Photo: Steve Wadden

Wound Assessment And Management Of An Unsheltered Individual: A Community-Based Case Study

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In recent years, the rising number of Canadians experiencing homelessness has drawn the attention of politicians, social advocates, researchers and health-care providers. In 2024, the Government of Canada reported that in 74 communities that participated in a Point-in-Time (PiT) count, nearly 60,000 persons were experiencing homelessness.[1] The Canadian definition of homelessness includes persons living in a range of scenarios, including those who are unsheltered, emergency sheltered, provisionally accommodated and at risk of homelessness.[2] Homelessness from an Indigenous - First Nations, Metis, Inuit, worldview includes "… individuals, families and communities isolated from their relationships to land, water, place, family, kin, each other, animals, cultures, languages and identities", impacting people's ability to "culturally, spiritually, emotionally or physically reconnect with their Indigeneity or lost relationships".[3]

People experiencing homelessness experience barriers to access skin health, foot care and wound assessment and management.[4,5] Barriers include poor nutrition, inability to communicate needs, lack of trust, difficulty managing and monitoring acute and chronic diseases (e.g., blood pressure, blood glucose), lack of access to appropriate medication and wound care.[4,5] Additional challenges include lack of access to fund transportation, organize appointments, use of electronic health tools/applications (e.g., cost and management of electronic devices), finances and the support of a friend or peer to attend appointments.[7-9] Of great concern are clients' descriptions of stigma

when trying to access health.[10] As a result, these persons do not access health care as they may feel judged, embarrassed, shamed or not heard.[10-12]

In this case scenario, the primary care nurses practice at the Ally Centre of Cape Breton clinic and in the Shelter in Sydney NS undertook an initiative to address the crisis of unsheltered homelessness.[12] The study was approved by the Research Ethics Board at Cape Breton University.

Case Presentation

In this case study, we share the story of PD, a 50-year-old male who has a history of living homeless and sleeping temporarily on friends' couches. He is diagnosed with spondylosis disease, history of ischemic stroke of the left cerebellum, hypothyroidism, bipolar manic depression, mental health and addiction issues. He lived with chronic pain that was initially managed with opioids. He then transitioned to methadone and was later switched to Suboxone™ through an Opiate Recovery Program. He then transitioned to his substance of choice, cocaine, and continued to heavily inject for the last 10 years.

He received intermittent care at the Centre, often for urgent issues. He did have a community-based physician and had been advised to find another provider. As a result, he was managed by the nurse practitioner and family physician at the Centre. In the community, he was assessed weekly.

The primary care clinic nurses are part of a harm reduction program. They met PD in the fall after he was discharged from the hospital, where he had been receiving intravenous antibiotics, wound care, pain management, mental health and substance use counselling, as well as nutritional support for early sepsis and a wound infection in his left forefoot. As part of his discharge plan, he was to return to the hospital for ongoing care. Instead, he arrived at the primary care clinic as he has trust-filled relationships with the interprofessional team. As well, he stated transportation to and from the hospital was "not possible as he was in pain and did not have funds".

With teamwork, the primary care clinic completed a holistic clinical assessment.[6] They assessed PD's wound and ordered ongoing oral antibiotics and dressing supplies. The team followed the five steps in the Wound Prevention and Management Cycle: assessing and reassessing at regular intervals; co-developing wound and foot care goals with the client; assembling the interprofessional team focusing on housing, nutrition, diabetes and wound care management; being creative and implementing the plan of care; and regularly measuring and photographing the wound (BWAT) and using this data to communicate wound progress between the team members.[13]

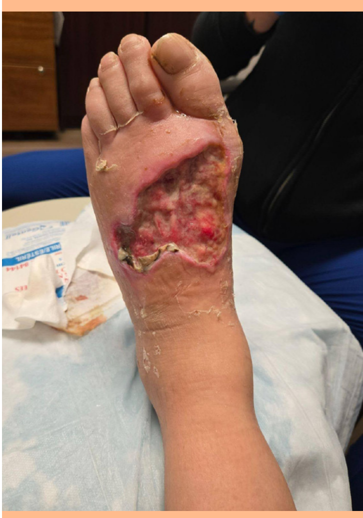
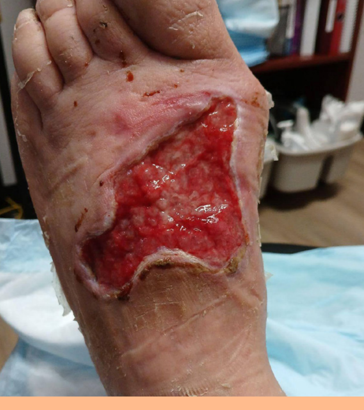
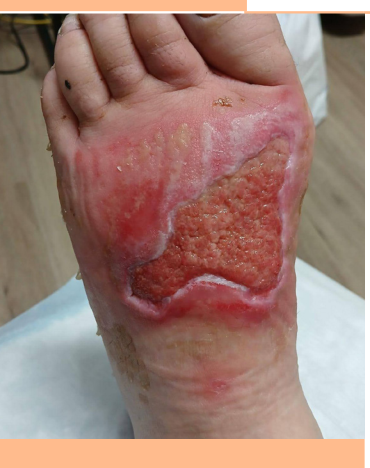
In partnership with the community nurses, the primary care nurses and physicians slowly engaged the client in his wound care plan. Wound progress was monitored using the BWAT and photography. Also, temporary housing was sought and the client agreed to live sheltered. While PD was living in temporary housing, the primary care nurses and physicians were able to regularly visit him to educate and monitor his wound progress, blood glucose levels, risk of infection, nutrition and hydration (See Figures 1-7).

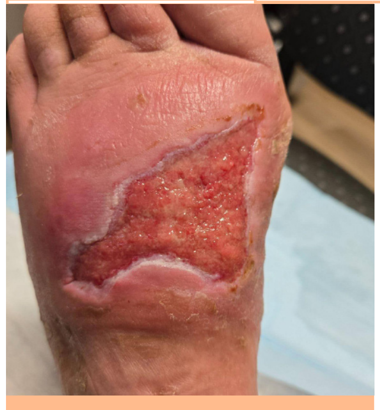
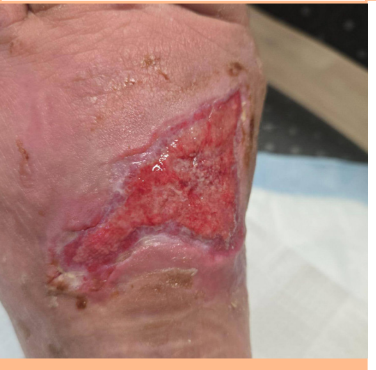
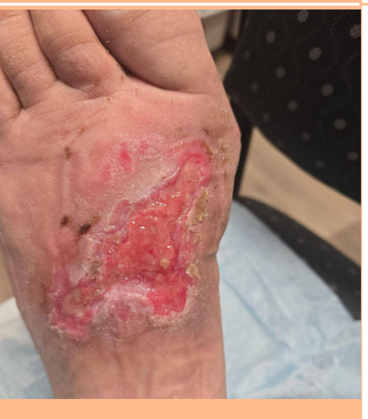
Discussion

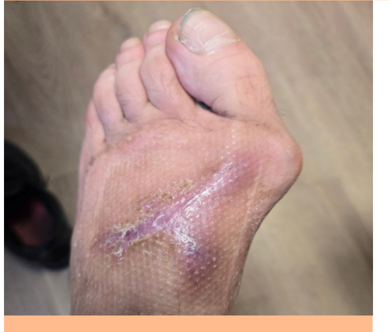
For clients experiencing homelessness, foot health, skin care and regular wound assessment and management must be provided in a space where the client can engage in trust-filled communication with health-care providers.[9,10,12]

Utilizing an interprofessional approach including a tailored clinical assessment of client preferences, age, gender, housing situation, mental health and addiction, nutrition, chronic diseases and foot and wound care enabled PD's health to improve. Adhering to best practice recommendations in wound assessment and management[14] provided support for the interprofessional team to co-create a plan in partnership with the client. Stable housing provided easier access to assess and reassess the client's overall health status and wound progress. Listening to PD's preferences and consistently reaching out to the client to reinforce self-care, access to dressing supplies enabled the team to support PD's progress.

Figures 1-7: Wound Progress

Date	Progress Note
 Oct 3, 2025	Living unhoused. Recently discharged from acute care. Reluctant to engage in care for diabetes, mental health or wound care. Wound Assessment: Width: 7 cm Depth: 0.5 cm Length: 6.5 cm. Full thickness, tendons visible. Peri-wound tender and toes and lower leg edematous. Antimicrobial packing in forefoot undermining, super absorbent cover dressing and gauze wrap (client preference). Pain: 8/10 very tender and expressed great discomfort during dressing change He moved his injection site and did not inject in the wound bed.
 Oct 15, 2025	**Week 2 reassessment:** Wound depth is reduced and tendons covered. Antimicrobial dressing and absorbent dressing continue. Wound Assessment: Width: 6.5 cm Depth: minimal Length: 7 cm. Dressing changed three times a week, and sometimes client does not attend nursing primary care clinic appointment. Client experiencing homelessness.
Oct 23, 2025	**Week 3 Reassessment:** Wound bed continues to reduce with a decline in wound area. Drainage increased. In discussion with client, PD was encouraged to come more frequently for wound care. Client experiencing homelessness.
 Oct 29, 2025	**One Month Assessment :** Width: 5 cm Depth: minimal Length: 4 cm. Increased cellulitis surrounding the wound bed, indurated, increased pain and drainage. Nurse practitioner ordered oral antibiotics. Client encouraged to attend primary care clinic for wound care. Pain: 9/10 expressed worsened pain and burning. Client experiencing homelessness.

Date	Details
Oct 31, 2025	Client agreed to move into sheltered housing. In this living scenario, the primary care nurses were able to meet the client to provide regular education to self-manage his diabetes and wound care. As well, the client has access to proper nutrition and hydration through regular meals, foot care, improved hygiene and laundry services, and it was easier to meet with the primary care nurses and physicians.
 Nov 5, 2025	**Week 5 Reassessment:** Oral antibiotics completed. Width: 7 cm Depth: minimal Length: 5 cm. Client engaged in wound care and attending clinic with primary care nurses. Client completed his first week in sheltered housing. Client pleased with progress of his wound healing. Pain: decreased 4/10 as wound closed.
 Dec 2, 2025	**Week 8 Reassessment:** Client continues to live sheltered. Engaging in self-managed wound care and dressing changes with topical antimicrobial and cover dressing. Visits with primary care nurses for appointments. Width: 6.25 cm Depth: Wound bed red, healthy with minimal slough Length: 3.25 cm.
 Dec 16, 2025	**Week 10 Reassessment:** Client continues to live in sheltered housing. Continues to engage in self-care. Client pleased with progress and grateful for nurses and physicians with persisted with his wound care. Width: 4 cm Depth: Red/pink with minimal slough Length: 2.5 cm. Pain: minimal pain, reports itching.
Jan 6 to Jan 28, 2026	Wound area continued to reduce in size. Client attends appointment with the primary care nurse and physician. Client showering and changing his dressing after each shower. Topical multi-composite dressing in place to protect the healing wound bed when PD dons socks and footwear. Wound area continued to close, no signs and symptoms of infection.


Mar 10 2026

By March 10 the area was closed and ongoing education was provided to remind client to protect new skin.

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