Clinical care for people experiencing homelessness with diabetes: new resources

"People experiencing homelessness haven't got uncomplicated diabetes… They have complicated diabetes. Sometimes it's even difficult for us to understand what kind of diabetes they have, and what treatment they need."

Dr Helen Partridge, Diabetes Consultant

From April 2023 to July 2024, the Pathway charity led a national project, funded by the Burdett Trust for Nursing, to examine ways to improve the nursing and allied healthcare of people experiencing homelessness with diabetes. The project was highlighted in an article in this journal last year.

The project has now produced online training resources, including: a Fairhealth e-learning module for nurses, allied workers, health support workers and hostel staff; a Queen's Nursing Institute's Homeless and Inclusion Health Programme clinical guidance resource for inclusion health nurses and diabetes specialist nurses (DSNs); and Groundswell leaflets on diabetes for people experiencing homelessness, which are free to access.

The project comprised: a literature review of 34 articles; a review of five safeguarding adult reviews; two practitioner and expert by experience workshops; a University of Plymouth-led practitioner survey (which generated 104 responses); visits to five areas of good practice; and 13 local quality improvement projects. In addition, two expert patients were interviewed, and they provided both video and audio content for the training materials that were produced.

The very active steering group for the project involved inclusion health nurses and DSNs, a diabetes consultant, a specialist inclusion health GP, a dietitian, an optometrist, a podiatrist, an occupational therapist and four experts by experience (i.e. people with a lived experience of homelessness who help steer health improvement projects).

Survey results

Homeless and inclusion health nurses and DSNs were the most common respondents to the practitioner survey. Care outcomes for people experiencing homelessness were perceived to be substandard, with outcomes felt to be "poor" or "very poor" in 57% of cases. 73% respondents also acknowledged finding diabetes management for people experiencing homelessness "challenging" or "very challenging", with 66% thinking diabetes complications occurred "more frequently", or "a lot more frequently" in this group.

An appetite for training in this area was revealed, but 91% of respondents had not received any specialist training.

Expert by experience and expert patient insights

Lived experience input was very important to this project. During the project, the four experts by experience and two expert patients told us:

- Patients can feel told off and looked down on when being given a diagnosis of diabetes. This can also happen when they are being asked about their own concordance to care (e.g. to a healthy diet). Sensitive language is needed.
- Patients are aware of how serious diabetes is, and this can scare them, and this isn't always considered.
- Diabetes is very complicated to understand. Leaflets on their own don't help very much. Much more time is needed.
- Managing diabetes when you are homeless is very difficult due to practical issues like medication storage, lack of access to a kitchen, etc. Home circumstances are not often asked about.

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Read more online

Improving care for people experiencing homelessness with diabetes

Samantha Dorney-Smith and Lynne Wooff describe an initiative to help homeless adults with diabetes overcome difficulties in managing their condition.

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Read it here

- Opportunities for health education and support are often missed (e.g. when people are admitted to hospital).
- Nurse explanations, support and case management can make a massive difference, but nursing time can feel limited.
- Good support in hostels is also vital, and can be lifesaving, but staff need training.

Visits to areas of best practice

Visits by the steering group to five best-practice areas that were identified during the initial phase of the project – Bolton, Bournemouth, Liverpool, Plymouth and St Helens – revealed some common approaches to successful care. These included:

- Strong partnership working between diabetes and homeless and inclusion health services.
- Outreach from diabetes specialists to homeless hostel and day-centre settings where vulnerable individuals are.
- Robust audits of clinical care.
- Training of homeless hostel, day-centre and outreach staff.
- Proactive use of continuous glucose monitoring (CGM) technology.
- Partnership working with eye-screening and podiatry services.
- A clear focus on prevention and screening.
- A personalised case-management approach for complex individuals.

You can find out about the excellent care being delivered in these areas in the online e-learning and guidance. The bid for the wider project was first prompted by the quality improvement work conducted in Bolton.

Lynne Wooff and Joanne Dickinson review the project caseload in Bolton. On account of this collaboration, 82% of 28 people with diabetes had their nine key care processes met at the last audit. Lynne has now been granted one day a week to work exclusively with the Homeless and Vulnerable Adult Team (HVAT).

Insights from the project

A huge number of insights were obtained from the collaboration of the clinicians on the project and are covered in the training.

Clinical insights

- Type 3c diabetes is more common in this population, but is not always identified and managed effectively.
- CGM can be used effectively in this population.
- Adaptations to insulin regimens (with long-acting insulins) for people with addictions can be effectively made.
- Mental health issues associated with diabetes are common and need to be identified and actively managed (e.g. eating disorders and insulin overdose risks).
- Nutritional and food-security screening, vitamin and mineral supplementation, and proactive support to improve nutritional status (e.g. supervised administration of nutritional supplements, and support from occupational therapists to budget and cook) are needed.
- Missed eye screening is common and needs proactive responses.
- Foot checks are being missed, but can be undertaken by inclusion health professionals in primary care and on admission to hospital.

Management insights

- Active collaboration between specialist diabetes services and homeless and inclusion health services greatly improves care and health outcomes.
- Outreach from DSNs also greatly improves care and health outcomes.
- This model of clinical networking has been shown to be great for national quality improvement (and could be applied to other areas of practice, such as epilepsy or respiratory care).
- Experts by experience have played a huge role in shaping this project and need to be actively involved in quality improvement.

Patient insights

- Insensitive language and approaches have led to disengagement after patients have accessed

specialist services, not before.

- Patients need (and want) a lot of diabetes education and support.
- Patients often look favourably on safeguarding interventions, even when we might not expect this. For example, one of the expert patients was held under a Deprivation of Liberty Safeguards (DoLs) procedure for diabetes treatment after multiple attendances at A&E, owing to concerns about his executive function and mental capacity. His retrospective response to being held was: "I'm glad that it happened. I needed someone to take control."

Quality improvement

The audit tools created for this project are now freely available (see **Resources available**).

The tool for DSNs focuses on looking at service access, communication with patients and whether clinical assessments ask the right questions about housing status and home circumstances. The tool for homeless and inclusion health nurses identifies whether clients have had their nine key care processes met, and what can be done to support this. There is also a tool for conducting exploratory conversations with individuals about their satisfaction with care.

In Leeds, the audit of care identified differences in perception between practitioners and patients about care, knowledge gaps in staff and missed identification of type 3c diabetes. The project has led to greater primary and secondary care multidisciplinary team collaboration (particularly between nurses and podiatrists), better use of clinical templates in both primary and secondary care, and a renewed focus on nutritional screening, as well as foot screening when people experiencing homelessness with diabetes are admitted to hospital.

In Salford, although some outreach care already existed, the audit revealed a need for greater outreach, and more proactive identification of people's housing status when in hospital. As a result, housing status is now being assessed routinely and recorded in clinic notes. New education sessions are also being planned for delivery at homeless hostel, day centre and shelter staff, and a new monthly pop-up outreach clinic will then take place at these sites on rotation. The team is looking at an increased use of CGM for this population.

Expert patient Kellie talks about how she felt when she was told she had diabetes.

In Edinburgh, the audit led to HbA_{1c} screening in a specialist homelessness practice, resulting in six new diabetes diagnoses and 12 prediabetes diagnoses in the first six months. The audit has also placed a new focus on care planning for people with an existing diagnosis, and in-reach to the practice from a diabetes consultant is planned.

Resources available

All the resources from this project are available now and include:

- A comprehensive project report providing detailed write-ups of every aspect of the programme.
- The Queen's Nursing Institute's Homeless and Inclusion Health Programme clinical guidance for nurses and allied workers.
- A free e-learning course for clinical practitioners and support workers on the Fairhealth website.
- Patient leaflet focusing on diabetes and eye health.
- New information leaflets for patients on diabetes and managing it from homeless charity Groundswell.
- Tools to enable practitioners in inclusion health and specialist diabetes services to embark on their own quality improvement projects.
- Top tips crib sheets for improving diabetes care, including one aimed at DSNs.

Upcoming journal articles will focus on approaches to best-practice nursing care and the results of the University of Plymouth audit, with the aim of being published in spring 2025. ■

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