The Queen's Nursing Institute

Transition to Homeless and Inclusion Health Nursing

Contents

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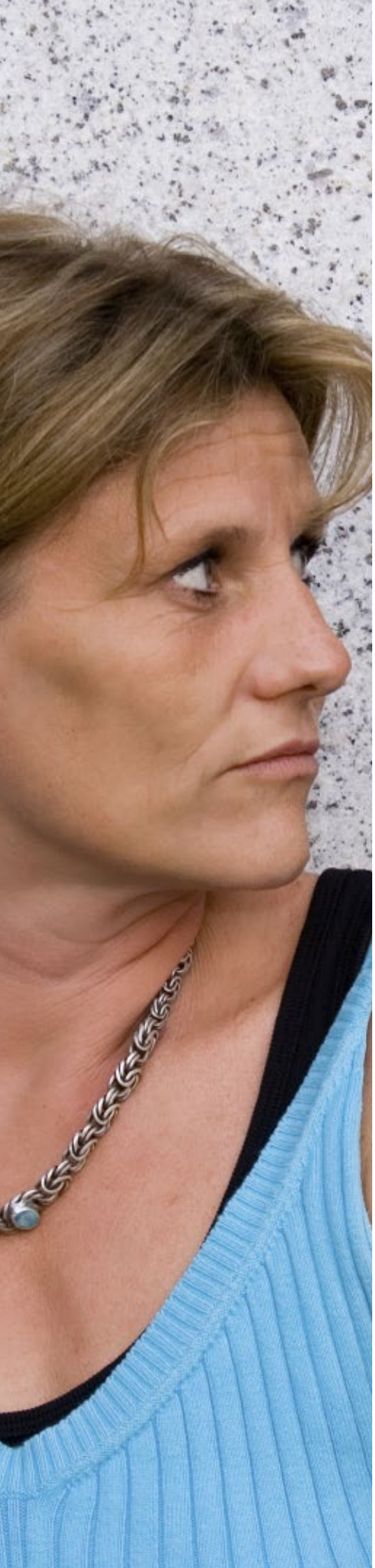

Chapter 2 - Making the transition

Completing this chapter will enable you to:

- consider your own concerns about starting a role in homeless health
- plan how to develop a better understanding of your community resources
- understand relevant legislation
- think about when to share patient information
- become more inclusive by tackling discrimination
- use some models of reflection to guide your continuous learning
- record your reflections whilst working through this online resource.

Introduction

You may have moved to homeless health nursing from any number of backgrounds. The most common roles before working in homeless health nursing are other community nursing posts. 83% of the homeless health nurses who completed a QNI survey had a previous role in another community nursing job, 16% came from an acute hospital setting, and less than 2% had their first nursing position in homeless health. This shows that although you can get a role directly in homeless health after graduation, it is most common to work another community nursing role to build up experience first.

As with starting any new role, it is very natural to have some concerns. The nurses we surveyed had some common concerns when they started their work as a homeless health nurse:

Area of concern	Percentage of nurses who cited it as a concern
1 The health and living conditions of their patients	68%
2 Not enough knowledge about working with social and housing conditions	67%
3 Not enough knowledge and health conditions	38%
4 Lack of skills expertise	32%
5= Not enough management support	26%
5= Anxiety about clinical decision making	26%
7 Apprehension about risk	22%
8 Apprehension about being a lone worker	17%

These concerns may be familiar for you, or you may have some of your own, but the learning from this resource should encourage you that you are not alone. You should take steps to address any concerns at an early stage so that you can start your role in a confident and positive way.

Understanding your patients and your community

The best way to develop your knowledge around how your patients are living and the social and housing conditions is to visit the homeless hostels, shelters, drop-ins, and support organisations in your area. This way you will learn how each patient reacts differently to their environment, and how it can have a different impact on their health. Learning about the community support available will help you to feel confident in practice situations and assist you when you give advice and support.

You may need to familiarise yourself with all sorts of services in your geographical area to understand the environments in which your patients live, and to help you understand what support is available for people in your area.

‘Local knowledge will be invaluable when giving care to your patients.’

This will also help you to have an easy reference when you need information quickly in a crisis. One way of doing this may be by spending some time safely exploring your local community in the day and evening. You can complete the reference table 2.1 and keep it handy for your practice. The list is not exhaustive so do feel free to add to it as you develop your understanding of the community.

Activity 2.1

- Complete figure 2.1 by adding your notes based on your local enquiries and observations.
- What have you learnt?
- How can you apply this learning to your work?

By doing the activity, you will develop a better understanding of the community in which you work. This local knowledge will be invaluable when giving care to your patients.

Activity 2.2

- Contact the organisations you have found out about and make them aware of your role. There may be opportunities for them to refer to you or vice versa, or for some other joint working in the future.

More information about the different health conditions you may come across when working in homeless health, and more information on risk assessment and management are covered in other chapters of this resource.

Figure 2.1 – Learning about your community

Housing	Your notes
What type of accommodation is available for homeless people (hostels/shelters)?	
What type of housing is in the area?	
What condition are the houses in?	
Are there derelict buildings and squats?	
Where is the local authority housing office? Is there easy access?	
Does the council house people in temporary accommodation, and if so, where?	
Is there housing for homeless young people, such as the YMCA or Foyer?	
Is there housing for homeless adults, such as hostels?	

Environment	Your notes
How clean are the streets?	
Is there any evidence of vandalism?	
Is there an evidence of substance use?	
Are there any parks and green spaces?	
Is there any evidence of rough sleeping?	

Health facilities	Your notes
Where are the local GP practices?	
Do any GP practices offer enhanced services for people experiencing homelessness?	
Where are the local pharmacies?	
Is there an NHS walk-in centre / minor injuries unit?	
Where is the local hospital/A&E Department?	
Where are the local community dental services?	
Where are the drug and alcohol treatment services?	
Is there a community podiatry service?	

Other local amenities	Your notes
Where are the supermarkets?	
Where is the local post office?	
Where is the community centre?	
Where are other local shops?	
Is there a local children's centre?	
Where are social services located?	
Where are the nearest courts?	
Where is the nearest police station?	
Where is the nearest prison and young offender's institution?	
Where is the nearest food bank?	
Where is the nearest day centre for the homeless?	
Are there any local soup kitchens/cafes/organisations serving meals for people who are homeless?	
Where is the nearest jobcentre?	

Transport	Your notes
Where is the nearest train station?	
Where is the nearest bus station?	
Other aspects	
Are there any unsafe areas?	
Is there a red light district?	
Is there a local domestic violence/sexual violence service?	
Is there a local refugee organisation?	
Is there a local immigration detention centre?	

‘Another way to feel more confident in your knowledge around your practice is to keep yourself up to date with relevant legislation.’

The legislative framework

Another way to feel more confident in your knowledge around your practice is to keep yourself up to date with relevant legislation affecting your patients and your work. In most cases, you will not need to know the full act of parliament, but it may be important to know a specific area of the law such as:

- **Section 188 of the Housing Act 1996**

This section outlines the conditions necessary for local authorities to accept an individual as statutorily homeless and thus offer accommodation. Key quote: ‘If the local housing authority have reason to believe that an applicant may be homeless, eligible for assistance and have a priority need, they shall secure that accommodation is available for his occupation’

- **Section 20 of the Children’s Act 1989**

This section highlights the responsibility of every local authority to provide accommodation for any children in need if they are lost, abandoned, have no one with parental responsibility towards them, or if the person who has been caring for them cannot provide them with suitable accommodation or care. This is highly relevant in homelessness. It also states that ‘every local authority shall provide accommodation for any child in need within their area who has reached the age of sixteen and whose welfare the authority consider is likely to be seriously prejudiced if they do not provide him with accommodation.’

- **Section 117 of the Mental Health Act 1983**

This specifies that people who are sectioned under the mental health act are eligible for after-care after they have left hospital, provided certain conditions are met. This may be relevant in a small number of your cases.

- **Section 17 of the Children’s Act 1989**

This section highlights the duty of every local authority to safeguard and promote the welfare of children within their area. It defines when a child is deemed to be ‘in need’ and when a child is deemed to be disabled.

- **Section 47 of the Children’s Act 1989**

This section highlights the process local authorities need to follow when they decide to take a child into care. Key quote: ‘Where a local authority are informed that a child who lives, or is found, in their area have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm, the authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child’s welfare.’

- **Part 1 (4)1C of the Health and Social Care Act 2012**

This section outlines the responsibility of the Secretary of State for Health (and by implication, the Department of Health, NHS England and CCGs) in addressing health inequalities. Key quote: ‘In exercising functions in relation to the health service, the Secretary of State [for Health] must have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service.’

- **Mental Capacity Act (MCA) 2005**

Some patients due to a mental health condition, learning disability, brain trauma or substance misuse may lack mental capacity, and so an understanding of the Mental Capacity Act and its five key principles will greatly help you. The five principles are that you should presume capacity, support individuals to make their own decisions, allow people the right to make unwise decisions, make decisions in the best interests of your patients, and choose the less restrictive option when making a decision or acting on behalf of someone who lacks capacity. The Social Care Institute for Excellence has a very helpful MCA online learning resource to further your learning.

- **No recourse to public funds**

Some residence permits in the UK include the stipulation that the person has ‘no recourse to public funds’. This limits their ability to access certain welfare and housing support. The GOV.UK page on public funds offers more details on this area.

The Medical Protection website offers guidance, summaries, and links to legislation based on topic areas.

Confidentiality and data protection

Homeless health nursing often requires work with very vulnerable people and building relationships with them. It is key to have strong knowledge about the information that you collect about your patients and the information you share with other professionals. This knowledge will also give you confidence when negotiating difficult circumstances and cases, such as in cases of insecure immigration status or adults or children at risk of harm. Many agencies may be involved with your patient (local authority housing, probation, health, police) and by sharing information correctly you may be able to help be an advocate for your patient's needs by explaining relevant health information.

However, as a registered nurse you have a duty to respect people's right to privacy and confidentiality. Confidentiality and data protection are fundamental principles of professional healthcare practice. There are however, exemptions where it is your duty to share information, for example to safeguard a child or vulnerable adult at risk of harm, and where you have gained consent to share specific information with other members of a multidisciplinary team.

Think about your consent to share information. Consider factors such as working in an area local to where you live, what information cannot be shared and what information might be shared with colleagues and wider multidisciplinary teams. In England, your patients are highly likely to have a Summary Care Record, which any health professional involved in their care can access under certain circumstances.

The Data Protection Act (2018) has six principles that must be upheld. It is crucial that you familiarise yourself with these principles as well to ensure that you maintain your accountability to your profession and your employer.

These principles are:

1. Personal data shall be processed fairly and lawfully and, shall not be processed unless – (a) at least one of the conditions in Schedule 2 is met, and (b) in the case of sensitive personal data, at least one of the conditions in Schedule 3 is met.
2. Personal data shall be obtained only for one or more specified and lawful purposes, and shall not be further processed in any manner incompatible with that purpose or those purposes.
3. Personal data shall be adequate, relevant and not excessive in relation to the purpose or purposes for which they are processed.
4. Personal data shall be accurate and, where necessary, kept up to date.
5. Personal data processed for any purpose or purposes shall not be kept for longer than is necessary for that purpose or those purposes.
6. Personal data should be handled in a way that ensures appropriate security, including protection against unlawful or unauthorised processing, access, loss, destruction, or damage.

You should also familiarise yourself with your own employer's Data Protection policy for further information.

Activity 2.3

- What are the eight key principles of the Data Protection Act and how do you think they will apply to your work as a homeless health nurse?

‘Homeless health nursing often requires work with very vulnerable people and building relationships with them.’

Anti-discriminatory practice

Many nurses are attracted to homeless health because of the opportunities to work with patients on a one to one basis often over a prolonged period of time in which significant relationships may be formed and change can be seen.

You will also be exposed to the way in which your patients choose to live and this may also influence your professional relationship and your approach to delivering care. It will not be your role to make judgements on the way in which people choose to live their lives. It will require you to apply the same anti-discriminatory practice and behaviour that you would practise in other settings.

If you have not worked in a community setting before, you will need to develop skills in managing relationships with patients and carers over time and ensuring that these relationships are positive. This may be achieved by spending time to understand their individual needs and build a trusting relationship. It will help you to care and advocate for your patients effectively. A relationship between nurse and patient in the community is unique and requires nurses to maintain strong professional boundaries that protect you and your patients.

If you work in the NHS, the NHS equality delivery system exists to ensure that the NHS is fair and accessible to all.

The Equality Act 2010 ensures a duty to take into account the need to:

- eliminate discrimination, harassment and victimisation
- advance equality of opportunity
- foster good relations between different parts of the community

Nursing in the community, it is important to consider whether your service is accessible to all people. In equalities law, the protected characteristics are:

- race (including ethnic or national origin, colour and nationality)
- disability
- sex and sexual orientation
- religion or belief (including lack of belief)
- age
- gender reassignment
- marital or civil partnership status
- pregnancy and motherhood

Be aware that discrimination can be blatant, but sometimes it is less easily identifiable. People’s attitudes towards others can subtly stigmatise, which can cause barriers to people who need healthcare. People experiencing homelessness can be especially vulnerable to this kind of stigma.

Activity 2.4

- Invent a profile of an imaginary person who is homeless. Choose their race, nationality, disability, sex, sexual orientation, age, name etc.

- How will you ensure this person receives a fair and accessible healthcare service? What changes might you need to make due to their protected characteristics?

Managing your time and development

When working with people with chaotic lifestyles, it can be challenging to manage your time effectively. You will need to balance spending time nursing your patients, agreeing team approaches to care, supporting carers, and developing relationships with community organisations. You are also likely to be working with some patients who may exhibit unpredictable and volatile behaviours, because of substance use or mental health conditions. Another part of your time will be spent ensuring you have put in place robust risk assessments for yourself, your colleagues, carers, dependents and other patients. Over time, you will develop better consultation skills that give you the confidence to meet everyone’s needs most effectively.

If you have come from a hospital ward environment, you may at the start feel isolated as an autonomous practitioner working in the community. Because of this, it is important to identify sources of nursing support and advice as soon as you can to minimise feelings of isolation. Check with your local Clinical Commissioning Group (CCG) to identify

community nurse or health inequality forums if these exists. Regional People Boards, established in 2020 incorporate local education and training board (LETB) which may have a lead who is involved with advising on training and development issues. In some areas, the Local Medical Committee (LMC) fund and organise education and training.

You can also join the QNI's free national network of professionals with an interest in homeless and inclusion health for learning events, networking, resources and the regular Homeless Health News.

You can join the free Faculty for Homeless and Inclusion Health, for a yearly conference and local networks and study days. If you are based in London, you can join the London Network of Nurses and Midwives homelessness group (LNNM).

Homeless Link also offers training courses around homelessness and health.

The wider homeless health multidisciplinary team is very important and the team can assist you as you start your new role. Effective homeless health nursing is built on foundations of good partnership and team working, and colleagues supporting each other.

Formal support through mentoring
As you complete this learning resource, it is advised that you identify a mentor who can support you and help you reflect on your new learning.

Ideally, this person would be a qualified nurse and trained mentor who has had experience of working in a homeless health setting. The NMC guidance gives the standards expected from those supporting learning and assessment in practice.

The main role of your mentor is to assist you in making the transition to the homeless health setting and help you to identify any additional support you may need. Ideally, you should meet your mentor regularly to reflect upon your learning and to get an experienced nurse's perspective on the challenges you face. Bring your reflective journal to your mentor meeting as a way of opening up conversations about the way you are learning, developing, and delivering your care.

Preceptorship and practice-based education
'Preceptorship is a period of support for people who have joined the register, to help their transition from student to qualified nurse or midwife.'

The Nursing and Midwifery Council (NMC) strongly recommends that all 'new registrants' have a period of preceptorship on commencing employment. The aim of this period is to ensure nurses are fully aware of their responsibilities under the NMC code, the code of practice for all nurses and midwives.

In 2018, the NMC produced standards for student supervision and assessment. This guides the purpose and quality of mentoring, practice education, and pre-registration education in practice.

The role of the 'preceptor' is to:
- facilitate and support the transition of a new registrant.
- facilitate the application of new knowledge and skills.
- raise awareness of the standards and competencies set that the new registrant is required to achieve and support to achieve these.
- provide constructive feedback on performance.

This is a crucial area of support as the first year in homeless health practice is often a stressful time and so it is important you seek sources of support

‘Be aware that discrimination can be blatant, but sometimes it is less identifiable.’

that can guide you as you develop your skills in a challenging and complex environment of care. Exercise caution when considering potential employers, and ask potential employers what sources of support they would offer you as you make the transition to homeless healthcare.

Clinical Supervision
In some areas, you may have regular clinical supervision sessions. Clinical supervision in the workplace is a way of using reflective practice and shared experiences as a part of continuing professional development (CPD). It has the support of the NMC and fits well in the clinical governance framework, whilst helping to improve nursing practice.

In autonomous roles, where there are risks involved such as in homeless health nursing, clinical supervision is all the more important to help support and guide future decision-making. As part of their inspection process, the Care Quality Commission may want to establish that nurses are accessing necessary clinical supervision time. If you work in the NHS, contact your Clinical Commission Group Lead Nurse or equivalent regarding what arrangements are in place for clinical supervision in your local area.

Professional reflective practice

However much you prepare and try to address your concerns ahead of beginning your homeless health nursing career, you will find that as you continue to practice and embed your learning, new strengths and new concerns will emerge. Your nursing practice should become the richest source of your learning. In all professional roles it is important to spend time actively thinking back on what happened in practice situations; how you felt, how you managed the situation and what the outcome was. This kind of thinking is called ‘reflection’ and regular reflection will help to improve your practice. Reflection is critical thinking and is a process of reviewing an experience of practice in order to describe, analyse, evaluate and so inform learning about practice. It is common for people to reflect back on situations when ‘something has gone wrong’ It is good reflective practice to reflect on a variety of situations from practice, including ones that ended with positive and negative outcomes.

Models can help some nurses structure their thinking, when undertaking reflective practice. There are many models of reflection that can be used. The model that is used is not as important as long as a process occurs. One of the most common models of reflection is Johns (1992), the basics of which are:

Johns’ model of reflection[11]
- Description of the experience - describe the experience and what were the significant factors?
- Reflection - what were you trying to achieve and what are the consequences?
- Influencing factors - what things like internal/external/knowledge affected your decision making?
- Could you have dealt with it better - what other choices did you have and what were those consequences?
- Learning - what will you change because of this experience and how did you feel about the experience? [12]

Models are simply tools that you are free to use to support your own reflective practice. More important than the choice of model itself, are the skills to reflect, read body language, think deeply and laterally, and ask yourself honest exploratory questions with a focus on personal improvement as a nurse.

In the ‘Gibbs reflective cycle’[13], there are six steps to aid reflective practice:

- Description: First you describe what happened in an event or situation
- Feelings: Then you identify your responses to the experience, for example, ‘What did I think and feel?’
- Evaluation: You can also identify what was good and bad about the event or situation.
- Analysis: The ‘Feelings’ and ‘Evaluation’ steps help you to make sense of the experience.
- Conclusions: With all this information, you are now in a position to ask, ‘What have I learned from the experience?’
- Action plan: Finally, you can plan, modifying your actions, based on your reflections.

The Driscoll Model[14]
Another model to support reflection is the Driscoll Model. It follows a simple three-stage process:
1. What happened? Describe the event in practice
2. So what? Analyse the event
3. Now what? Take action based on the result of learning from experience in clinical practice

Johari Window [15]

When making the transition in to a new working environment a model such as the Johari Window might help to raise your self-awareness, personal development, and group relationships. Your relationship with your colleagues and employer may feel very different.

Figure 2.2 – The Johari Window

1 Known self Things we know about ourselves and others know about us	2 Hidden self Things we know about ourselves that others do not know
3 Blind self Things that others know about us that we do not know	4 Unknown self Things that neither we nor others know about us

The Johari Window may help you explore your own behaviour and attitudes at a deeper level. By working with others to complete it, you can learn new things about your impact on others. The challenge is to explore and understand a little bit more about you using this framework.

By considering the four domains, it should assist you to identify what you know, what others know, and what is yet to be discovered. It can assist to get feedback on performance and increase self-awareness of your own practice.

An example: using the Johari Window to reflect on a scenario

A patient attended for a travel vaccination late one afternoon. She appeared nervous and said that she didn't like needles but was keen to have her 'jabs' as she was travelling on her gap year and would be visiting many high risk areas. As soon as I administered the vaccine she stated she felt unwell and then collapsed.

1. Known self - these are things that you know about yourself and that you may consciously present to others

I felt happy that I had the ability to rely on my knowledge of travel immunisations and the management of anaphylaxis.

2. Hidden self - these are things that you know about yourself but you choose to hide from others

I felt scared as I was alone with the patient and felt totally responsible for the event. I was worried about whether or not I would know what to do and how to treat her. I felt an initial panic come over me and my heart was pounding in my chest as I assessed the patient's condition.

3. Blind self - these are things about you that others can see but are unknown to you

When reporting back to my senior nurse the anxieties I had about this patient and how I acted, I was somewhat surprised at the amount of faith she had in my ability to cope. She stated that she could see how I had developed over previous months and knew that this type of situation 'would not faze me'.

4. Unknown self - these are feelings and abilities that you are not aware of and which others have not seen

As I grow in experience, I feel that I am working towards a more senior role within the practice.

'However much you prepare and try to address your concerns, you will find that new strengths and new concerns emerge.'

Adapting reflective practice to a homeless health setting
You may want to come back to this section later, if you have not yet started a role in homeless health. It may help guide your reflections once you have had some experience in practice.

Homeless health nursing is an area of advanced nursing practice[16]. Health needs are likely to be complex and set against a background where the landscape of homelessness is also complex. You need to be creative and skilful in your nursing practice to effectively listen and respond to the needs of your patients.

You may choose to focus your reflection upon some key themes of relevance to homeless health nursing:
- The quality of your engagement with patients
- The quality of your caring
- The quality of your partnership working
- The effectiveness of your intervention

How well do you feel you engage with patients experiencing homelessness? The Burford Model of Reflection[17] is a series of questions designed to promote deeper thinking about a patient and their life circumstances. The tool may help you to reflect on your patients and their families.

Figure 2.3 - The Burford Model of Reflection (adapted) [18]

1. Who is this person experiencing homelessness?
2. How is this person feeling? How are their family, friends, or carers feeling?
3. How do you feel about them?
4. How has poor health contribute to them being homeless?
5. How has being homeless affected their health?
6. How has being homeless affected their usual life patterns and roles?
7. What support do they have?
8. How do they view the future for themselves and others?
9. Can you now view their illness experience through a homelessness lens?

This model will help you to gain a better understanding of the patient and help you to engage and effectively nurse the patient. Having a better understanding of what homelessness and illness means to the patient and their family, friends and carers should help you to respond to their needs more effectively and for your intervention to have more therapeutic value.

You will not know the background to each of your patient's lives, when you start working with them. The stories that your patients tell you in homeless health settings are likely to contain accounts of suffering and of loss as well as illness[19]. They may or may not contain issues around fleeing trauma, offending behaviours, domestic violence, substance misuse or childhood trauma.[20]

Activity 2.5
- Ask a mentor to observe your interactions with a patient who is homeless

After the appointment, ask them to comment on:

o Your communications skills
- How did you show caring and compassion in your responses?
- How did the patient respond?
- Did you speak in a clear, unrushed way?
- Did you demonstrate open-minded and non-judgemental values?

o Your practice
- Did you meet the health needs of the patient in the most effective way?
- How could you act more effectively in future practice?

When you deepen your awareness of yourself in practice, you will be able to manage and develop yourself further.[21] Emotional upheaval, skill limitations, or fear of sanction may prevent you responding effectively to the needs of your patients. Lone working, negative attitudes, heavy and complex workloads have been noted as challenges in homeless health nursing[22]. When you understand these challenges and how they impact you emotionally, you may become better placed to prevent the risk of burnout occurring.

Writing reflectively

Although models can be helpful to guide your process, the key to writing reflectively is to structure reflective work into your everyday practice, to be brave and ask yourself tough and difficult questions, to be honest with yourself and to be committed to learn from experiences.

Some questions to use when writing reflectively

The questions you can ask yourself when reflecting are limitless, and the best insights may come from the questions you have thought of yourself. However, as a starting point here are some questions you could use to think back over an experience to extract key learning to improve your practice.

- Where the event took place?
- Who was involved?
- What happened?
- How were you involved?
- What your feelings were at the time?
- What contribution did you make?
- What happened after the situation?
- What did you learn from this experience?
- Did you gain any new knowledge?
- Did you gain any new skills?
- What does this mean for your ongoing personal and professional development?

Maximising learning time

Think of every experience as a learning one. It can help to 'talk as you go', externalising thoughts, and sharing knowledge and insights.

- Capture all learning opportunities, however minor
- Try to promote professional conversations with the mentor
- Develop 'case studies' that you can use to promote understanding
- Try to make time for a short 'review and evaluation' session at the end of each day

Reflection can take many forms and can be focused on your experience with a patient over time, as shown by the example in figure 2.4:

Figure 2.4

A homeless health nurse and member of the QNI's Homeless Health Network writes about her work and the impact it has on her and her patients. John is a pseudonym.

I chose this story because I wanted to honour the huge efforts made by a man to change the path of his life.

The worst part was the smell as he peeled off his dressings - the awful odour of a large colonised wound that has been neglected. It permeated everything and stayed long after he had left my room, as if to remind me of what needed to be done. He looked utterly dejected as we surveyed the extensive leg ulcer. 'Am I going to have my leg amputated?' he asked.

John had been homeless for about 3 years when he first presented with a

‘When you understand these challenges and how they impact you emotionally, you may become better placed to prevent burnout.’

small wound on his leg. He was sleeping rough and saw no prospect of getting into housing as he had a very large amphetamine and heroin habit. This meant that rent and bills were highly unlikely to be paid. He also had arrears from a previous tenancy. John was a persistent and prolific offender (PPO) with a long list of drug related offences. He also had a childhood history of neglect and physical abuse. His physical health was poor. He had a deep vein thrombosis (for which he was prescribed injections but his compliance was irregular), a blood borne virus infection contracted through injecting drugs (for which he had been referred to the hospital for ongoing care but had failed to attend any appointments) and now this large infe cted leg ulcer. He felt that no one cared.

John viewed the failure of agencies to provide him with housing as the reason no one cared about him. In all probability this was just the tip of the iceberg - he had little contact with his family and few friends. The odour from his wound had meant that he had been isolating himself from others, including services designed to help him, and this merely reinforced the notion that he was difficult and unwilling to engage and that, consequently, no one cared.

In truth, I felt as overwhelmed by the difficulties of John’s situation as he clearly did on that day.I had seen him intermittently to dress his leg wound but he always failed to return until weeks, or even months later, for his next dressing. That day though, he seemed desperate. I cleaned up the wound and applied dressings which I hoped would reduce the odour and then, as I had done on many occasions before, I explained that the wound needed specialised bandaging to get it to heal much more quickly. The only thing preventing us doing that is that he would have to come to have them changed twice a week without fail. ‘Will it get rid of the smell if I do?’

Malodorous wounds can have ‘enormous psychological impact on quality of life causing embarrassment, social isolation, withdrawal and poor self esteem’ (Gethin, 2010) so it was unsurprising that John felt desperate.

We agreed that he would attend the following week for a Doppler scan of his leg and assessment for bandaging. If he turned up I would ask the housing team to place him in temporary bed and breakfast accommodation for a short period to help his wound heal. This would be a start, and if there were no issues I would call a meeting of all of the services involved to see if we could find a longer term solution to his housing problems.

Thursday arrived, and so did John. He was compliant with the various procedures required to assess his circulation and left with his leg safely bandaged. I contacted housing and, in spite of some misgivings, they agreed that he could have bed and breakfast accommodation for the weekend. We decided that they would issue accommodation letters only if I had been able to dress John’s wound twice a week. If he complied for a period of a month then they would consider offering him the opportunity to go into a hostel.

It was a bit irregular at first but over time he stuck rigidly to his twice weekly appointments with me and within a month the improvement in his leg wound was evident. He was thrilled.

Over the previous three years many attempts had been made to get John into a hostel or housing. It was clear that housing alone was not the answer and that, rather, a ‘package of care’ was required. This involved ensuring that he was given an Opiate Substitute prescription as soon as possible after being given accommodation such as a hostel bed. This would help to ensure that he had sufficient funds to pay his service charge for the hostel. This seemed like a good place to start and I met with and arranged this with his PPO officer and the local criminal justice prescribing team. Initially Opiate Substitution Prescribing was the main focus of his support package and once on a prescription it was possible to get much more engagement with John. The team agreed to allow him to pick up his medication from his local pharmacy rather than walk back and for to their premises every day because of the pain in his leg.

Combined with an improvement in his hygiene, clean clothes and no odour from his wound, a personable and chatty man developed over the weeks. He appeared to enjoy contact with staff at the pharmacy where he collected his dressings and this daily contact with the pharmacist meant that his drug compliance also improved and it was possible to change him from injections to tablets for his DVT.

Whittington (2011) suggests that to work effectively with someone who is homeless it is often necessary to depart from or adapt traditional ways of working. Agencies who had worked with John before were reluctant to do so again and needed some persuasion. Placing trust in him and negotiating with services required an element of risk taking on my part. If this strategy had failed then it is likely that the same agencies would be more reluctant to assist me and my patients in the future. Settling into a hostel after a long period of rough sleeping and a chaotic lifestyle was difficult but with the regular support meetings and a dedicated worker, days turned into weeks, and weeks into months. Throughout he maintained attendance for his twice weekly dressing changes. It was during one of these sessions that he asked

me if I could get help for him to 'get his head sorted'. As I turned the bandage around his heel he told me that had been sexually abused whilst in prison and that he felt unable to wipe the memory; that he felt dirty and ashamed. The discussion went on long after the bandaging was complete and eventually he agreed that I could refer him to a specialist rape counselling service. Locally, such services have an 18 month waiting list however, staff suggested that John be referred to the same service in the next county whose waiting time was only six weeks. His support worker at the hostel agreed to take him to his assessment appointment. He returned to the hostel elated.

It took ten months to heal his leg wound but in that time much more had been achieved by John and the many agencies that have produced a complex patchwork of care to help him move on in his life. Last week when he came for fitting of the support hosiery that will replace his bandages he brought me a bag of sweets to say thank you. 'None of this would have happened if it hadn't been for you. We make a great team don't we?'

According to the Revolving Doors Agency report Complex Responses (2011), it was suggested that 'adults with multiple needs wanted consistent, positive and high quality relationships with staff, in which trust and respect were key factors. Certainly I had tried on many occasions over the years to provide care for him based upon these central tenets but it is this last simple statement made by John that demonstrates that whilst he valued my help in addressing his many complex needs he also recognised the value of his own contribution to the improvement in his health and wellbeing.

This time HE had made all the difference.

Listening to experienced others

The QNI asked nurses experienced in homeless health about the advice they would give to nurses starting in this area of advanced specialist nursing. Here are some of the quotes, which you may find helpful to reflect on as you start in your role:

- *'I had to learn to respect how other people choose to live and not judge them.'*
- *'It can be lonely at first but you are not on your own, there is always a senior member of staff to help. This will be an exciting challenge in your professional life.'*
- *'It will be completely different to anything you have done before be prepared for a long and steep learning curve - but it will be very worthwhile.'*
- *'It is totally different to working in a hospital and/or nursing home environment so be prepared for a shock however it's well worth the transition.'*
- *'You will need to learn to work with chaotic clients and chaotic lifestyles, thinking outside the box in order to engage them in your service.'*
- *'You will need to think about yourself more, don't put yourself in any situation that may put yourself or any colleague at risk, think ahead about where you are going and who may be there.'*

You can continue to listen and reflect on the experiences of others as well as your own, by asking the advice and guidance of more experienced homeless health nurses, joining the QNI Homeless Health Network and being committed to listen and reflect on the experiences of your patients.

‘In truth, I felt as overwhelmed by the difficulties of John’s situation as he clearly did on that day.’

Summary

This chapter highlights some considerations, and guiding legislation you will need working in a homeless health environment in a community setting. It gives you a range of support from networks, individuals, and ways you can support yourself as you embark on this interesting, diverse, exciting, human and demanding area of advanced nursing.

Finally, it has recommended a reflective approach to learning with the aim to support you to work through this online resource with support and at your own pace.

Further learning resources

The following are some of the key national documents, which will help your early learning around homeless health nursing. These are good documents to read and networks to join as part of your induction.

- **Homeless Health Network**

The QNI’s Homeless and Inclusion Health Programme is a network of people working in the community to improve homeless healthcare across the UK.

- **Health Assessment Tool**

The QNI’s Health Assessment Tool is a guidance and questionnaire document to support nurses to undertake holistic health assessments with people who are homeless.

- **NMC Code**

The 2018 NMC Code guides the standards and behaviour of all nurses.

- **The Faculty for Homeless and Inclusion Health**

The Faculty for Homeless and Inclusion Health is a multi-disciplinary network for homeless health professionals.

- **Commissioning Standards – homeless health**

The Faculty for Homeless Health’s accessible commissioning standards define good quality homeless healthcare.

- **Homelessness: applying All Our Health**

Public Health England’s ‘All Our Health’ resource is aimed at all nurses, midwives, and allied health professionals to improve public health. The homelessness chapter contains additional learning.

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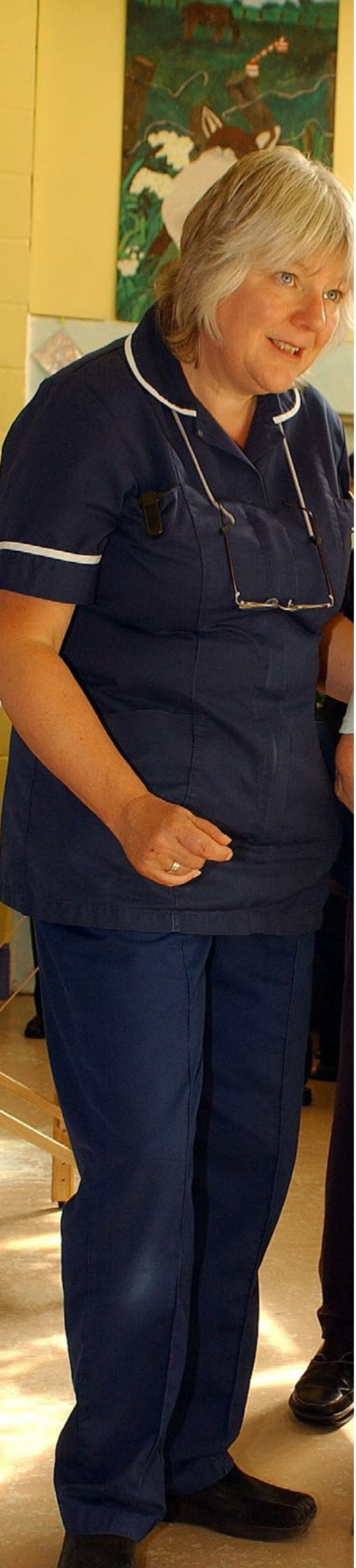

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