Skin, Wound And Foot Care For Individuals Experiencing Homelessness In Canada

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How to cite: Telegdi E, Kuhnke JL, Parsons L, MacKenzie S, Fitzpatrick S, Alam S, O'Neil A. Skin, wound and foot care for individuals experiencing homelessness in Canada. Wound Care Canada. 2026;24(1): 48-65. DOI: 10.56885/207248bvueuv

Across Canada, there is growing awareness of the health and well-being of individuals experiencing homelessness (IEH), including the impact to skin health, foot health and the risk for the development of wounds and wound-related complications.[1] While best practice recommendations for the prevention and management of wound care are robust, and there are strong efforts to support the integration of wound care best practice across all provinces and territories,[2] there remains a need for increased attention to providing wound care for IEH, who present as a high-risk and under-prioritized population.[1,3]

If we are to truly embrace the concepts of diversity, equity and inclusivity, we must accept that institutionalized care will not be a fit for everyone. Although person- and patient-centred care are often used interchangeably, there is a distinction which should be understood. In the true sense of the word, a patient is defined as the 'one who suffers'. Although it places the patient at the centre of the care model, it does not necessarily consider the full scope of what it means to be a person. Person-centred care acknowledges that an individual does not exist in isolation, but in the broader context of family, intersectional social location and social and political norms. It should include the concepts of relationship, family and client-centred care as parts of the whole person, which may come into conflict with the health-care system, when decisions are made about treatment plans and when trying to achieve the best health-care outcome for the person at the centre

of the circle of care.[4] This is an important concept when one considers wound healing outcomes in IEH, as reasons for homelessness are as multifactorial as barriers to care. It is also important to understand that the incidence of IEH is as high in rural and remote communities as in many Canadian inner cities.[5] In both, IEH may be between 0.20-0.35% of the total population.

It is well recognized that health-care outcomes are tied to social determinants of health.[6] The traditional model of appointment and follow-up may not work for structurally excluded persons experiencing health care issues. As a result, IEH experience significant barriers to receiving timely and effective health care. This is true of rural populations where access can be further limited by non-medical factors such as reduced transportation, child care and elder care.[7] Community care has also been shown to give better adherence to therapy, can be patient specific instead or tied to the more rigid plans of larger central care and cultural safety.[8] This is especially true in addressing chronic disease issues where the longitudinal intersection of the person and health-care systems can be lengthy.

Therefore, in the spirit of being inclusive of the diverse populations which access health-care systems in Canada and addressing these concepts, we came together as three committed teams to highlight ways in which concerted and strategic efforts are being made to provide high quality foot health, skin and wound care to IEH in our communities. This presentation is from geographically and demographically diverse locations: Calgary, Toronto, and Cape Breton. We aim to highlight efforts to promote best practices for IEH that are evidence-informed, low-barrier, and meet the needs specific to each community served. As well, we highlight similarities, differences, innovations and implications for future research, program and system level change recommendations for increasing equity in health outcomes and improving the skin health of IEH.

Individuals Experiencing Homelessness: Who They Are?

Care of persons' skin and wounds when experiencing homelessness is a present and ongoing challenge in Canada. IEH occurs in all communities across Canada[9] and the numbers of IEH are growing.[10] Compared with a point-in-time count in 2018, a count conducted in 2024 showed that the number of people living in an unsheltered location quadrupled (a 303% increase), making this the fastest-growing segment of the homeless population.[11] Holistic care of IEH is crucial as the relationship between homelessness and health outcomes are related, complex and interrelated.[12]

Persons experiencing homelessness include four categories, that are not all inclusive. These include persons:

1) unsheltered (living in parks, tents, sidewalks, garages, attics)
2) emergency sheltered – living in shelters for the night, in a shelter due to family violence or fire
3) people housed provisionally or in interim housing while waiting for permanent apartments or housing and
4) those persons living at risk of homelessness due to unstable employment, unemployment, housing where they may be evicted, or experiencing violence, trauma.[13]

It is important to note that while making up only 5% of the Canadian population according to the 2021 census, 35% of homeless individuals identified as Indigenous during the 2020-2022 national Point-in-Time count.[14] The overrepresentation of Indigenous peoples amongst IEH highlights ongoing colonial violence as a significant structural determinant of health. Further, there exists a distinct and self-determined definition of Indigenous homelessness:

"Indigenous homelessness is a human condition that describes First Nations, Métis and Inuit individuals, families or communities lacking stable, permanent, appropriate housing, or the immediate prospect, means or ability to acquire such housing. Unlike the common colonialist definition of homelessness, Indigenous homelessness is not defined as lacking a structure

of habitation; rather, it is more fully described and understood through a composite lens of Indigenous worldviews. These include: individuals, families and communities isolated from their relationships to land, water, place, family, kin, each other, animals, cultures, languages and identities. Importantly, Indigenous people experiencing these kinds of homelessness cannot culturally, spiritually, emotionally or physically reconnect with their Indigeneity or lost relationships."[15]

Prioritizing Skin Health And Wound Care For Persons Experiencing Homelessness

Individuals experiencing homelessness (IEH) require comprehensive health assessments including management and treatment for acute and chronic illnesses.[1,16] Assessments should be tailored to meet the person's needs, be relevant to age, gender, Indigenous heritage and presenting mental health, physical and social needs.[1] Health assessment should include nutrition, mental health, cognitive status, substance use and medication(s), oral health, skin assessment, wound assessment and foot health screening. Conducting focused and regular assessments are essential with the goal of improving health outcomes; this includes providing a care environment that promotes safety and trust for those accessing services.[17] This may be challenging as clients may come to an appointment and not be able to return or be assessed for follow-up.[18] In Switzerland, researchers studied 123 IEH; they report that mental health, musculoskeletal and psychiatric issues were a priority. As well as needing support to navigate the health care system, IEH may be hesitant to access or seek care.[19,20]

Individuals experiencing homelessness are often unable to access basic amenities such as washrooms, showers, hygiene items, laundry services, adequate nutrition or weather-appropriate clothing and footwear. These conditions are compounded by lack of transportation requiring long periods of ambulation, few opportunities for lower leg elevation, including safe periods of sleep, improperly fitted mobility devices and lack of access to find shelter from extreme weather conditions.[21] Significant systemic barriers prevent unhoused individuals from receiving consistent and adequate health care. Appointment-based primary and specialty care result in IEH being systemically marginalized from receiving needed care for acute care and chronic disease management. In order to provide equitable access to skin, wound and foot care services to IEH, organizations providing these services must find ways to meet the needs of the populations they serve, including offering drop-in services that are flexible, allow for drop-in access and offer consistency in both access to health-care providers and collaboration to ensure continuity of care. Further, these services must be adequately resourced to not only provide skin, wound and footcare, but also meet the basic needs of IEH including access to clothing, socks, nutrition, transportation assistance, and robust care coordination to support follow-up, as well as referrals that address social determinants of health including income and housing support.[3,17,18]

Therefore, we present three interdisciplinary, integrated, and comprehensive approaches in promoting skin checks, wound care and foot care for individuals who are unhoused. The following details the importance of building integrating teams to address prevention, low-barrier and trauma-informed point of care service and embedded evaluation.

Case A: Toronto, Ontario

Best Practices to Improve Skin, Wound, and Foot Care for Individuals Experiencing Homelessness: South Riverdale Community Health Centre, Toronto ON

Background: South Riverdale Community Health Centre (SRCHC) in East Toronto is one of 75 CHCs across Ontario; in 2026 they celebrated 50 years of service.[22] As a model of care, CHCs serve populations that have traditionally faced barriers in accessing health services. This includes IEH, individuals who are non-insured and people living in poverty. SRCHC uses a values-based model of care grounded in a commitment to reconciliation and relationship, health equity and social justice, meaningful engagement, holistic approach and evidence and

values informed practice. In the 2024/2025 fiscal year SRCHC served 15,402 individuals across its network of programs. Of these, 63% identified as racialized, 57% were living on a family income below $40,000 and 30% live with more than 10 acute, recurrent, or chronic conditions.[22] In 2024/2025 the centre recorded over 148,113 encounters in their Electronic Medical Record (EMR).

SRCHC's work is grounded in integrated, interprofessional and collaborative holistic care. As an anchor member of the East Toronto Health Partners Ontario Health Team (ETHP OHT), SRCHC helps to align priorities and integrate care across organizations to build a healthier and more equitable East Toronto.[23]

This inquiry, therefore, demonstrates how SRCHC has adopted best practices for the prevention, assessment, and management of skin, wound and foot care with a specific focus on efforts to improve health equity for people accessing care within the Substance Use & Mental Health (SUMH) department, including 'People Who Use Drugs' and IEH.

SRCHC was an early adopter of harm reduction-grounded care for People Who Use Drugs. In a recent demographic survey of clients who provided housing information, 9% reported experiencing homelessness; this high proportion of individuals engage with SUMH services. As well, skin health, wound and foot care has been a high-demand service specifically within the Moss Park Consumption and Treatment Service (CTS) program. CTS focuses on supervised consumption and overdose response for People Who Use Drugs along with wrap-around services such as nursing-led primary health care and social service supports. During the 2024/2025 fiscal year, the team saw over 900 individuals. The persons accessing this service are at increased risk of inequitable health outcomes related to being un/under-housed and further complicated by substance use and substance use stigma.[12,24] At the intersection of experiencing homelessness and substance use, multiple factors have been identified that increase the risk of skin breakdown and complicate wound healing.[18,25] For People Who Use Drugs, stigma experienced within the health-care system results in barriers to accessing appropriate and compassionate care for skin, wound, and foot health issues.[26]

In 2019, East Toronto Health Partners Ontario Health Team (ETHP OHT) became one of the first health teams to join the Registered Nurses Association of Ontario's (RNAO) new Best Practice Spotlight Organization® Ontario Health Team (BPSO® OHT) program.[27] The goal of the BPSO® program is to optimize health outcomes through consistent use of evidence-based practices and staff engagement to create cultures of learning and improvement.[28] The ETHP joined the BPSO® OHT to leverage RNAO's guidelines and implementation processes, anchoring their work within evidence-based frameworks, and aligning with the quintuple aims of improved provider experience, patient outcomes and experience, lower cost of care and improved health equity.[29] SRCHC has been one of the champion organizations of this work with a focus on facilitating change, transferring evidence into practice and evaluating and monitoring outcomes within a health equity lens.

Methods: In 2024, the team selected the RNAO Best Practice Guideline (BPG) for Diabetic Foot Ulcers: Prevention, Assessment and Management[30] in alignment with Ontario Health's prioritization of lower limb preservation (LLP). The SRCHC formed an interprofessional working group to focus on guideline implementation including clinical leaders, Registered Nurses (RN), Registered Practical Nurses (RPNs), Chiropodists (DCh) and Information Management (IM) specialists to work toward conducting a gap/opportunity analysis. Opportunities and change ideas were first identified by the group in a brain-storming session and then voted on individually by group members based on priority, feasibility and impact of intervention. This resulted in the collective selection of multiple recommendations/good practice statements from the guideline to be implemented (See Figure 1), including standardized wound assessment tools and documentation, building wound care capacity across teams, and mapping and standardizing

Recommendations and Good Practice Statements
Self-Management
Recommendation 1.0: When delivering self-management support, the expert panel suggests that health providers use person-engagement strategies that are tailored to persons at risk of or living with a diabetic foot ulcer and their care partners.
Wound Assessment
Good Practice Statement 3.0: It is good practice for health providers to regularly conduct a comprehensive and consistent wound assessment and document the presence and characteristics of a diabetic foot ulcer.
Specialized Wound Care Team
Recommendation 3.0: The expert panel suggests that health service organizations implement a specialized wound care team to support persons at risk of or living with diabetic foot ulcers.
Plan of Care/Treatment
Good Practice Statement 4.0: It is good practice for health providers to implement a plan of care with the person living with a DFU and their care partners that includes evidence-informed management options.
Recommendation 4.0: The expert panel suggests that health providers use virtual care platforms in conjunction with in-person services to supplement the provision of diabetic foot care services.

Figure 1: BPG Recommendations and Good Practice Statements Implemented by SRCHC's Foot Health Working Group. Permission: South Riverdale Community Health Centre

both internal and external escalation of care pathways. Subsequently the group developed an implementation and evaluation plan to address skin, wound and foot care for SRCHC clients across programs.

Results: As part of this working group, there was an increasing awareness that IEH and substance use are populations at increased risk for skin, wound and foot complications. The SUMH Department RNs, particularly those within the Moss Park CTS, perform a high volume of complex wound care, resulting in 227 encounters between October 1st, 2025 - January 31st, 2026 (See Figures 2 and 3). SRCHC's BPSO® OHT BPG implementation offered an opportunity to increase standardization and quality of care, strengthen integration across the CHC and its partners and embed IM systems to optimize the EMR for clinical and demographic data collection. This embedded infrastructure enables evaluation and demonstration of the impact of this work within the department and across the organization.

Figure 2 & 3: An Individual Experiencing Homelessness presents with a soft tissue infection caused by a traumatic injury – from initial presentation to near full resolution. Permission: Erin Telegdi

CTS To Enhance Accessibility

The Moss Park CTS offers low-barrier harm reduction care for People Who Use Drugs, many of whom experience homelessness. A key health-care feature is the consistent presence of RNs for most operating hours, with services running Monday-Saturday, including late evenings. People accessing services may receive nursing care on a drop-in basis, including into the evening hours when service volume and demand for clinical care is highest. This ease of accessibility supports the development of strong therapeutic relationships and facilitates holistic care (See Figure 4). As the Moss Park CTS program has evolved it has incorporated the interprofessional clinical team from within the larger CHC. The service now offers drop-in Nurse Practitioner (NP) hours multiple times a week in the late afternoon and evening, as well as episodic drop-in chiropodist (DCh) hours, where health education and health promotion activities related to foot health have been provided. Facilitated by warm handovers from CTS RNs, community health workers and harm reduction workers, the DCh has built strong relationships and trust with the CTS community, which has supported uptake of consultation, treatment and provision of off-loading devices and orthotics. The strong focus on relationship-building at the CTS has resulted in successful integration of NP and DCh drop-in hours, with interprofessional care leveraged to provide an increasingly wide range of health-care services and increased continuity of care. Crucial to these efforts is the embeddedness of healthcare within the CTS service. Bringing care to people and meeting them where they are at is a fundamental way in which SRCHC's work is grounded in health equity.

Figure 4: The Clinic Room at the Moss Park Consumption and Treatment Service. Permission: SRCHC. Permission Erin Tegladi

Assess Need, Standardize Documentation and Increase Capacity

The Foot Health Working Group conducted a detailed gap/opportunity analysis to assess program strengths and needs (See Figure 5).

A key issue identified was the lack of standardized assessment tools for wound care and accompanying documentation, as no consistent approach existed in the EMR, nor was there a wound care workflow across the organization. While Wounds Canada's (2025) Inlow's 60-Second Diabetic Foot Screen[31] is already standardized within our Diabetes Education Community Network of East Toronto program, this was not yet fully utilized across all programs. With IM support we adopted the Bates-Jensen Wound Assessment Tool (BWAT)[32] within the SRCHC EMR. We also made the decision to collect additional information related to wound etiology, cause(s) of wound, spaces to document a wound management care plan and contributing social factors (See Figure 6). This facilitated a more accurate depiction of the complexity of care and increased care consistency within and across programs. Training on the BWAT tool was then provided to all clinicians. This provided opportunity for clinicians to discuss the BWAT use, ask questions and provide feedback.

In partnership with the Downtown East Toronto (DET) OHT, education was offered to nurses across SRCHC, including RNs. This educational opportunity, facilitated by Wounds Canada, focussed on best practices in wound and foot care. This inter-organizational capacity building opportunity coupled with the intra-organizational adoption of the BWAT has worked to set a foundation for increasing the standard of care and consistency of documentation within the organization.

Opportunities & Change Ideas

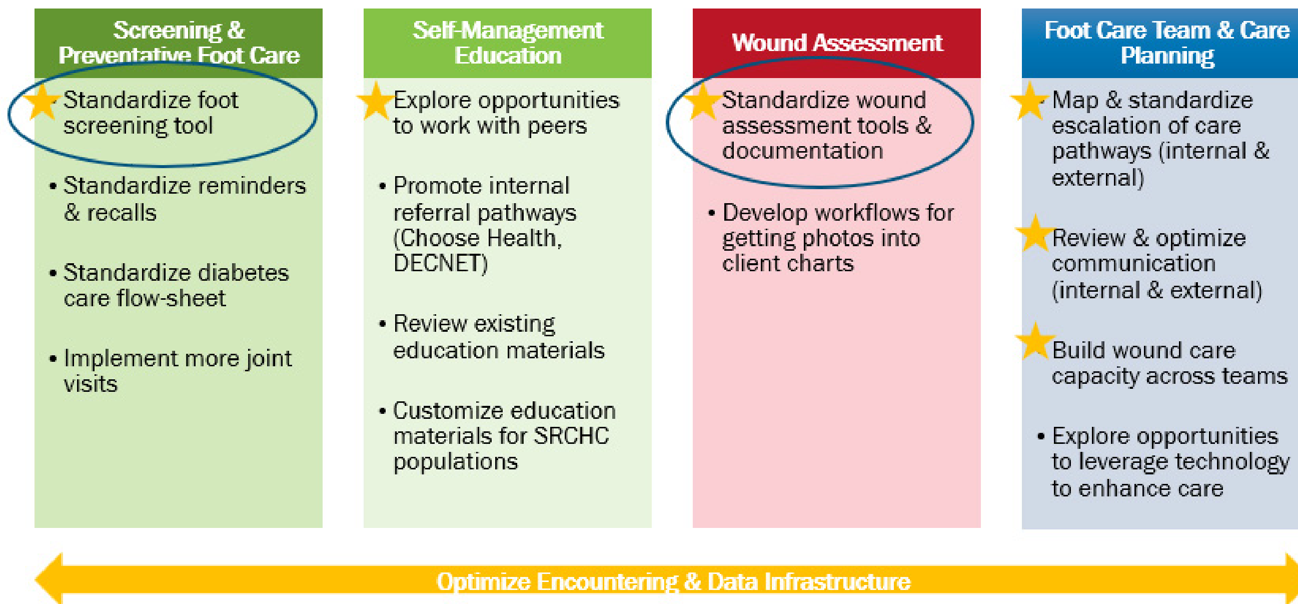

Figure 5: Foot Health Working Group Needs Assessment. Permission: SRCHC.

Customized Bates-Jensen Wound Assessment Tool

Instructions Lock Print Graph Explain

Jul 28, 2025
Diabetes Test

Bates-Jensen Wound Assessment Tool

Complete the rating sheet to assess wound status. Evaluate each item by picking the response that best describes the wound and entering the score in the item score column for the appropriate date.

- Wound 1
- Bates-Jensen Wound Assessment Tool Score
- Wound 2
- Bates-Jensen Wound Assessment Tool Score
- Wound 3
- Bates-Jensen Wound Assessment Tool Score

Updates Include:

- Space to describe wound etiology, risk factors, health-related & social factors
- Addition of foot images to mark wound location
- Automated scoring
- Addition of a care planning section
- Can use the same form to assess up to 3 wounds at a time

Figure 6: Bates-Jensen Wound Assessment Tool as Developed by the Foot Health Working Group and with the Support of Information Management Specialists. Permission: SRCHC.

Additionally, work was done to leverage partnerships in the DET OHT to develop and standardize escalation of care pathways for individuals with wound complications requiring specialty follow up, including timely access to vascular assessment and treatment plans.

Footwear Provision: Meeting Basic Needs

In the fall of 2025, the Foot Health Working Group was able to secure project funding to provide new footwear to clients. With guidance from the DCh and foot care RPN, winter boot and running shoe styles were pre-selected for their foot health promoting features, such as wide toe boxes, waterproof materials, Velcro™ or lace fastening, and supportive sole structure. RNs in the SUMH Department were provided with foot measuring devices so that correct sizes could be selected and footwear ordered for individuals identified as high risk for lower limb complications. This initiative began its rollout in the winter season and enabled IEH to access weather-appropriate footwear. In addition to footwear, foot care kits were created and provided to clients, and included items such as socks, gentle cleansers, foot files, and moisturizer to promote skin health (See Figure 7).

Still in its early stages, this initiative has thus far resulted in 58 clients receiving footwear, including 20 who identified as IEH. This intervention has enabled individuals, who cannot afford appropriate winter footwear, and are at high risk of exposure-related injuries, to receive well-fitting and season-appropriate shoes. Community health workers and RNs involved in fitting and connecting high-risk CTS community members to winter boots note the positive impact of choice - that is, being able to pick one's own winter boots and not have to rely on donations that may be of poor quality and/or fit. For some, this was the first time in many years that they had a new pair of winter boots that were fitted for them and that they were able to choose. They also reflected on the positive emotions expressed by community members when they received footwear - that this gesture made them feel loved and cared for, and that this new footwear would help them to care for their health. One person put on their new boots and danced. While this initiative has helped to reduce the risk of skin breakdown, it has also promoted people-centered care and dignity, and enhanced feelings of inclusion and being cared for in community. Based on impact as assessed in this early stage, this initiative had its funding extended and will be able to support the provision of appropriate footwear for the change in seasons.

Figure 7: The Foot Health Working Group Making Foot Care Kits for Clients. Permission: SRCHC

Figure 8: A Pair of Fitted, Waterproof Boots. These replaced a pair of plastic sandals in the middle of the winter, where Toronto saw heavy snowfall. Permission: SRCHC

Demonstrating Impact

Infrastructure to demonstrate impact has been embedded into the BPG implementation Working Group from the outset, with participation of the IM team integral to the process and to the interprofessional team. To date, data collected from our EMR demonstrated 14 instances of use of the new BWAT tool representing 10 individuals, in addition to 183 60-Second Inlow's Diabetic Foot Screening assessments[32] completed during the same period, reflecting the preventative work embedded in our Diabetes Education Community Network of the East Toronto program. To increase uptake of the BWAT tool, we are including training in our new hire, on-boarding processes and increasing ease of access to the tool within the EMR interface. The Working Group is developing wound care-specific custom encounter forms that include encodes relevant to chronic and lower limb wound care in order to increase data reliability and accurately reflect complexity of care. The iterative work of the IM team allows for ongoing assessment of Working Group initiatives, as well as ongoing improvements to streamline workflows for clinicians and demonstrate the impact of prioritizing skin, wound, and foot care for IEH who access SRCHC services.

Discussion: While SRCHC's implementation of the Diabetic Foot Ulcers: Prevention, Assessment and Management[30] remains in its early stages, there have already been significant learnings as they relate to meeting the skin, wound and foot health needs of IEH and sustainability of evidence-based practice.[33]

Ongoing Education And Training For Staff

Increasing wound care capacity across the SUMH Department RN team through education/training and standardization of wound assessment and care planning via adoption of the BWAT has served as fundamental first steps in working toward continuous improvements in skin, wound and foot care. This has improved consistency in wound care treatment plans, which has supported our shared-care model and supported RNs who are building their own capacity in wound care knowledge, skill and judgment. As a next step for standardization, we will be implementing the integration of Inlow's 60-Second Diabetic Foot Screen[31] across the organization, including training and workflows to broaden its use. Within the SUMH Department, this approach will promote regular screening for clients with diabetes, improve detection of peripheral neuropathy across multiple aetiologies and support the identification and management of associated risk factors.

Staffing Capacity

Embedding drop-in DCh services into the Moss Park CTS has inspired the creation of a dedicated DCh position within the SUMH Department, which will greatly increase the accessibility of this crucial specialty service for IEH.

Partnerships And Care Pathways

Continuing to leverage partnerships across OHTs, work will be undertaken to optimize standardized escalation pathways for individuals with wound complications requiring specialty follow up, as well as looking to increase internal capacity to assess and manage wounds related to vascular disease as part of limb preservation efforts.

EMR Infrastructure

Led by IM and informed by clinician feedback, work will continue to build infrastructure within the EMR to support clinicians in their uptake of best practices in skin, wound and foot care. This will enhance data quality, support a shared-care model and facilitate an accurate reflection of the complexity of care and demonstrate impact of the work being done to support IEH.

Conclusion: IEH are a population at increased risk for skin, wound and foot complications. Meeting the complex needs of IEH through relationship-based, integrated and low-barrier approaches is a priority for SRCHC's SUMH Department. The Foot Health Working Group has provided an invaluable opportunity to focus attention on building capacity across the organization and developing infrastructure to meet the needs of IEH in the community and enhance a values-based commitment to meeting people where they're at.

Case B: Calgary, Alberta

Providing Wound Care To A Downtown Population Of IEH

Background: The Sheldon Chumir Wound Clinic (SCWC) is a downtown inner-city clinic where complex wounds are assessed and treated.[34] Care is provided seven days a week from 0800-1600 hours. The clinic is adjacent to a busy urgent care centre, a safe drug administration centre and two organizations dedicated to addressing the needs of IEH: the Mustard Seed organization and the Drop-In Center. Physicians staff the clinic Monday-Fridays and are available for consultations. The building also houses an Indigenous care centre, urgent care centre, family medicine clinic and an infectious disease/sexually transmitted disease (STD) clinic. The clinic sees a wide range of wound aetiologies in two streams. The first is a traditional stream where patients are referred and seen in clinic with a traditional appointment and treatment process. The second stream is a drop-in line, where patients are treated according to their choice of when to present for care. In the second stream, the most common wound aetiologies are trauma (burns, bites, person on person violence wounds) and frostbite.[35] Other wound aetiologies identified are chronic venous ulceration and neuropathic wounds, especially from diabetes.

It was recognized that many of the IEH were not doing well in the traditional appointment based 'front desk' system and that care was not perceived as being culturally sensitive. It was recognized by front line staff that patients were coming into clinic with wet/inappropriate dressings and infected wounds because of missed appointments. Reasons for missed appointments were transportations issues, early appointment times conflicting with mealtimes at local centres, substance and mental health issues and even not having a reliable means to check the time. As most did not have cell phones, rebooking appointments was difficult and many patients were being re-referred to the clinic after being triaged in the urgent care centre because of new wound infections. This also compounded the total cost of care and increased the amputation risk. Patients were also very discouraged or triggered by the presence of security personnel who were active in this busy downtown medical centre.

This led to rethinking how to provide non-judgemental and barrier free care. It was decided to abandon the time-based appointment system and to create a drop-in line. Patients were made aware that the clinic would devote a nursing line to the drop-in system from 0830-1530 hours and appointments were not required. So long as they attended between these hours, they would be assessed. As most patients were referred from the urgent care centre a chit system was initiated. This was a paper document which had the clinic opening times and could be shown to security personnel who were then trained to recognize this as a valid reason for being in the building. The patient was only required to show the chit and a verbal exchange with security was not required.

The population was studied from January-December 2021. Since initiating this model over two thirds of patients have kept their follow-up appointments. The drop-in service was accessed by 119 patients for a total of 798 clinic visits. The average patient age was 46.0 years (73.9% male, 26.1% identified as female). Of these 76.8% were eligible for the drop-in line and returned for more than one visit. Of these 26.8% (n = 32) were followed until wound closure. Of note, patients who were followed until wound closure were seen on average for 9.9 total visits over 120.8 days, compared to just 3.0 visits over 21.4 days for those lost prior to wound closure.[35]

As outcome data is not available from before initiating this system, it is difficult to say with certainty that this has improved wound closure and reduced amputation rates, but informal discussion with patients suggests that this system is considered culturally safer for this population.

Case C: Cape Breton, Nova Scotia

Providing Foot Health In A Primary Care Clinic With A Focus On Diabetes Mellitus: A Qualitative Inquiry

Background: Health of feet and wound care for individuals experiencing homelessness (IEH) are of significant importance due to the increased risk of infection, barriers to care and lack of timely access to services.[36,37] Skin and wound conditions may include arm, face, leg and foot trauma, skin maceration/infections, nail infections/trauma, callous (mild to significant), corns and foot deformity.

Foot health is especially important for IEH and/or for those at risk of foot complications, especially when persons live with diabetes mellitus, diagnosed or undiagnosed. Provision and education on basic foot health involves building a trust-filled relationship, offering of foot hygiene, skin and nail care and conducting foot, sock and footwear assessments for all weather conditions.[18,37,38] Foot care services are typically provided by licensed nurses and chiropodists/podiatrists with specialized training.[39] Offering funded foot health services in primary care provides a gentle reminder of how assessment of an individuals skin and foot health can improve their overall health and well-being.[18]

Method: The following is part of a larger study. In this inquiry, researchers aimed to evaluate the services offered via the foot health program operationalized at the Primary Care Clinic (PCC), which also offers Harm Reduction services (Sydney NS). Weekly foot heath clinics are held by a registered nurse trained in Advanced Foot Care in primary care and focus on provision of foot care, preventative education, assessment of skin infection(s) and provision of socks and fitted footwear. The Bates-Jensen Wound tool and the Inlow's 60-second Diabetic Foot Screen are embedded in the EMR. This study took place at The Ally Centre located in an urban setting of approximately 30,000 persons[40] in a province of 98,808 (2022) persons.[9] According to the Homeless Hub (2021), 325 persons were experiencing homelessness; 37% experienced chronic homelessness; and approximately 20% abide in emergency shelters.[9]

Foot Health Program

The Foot Care program has been operationalized by the PCC team for several years. The nurses alongside the peer, outreach and overdose prevention workers, identify clients at risk of skin, foot and footwear issues. As well, clients who access the harm reduction site, overdose prevention services and drop-in-setting (tea, coffee, meals, clothing, clean injection supplies) are welcomed to attend the foot health clinic via appointment or drop in and off-site outreach foot care is also available.

Research Ethics Board approval was from Cape Breton University and The Ally Center of Cape Breton.

Data Collection: To evaluate our foot health services we conducted face-to-face interviews 25-35 minutes between September to December 2025. A twenty-dollar coffee card was given to each participant upon completing the research interview. Interviews were open-ended and the main questions focused on why the client attends the foot health clinic, what were the benefits, and what were areas for improvement.

Data Analysis: Interview data was hand recorded and typed verbatim. Participants reviewed their typed answers with the researcher and added in additional notes as needed. Themes that emerged from the data focused on the benefits of the foot health service and areas for improvement.[41,42]

Eight adults engaged in in-depth research conversations (1 female; 7 males, 39-72 years). Participants attended the foot health clinic weekly, then twice monthly or monthly. Five of the eight participants smoke one-pack of cigarettes (or more) daily and three identify as having diabetes mellitus. Each receives care for mental health issue(s) and

substance use disorders from the physicians, nurses, a social worker and a psychiatrist. All participants are housed in shelters, supportive housing, live with family or in an apartment.

Findings

Knowledge of Nail and Skin Pathologies: The primary finding consistent across participants' stories was the presence of maceration, pain, blisters, and nail and skin infections (fungal, bacterial) that drew them to seek foot care. This varied depending on their underlying health issues, footwear, weather conditions (hot, humid, cold, snow/ice) and housing situation.

Overall, participants exhibited good general knowledge of the need for basic foot care and footwear. For several, seeking care was initiated when told they have diabetes. One participant noted:

> "Well for start, I have diabetes, for maybe two years or longer now. I was on the street, then a little apartment and now in supportive housing, which I love. I have probably got decreased circulation from smoking. In the last two years, my vision has changed a lot. I cannot cut my own nails or really see to cut them on my own. Because the nurse cares for my nails and skin, it makes me feel like I belong to society, like when I worked full time. When I come for foot care, the nurse helps me with socks and shoes; they talk to me and share health information with me. As well, they trim and file my fingernails the way I like."
> *(Participant 1)*

For three participants, living with peripheral arterial disease (PAD) and wounds was identified as a key risk factor for leg and foot problems and for seeking foot care.

One stated:

> "Well, hands and feet are very important to me. I have worked hard all my life. Feet are like the barometer of my health even though I smoke. When I had my stroke, I developed skin and toenail fungus, it smelled terrible, I was embarrassed. It was the foot care nurses that helped to identify the pain in my skin [feet] with my doctor, as well they got me proper wound care. My hand is crooked from the stroke, and the nurses trim my fingernails every few weeks as I cannot do that."
> *(Participant 2)*

Another stated:

> "The foot care nurses trim my nails, but they also check the swelling in my legs, I used to wear compression socks before I became homeless. Now that I am in the shelter the nurses are helping get my 'leg tests' [ankle brachial index] and compression socks organized…I need my foot care to stay alive. I think foot care is like the overall general health monitor. If you do not have good feet, you do not have good health. As well, I like to walk…I miss walking long distances outside to hunt."
> *(Participant 6)*

A third participant stated, the key is to:

> "Just show up and get foot care. When I started to come here, I was living with a lady that died. I had no doctor. I came in crying for help. I would have lost my legs to wounds after my heart surgery. See my right leg is not perfect but at least I look after it now, and I can walk. I still smoke, but I am trying to reduce the number I smoke.

> I come to the PCC for foot care every month. I could not walk, I had shoes with a deep crack in the bottom, they gave me new shoes. As well, I think they called it 'athletes' feet, my skin was broken and sore; so painful I could hardly walk. The nurses saved my feet. My nails were curled forward like the letter 'C' under my feet. The nurse was very good; she washed my feet and slowly trimmed them back to a good length."
> *(Participant 7)*

Challenges To Applying Foot Health Knowledge: All participants discussed changing vision and not being able to reach their feet to safely trim or file their nails. Reasons included: weight (abdominal girth), lack of physical flexibility, vision changes, lack of foot instruments to accurately trim and file, lack of privacy in the shelter and lack of confidence. One participant stated:

> "I come to the clinic to get the nurse to remove all the callous from my heels and the sides of my feet. I can sort of do it at home, but the foot nurse does a better job. As I walk great distances, I am glad for the foot care and monthly foot care; my feet would not be in as good shape as they are. As well, I can access dry socks; they are so expensive these days, you know just one more thing to buy on my cheque."
> *(Participant 8)*

Another stated that living in shared housing with family does not mean he has someone to help with his foot care. He stated:

> "To me, footcare is health, I know that you must look after your toes or you will end up losing them from the cold, wet boots, and sleeping in the woods. Hey, look at me, if it was not for foot care nursing, I would have probably lost all my toes. What I have had to do to get my two big toenails back is a lot. I come regularly and they are now starting to grow back. I had really bad skin and nail fungus. The doctor has helped too. I walk long distances 12-15 kilometers every day and when my nails do not feel right in my running shoes I go and see the foot care nurse. As well, the foot care nurse files my fingernails; this is important as I always forget. When I was homeless in the tent my toes and skin on my feet were in bad shape. This is why I regularly come here to get them done."
> *(Participant 5)* (See Figure 9.)

Figure 9: Summer Footwear And Borrowed Socks

Complicated Living

One of the common themes from the participants was the challenge and responsibility of living with co-occurring diseases, such as: mental health issues (schizophrenia, bi-polar), diabetes, PAD, heart attacks, smoking and substance use and addiction (opioids, stimulants, alcohol). Many slept with their socks and shoes on for fear of them being stolen. For some, accessing foot care was complicated by unstable housing or changes in housing (moving from a shelter to supportive living, loosing housing due to

mental health and social issues).

A participant described the following about the importance of foot health:

> "If you want to be able to walk properly, you must keep your feet clean, have dry socks and shoes. Clean socks are important. I come here because the doctor and the nurses helped diagnosis my skin disorder and got me a dermatologist appointment. They care about my substance use and have helped get me support.
>
> I could not get this organized on my own due to my health. The clerk calls and emails me to remind me of my appointments and I really like this, otherwise I would miss my appointments.
> In terms of shoes, appropriate shoes and boots, relevant to the weather are key. The cost of boots and shoes is crazy and then the soles fall of my used runners and then I have to try and find another pair. Because I only buy used from the recycle stores it is not like I can take the shoes back to the stores and say hey, 'the soles fell off'."
>
> *(Participant 4)* (See Figure 10.)

Figure 10: "These were worn out when I bought them"

Living with complex diseases can be challenging. A participant stated the following about why he visits the clinic:

> "Well you know, I come for foot care because I get to talk about my health in general. You know if I have any 'heart flutters' the nurse is going to assess me and help me see my heart doctor or the physician here. Or if my 'surgical wound' is tender the nurse is going to check it for me. When the nurse does the foot care, I get to share about my health and things I am working on, like smoking less."
>
> *(Participant 4)*

Money Matters

All participants described the importance of having access to funded foot healthcare. Participants were deeply aware of the general cost of foot care at various service providers across the city. Prices described varied from $45.00 to $125.00 per visit. They shared that foot care should be funded at no charge especially when living with a "couple of diseases" *(Participant 3)*. A participant stated:

> "When I worked, I had lots of money for foot care. I used to go for manicures. I used to get acrylic nails for $45.00 every two weeks. Then I earned $3,000.00 a month and money was not an issue. Now I am at $1,000.00 a month and have diabetes. So, I use $217.00 for rent and $785.00 for food, toilet paper, a bus pass, garbage bags, clothes and soap. I am not complaining as my rent is covered. I am grateful for what I get… but I know foot care is usually $55.00 to 65.00 dollars, especially for people with diabetes that is not fair and is too costly."
>
> *(Participant 1)*

Two participants shared that offering foot care as part of the community care was appreciated.

> "I come as the foot care is free, let's be realistic, I do not have an extra fifty bucks and a taxi ride to get to a foot care clinic on my fixed income. I tried to go to a clinic, but I left it was too expensive, so I just let my nails grow, I could not reach them"
>
> *(Participant 5)*

Another stated:

> "I live in a building where people are paying $55.00 to 125.00 to have their nails cut and sometimes up to $250.00 if it is a 'fancy nail place'. I wonder how they afford that? I had my nails cut too short at one of those places, so now I come here, every month and you the foot nurse often approaches me to remind me; the team here has saved my feet."
>
> *(Participant 7)*

Discussion: This small community-based inquiry was conducted with persons who live with complex disease(s) and who have experienced homelessness. The rich data collected revealed that participants often stated they were grateful for the foot care, socks and footwear service. In individual interviews each person described the importance of affordable, accessible foot health care services. They emphasized that publicly funded foot health services were essential, including upstream health education that could lead to the prevention of skin, nail and foot and ankle issues.[39,43]

Participants views were based on attending the foot care services as they knew the nurses also check their overall skin health and discuss any other issues. As well, at the footcare visit, if a health issue was identified (new wound, rash, trauma) the nurse would ask a team member to assess them and this often led to timely care and follow-up wound treatment.[1,44] This is similar to the literature where interprofessional teams deliver a wide scope of services to individuals in a timely manner, often using a drop-in approach.[44] As well, participants described that attending the foot health clinic may have been a step in building trust with the PCC team members.[43]

Participants acknowledged that their housing status impacted their ability to engage in self-care (e.g., showers, bathing, dressing in clean clothes, eating) and that the stability of their housing influenced their self-care.[45] Each described their preferences for how they used to care for themselves and how foot care was a space they could discuss they their life challenges, hopes and clinical health issues.

The foot care program has quickly become the most well-attended and sought-after service within the clinic, with consistent participation and strong follow-up from clients. This level of engagement highlights how much participants value access to foot care services. The non-judgmental, client-centered approach utilized by the foot care nurses fosters trust and creates meaningful opportunities for relationship-building, health education, early intervention and connection to additional supports within the clinic.

Three Case Study Results

Several common themes are noted across these case studies, including the acknowledgment that IEH with skin, wound and foot complications often present with complex, multiple acute and chronic health conditions. Diabetes and peripheral vascular disease, similar to the general population, account for significant risk related to skin, wound and foot health.[46] Additionally, immunosuppression, lack of sleep and malnutrition are risk factors experienced by IEH that contribute to both skin breakdown and impaired wound healing.[1,2]

Key learnings from these case studies speak to the need for well-funded and resourced programs to address the complex health needs of IEH. For clients this includes timely access to interdisciplinary teams with ongoing opportunities for skin health, wound

care programs and foot care services.

For clinicians, standardization of foot health and wound care assessment and management are key to consistency in care planning, low-barrier access and referrals to specialty care. As well measurement of foot outcomes need to be strategically embedded within in EMR systems.

Overall Discussion

The three case studies presented here demonstrate the importance of addressing skin, wound and foot care in IEH. Strong interdisciplinary teams can meet the unique needs of IEH in their communities through programming that is integrated with strong internal and external partnerships resulting in the provision of low-barrier, trauma-informed and evidence-based care. More research is needed to further explore how to best co-create health services to meet IEH needs.

At point-of-care, these case studies have demonstrated the importance of finding ways to meet people where they are at, providing care that is trust-filled, non-judgmental, trauma-informed and evidence-based. Building strong interdisciplinary teams that are able to provide this appropriateness of care requires efforts of organizational leadership to address pay-equity, robust orientation, training and staff engagement and strong efforts to support staff retention. Providing trauma-informed care requires consistency of services and staff. This consistency is key to building strong therapeutic relationships rooted in trust and facilitates follow-up and consistency of care.

Designing low-barrier programming requires meeting the unique needs and environmental conditions of the population served, and will vary across urban and rural settings, with consideration for varying provincial/territorial and municipal resources and health-care priorities. Across all three case studies, we find that skin, wound and foot health for IEH is not recognized or prioritized at the government level, requiring creative and iterative program planning at the organizational level to fill this gap and provide needed services to this high-risk population.

These case studies have also demonstrated the need for increased research on the unique risk factors and care needs related to skin, wound and foot health for IEH, as well as more robust education for care providers to meet the needs of this population. Stronger engagement from government is required to prioritize and adequately fund care for IEH and, ultimately, prioritize housing to increase the overall health and well-being of IEH.

Overall Conclusion

Individuals experiencing homelessness represent a population with unique and largely unmet needs related to skin, wound and foot health. The three case studies presented in this inquiry highlight the ways in which strong interdisciplinary teams across Canada are engaging in robust and innovative approaches to care to meet the needs of this population. These case studies all demonstrate the strong impact of intervention and program planning and serve as exemplars for approaches to care for IEH. Evidence-based, low-barrier and trauma-informed care are fundamental aspects of care provision for IEH. Additionally, consideration for the unique needs based on local populations and local contexts are necessary for the creation and operation of programs that are responsive to the complex and varied needs of IEH across Canada. These approaches to care work synergistically to create increased quality of care and improved equity of outcomes for skin, wound and foot health in this equity-deserving population.

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