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Résumé

Stratégies d'apprentissage et d'intégration des connaissances chez les infirmières et les intervenants au service des sans-abri

Manal Guirguis-Younger, Ryan McNeil et Vivien Runnels

Répondre aux besoins des sans-abri est souvent une tâche difficile pour le personnel de la santé, vu les problèmes complexes qui touchent cette population et les lacunes en matière de connaissances. Comment améliorer la capacité des intervenants à dispenser des soins aux sans-abri? Les auteurs ont analysé les stratégies d'apprentissage et d'intégration des connaissances mises en œuvre par des infirmières et des travailleurs de la santé employés par des organismes de services aux sans-abri dans une ville canadienne. Huit intervenants ont participé à des entrevues semi-structurées; les données ont été soumises à une analyse narrative ainsi qu'à une analyse comparative constante. On a cerné trois stratégies : intégration des expériences passées dans l'exercice clinique; interaction avec les clients pour cerner leurs besoins et leurs limites; échange de connaissances entre professionnels. Une meilleure appréciation de ces méthodes pourrait inciter les programmes de sciences infirmières et les organismes de santé à mieux transmettre aux intervenants les compétences nécessaires pour dispenser des soins aux sans-abri.

Mots clés : sans-abri, sciences infirmières

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Learning and Knowledge-Integration Strategies of Nurses and Client Care Workers Serving Homeless Persons

Manal Guirguis-Younger, Ryan McNeil, and Vivien Runnels

Health-care workers serving homeless persons often face difficulties in addressing the needs of this population due to the complexity of the health challenges and gaps in clinical knowledge. How can health-care workers enhance their ability to care for this population? The authors explore the learning and knowledge-integration strategies of nurses and client care workers employed by organizations targeting homeless persons in a Canadian city. Semi-structured qualitative interviews were conducted with 8 health-care workers. The data were examined using narrative analysis and constant comparative analysis. Three strategies were identified: integrating past experiences into clinical practice, interacting with clients to identify care needs and boundaries, and engaging in interprofessional knowledge exchange. A better understanding of these strategies may help nursing programs and health-services organizations to equip health-care workers with the skills they need to serve homeless persons.

Keywords: homeless persons, education, nursing, evidence-based medicine

Introduction

Thousands of Canadians experience homelessness each year, although the extent of homelessness is unknown. Statistics Canada (2001) has estimated that, over a 1-year period in Canada, more than 14,000 persons stay at least one night in an emergency or temporary shelter intended for persons with no place of residence. Critics, however, point out that this estimate underreports the number of persons who are homeless because it does not include rough sleepers and the hidden homeless (Frankish, Hwang, & Quantz, 2005). Elsewhere it has been estimated that as many as 150,000 persons experience homelessness each year in Canada (Laird, 2007).

Persons who are homeless often have diverse and complex health challenges that are unmet by mainstream health services, resulting in mortality rates several times higher than those for the general population (Guirguis-Younger, Runnels, Aubry, & Turnbull, 2006; Hwang, 2000; Hwang et al., 1998). Previous studies have reported that the health status of this population is impacted by high incidences of substance use, mental

health challenges, traumatic brain injuries, mobility impairments, and chronic and infectious diseases (Hwang, 2001; Hwang et al., 2008; Klee & Reid, 1998; Kral, Molnar, Booth, & Watters, 1997; Nyamathi, Leake, & Gelberg, 2000). Both the severity and the complexity of these health challenges are exacerbated by a life of homelessness. Persons who are homeless face barriers to accessing primary, secondary, and tertiary care due to poverty, discrimination, and social and geographic isolation (Hwang, 2001; Kushel, Vittinghoff, & Haas, 2001; Wen, Hudak, & Hwang, 2007). The demands of meeting basic needs, such as food, shelter, and addiction management, make it difficult for clients to access medication and adhere to treatment and its follow-up with nurses, physicians, and care specialists (Gelberg, Gallagher, Anderson, & Koegel, 1997; Kim, Kertesz, Horton, Tibbetts, & Samet, 2006).

Over the past decade, community and health-care leaders across Canada have sought to develop specialized services that are responsive to the health needs and challenges of homeless persons. These include integrated health and social service networks, shelter-based health services, mobile health units, and specialized health facilities offering harm-reduction, mental health, primary care, hospice, and palliative services (Daiski, 2006; Hwang, Tolomiczenko, Kouyoumdjian, & Garner, 2005; Podymow, Turnbull, & Coyle, 2006; Podymow, Turnbull, Coyle, Yetsir, & Wells, 2006). Persons who are homeless pose significant and unique challenges for nurses and client care workers. In addition to providing physical care, nurses and client care workers may have to address clients' emotional needs in order to maximize positive health outcomes (Nyamathi et al., 2008). The requisite skills to address these needs are not always included in formal education. Consequently nurses and client care workers have to identify and develop strategies for obtaining knowledge and integrating it into their practice. This article explores the learning and knowledge-integration strategies used by nurses and client care workers employed by health-care organizations that target homeless persons.

Methods

Design and Procedure

Semi-structured in-depth qualitative interviews were conducted with eight nurses and client care workers as part of a Social Sciences and Humanities Research Council-funded study investigating the health and end-of-life care needs of homeless persons. A case-study design was used to explore multiple factors entailed in delivering health care, including nursing care, to persons who are homeless (Yin, 2003). The interview guide was designed to allow the participants to describe in detail their role as providers of health care to homeless persons. Participants were

asked to share their impressions of the barriers to and facilitators of health-service delivery, training and education needs, and strategies used to facilitate their work with homeless persons. The study was approved by the Research Ethics Board at Saint Paul University in Ottawa, Ontario.

Participants and Setting

Data were collected through individual interviews conducted on the premises of organizations providing health care to homeless persons. Services provided by these organizations included primary care, mental health care, rehabilitative care, and end-of-life care. The sample comprised four registered nurses, one registered practical nurse, and three client care workers. Client care workers provide personal support such as assistance with basic hygiene and medications and monitoring of needs. They receive formal training at the college level.

Institutional permission was obtained to access the premises of the participating health-care organizations. Potential participants were then given a letter outlining the study and requesting them to indicate their willingness to take part by contacting the research team to schedule an interview. Interviews ranged in duration from 1 to 3 hours. One interview was conducted over two separate sessions. Detailed information about the participants and the setting is withheld in order to avoid compromising participant confidentiality.

Data Analysis

The interviews were audiotaped and transcribed verbatim by research assistants. The transcriptions were kept in separate files and line numbers were assigned to facilitate coding. The transcriptions were then examined using narrative analysis and constant comparative analysis (Reissman, 1993; Strauss & Corbin, 1990). The purpose of the analysis was to identify themes related to the special knowledge and competencies of nurses and client care workers providing services to homeless persons. The transcripts were independently reviewed by two members of the research team. Significant themes and sub-themes were identified through multiple discussions and explication of each theme.

Findings

Analysis of participants' experiences identified three primary strategies used to acquire knowledge and facilitate its integration: informing one's practice by integrating past professional experiences with marginalized populations or experiencing marginalization oneself, establishing and implementing a client-centred approach, and increasing one's ability to

address client care needs by engaging in interprofessional knowledge exchange.

Integrating Past Experiences

One of the main themes that emerged was integrating one's personal and employment experiences into frontline health-care work. By integrating past experiences into their work with homeless persons, participants were able to (a) contextualize client care needs, (b) integrate effective and efficient communication strategies, and (c) address situations requiring immediate attention and prioritize clients' needs.

Contextualizing clients' needs. While participants reported diverse professional and personal experiences, from serving with the armed forces to acting as caregiver to an elderly parent, these experiences shared many characteristics insofar as they helped the participant to prioritize and attend to the care needs of clients. One nurse recounted a personal experience:

> *I lost my mother when I was 40, and she was only 62 and she died of breast cancer. I went through the whole journey with her over 2½ years. I knew what I wanted for my mother — I knew what comfort I wanted for her and I knew what services I wanted available to her.*

The participant drew upon this experience to better understand end-of-life needs and to address the emotional needs of clients.

Participants believed that it was inappropriate to deny services to clients who are disruptive or even abusive. They explained that when working with this population they viewed such behaviours in the context of mental illness, addictions, and the broad set of difficulties facing persons who are homeless. When using this approach, participants drew strength and confidence from their previous experience working with difficult persons, such as angry customers. A client care worker explained:

> *I had to deal with people at the office where I used to work, and they had problems too… they would get upset also. That prepared me in a way… some of the cases were very hard but I always managed to work through it.*

Integrating communication strategies. Communication strategies used in prior work settings were often adapted and integrated into clinical practice. These included strategies to communicate with clients and to ensure privacy of health information. One nurse described a particularly helpful strategy that he used to ensure patient confidentiality:

> *We've had issues where family members want to know more about the client and the client doesn't want that… We've actually developed systems*

> *where we would relay information on the phone. We would use a code I came up [with]. I used to be in the military, so I came up with this. I would say, "How old are you?" The response was "Happy Easter." Then I knew I was talking to his sister. I could relay everything to his sister, because we had issues with his ex-wife calling and people telling her information.*

This strategy was helpful in respecting the client's choice of whether to disclose health information to family and friends. Another participant drew upon previous experience working as a dispatcher for a trucking company:

> *I had to deal with truck drivers. I was a dispatcher… talking on the phone… receiving calls from companies. That helped, because here we answer the phone quite a bit, we're talking with the public, and there's appointments to be written down or… just talking with people. People at the office where I used to work… they had problems too, like "Where's my van"… "I have a pickup to do"… They would get upset also. So that prepared me in a way.*

Addressing immediate situations and balancing the care needs of clients. Participants identified professional skills they had developed that helped them to address situations requiring immediate attention and to prioritize clients' needs. Experience with demanding situations in a variety of settings helped them to engage confidently in clinical decision-making, devise strategies for identifying urgent needs, and prioritize care tasks in an unpredictable environment. One nurse described the decision-making process:

> *You figure out who is the most important… you're most worried about the person with the oxygen, and once that's taken care of you can worry about the person that's in pain. And then you deal with… on the phone you just ask the client care worker to take a message, and then what you do with the person that's intoxicated — you would deal with them probably last, because it's not going to change if I deal with it 5 minutes from now or 5 minutes after [that].*

Establishing and Implementing a Client-Centred Approach

Participants identified the important role played by client-focused strategies in the deliverability of health services to clients. They established the necessary conditions for a client-focused approach by (a) engaging in transparent discussions with clients about all aspects of their care, (b) communicating to clients the consequences of their decisions, and (c) developing and following a treatment plan in keeping with the client's

preferences. This allowed them to implement care strategies that were respectful of clients' individual needs and experiences.

Establishing conditions for a client-centred approach. Service refusal and non-compliance with treatment among homeless persons can often be linked with mistrust of mainstream health services and difficulty adjusting to institutions providing services (Hwang, 2001). Nurses and client care workers stated that building trust is a necessary step in facilitating effective service delivery to marginalized individuals. One nurse observed:

> *First, they have to trust me, and the trust sometimes takes a while… After a while of seeing you, they warm to you and then start telling you the whole story, and then you can really help them and assess what they really need.*

Participants also built trust by engaging in informal activities with clients. A client care worker reported:

> *Talking with them. Spending time with them. Playing cards with them. Bringing them down to the big TV room. Taking them out for a walk or taking them with their wheelchair. Just trying to find a way to get close to them.*

Trust-building had three further components: maintaining transparency concerning health status and treatment, implementing client-paced treatment, and establishing boundaries and consequences with respect to behaviour.

Transparency. Participants identified honesty as a necessary condition for a trusting relationship between health-care workers and clients. One nurse observed:

> *You don't lie to them. You tell them. Honesty is your best bet with this clientele… And you stick to your word too. That way they know if you say something you mean it. And then, eventually, they trust you after a little while.*

The participants also said that honesty helps to establish a context whereby services can be provided by health-care workers and accepted by clients. Both nurses and client care workers expressed a belief that the strategies of gentle persuasion and respectful confrontation can help clients come to terms with their condition and consider treatment options. A nurse clinical manager explained:

> *We just give them time, ask questions subtly, just like, "Who are you connected to?" And then we get more information from that person, and it just opens doors… A lot of guys will come and say, "I have no addiction,"*

> *and then you'll look at them in a while and [ask], "Okay, why are there track marks on your arm?"*

Client-paced treatment. Because mental illness can complicate treatment, participants made sure that treatment was paced to accommodate the client's needs and preferences. One nurse reported:

> *We have a guy right now here — he has terminal cancer. He wasn't getting treatment for ages because he believed that was just an excuse for some surgeon to go in and steal his kidney. Fortunately he keeps coming back here and we've been able to start treatment. However, it's taken us a year to get to that point.*

By disclosing details of the treatment plan and assuaging fears, nurses and client care workers were able to ensure that crucial health interventions were accepted by their clients. Participants viewed the time taken to develop relationships and accommodate clients' needs and preferences as a necessary part of health-service delivery.

Boundaries and consequences. Participants stated that the majority of their clients received health services primarily in shelters or through affiliated organizations. In an effort to keep clients in contact with services, participants encouraged them to follow established shelter rules. Participants conveyed the idea that setting clear limits facilitated the delivery of health care by clarifying expectations and allowing clients to assume part of the responsibility for their own care. One nurse stated:

> *You're just straight up: you can't do this, you can't do that, I will do this for you, I won't do that for you, if you do this we'll have to send you to… if you come back drunk we'll have to send you to outreach, if you come sober I won't… And it just happens over time. Because they see we actually do care about them and we want what's best for them. So they begin to trust us. And that's how it kind of works.*

Implementing a client-centred focus. Both nurses and client care workers used the term "client" rather than the customary "patient" to describe persons accessing health services. This use of language reflects the multiple dimensions of care delivery in particular settings. The care provided by the participants was focused on the physical, social, and emotional needs of clients.

Basic needs. Persons who are homeless face many challenges that may cause them to focus primarily on meeting basic needs such as food, clothing, and shelter. Nurses and client care workers were keenly aware that their clients frequently lacked the basic necessities and that it was critical this issue be addressed as part of service delivery. One client care worker said:

> *First, well, I give them what they need. I give them soap, towels, toothbrush, toothpaste, deodorant. And if they need clothes I'll get them clothes. Make sure the TV is going for them and just talk with them.*

Participants indicated that this approach helped to make clients "feel at home." They further engaged with clients to see how they could help them meet basic needs and any additional needs that were revealed once a relationship had developed. A client care worker put it this way:

> *If I see something is not right or missing, I contact the head nurse, and she always is able to give me an answer, or she will give me a contact [so] I can find out what we need for this person.*

Respecting clients' physical space and being attuned to their personal vulnerabilities. Nurses and client care workers were aware that homelessness creates the conditions for vulnerability to violence and trauma. They therefore sought to create a safe atmosphere for their clients. A nurse reported:

> *You ask them if there's anything they need. You explain that, you know, "This room is your room and you've got a TV — you can watch whatever you want." And you tell them basically what time the meals are, you know, "You can ring the bell, you can come to… or only ring the bell if it's an emergency."*

Participants were accepting of the needs and experiences of clients and were prepared to assuage their sense of being stigmatized because of their homelessness. A client care worker stated:

> *I can talk with them. I don't care what these people have done. Doesn't matter to me. My job here is to help them, and that is what I will do.*

Honouring clients' lives. Nurses and client care workers indicated that an important part of creating a client-focused model of care was honouring clients' lives and narratives. To them, a component of holistic care was the setting aside of time and physical space to sit with clients and listen to their stories. A nurse observed:

> *No one grows up saying, "Gee, when I grow up I want to be a homeless person who has nowhere to live." Everyone has a story of how they got there and why they got there. And some of it is tragic, some of it is funny, and some of it is painful. But it's a story that they want to tell.*

Participants believed that if clients want to share their personal stories, then they should listen.

Engaging in Interprofessional Knowledge Exchange

Participants described interprofessional knowledge exchange and integration strategies that enhanced their ability to provide care. These strategies were multifaceted and reflected the important role of knowledge about client needs and specific clinical approaches. The strategies included: seeking formal and informal opportunities to acquire knowledge from other health-care workers and from experts, identifying complementary clinical roles, and offering emotional support to co-workers.

Continuing education, both formal and informal. Participants sought out formal and informal opportunities to engage with other health professionals and local and regional experts to better understand the health-care needs of homeless persons and to devise strategies for improving care. Through opportunities such as orientation and refresher courses and workshops, peer observation of practice, and discussions with members of the care team, participants learned how to address clinical challenges and gaps and emerging health trends such as increased drug use and co-occurring HIV/AIDS and hepatitis C. One client care worker said:

> *I'm always willing to learn. I take courses at least once or twice or three times a month. I get into every course that's going by. Tonight I'm going on a 3-hour course… on diabetes. Friday I'm going to the one on palliative care.*

The diverse and complex care needs of homeless persons required participants to develop strategies for integrating knowledge into their work setting. Participants engaged with other health professionals to identify possible ways of doing so. This helped them to contextualize knowledge and then use it. One participant reported:

> *My first couple [of] shifts, I had a buddy shift with another RPN. She showed me what you do and things like that. Honestly, you really start relying upon the client care workers. When I first started here, I relied upon the regular client care worker, or a client care worker that knew the clients.*

Identifying complementary roles. Participants expressed the view that the complementary roles of nurses and client care workers served to enhance overall care. Under the close supervision of nurses, who provided feedback and constructive criticism, client care workers learned skills that could be applied in other health-care settings. "I worked in the community for almost 13 years and we didn't do dressings," said one client care worker. "Here we have the chance." A nurse clinical manager elaborated:

> *Because we have close to 60 people that we technically see every day, the client care workers really have to do the hands-on. I teach them how to do*

> *the dressings. I teach them how to do insulin, how to monitor blood pressure, how to check blood sugars. And then they can do it on their own.*

According to client care workers, this system had a positive effect on their confidence and their job satisfaction.

The complementary roles played by the health-care workers was acknowledged and valued by their organizations, as was the collaboration of all team members in developing trusting and meaningful relationships with clients. Because of their heavy involvement in the provision of health and social care, client care workers helped to contextualize client needs and to communicate undocumented health and social care needs. This in turned enhanced the ability of the care team to address changes in a client's condition. "The client care workers are very good at making them feel comfortable," explained a clinical coordinator, "so they open up to them."

Offering emotional support to co-workers. Participants indicated that supporting the emotional care needs of team members was part of the knowledge-exchange process. It enabled them to critically reflect on the meaning of their work in a safe and supportive environment and to integrate their experiences into their professional practice and build self-confidence:

> *When our clients are in bad shape, or end of life, we respect each other — we give moral [support to] each other.*

An environment of sharing and mutual support was also seen as important for team chemistry and for maintaining a positive culture.

Discussion

Contemporary nursing practice and education are centred on evidence-based practice. Sackett, Straus, Richardson, Rosenberg, and Haynes (2000) define evidence-based medicine as "the integration of best research evidence with clinical expertise and patient values" (p. 1) and as having three key components:

- research approaches that emphasize quality in the production of evidence, to avoid bias and to produce "the best research evidence" (p. 1)
- a view of expertise as "the ability to use our clinical skills and past experience to rapidly identify each patient's unique health state and diagnosis, their individual risks and benefits of potential interventions, and their personal values and expectations" (p. 1)
- the identification of patient values as "the unique preferences, concerns and expectations each patient brings to a clinical encounter and

> which must be integrated into clinical decisions if they are to serve the patient" (p. 1).

Through the use of these components, according to Sackett et al., health professionals and clients can "form a diagnostic and therapeutic alliance which optimizes clinical outcomes and quality of life" (p. 1). While the participants in the present study may not have received formal training and education in evidence-based practice, it is clear that they had integrated these components — in particular the second and third — into their practice. The nurses and client care workers indicated that research was welcome; they expressed an interest in research findings and education.

The findings show that nurses and client care workers do not rely solely on "hard evidence" when addressing health-care needs. Although chronic conditions and co-morbidities may have led them to focus on health status, the participants indicated that engaging clients and addressing barriers to compliance with treatment were a necessary first step. The findings further suggest that nurses and client care workers see the importance of supporting each other practically and emotionally and sharing knowledge about their clients' needs and experiences. Continuing education and professional development opportunities play an important role in the professional behaviour of health-care personnel. However, relationships among health-care workers who value experiential knowledge and demonstrate a willingness to incorporate such knowledge into their practice suggest that adaptations are being made to evidence-based practice. Such strategies are a response to the diverse care requirements of persons who face challenges in meeting basic needs, engage in high-risk behaviour, and lack access to health services. Nurses and client care workers providing services to homeless persons in shelters or in community settings are extending essential medical services to those who are traditionally underserved medically. These health professionals play an essential role in closing service gaps and reducing inequities in health-care delivery. The strategies described by the participants in the present study could be used by nurses and client care workers in mainstream settings to provide health services to homeless persons, thereby facilitating even greater access to care. This would be a small but important step in reducing the health inequities experienced by persons who are homeless.

Capacity-Building and Critical Approaches

These findings raise important questions for health professionals, academics, and health-services organizations. How can nurses and client care workers enhance their ability to provide care to homeless persons? How

can the strategies described in this article be built upon to optimize service delivery and improve health outcomes? The literature on research utilization proposes a number of ways to help nurses and client care workers enhance their ability to use research, address knowledge deficits, and improve practice. These include contextualizing learning within the practice setting, encouraging reflective practice, identifying opinion leaders, and supporting communities of practice (Gabbay et al., 2003; Locock, Dopson, Chambers, & Gabbay, 2001; Schön, 1983; Senge, 1990; Wenger, McDermott, & Snyder, 2002). The participants in the present study worked collaboratively to improve client care, thus forming a community of practice based on client needs. An excellent approach is to consider how best to support the ability of health-care workers to play multiple roles by developing a community of practice.

Critical approaches that feature questioning and analyzing workplace arrangements and practices that facilitate new and evidence-based learning, or that address barriers, may be helpful. One example of a critical approach to knowledge exchange is the Registered Nurses Association of Ontario's (2002) *Implementation of Clinical Practice Guidelines* toolkit, which assesses environmental readiness for the implementation of clinical practice guidelines and identifies areas that need to be addressed in the implementation of health-care innovations. Areas that the tool identifies as important include workplace structure and culture, communication, leadership, knowledge skills and attitudes of the target group, commitment to quality management, availability of resources, and interdisciplinary relationships.

Conclusion

Capacity-building to serve homeless persons through evidence-based practice must consider not only the best available research evidence but also professional expertise and client preferences. The conditions necessary for the delivery of health care to homeless persons — such as relationships of trust among staff and between staff and clients — must be emphasized in nursing education programs and by health-care organizations. Knowledge exchange can be facilitated through critical reflection on the institutional and operational contexts of health-service delivery for this population. Knowledge exchange has the potential to improve care by accounting for the diverse needs and experiences of homeless persons and to equip health-care workers with the skills they need to face complex challenges and achieve improved outcomes. The application of the present findings to other health-care settings will require further research and the development of a transferable model of care.

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