Wound Care in a Drop-In and Rehabilitation Centre: A Calgary Perspective

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Delivery of best practices in wound care is challenging for many teams, especially for those working with street/homeless populations. The following interview was conducted by Janet Kuhnke with nurses from the Calgary Drop-In & Rehabilitation Centre (http://www.thedi.ca/) in Alberta to illustrate the journey of clinicians providing skin and wound care to indigent and homeless clients.

What inspires you to come to work every day?

Our inspiration comes mainly from our clients and the staff's dedication at the Calgary Drop-In Centre. Our clients trust us with their care, which comes with some difficulty from a population who have had many doors slammed in their faces and experienced stigma that would prevent them from asking for assistance. It is humbling to be "welcomed" by the clients and asked for help.

Staff come to work daily with smiles on their faces. They appreciate the feedback from our small nursing team and the education we provide daily. It is an honour to work with such amazing people.

How did you get involved in wound care?

We had no choice but to seek out wound care education. Working in the largest homeless shelter in North America (approximately 1200 clients sleep here per night), we see a large number of wounds. As well, many of our clients have several chronic diseases (diabetes, respiratory diseases, claudication due to many comorbidities, as well as addictions) that lead to wounds.

Community-acquired MRSA is prevalent among the homeless population we serve. Clients may have a small bed-bug bite, but the scratching and picking at the area often lead to MRSA infection. In order to provide our clients with the best care possible, Renae and I (Genevieve) have ensured that our wound care knowledge and best practice guidelines are kept up to date by attending courses and conferences.

Key messages

- **Wound care is practised in a diversity of settings, including drop-in centres.**
- **Evidence-based wound education is important for nurses and clinicians serving the homeless population.**
- **Best practices in wound care are achievable with the homeless population.**

What are some of the wound types you see in your setting?

- Wounds infected with MRSA
- Diabetic ulcers/amputations
- Lower leg ulcers – acute and chronic
- Abscesses – soft tissue
- Frostbite (with amputation)
- Porphyria cutanea tarda
- Street feet
- Surgical wounds

What are some of the strategies you have used to manage each wound type?

Wounds with MRSA may start with a bed-bug bite or trauma to a lower limb that becomes infected. The clients often try to treat these wounds themselves with copious amounts of topical antibiotic cream and gauze dressings. As nurses, we will cleanse the wounds with antimicrobial washes and provide clients with an antibacterial skin cleanser with which to shower. This helps other open areas from becoming further infected. We also offer a mild antibacterial wash for persons living with diabetes to help keep their feet clean. For open wounds, antimicrobial dressings are used. We see the clients two to three times per week for wound care depending on the needs of the wound and client.

Mental health issues and addictions play a large role in missed appointments.

Diabetic foot ulcers are kept as dry as possible. We will paint the wound with an antimicrobial swab/solution. Clients are then provided with additional antimicrobial swabs/solution to paint

wound areas in between seeing the nurses for wound care.

Wound abscesses and cellulitis are common in the homeless population. After abscesses have a surgical incision and drainage, they may be gently packed with an antimicrobial dressing. Many clients will also be on intravenous antibiotic therapy through our urgent care centre. Unfortunately, due to the fact that they are homeless, they are not provided with a home parenteral pump for the antibiotic therapy and therefore must go to urgent care every 12 hours; this schedule can lead to non-adherence of their intravenous therapy.

Frostbite occurs to localized tissues and is related to wet and improper clothing, wound infections, diabetes and previous frostbite. In the clinic, frostbite wounds are seen in varying phases of healing. Clients are seen two to three times a week for wound debridement and wound care/dressing changes. We often monitor these clients for four to six months depending on how long it takes for the frostbite to totally declare itself. These wounds are kept as dry as possible, and we paint the affected areas with an antimicrobial swab/solution. Many of these frostbite wounds are non-healable and lead to spontaneous or surgical amputation of affected fingers and toes. For this care, the clients are referred to the outpatient burn clinic to be assessed by a team and a plastic surgeon.

Porphyria cutanea tarda (PCT) is a subtype of a complex group of diseases. Porphyria cutanea tarda results from a deficiency of the enzyme uroporphyrinogen decarboxylase. As many of our clients drink alcohol on a daily basis and spend a large amount of time outdoors, we have seen an increase in the blistering of hands and face due to this condition. We provide the clients with education around alcohol consumption and encourage reduction of sun exposure (especially in the summer).

Many of our clients work outdoors, so we provide them with an SPF 30 sunscreen and encourage them to use it on their face and hands. We ensure that they have hats, wear long-sleeved shirts and encourage them to stay out of the sun when possible. If the client is willing, we will have them assessed by an outreach physician for lab work and hepatitis C virus work-up; if the client is positive, they will then be referred to the hep-C clinic. These clients will then be referred to dermatology and internal medicine depending on the severity of their condition and results of lab tests.

Blistering of the hands and face is difficult to manage in this population. Antimicrobial dressings are used to manage infection, and we keep any open and weeping blisters covered on the hands to prevent further infection and aid in healing. Sunscreen and moisturizers are regularly offered. If needed, the client may have to take oral antibiotics.

Working in the largest homeless shelter in North America we see a large number of wounds . . . [and] many of our clients have several chronic diseases that lead to wounds.

"Street feet," or "immersion feet," are common. When initially assessed for street feet, the client's feet are rewarmed, pain is relieved, wounds are cleansed and infection is managed. For less com-

plex injuries we use anti-fungal creams and powders. Clients are referred to the community foot care nurses for ongoing foot care.

Surgical wounds are kept covered until well healed. Antimicrobial dressings are used as needed, and we see the client for dressing changes every two days.

Is there a multidisciplinary approach to wound care in your agency? If so, how is it organized?

We have a multidisciplinary approach and work with outside agencies to provide our clients with the best care possible. Through Alberta Health Services our agency is partnered with the Sheldon M. Chumir Wound Care Clinic for home-care referrals.

The wound care nurse from Sheldon Chumir acts as a liaison between the Calgary Drop-In Centre and the Alberta Health Services wound care clinic. The goal is to gain a rapport with the client and refer them to the clinic for further assessment and a treatment plan. The wound care nurse is also an Alberta Aids to Daily Living (AADL) authorizer for pressure gradient stockings, high-risk footwear, total contact inserts and wound management products.

Community foot care nursing is provided one day per week through a nursing agency. Referrals for foot care are made directly from our office. Alberta Health Services' chronic disease management nurses and dietitians are available to support clients at the Calgary Drop-In Centre. Referrals are made directly from our office. The chronic disease nurse has an office onsite and is available during the week. The dietitian is here weekly to support persons with diabetes and chronic diseases.

As well, our team regularly connects and collaborates with the Calgary Urban Project Society (CUPS) Community Outreach Clinics; CUPS focuses on health, education and housing issues. Physicians and nurse practitioners from CUPS hold outreach clinics at the Drop-In Centre several times per week.

How do you communicate the care plans between staff members?

As we are working with external agencies, the majority of our communication is verbal and through clinician charting. We case-conference together to discuss care plans for clients.

Dressings "to go" are effective. We understand our clients need to work, so we provide them with the education and dressing supplies to take with them.

What is your greatest challenge delivering wound care in your setting?

Adherence and follow-up by the client. Many of them pick up temporary work and if they get work, they won't follow-up for wound care.

Mental health issues and addictions also play a large role in missed appointments.

Costs of dressing supplies are high for a not-for-profit organization. To make sure we select the most effective ones, we continually educate ourselves by meeting with vendors at conferences and attending education days.

Staffing is a challenge for a building that houses up to 1200 clients. The Calgary Drop-In Centre is a not-for-profit organization that's not mandated to provide health services—but they do. They are committed to the care of the clients they serve, but with only two full-time registered nurses this can be challenging as wound care is only one small part of our role at the Drop-In Centre.

What changes have you been able to bring to wound care delivery in your agency?

Some of the changes we have been able to bring about are improved diabetic foot care and assessments. We are committed to completing a diabetic foot screening and assessment on all our clients with diabetes, or suspected of having diabetes, this year.

Topical antibiotic cream with gauze was the "go-to" dressing used by our staff and clients. We try to provide staff education about best practices to ensure wounds are cleansed and covered until the client is able to see Renae or me, or go to an urgent care centre.

What are some effective client-centred strategies you use to deliver wound care?

By providing clients with appointments for their wound care needs, we have better adherence. Clients don't want to wait outside our door any more than they want to wait in an emergency room. Pre-booked appointments help to accommodate their needs.

Dressings "to go" are effective. We understand our clients need to work, so we provide them with the education and dressing supplies to take with them. They then can change their own dressing between nursing visits.

We assess clients without provincial health insurance in order to support them and treat their wounds.

We do not require a doctor's order to assess and treat wounds. We work within our scope of practice as registered nurses and follow best practice guidelines.

We provide the client with antimicrobial swabs/solutions and antimicrobial skin cleansers to keep non-infected skin/areas clean. Many of the clients rough sleep in the summer and are more prone to a breakdown in their skin integrity.

We have a multidisciplinary approach and work with outside agencies to provide our clients with the best care possible.

In summary, delivery of best practices in wound care is possible in a drop-in and rehabilitation centre environment. With support from agency leaders, managers, clinical nurse co-ordinators, nurses and physicians, such centres can deliver best practices in wound care. Though this can be challenging, education, sharing of knowledge and a commitment to client-centred care can make it possible.

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Genevieve Wright *is the Clinical Nurse Coordinator at the Calgary Drop-In and Rehabilitation Centre where she facilitates continuing education, professional development and evaluation of clinical skills for nursing staff. Genevieve has her S.W.A.T (skin-*

wound-assess-treat) Advanced Level II certificate of completion.

***Renae Kapteyn** graduated from nursing in 2012 after completing her final senior focus practicum with Genevieve and has attended numerous wound care education days/conferences to improve her wound care knowledge.*

Resource List

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