The impact for adult patients in Primary Care

ABSTRACT

Purpose: To understand the homeless lifestyle, how this impacts on the care received in Primary Care services and how these services could improve to benefit the homeless.

Method: A critical review of literature using a systematic search across databases Medline and CINAHL, as well as searching UWE library for the appropriate articles.

Findings: The homeless lifestyle and the needs of those meant that certain areas were identified, these being mental health support, support with substance abuse, self-neglect and poor nutrition. Homeless people felt that there was difficulty in accessing healthcare services and that they were judged by healthcare professionals.

Conclusions: For there to be improvement in the health and wellbeing of the homeless it is essential that there is access to health services and support for mental health and addiction. A suggestion to improve the care is to create an awareness package for healthcare professionals to understand the needs of the homeless and improve engagement, reducing lack of support and judgement felt by the homeless.

Summary:

What is known on this subject?

Statistics acknowledge the increasing numbers of homeless in the UK, this impacts the needs of those who are homeless as there is a lack of support from

healthcare services. The little support and difficulty to register with GP surgeries creates a negative effect on the health seeking behaviours of the homeless.

What does this review add?

This review looks at the homeless lifestyle and the most common areas of healthcare needs for those who are homeless. This helps suggest a plan to improve healthcare services in order to provide for the needs of the homeless.

Key Words: homeless, healthcare, needs, services, service improvement

1. INTRODUCTION

Homelessness is still an ongoing issue in the UK. Statistics show an estimated 3569 people sleep rough on a night in England, which is an increase of 30% from the year before and tragically double the number since 2010 (DCLG, 2016). Although these figures are likely to be higher as there are many homeless that stay in hostels, at friends or families or other accommodation, this is known as hidden homeless and these people are not included in the numbers (Homeless Link, 2016).

Crisis (2016) recognise the increase of homelessness due to cuts in housing benefit, funding for homelessness services and the lack of housing. It is highly likely these changes will cause a further increase in homelessness. This will impact on nursing practice as those who are homeless are more likely to suffer with ill health and face long term health problems, Homeless Link (2010) found that 41 per cent of homeless reported a long term physical health problem compare to only 28 per cent of the general population, therefore as nurses we will be treating these patients in community and hospital services.

The average age of death for those who are homeless is only 47 compared to the most common age of death in the UK for men being 85 and women 89 (Thomas, 2012; Office for National Statistics, 2016). The large gap in ages of death can be down to poor health and wellbeing for the homeless with up to 80% of homeless having mental health problems (Homeless Link, 2014). The challenge for adult nurses is to help recognise the urgent need for supporting this vulnerable group of adult patients, both physically and psychologically and identify the skills required to support holistic care. The statistics highlight that healthcare has to improve, to meet the needs of the homeless, improve mortality rates and quality of life.

This study will explore the homeless lifestyle and how it impacts on nurses and other healthcare professionals care for the homeless in Primary Care. The literature will help highlight the issues of being homeless, giving more insight on how nurses,

healthcare and systems can improve to support the needs of the homeless, as well as suggesting a service improvement plan to develop the care delivered by healthcare teams which will ensure those who are homeless receive good quality, holistic care they are entitled to. This will improve the health and wellbeing and patient experience in the long term. Jackson and Irwin (2011) state how nurses should treat everyone with dignity and humanity, to understand the needs of the patient and show care and compassion to respect each individual equally as dignity, equality and diversity are the fundamental rights for all individuals.

2. METHODS

This chapter will explore the process in which evidence is found to carry out a critical analysis. The ability to think critically is an important factor within the nursing profession, to be able to deliver safe and high quality healthcare there is a need for critical thinking as well as experience and decision making in practice (Benner *et al,* 2008). This has become a an important factor in nursing as the Nursing and Midwifery Council (2015) state to always practice in line with best available evidence.

2.1 Search Strategy

Firstly a wide search of literature was performed using the University of the West of England (UWE) online library to identify key themes around the homeless lifestyle and the support offered. Finding key themes is important for searching databases as it helps start the process of finding the key words that refer to the topic, as databases gather information from the use of keywords (Aveyard, 2013). The databases CINAHL and MEDLINE were chosen to select papers for this review, CINAHL was used as it is a good source for qualitative studies in the nursing profession and MEDLINE being a great source for research in the medical field, especially for UK papers around homelessness as well as all research being peer reviewed makes it a worthy database (Wright *et al, 2015;* U.S National Library of Medicine, 2016).

The diagram in Appendix 1 shows the process of the search for appropriate articles. Using an asterisk helped to widen the sensitivity of the search, also known as truncated words. This will search for the key word and other words that begin with the searched word which will locate more articles as spelling may be different in countries such as the US to UK (Harvard, 2007). To further enhance the search, the Boolean phrases AND plus OR were used to include more papers with each of the key terms searched for (Gerrish and Lacey, 2010).

Inclusion and exclusion criteria was used to establish the scope and validity of the reviews searched for (Meline, 2006). The articles used for this review were included due

to relevance of adults living a homeless lifestyle, many articles were excluded due to their relevance with palliative care, dentistry and homeless youth under the age of sixteen, these could not be used as the topic is focusing on homeless in the community and accessing GP practices which has relevance to adult nursing, not specifically the end of life or dentistry. From the relevant research that had been found, a technique called snowballing was used to improve understanding of the topic and key themes as well as identifying major writers that have been referenced within the chosen articles and carried out further studies (Davis *et al,* 2011).

2.2 Limitations

A limitation of the research was the lack of studies based in the UK, this meant American and Canadian articles had to be used which were transferable to the healthcare system in the UK. Leung (2015) explains how qualitative research can focus on a certain population or local area therefore generalisability may be limited, on the other hand Larrabee (2009) states that gathering evidence from other locations as well as the UK gives more consistency to the findings as there has been a broader search of literature to be able to gather conclusions.

Many articles were excluded due to the relation to dentistry and palliative care, even though these are areas of nursing these are specific topics that are not going to be covered in this review. If these were included the topic area would be too broad and there may be excessive information sources which would cause difficulty in choosing what needs to be included in the review (Dawidowicz, 2010). Therefore these articles were excluded to keep the review focused on healthcare services in the community.

Another limitation is the articles that had been located but were outside the ten year parameter. Tappen (2011) suggests that going back fifteen to twenty years when researching is useful to find the original work which is of importance. However due to the ever changing protocols and guidelines within nursing and the increasing dilemma of homelessness it is important to keep within ten years to make sure the literature is up to date when relating to the topic (Stevens, 2013).

2.3 Critiquing Tool

The Holland and Rees framework (2010) will be used to critically review the selected articles as there are two different checklists for qualitative and quantitative studies and has a simple layout to follow and understand. The critical appraisal skills programme (CASP, 2013) will be used alongside the Holland and Rees framework to make sure all areas have been identified as the tool consists of checklists to ensure studies have been appraised correctly (National Collaborating Centre for Methods and Tools, 2011). The main areas highlighted from the review were, mental health, substance

abuse and neglect, hunger, poor healthcare support and difficulty accessing health care services, these will be elaborated on within Chapter 3.

3. CRITICAL REVIEW

This chapter will focus on the main themes that have arisen from the four articles chosen to support this review. The literature includes a cohort study which looks at the mental health problems of the homeless and the relationship with health service (Hodgson, Shelton and Bree, 2014), a qualitative papers that explore the issues of homelessness and the perceptions of the homeless regarding their health and healthcare experiences (Rae and Rees, 2015), a quantitative paper examining substance use among homeless and the prevalence between this and access to healthcare and addiction treatment (Palepu *et al,* 2013). The last paper is a quantitative study focusing on substance abuse severity among homeless and non-homeless adults (Huntley, 2015). These papers will be compared and discussed below, Appendix 2 will include an overview of the selected papers.

3.1 Impact of Mental Health and Difficulty Accessing GP Services

The study by Hodgeson, Shelton and Bree (2014) has recognised a problem in homelessness and mental health, it was found that a high percentage (87.8%) of young people in the sample who were homeless had psychiatric disorders, those most common being post-traumatic stress disorder (PTSD) and anxiety with addiction to alcohol and substances making this a worthwhile topic to research. Due to the study being carried out in one area of Wales and majority of the sample being white British, the results may lack generalisability, although results from studies carried out in Western countries identified a high prevalence between homeless and mental health illnesses therefore Hodgson, Shelton and Bree's (2014) findings can be transferrable to other ethnic groups (Fazel *et al,* 2008). Using random sampling in additional areas in the UK would remove any bias as it would represent a larger target population for cultural groups and as such become more generalisable (Aaronson, 2011).

Shelton *et al,* (2009) acknowledges how mental illness can increase the risk of homelessness as well as hindering the process of moving on from being homeless and managing the tasks involved. Being homeless can increase the chances of developing a mental health illness as well as making a current one worse, finding a place to live can make an enormous difference to one's mental health (Mind, 2014). The study found that nearly a third (31.1%) of the participants had accessed mental health services within the previous six months which was a limited number considering there were 87 per cent with a mental illness. Furthermore these statistics could lack validity due to the participants who were living in temporary accommodation being supported to join a

General Practitioner practice which may have increased the chances of the participants reaching out and using the service, as GP's would refer those to relevant services, these numbers may not reflect the rest of the homeless UK population suggesting mental health service use could be lower.

The limited numbers of homeless using mental health services could be related to the difficulty in accessing services, a quantitative paper by Rae and Rees (2015), (see Appendix 2), looks at the experiences of homeless regarding healthcare. Many felt they were low priority, had prejudice against them and were not listened to by nurses, in other literature healthcare experiences are positive where clinicians have listened, did not judged and showed an interest and concern for the patient, therefore this compassion and respect should be carried out for every patient as well as the homeless, attending GP surgeries to ensure there is equality for all patients with different backgrounds (Raven *et al,* 2011). Not only does the paper recognise the discrimination that is being faced but there is a major issue with the homeless registering with a GP surgery, a study by Williams and Stickley (2010) had found that a homeless person is 40% less likely to be registered with a General Practitioner in the UK compared to a domiciled person, many of the participants had been refused registration as they had no fixed abode therefore proof of address could not be presented. The Health and Social Care Act (2012) brought in statutory duties in the NHS (National Health Service) to have regard to the need and reduce inequalities, although Woolcott (2008) acknowledges that there is a lack of improvement in access to primary care. The CQC (Care Quality Commission) (2016) expect all practices to register those who are homeless with no fixed abode, the homeless are able to use a temporary address or the practice address can be used to register them, therefore it is unclear as to why homeless patients are having difficulty to register. This may be a limitation in the study as the inconsistency of services has not been examined and without interviews with healthcare professionals to ask why there is a hesitation to register the homeless as patients the issue cannot be resolved, although education on this process would benefit healthcare workers to ensure all practices understand that the homeless can be registered.

Research by St Mungo's (2016) showed worrying evidence in the lack of mental health services for homeless due to budget cuts, leading to longer waiting lists limited levels of intervention meaning people are sleeping rough for longer, with homelessness itself causing a deterioration in mental health and those with complex needs having limited or no support, this prevents the homeless from succeeding to find jobs and better their circumstances (Reeve *et al,* 2006).

With budget cuts to services leading to limited support, more pressure will be put on the use of GP services. Homeless link (2014) had acknowledged that many homeless

were refused access to a GP due to missing previous appointments, attending an appointment can be challenging due to the transient characters of the homeless, with this in mind more community services or walk in centres should be available for the homeless to attend at any time to give support with mental health, substance abuse and any further issues (Crisis, 2005). On the other hand Rae and Rees (2015) had discovered from interviews with the homeless that flexibility from the GP was appreciated and meant there was improved patient engagement and increased support from day services, as a result these GP practices who understand the homeless lifestyle and needs will receive positive outcomes but many of the participants who felt they did not receive good care from their GP practice would rather visit A&E (Accident and Emergency) department, this correlates with the study by Hodgson, Shelton and Bree (2014) where a quarter of the participants had attended an emergency department. Furthermore, Homeless Link (2014) state that a homeless person visits A&E four times more than the general public, which suggests that homeless are using emergency departments as their preferred choice of healthcare. If the homeless were made to feel welcome in their local primary care settings then this may reduce the numbers of homeless using A&E and decrease the unnecessary use at a time when there is tremendous pressure to see patients.

Participants in the Rae and Rees (2015) study had mentioned that they had been released from hospital or prison without any place to stay or any information given to them on where they could find shelter, St Mungo's (2012) had found that more than 70 per cent of homeless people were being discharged from hospital back to the streets leading to an increase in damage towards their health. Following this research the Department of Health (2015) had announced a ten million fund to improve the discharge process for homeless people when leaving hospital, Homeless Link (2015) were commissioned to evaluate the project which had very positive outcomes, this included 69 per cent of homeless having appropriate accommodation after discharge, 72 per cent not having to be readmitted 28 days post discharge and 84 per cent of voluntary sectors reported a good working relationship with the NHS and most importantly patients stated there were higher standards of care as there was non-judgemental treatment and more support in hospital and post discharge. This hard work could be undone without further long term investments, although these statistics demonstrate that when communication is improved between services and staff are educated on the support for homeless post discharge, this will ultimately prevent re admission of the homeless which will save the NHS money and improved discharge policy will have a major impact on the lives of the homeless, improving their chances of better health.

Although services have improved in certain areas, there are still difficulties to overcome. Healthcare professionals have a difficult task in helping homeless patients to improve or manage their mental health condition. Many of those who are homeless may feel it is too late therefore have no interest in getting help, within the findings of Hodgson, Shelton and Bree (2014) out of the 121 participants, 10 had refused to take part for the second time due to lack of interest. For those who want help, the advice given to manage the symptoms would usually include listening to music, having reassuring thoughts, getting enough sleep, physical exercise and eating a healthy diet (Mind, 2015), however this advice is not beneficial for those who are homeless. Research has identified how lack of sleep contributes to obesity, poor diet as well as increasing mental illness, drug abuse and higher rates of violence meaning healthcare professionals are limited in the support they can offer if accommodation is not available (Olsen, 2014). Many homeless may not seek assistance as they have little motivation and low self-worth or feel embarrassed because of their mental health illness, due to feeling stigma and discrimination as a result of being homeless, having a mental health condition would add more pressure making it harder for homeless to ask for help and deny having any mental health issues (O'Reilly *et al,* 2009).

Furthermore, improving services by increasing staff awareness, providing homeless with more care and dignity will give those who are homeless a more positive experience, as past events have caused personal trauma which could impact on communication, but having awareness to help improve those skills and communicate positively may reduce the chances of homeless patients not attending the services provided to aid recovery (Mental Health Network NHS Confederation, 2012).

To summarise, it is essential that those who are homeless have access to GP practices and mental health services as there is a link between high percentages of homeless suffering with mental health conditions, especially anxiety and PTSD (Rae and Rees, 2015; Hodgson, Shelton and Bree, 2014). Although there are currently budget cuts to mental health services, nurses and healthcare professionals have a responsibility to provide support and refer to services that can help to manage the illness and provide stability to lead a life off the streets.

3.2 Substance Abuse, Self-Neglect and Poor Nutrition

In a quantitative paper by Palepu *et al* (2013), it was found that problematic drug use was associated with physical and mental health needs that were not being met, with many of those who are homeless having chronic health conditions as well as ever having a diagnosis for a mental health problem were also linked with the health care needs that were not treated. This compares with another quantitative study used for this review,

Huntley (2015) established that mental health status and being homeless were significant predictors of substance abuse severity in adults, this was also a factor for adults who were above the homeless status. There may have been social desirability bias used in the paper by Palepu *et al* (2013) as three poor cities in Canada were used, therefore these would be classed as vulnerable areas where people may face increased ill health and homelessness compared to additional areas within Canada, therefore the prevalence of drug and alcohol addiction would be higher in these areas. However the findings of unmet physical and mental health needs and lack of services or support for the homeless correlates with the findings from Huntley (2015) as there were participants without support for mental health disorders facing addiction issues, therefore this ensured the validity of the findings from Palepu *et al* (2013). Although the study by Huntley (2015) had limitations due to the use of convenience non-random sampling, having a potential for bias due to the lack of consideration for the whole population, meaning there is low external validity (Emerson, 2015). However the sample consisted of all ethnic groups, variety of socioeconomic status and mixed genders, this ensures generalisability of the findings and with a census from Office of National Statistics (2011) identifying England and Wales as becoming more ethnically diverse, this confirms the need for research to include all ethnic groups.

Due to drug and alcohol abuse being associated with significant mortality and morbidity it is a concern that those with a high comorbidity burden are not receiving help, it is highlighted that those scoring low physical and mental health scores with two or more chronic comorbidities were connected to having unmet health care needs (Baggett *et al,* 2010). On the other hand, it was found among the homeless, having a chronic medical condition had an increased the chance of having a doctor as their usual care source, although this likelihood decreased with each year the participant had spent homeless (Palepu *et* al, 2013; Khandor *et al,* 2011), this outcome related to a study from Eyrich-Garg *et al* (2008) as the results found that those with a limited or smaller amount of social support were associated with a longer length of time being homeless. This evidence suggests there are mental and physical needs that are not being treated, therefore drugs and alcohol are being used as an alternative where there is lack of support and services to help those who are homeless (Palepu *et al,* 2013; Huntley, 2015).

Within the study by Palepu *et al* (2013), having a primary care provider had a positive association with accessing treatment for addiction, reinforcing the importance of engagement in care for patients. As discussed previously this compares with the experiences of patients in the UK study by Rae and Rees (2015) as they had expressed that when there was flexibility from the GP it had helped keep the patient engagement as healthcare professionals had been accommodating, making the homeless feel staff are willing to help, therefore patients would turn up to appointments and get referred

to further services to ensure drug and alcohol addiction was being treated. Access to addiction services needs to be improved as substance use can be a major barrier for a homeless person to progress towards residential stability or to engage in mental and physical health care (Patterson *et al*, 2012). Huntley (2015) highlighted mental health status being a critical factor of substance abuse severity even for those who are past the homeless status, Karim (2006) suggested how housing first models for rehabilitation have improved mental health as a result of housing being provided, but further evidence has found that when homelessness is dealt with, after a period of four years there are high levels of mental illness continuing in former homeless people, although it is not known what mental health support was used in this period of time (Martijin and Sharpe, 2006). Therefore, if there is limited support from mental health services the mental illness will worsen and homelessness will be prolonged it is essential that addiction and mental health are both treated and have continued support once off the streets to end the cycle of mental health issues and substance abuse. The continuation of support is important as it was recognised that those who were homeless had an increased association with accessing addiction treatment, this may be due to support workers or councillors who attend shelters help to direct them to services for addiction compared to those who are in vulnerable housing who receive limited support and may continue or relapse into substance abuse (Huntley, 2015; Palepu *et al,* 2013).

All the studies discuss the difficulties in accessing healthcare, the unmet, physical and mental health needs and those living with chronic health conditions (Rae and Rees, 2015; Hodgson, Shelton and Bree, 2014; Huntley, ; Palepu *et al,* 2013). These is indication of the difficulty in accessing healthy food, evidence suggests that an inadequate food and nutrition intake contributes to ill-health, chronic health conditions and premature death (Feantasa, 2017). The participants in the study by Rae and Rees (2015) stated that the lack of resources such as money, shelter and food influenced their health, with limited money more junk food is eaten because it is cheaper therefore there is a lack of choice to eat healthier options, furthermore charities that provide food may not have a large variety of choice to cater for any cultural diet requirements for those who are homeless and the services may have limited meal hours, infrequent opening times and the distance to travel may create a barrier for an individual to obtain a meal from the charity (Tarasuk *et al*, 2009). Having nearby access to charities or money to buy nutritious food would suggest an improvement in an individual's health, although those who are homeless can choose in how they spend their money, therefore it cannot be assumed that money would be spent on food as items such as drugs and alcohol may be a higher priority.

In summary, there are similarities in findings with mental health being a contributing factor for substance addiction. Eighty per cent of respondents in findings

from Homeless Link (2010) reported some form of mental health issue, Crisis (2017) recognises that 39 per cent of homeless people surveyed reported they were taking drugs or recovering from a drug problem and those taking drugs are seven times more likely to be homeless compared to the general population (Kemp *et al,* 2006). There is a need for comprehensive health care services that include mental health support and addiction treatment within primary care and the community to prevent and help those with addiction to drugs and alcohol.

4. PLAN TO IMPLEMENT SERVICE IMPROVEMENT

This chapter will focus on the key finding from Chapter 3, identifying how adult nurses and healthcare services can improve their care and support for the homeless. The service improvement plan will be identified, discussing ways in which the plan can be implemented as well as an evaluation. Lastly, there will be a reflection of personal learning from completing this project.

4.1 Key Findings from Chapter 3

Chapter 3 had identified the lack of care and support homeless people face from healthcare professionals. Considering the complexity of needs for those who are homeless and lack of awareness adult nurses and other healthcare professionals receive around the healthcare needs, there is no doubt the care and support for the homeless is not being implemented. Although not every issue can be discussed from the findings, it is evident that adult nurses and other healthcare professionals can make a change and increase positive engagement with homeless patients, maintaining dignity, reducing the judgement and stigmatisation that those who are homeless feel they receive from healthcare workers and improve communication. This will ensure each individual's healthcare needs are being met and the homeless will have positive outcomes from healthcare services.

The NMC (2015) acknowledges how nurses should always treat people with kindness, respect, compassion and assumptions are to be avoided, to recognise diversity and individual choice. Although the participants from Rae and Rees (2015) had commented on the prejudice against them and how it was hard to talk to nurses on times as they did not listen, when one is not treated as an individual and communication is poor this blocks engagement between the patient and nurse. If nurses could treat the homeless with respect, there would be more willingness from the patient to communicate with healthcare professionals, discussing their healthcare needs and the services available to aid the treatment process. If nurses could receive more education on the homeless lifestyle this would provide an increased awareness of the different health problems of the people who are homeless, which would lead to an expansion of

knowledge to give an in depth assessment of the needs of homeless patients on first contact (Chung-Park *et al,* 2006). This increase of knowledge and awareness will give healthcare professionals insight into the available services and resources for homeless people, therefore collaborating with other health and social care professionals is essential for the care of the patient, the NMC (2015) states, a timely and appropriate referral should be made to another practitioner when it is in the best interest of the individual needing any action, care or treatment (Wen *et al,* 2007).

Having an increased awareness for adult nurses to provide positive engagement with the homeless consolidates the values of nursing, especially the 6Cs; care, compassion, competence, communication, courage and commitment (NHS England, 2016). When each of these values are carried out patients feel supported and cared for, homeless people will feel that healthcare professionals want to help them and treat them as equals to provide holistic care. Good communication improves patient quality of care and is essential for building a therapeutic relationship between patient and nurse, improvements in communication will help homeless people to not feel judged or treated unequally, therefore relationships can be built between patient and healthcare professional to allow the mental and physical health of homeless patients to be managed appropriately (Kourkouta and Papathanasiou, 2014).

4.2 Service Improvement Plan

For changes to be made within the NHS and primary care setting, a plan needs to be put in place to ensure all homeless patients will receive effective healthcare. There are many nursing assessment tools for older people, diabetes and many other specialities, although for people who are homeless there are lack of tools and resources for healthcare professionals to follow (National Institute for Health and Care Excellence, 2017). In 2014 the Queens Nursing Institute (QNI) had recognised a need for developing a health assessment tool for community nurses who work with homeless people after a survey had identified that there was no regular system in place for screening homeless patients. It was found that around 70 different methods were being used to assess homeless patients with many nurses using no assessments, homeless suffer with substance abuse, severe mental health conditions and many seeking asylum therefore complex knowledge and skills are needed as well as flexibility and a compassionate attitude. Therefore it is essential for healthcare professionals to have access to an assessment tool, care plan or awareness package to support homeless patients (Osborne, 2014).

To implement service improvement an awareness package would need to be created to educate healthcare professionals. The package should include protocols and

assessments to follow when in contact with a homeless patient, the package should answer the following questions:

- Is the patient identified as homeless?
- Are staff aware of the importance of identifying homeless people and are there set questions to ask to ascertain a person's housing status?
- Are staff aware of the housing options for patients and who needs to be informed?
- Have relevant support agencies been contacted?
- Is the patient linked with any support services? If not appropriate action must be taken to refer to relevant services such as substance misuse, mental health or supported housing projects etc.

The use of this package will give healthcare professionals the confidence to communicate appropriate information when providing a service to homeless patients. Training could be provided on the issues homeless patients face and how these can be managed, when healthcare professionals are giving insight into the homeless lifestyle, prejudice and stigmatisation may be reduced (Homeless Link; St Mungo's, 2012).

The package could be made available online for all healthcare professionals to access, communication is essential to inform all members of staff about the online awareness package. Multi-disciplinary team meetings, or staff briefings would provide the chance to disseminate the use of the new awareness package, it is important that all healthcare professionals are informed about the importance of the package to ensure it is put to use when working with homeless patients to benefit the care they receive. It is inevitable that there will be barriers faced when making changes, nurses will need to analyse the gap between current practice and the recommended changes, this will help identify any potential barriers that will be faced (NICE, 2007). The main barriers for the use of the awareness package are the healthcare providers' attitude towards change and their beliefs of the homeless. The need for the awareness package is to increase the way adult nurses communicate and engage with homeless patient to provide more support, as nurses work as part of a team colleagues may positively influence others to change their practice and managers can use their position to reward nurses who demonstrate positive and compassionate attitudes towards homeless, this can be done through appraisals which will reinforce positive behaviour and overcome the barriers faced (Parkinson, 2009).

4.3 Evaluation of Service Improvement

To evaluate the difference the awareness package has made to the experiences patients face in primary care services, a study similar to Rae and Rees (2015) could be

used. The use of interviews with patients who access care in areas where the awareness package has been implemented will identify if there are positive outcomes. The findings can be compared with the results from the Rae and Rees (2015) study to evaluate if changes on homeless patients perceptions on the way they are treated by healthcare professionals has improved. Using qualitative research methods such as interviews give a more detailed insight into sensitive areas where people may not want to talk about issues in large groups but feel comfortable in a one to one interview (Gill *et al,* 2008). This method would be appropriate to gather the perceptions of homeless and could be used to gain further perceptions from staff members on the effectiveness of the awareness package. It may be difficult to keep contact with the participants due to many homeless having no fixed abode and using temporary accommodation such as hostels that may only be able to provide shelter for a small period of time, therefore homeless participants will have to find alternative accommodation which could mean moving location (Shelter, 2014). Although, if relationships are improved between homeless and health professionals more contact and effort from the homeless will be made to stay in the area to have access to the local primacy care services.

Furthermore, it was discussed in chapter 3 that those who are homeless visit Accident and Emergency four times more than the general population, this is due to the negative experiences homeless have faced in primary care, therefore they will only attend healthcare services when there is an emergency (Rae and Rees, 2015; Homeless Link, 2014; Hodgson, Shelton and Bree, 2014). Therefore if homeless patients are receiving improved care due to the awareness package then A&E admissions of the homeless will decrease as the homeless will be accessing primary care services to manage their healthcare. This will have a positive impact on the cost of treatment for the homeless, St Mungo's (2013) investigated the cost of healthcare for the homeless. Due to homeless not accessing healthcare services this will lead to a deterioration in health and an admission to A&E with a longer length stay and multiple readmissions to treat the chronic illnesses, as a result this will have a major implications financially on the NHS. If the cost of treatment can be reduced and save the NHS money then there will be increased positivity to use the awareness package and make improvements in care and improve the health and wellbeing of the homeless.

4.4 Personal Learning

The homeless lifestyle is not an area focused on within the adult nursing degree, during a placement at a GP surgery there were many patients who were homeless and I had found myself interested in this area, wanting to have more information surrounding the care and services available for the homeless. It was surprising the different healthcare conditions homeless people face both physically and mentally and the lack of

support and judgement they faced from healthcare professionals. This meant there was change needed in the way homeless people are treated.

The research had indicated that when healthcare professionals were flexible, friendly and listened to the patient, there was an increased positivity towards engagement and wanting to improve their health by attending various addiction or mental health services. Having an awareness of the homeless lifestyle and understanding their needs can help to build a therapeutic relationship, therefore homeless patients would feel comfortable as they are not facing judgement or discrimination. This change in care by healthcare professionals is a positive step for homeless patients to receive better quality care and an improved quality of life.

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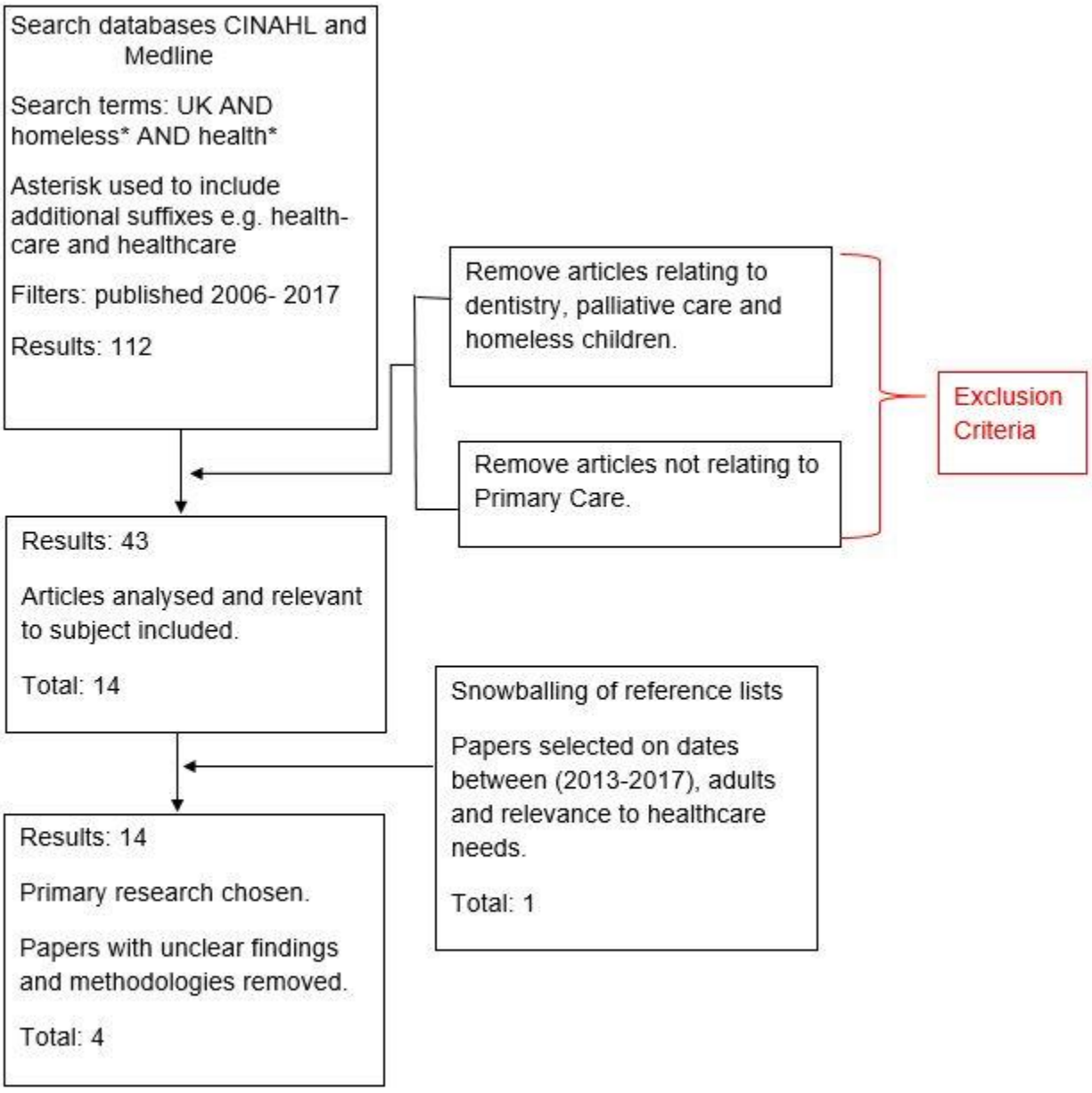
APPENDIX 1


Search databases CINAHL and Medline
Search terms: UK AND homeless* AND health*
Asterisk used to include additional suffixes e.g. health-care and healthcare
Filters: published 2006- 2017
Results: 112
Remove articles relating to dentistry, palliative care and homeless children.
Remove articles not relating to Primary Care.
Exclusion Criteria
Results: 43
Articles analysed and relevant to subject included.
Total: 14
Snowballing of reference lists
Papers selected on dates between (2013-2017), adults and relevance to healthcare needs.
Total: 1
Results: 14
Primary research chosen.
Papers with unclear findings and methodologies removed.
Total: 4

APPENDIX 2

Paper	Aim of research	Positives following Holland and Rees Framework	Negatives following Holland and Rees Framework	Ethics	Healthcare needs highlighted
Hodgson, Shelton and Bree (2014)	To assess the prevalence of psychiatric disorders and comorbidity among a UK sample and examine the longitudinal relationship between psychiatric conditions and different types of health service	Relates to similar study findings Transferrable to other locations Good use of methods	Recruitment of participants at temporary accommodation may mean more access to healthcare affecting results Number of participants lost from study at follow-up Majority of sample white British	Approved by ethics committee	High prevalence of psychiatric disorders, psychiatric comorbidity Low use of healthcare services
Rae and Rees (2015)	To understand the perspective of the homeless about their healthcare encounters and how their experiences of receiving healthcare influence their health-seeking behaviour	Appropriate method and research design for aim Findings produce positive recommendations to improve care	Convenience sampling Unable to use bracketing	Approved by ethics committee	Neglect from healthcare providers Negative experiences in ~~healthcare, few~~ positive Judgement and prejudice from healthcare professionals

Palepu *et al* (2013)	Examine the prevalence of substance use disorders among homeless and vulnerably housed adults in three Canadian cities and association with unmet health care needs and access to addiction treatment	Generaliseable due to large sample size, mixed gender and ethnicity Structured interviews to minimise bias Sampling strategies and validated screening tools used	Desirability Bias True size of population not known No use of follow up care	Approved by ethics committee	Substance use highly prevalent, drug use linked with unmet physical and mental health care needs. Problematic drug use associated with greater likelihood of accessing addiction treatment compared with alcohol use
Huntley (2015)	Determine whether mental health status and being homeless were significant predictors of substance abuse severity among adults and whether mental health status was a significant predictor of substance abuse among adults over homeless status	Mixture of gender, ethnic groups and socioeconomic status Equal amount of participants to compare against	Convenience non random sampling Smaller sample size No follow up	Approved, consent gained Participants able to ask questions and assisted with reading or understanding the survey	Mental health status and being homeless are significant predictors of substance abuse severity among adults Mental health status was a significant predictor of substance abuse severity over and above homeless status