impact greatly on how people feel about themselves and have been shown to exacerbate already felt stigma [9]. This study demonstrated that with specialist, directed wound care treatment, usually nurse-led, people living with leg ulcers felt more positive, engaged and supported with their wound care plan. The narratives within this study clearly demonstrate an improvement in ulcer healing and continued prevention after healing.

Background

The Camden Homeless Health and Care Network (HHCN) was established by Camden CCG in 2017. Members of the group consisted of both primary and secondary care clinicians, CCG Commissioners, the Local Authority Adult Pathway Service and Outreach Teams, Public Health, the MET Police, London Ambulance Service and multiple Voluntary Sector Organisations.

The main purpose of the network was to develop, implement and drive system-wide changes through a joint approach between local agencies working together to improve the experience and outcomes for people experiencing homelessness with health and care needs in Camden.

In 2018 two funding opportunities specifically designated to focus on addressing physical health needs of the homeless population were discussed at the HHCN.

I. Source of funding

FLIC (Fulfilling lives in Islington and Camden), funded by the National Lottery Community Fund, allocated funding of £70,000 specifically to be used to improve the physical health and wellbeing of the local homeless population.

Public Health Camden had placed a bid for Section 106 monies and funding was awarded to the sum of £55,000, again, for the purpose of improving the physical health of the homeless population. This was to cover the Covent Garden & Holborn ward, as well as surrounding wards. The geographical scope of this project was extended to the Bloomsbury and Kings Cross wards, given the majority of rough sleeping in Camden occurs in the south of the borough.

II. Gap Analysis

The members of the HHCN identified gaps in service provision and outlined a proposal for best use of the funds. It was recognised that there were gaps related to outreach nursing for the homeless population, as well as limited wound care services available for people who are homeless in the borough.

A general consensus was reached to address both these health inequalities and agreement made to form working groups to support the development of two pilot projects that would work independently yet alongside each other, with the overall objective to improve quality of care for the homeless population.

III. Clinical need

Camden Health Improvement Practice (CHIP) is based in Camden and provides Primary Care to the homeless population. Within the framework of its service, CHIP

has a GP who provides routine planned 'GP Outreach' to non-engaged homeless patients who are of clinical concern. The GP can provide GP services, flu jabs and phlebotomy in the hostels but the GP cannot provide dressings or specialist nursing care.

In terms of wound care, although a Tissue Viability nurse with specialist interest in the homeless population would voluntarily attend CHIP on a monthly basis, historically, there are no specialist, nurse-led wound care service for those experiencing homelessness in London.

It has been recognised that patient non-engagement with medical services is a major marker for premature death and morbidity within the service.

The non-engaged patients are generally mobile and difficult to engage due to their complex care needs, therefore unsuitable for District Nurse referral as per the current specification.

IV. Clinical input

Both pilot projects were nurse-led with GP supervision.

For the duration of the projects, CHIP, whilst under the management of Turning Point, provided the nursing input for both the Outreach Nursing service and the Tissue Viability specialist nurse-led wound care service, GP supervision, clinical room and equipment.

V. Limitations of the projects caused by the COVID-19 pandemic

Project 1, the Nurse Outreach Health Engagement Service started in October 2019. The intention was for this project to run with the funds available until June 2020, however, this project was brought to a close in mid March 2020 due to the COVID-19 pandemic. As such, due to the high level of need for extra provision during the time of the first wave of COVID-19, the remaining funds were then rechannelled into COVID-19 specific nursing care and will not be covered in this report.

Project 2 ran between August 2019 and March 2020 and was not impacted by the COVID-19 pandemic.

Pilot Project 1

Nurse Outreach Health Engagement Project

CHIP holds a register for patients who have high morbidity and have been placed on an end of life register due to the level of clinical concern. The Outreach GP service oversees this list. Correlation exists between those who are known non-engaged and on the end of life register the practice holds.

Aim

- Identify CHIP patients within Camden hostels with long term health condition and low levels of health engagement
- Identifying the barriers that impact on Primary Care health engagement
- Providing nursing care within the hostel to address immediate nursing needs within the capacity of the environment
- Identifying reasons why patients access secondary care and self-discharge before receiving medical help
- To work alongside the Care co-ordinator to improve engagement with health care within Primary Care settings
- To create a role of Hostel Health Leads who can assist with referrals and engagement
- To work with Hostel Health Leads and create a training schedule to assist in their role development
- To work in collaboration with the Find and Treat Team and Hepatology services in Camden to take a broader approach on health improvement.

Outcome measures

- Barriers for engagement in Primary Care identified
- Engagement with Nurse Outreach treatment
- Impact on individual health – qualitative analysis
- Did engagement with nurse outreach improve engagement within primary care services – GP/Tissue Viability/CHIP based nursing clinic/Hepatology/HIV services?
- Those identified with leg ulcers – was wound healing demonstrated?
- Was there a reduction in A&E attendance for primary care nursing needs?

Structure of the project

1. The Outreach nurse was provided by CHIP when under the management of Turning Point. The nurse provided one, four-hour session per week to the hostels of Camden on a rotational basis. A CHIP GP was available to clinically supervise and discuss concerns that arose throughout the outreach sessions.
2. The project targeted non-engaged, CHIP patients that were identified via the hostels and cross-checked with CHIP's EMIS health records (GP software).
3. The hostels of Camden were requested to allocate a Health Lead for their team and they worked directly with the Outreach Nurse. NHS emails were set up for each hostel Health Lead.
4. The role of the Hostel Health Lead was to help identify clients that required health input who were NOT engaging in health care management.
5. Education and feedback events were held to assist development of the Hostel Health Lead role.
6. Following identification and referral of non-engaged patients, further gathering of data was obtained by the Outreach nurse. The intention behind a clinically-led selection of clients was in order to ensure that the patients are genuinely chronically non-engagers. This was to avoid the unintended consequence of reducing appropriate attendance of engaged/potentially engaged patients to clinics at CHIP.
7. Through the data collected of the distribution of clients, a maximum of three hostels were targeted per week.

8. Other services accessed by individual clients (e.g. iCAS, SCDS, CGL) were identified and – MDT approach discussions were had to establish best roots toward engagement on an individual client basis.

9. Primarily, the involvement with the client was to establish reasons behind non-engagement, to work with hostel staff, key workers and Groundswell to encourage engagement to the service based at CHIP. In the circumstance that non-engagement continued, the Outreach nurse provided nursing care, including wound dressings in the hostel clinical space as a means to further establish rapport and understanding of underlying causes of non-engagement and continued barriers to accessing health

Scope of nursing care provided in the hostels

- Blood tests, topical swabs
- Blood borne virus screening
- Sexual transmitted Infection screening
- Vaccinations
- Health education
- Asthma/COPD checks
- Diabetic foot checks
- Cardiovascular screening – BP/oxygen saturation
- Urine analysis
- Wound care of leg ulcers – initial assessment and dressing to be provided to those who are not currently attending the practice to have dressings managed and will be offered as an engagement measure to encourage attending the surgery for full wound management
- Identification of escalating health needs and when GP input is required
- Local health service referrals.
- Further functions of the nurse included overall health education for the client and hostel staff, flu and pneumonia vaccination.

10. On-going management was discussed between clinicians at CHIP's weekly clinical meeting, allowing any concerns that had arisen to be discussed with the team of GPs and nurses.

11. The nurse recorded notes on the practice EMIS system.

12. The nurse followed the same safety procedures for home visiting as Camden District Nurses in relation to:

    b. Lone visiting

    c. Personal protective equipment/ sharps policy

    d. Disposal of clinical waste

    e. The hostels were required to sign-up and agree to provide a safe environment for the nurses to work

13. Identification of non-CHIP clients with leg ulcers that are registered at practices in the South Locality of Camden were invited through correspondence between GP-GP to attend the TV service as part of the outline for Project 1.

14. For clients that were referred but not registered at CHIP, assistance to have them attend and register at CHIP was offered.

15. Educational events were held on two occasions to support the learning of hostel health leads.

16. Due to the number of hostels within Camden and the limited time and scope of the project, the project was scheduled to run in two cycles. Each cycle was to run for four months and allow capacity for the nurse to visit to each hostel multiple times on a rotational basis.

17. Cycle two was brought to a close early (March 2020) and as such, it has only been possible to assess outcomes from the first cycle.

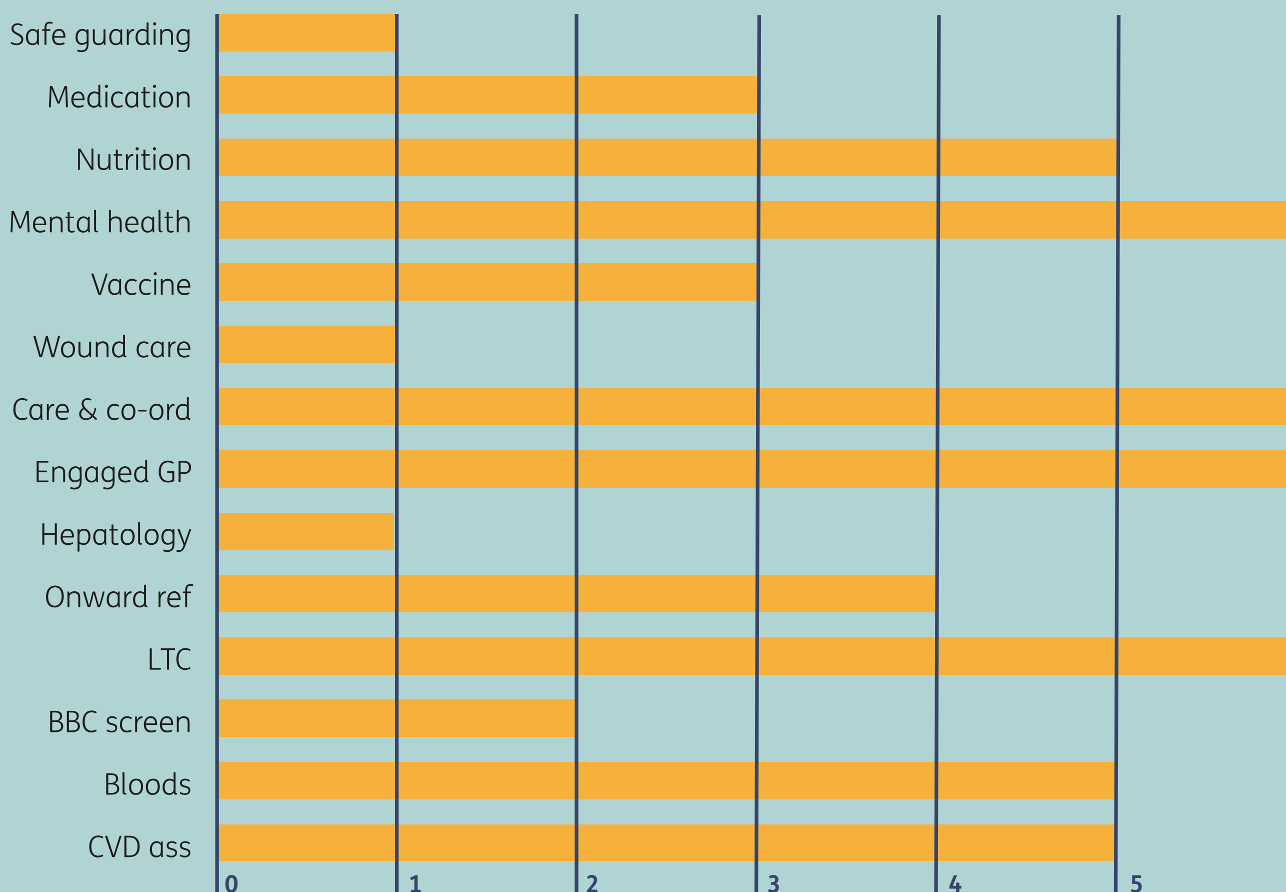
Results

Between October 2019 and February 2020, approximately 45 hostel visits took place by the Outreach Nurse. The nurse worked closely with those referred to her and was able to positively impact each individual. She was successful with identifying barriers for engagement in primary care, improving attendance with the GP, hepatology and other secondary care services, progressing care and engagement to enable attendance into both primary care and secondary care services, addressed medication issues with the GP, nutrition, mental health, cardiovascular assessments, wound care, long term conditions (LTC), blood tests, BBV screening and also assisted with a safeguarding concern. Table 1 provides an overview of the types of nursing involvement that took place during the project.

Overall, with the clients the nurse worked with, there were no A&E attendances during the course of the study, apart from one that was in relation to an accident and required immediate medical treatment. In one of the clients who wound care was a part of her management, healing was demonstrated (Appendix 1).

Outcomes from visit

Table 1: Areas of nursing input throughout cycle 1



Limitations

There were several limitations of the project. These include the following:

- The Outreach Nursing service was only available for homeless patients registered at CHIP. It is recognised that CHIP serves approximately 25% of Camden's homeless population. The other proportion are either registered with other GP surgeries around Camden/neighbouring boroughs, or not registered with a GP.
- Because of limited staffing availability, the sessions at the hostels could only take place once a week and a rotation system around all the different hostels was required.
- Because of the rotational system, building rapport and continuity of engagement was interrupted.
- On several occasions patients were not present when the nurse attended, or they chose not to be seen and engage.
- From the feedback request sent out, only two were received back.
- Because of limitations on both time and staffing, it was not possible to provide nursing outreach services to the homeless who were not in the hostel pathway system. Rough sleepers fell outside the scope of this project.
- Due to the global COVID-19 pandemic, the project was discontinued early in the second cycle and so data could only be considered from outcomes of the first cycle.

> ***Sometimes you do make mistakes, you miss appointments. It happens it's life. Especially in my style life, having drug problems, no benefits... so it's not so easy for me. I don't blame no-one it's my fault what happened to me, I put myself in that position.***
>
> Rob

Summary

Overall, despite the multiple limitations to the pilot project, the outreach nurse was able to demonstrate improved health engagement and outcomes with the patients encountered.

The nurse was able to provide holistic nursing care and reduced the frequency of attendance to A&E, and consequently, reduced the rate of hospital admissions.

Positive feedback was received indicating:

- The outreach nurse session was found very useful
- The nurse was easy to talk with
- Outstanding health needs were addressed
- A statement was made that without the nurses assistance in engagement, the client would not have attended to see the GP to manage their health needs.

The following feedback received from the Hostel Health Leads:

"I thoroughly enjoyed meeting other health leads and attending the training provided. I feel my relationship with the nurses at CHIP was greatly improved as I'd never had contact with them prior to this pilot."

"The nurse was very helpful in providing support with finding out who was not engaging with services. It was extremely difficult to engage the client's at our hostel. Discussing the referral with the nurse was easy and she was easily approachable. The referral process was easy, bar getting the clients to accept and sign up for the pilot"

"I very much enjoyed the role of Health Lead. It was good to see residents engaging who wouldn't normally engage. It would have been better to get more clients to attend."

Recommendations

Although the study was cut short and had various limitations, overall, it has been demonstrated that having direct nursing interaction through an outreach approach for those who are known to be hard to engage, improved levels of engagement in health services, with many positive nursing outcomes obtained.

Moving forward, it is recommended that primary care services should be more targeted to the needs of homeless people as follows:

- In order to maintain their health, clinical provisions being integrated with other services homeless patients require.
- To improve health outcomes and reduce financial burdens on the NHS, greater investment in the homelessness sector for approaches known to effectively help people engage with and co-ordinate their care is required, such as funding for outreach nursing.
- As the study was limited to patients registered at CHIP, a recommendation is to consider a Homeless Health Outreach Nurse that is linked to, and following the framework of District Nurses.
- A review of the District Nursing service to incorporate homeless health care provision is recommended.
- A further limit to this study was that those who are rough sleeping fell outside the remit of this study. It is recommended that Outreach Nursing provision for rough sleepers be considered in order to assist with improving health outcomes.

Frances' Story

Living with a chronic leg ulcer for over 10 years was the daily reality for Frances; a 40-year-old woman working full-time in retail and living in a squat. This woman had injected heroin for most of her young adult life but was now clean and had not been using for many years.

The leg ulcer was 30 cm long and spread around the circumference of the lower limb. It was deep, raw, and bleeding. Despite Frances being in agony, and the fact the pain was made worse by being on her feet all day, she had learned to live with the pain and to some degree accept it. She was careful to hide the smell from her colleagues, although they were aware there was some problem due to her limp.

Frances no longer considered herself homeless and was initially reluctant to visit CHIP. Her life had changed significantly, she was drug free and was now off the streets, squatting instead. Visiting CHIP was a reminder of where her life had been and some of the things she had had to overcome.

However, Frances was desperate. She had been hiding her wound from everyone – she had not engaged with a GP for years after a negative experience where she was confronted with a conversation about HIV, her partner of over 10 years had never once seen the wound, and she had distanced herself from her family.

Upon arrival, the tissue viability nurse and Frances sat down to discuss the current

clinical presentation of the wound and the treatment that was available. It was important to navigate these early conversations carefully in order to build trust and overcome the woman's fear of services. The 'light bulb moment' came when the woman was told this wound was healable. She was dumbstruck and could not believe it. She had come to accept living in constant agony and shame as a part of her life.

The treatment plan included two weekly appointments, and the gold standard therapy of compression bandaging. The patient attended most appointments, although when life did get in the way, the team remained positive and encouraged her to come back. Within three months the 30cm ulcer and halved in size and three quarters had healed.

It was encouraging for Frances, the prospect of a leading 'normal life' was no longer a fantasy, but within reach. She was excited at the prospect of wearing whatever she wanted, going to the beach, swimming, and most importantly, reconnecting with her family. Living a life without shame and a painful secret was within reach.

Frances' story is a demonstration of what's possible, and testament to the fact that many wounds are preventable, treatable and healable. It highlights the power of positive communication, the importance of taking time to build a relationship and the need for specialist treatment. Wounds can be healed, and people can live more fulfilling lives without these secrets.

Pilot Project 2

Tissue Viability Wound Care Service

The nurse-led, specialist wound clinic for people experiencing homelessness was the first service of its kind in London. A specialist Tissue Viability Band 8b nurse with particular interest in working with the homeless population was appointed to co-design and lead the pilot project.

Skills and Expertise of the nurse:

- Specialist nurse with in-depth knowledge of lower limb vascular conditions and wound care management.
- Experience of leading and managing teams in a large teaching hospital and running autonomous vascular, leg ulcer clinics.
- Experience also of visiting a homeless GP practice for monthly wound and lower limb clinics for eight years – this supported the experience of working with this group of people.

Wound care is a taboo subject and there is a significant amount of stigma associated with people living with an open, malodourous, exuding wound, while experiencing homelessness. Often patients will not engage with mainstream services because they have encountered a previous poor experience, prejudice or are embarrassed by their condition. The Wound Clinic aimed to provide wound care expertise and lower limb assessment for this population. The clinic was person-centred and encompassed the values of engagement, compassion and trust.

> *"The hardest part of the leg ulcer was the stigma attached to it, the shit I get off it. People taking the mic... It hurts inside like, cos you're a person whether you've got a wound or not yeah you're still a person and it doesn't really matter what you've got wrong with you. People should accept you for who you are.* James*"*

Aim:

- Offer a comprehensive lower limb wound assessment and management service for people experiencing homelessness at risk or living with an open wound or leg ulcer.
- Review patients in a primary care setting, reducing the presentation to A&E departments or walk-in centres for dressing changes and facilitating swifter discharge for those who required specialist wound care provision in the community.
- Reduce the patients' pressure and anxiety around the risks of having no choice but to change dressings themselves.
- To reduce pain and promote healing for those suffering with lower limb wounds

Structure of the service:

- The clinic ran two days a week (Mon and Friday) for eight months (Aug19 – end of March 20).
- The service was open to referrals from hospital discharge teams and other GP surgeries across the South of Camden.
- The clinic was single nurse-led, based at CHIP and ran alongside a GP session.
- The TV nurse specialist was available to discuss cases with the Outreach Nurse (Project 1).
- The TV nurse specialist held educational events aimed at hostel health leads, and other Camden practice nurses.

Equipment needed and support required:

- Generic supply of wound dressings, bandages and advanced vascular Doppler equipment
- Clinic space facilities washing legs and disposing correctly of the contaminated waste.
- Clinical work flexibility – i.e. ability to go out and see a patient, visit a hostel or provide wound advice over the phone, by virtual meeting or email. Whatever proves to be necessary to connect with the client and the people supporting them.
- Admin support for appointments
- Attached to a GP service to enhance effectiveness of the service.

Conditions addressed in the clinic:

The following is a list of conditions that were addressed in the clinic:

- Venous leg ulcerations (affecting both the injecting and non-injecting population)
- Venous eczema or skin related complaints to the lower limbs
- Other skin related conditions, scabies and psoriasis
- Self-harm related wounds on the lower limb
- Chronic groin abscesses in the injecting population
- Recurrent cellulitis and erysipelas or patients at risk of soft tissue infections
- Dependent swelling 'oedema' secondary to patients sitting with their legs down all day/night or walking for long periods of time without leg elevation or rest
- Amputee patients with a history of peripheral arterial disease or who had vascular-related injuries resulting in the loss of a limb (e.g. surgical ligation of main arteries due to infected or burst pseudoaneurysms)
- Pregnant women experiencing homelessness living with symptomatic varicose veins (and venous hypertension), at risk of venous ulceration to be managed conservatively in view of venous intervention at a later stage post-partum.

Overview of the project:

- A total of 113 patient reviews were completed (31 of these were new patients) – complex wound care requires a significant amount of dedicated time to engage with and clinically assess a person presenting with a wound (remove dressing, cleanse wound and skin, assess, measure and redress).
- Over 13 hours of telephone advice were provided during the eight-month period; this facilitated the engagement of clients and allowed timely rearrangements of DNA'd appointments.
- Three educational study days were organised within the eight-month timeframes; many hostel leads and practice nurses attended, providing very positive feedback.

Feedback from the evaluation:

"I am a lead nurse working in a drug service in the community and I have never completed wound care training. I currently see 1-2 people living with wounds a week and this ranges from leg ulcers, cellulitis, abscesses and amputations. One of the main challenges when managing wounds in patients that are homeless is not making it to the GP appointments for review".

Describe how the wound care study day has helped your knowledge?

"Really expanded my knowledge on wounds. How to assess and treat them. What to look for and the risk factors".

What could be improved?

"Can we practice the aseptic technique?"

What will you bring back to your current practice?

"I will be able to do basic assessment of wounds and put together a basic wound care kit. I will have a better knowledge of how to treat the wounds".

Any other comments:

"Very informative".

"I work as a lead nurse at a general practice in Camden and on average see about 3-4 people with wounds a week. The types of wounds I see include, leg ulcers, burns, post-op wound infections, pilonidal sinus and superficial lacerations. I last completed wound care training 10 years ago! My main challenges when managing wounds in patients that are homeless are from my previous experience in a surgery based in Tower Hamlets – The attendance of the homeless patient was difficult to maintain UNTIL a rapport and trust was built-Contacting the homeless patient was sometimes difficult as they had no fixed abode or a mobile to contact".

Describe how the wound care study day has helped your knowledge?

"It has already improved my practice- My newly acquired knowledge has led me to change the dressing management originally used on a lady who had a hyper granulated wound- We are now seeing good results that have not been seen for the past year!"

What could be improved?

"Finding a way of inviting the practice nurses to bring them on board with the current expert wound advice that was shared with me. Offering joint appointment reviews with patients at the practices?"

What will you bring back to your current practice?

"I have bought back new and effective ways of treating wounds".

I have improved the management of a diabetic patient- in providing new hosiery which was discussed by one of the speakers at the wound study day".

Any other comments:

"This was an exceptional wound study day aimed specifically at 'the homeless'.

Jemell has given me an insight into helping the homeless and the difficulties they face with accessing the correct wound care. I have applied her advice/ knowledge in my everyday work with my patients and will continue to do so as it was an extremely worthwhile study day with relevant slides and expert speakers- sharing their knowledge, and in return improving patient care".

- The continuous support and expertise of the FLIC Navigator teams was paramount; their exceptional engagement and support with clients was essential in maintaining the momentum of attendance and keeping clients positive with their care.
- As emerged from this experience, the majority of patients who attended the wound clinic were malnourished and this undoubtedly affected wound healing, along with their mood, sleep, mobility, energy levels and overall health.

Outcomes: An overview of the themes/trends

A prospectively maintained database was analysed. This showed statistically significant improvement in multiple wound-related outcomes: pain, stigma, sleep, mobility, wound healing, wound exudate, and wound smell.

Summary

The project has been seen and widely recognised as a dynamic and innovative integrated approach to working with people experiencing homelessness, living with or at risk of a wound or lower limb conditions.

Expert clinical assessment has potentially prevented the risk of vascular-related pathologies caused by acute or chronic damage to the venous and arterial systems of the lower limb such as abscesses, pseudoaneurysms and infections.

The clinic was considered a huge success and patients willingly engaged with the nurse to manage their wound, to learn about their own condition with the goal of preserving skin and vascular health, integrity and risk prevention.

It is important to understand that without the earned trust and engagement of the clients, their positive feedback, and word-of-mouth, the clinic would not have succeeded.

Although medical advice was rarely needed, being attached to a Homeless GP surgery supported integrated working and the provision of holistic patient care.

The overall impression is that the achievements of the clinic were directly linked to the dedication, skills and commitment of the specialist nurse and care navigators towards this group of patients.

> ***"They're just so down to earth, they don't judge you in any way whatsoever. You could be whatever you are and they don't judge you, they just take you for who you are.***
>
> James

Recommendations

Wound Clinic ideally to be linked to a primary care homeless GP practice.

Nurses are required to run the clinic. It is essential that they have some experience of working with people experiencing homelessness or inclusion health. They should be trained in tissue viability and leg ulcer care.

The clinic should run once or twice a week, initially. As patient numbers increase the service can be expanded to accommodate need.

The clinic needs to complement and coordinate with the outreach system – although outreach may address wound dressings, it may not provide adequate clinical assessment. Consider specialist outreach once a month or more frequently depending on numbers and advice needed.

Monthly MDT meetings potentially involving local A&E and Vascular Units to look at frequent attenders for wound related issues. These links and connections with local hospitals are essential in preventing avoidable admissions.

Offering a holistic, multidisciplinary approach and, overall, a positive experience will in turn reduce hospital attendance and clinic appointment DNAs.

Monthly virtual clinics to reach out to clients who chose not to, or are unable to, attend the clinic.

Regular training days with support of industry.

It is suggested that care navigators/hostel leads are also approached to establish if they wish to learn more about wound care prevention and management and if they would be willing to do dressings with the oversight of a specialist nurse. Thinking outside the box can assist with reaching people who would otherwise not engage.

As emerged from this experience, the majority of patients who attended the wound clinic were malnourished and this undoubtedly affected wound healing, along with their mood, sleep, mobility, energy levels and overall health. Going forward, the tissue viability clinic should link in with local dietetic services as an integrated approach to this important aspect of care.

The key to running a successful clinic is multidisciplinary working, Tissue Viability and Homeless Health skills and expertise.

Ultimately, wound care can be brought to people working in the area of homeless health – the delivery of wound care needs to be set within the context of whom the clients wish to see and where they want to go.

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Appendix 1

Case studies Outreach Nurse Pilot Project

Case 1:

Non engaging patient with chronic leg wounds.

- 6 month prior to outreach service TWO leg ulcer hospital admissions (11 bed days in total)
- 4 months prior to outreach service TWO leg ulcer related A&E attendances

Outreach Nurse engagement – dressings x1 and education on self management and care/red flags

Outcome:

- Healing of leg ulcer.
- NO further hospital A&E attendances or admissions related to lower limb wounds during or two months post outreach nurse engagement.

Case 2:

Previously non-engaging client. Multiple health needs unaddressed

- Seen consistently throughout the engagement project.
- Emotional and mental health support
- Motivational discussions
- Vaccinations
- Identification of being behind in her nutrition support - nutritional supplements re-started.

Outcome:

Client engaged with CHIP GP and booked in for review through assistance with hostel key worker.

History of non-engaging with primary and secondary care. Known to the outreach GP, however, often when the Outreach GP attended he was intoxicated making clinical assessment challenging.

Engaged well with Outreach nurse

- Identified not bathing due to fear of falling in the shower due to a combination of fears relating to both poor vision and intoxication (not bathed for three months).
- Identified he was due blood tests and investigations – these were completed and he was found to have significant deficiency in iron and vitamins – although replacements were supplied, he was non-compliant with medication and hoarding prescription paper.

A lack of Vitamin B1 is known to increase the risk of Wernicke-Korsakoff Syndrome, cerebellar degeneration and cardiovascular dysfunction in those who are alcohol dependant.

Outcome:

- Assistance with care co-ordination to undergo review and management of eye condition at Moorfields eye hospital (under their care since 2014 with recurrent periods of DNA's) – attended x2 appointments and has now completed surgical procedure to correct vision
- Good recovery of vision
- Significantly reduced risks of falls
- Able to self-care and maintain personal hygiene – started bathing again
- Dossett box issued and client now compliant with medication
- Social care assessment for needs put in place.

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