

The role of the public health nurse in meeting the primary health care needs of single homeless people: a case study report

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Links between homelessness and ill health are well established. However, homeless people are less likely to access traditional health care due to administrative barriers and hostility of professionals. For this reason more flexible modes of health care delivery, including nurse led care, have been explored. There has been a rapid increase in innovative nursing roles over the last two decades and the literature suggests that a clear role definition, good interprofessional working and supportive cultures are some of the features which ensure role effectiveness. A large study exploring new roles in nursing and midwifery in Northern Ireland identified an innovative nurse led approach in meeting the needs of single homeless people. The aim of this paper is to explore the effectiveness of this role using a public health framework. A case study design was used incorporating semi-structured interviews with analysis of secondary sources and a period of observation. Results demonstrated that the role fitted within a public health framework in that it involved assessment of need, skills to meet need, facilitation of access to care, partnership working, health promotion, health protection and influencing policy, and strategy development. The conclusion is that the role met the set criteria for innovative nursing roles. Furthermore, this practitioner meets the criteria for advanced nursing practice, providing evidence of effective nurse led care that meets the health agenda of targeting inequalities in health.

Key words: advanced nursing practice; case study research; homelessness; innovative role; primary care; public health

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Introduction

Over the past century the living standards of people in developed countries have improved substantially, resulting in improved health and increased life expectancy. Some policy analysts have argued that the gap between rich and poor has widened contributing to social exclusion and the possible development of an underclass (Byrne, 1999; Honkala *et al.*, 1999). In response to this, there is a global

realization that measures need to be put in place to tackle health inequalities (Honkala *et al.*, 1999; Makenbach and Stronks, 2002).

Successive UK government policy directives have advocated the targeting of health services to meet the needs of vulnerable and socially excluded people (Department of Health, 2003; Department of Health Social Services and Public Safety (DHSSPS), 2004). Several governments have identified the homeless population as a particularly marginalized group (American Public Health Association (APHA), 1997; Commonwealth Advisory Committee on Homelessness, 2001). In the UK, the Scottish Executive set up a Homelessness Task Force in 1999 (Quiglar and Peace, 2003) to address the

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specific needs of the homeless population, and in England, a Homelessness and Housing Support Directorate (Office of the Deputy Prime Minister, 2005) has recently been established.

The link between homelessness and ill health is well documented (Crane and Warnes, 2001; Love, 2002; Pleace, 1995) and adverse outcomes such as prematurity and low birth weight for homeless mothers (Little *et al.*, 2005). A report, commissioned by National Health Service (NHS) Scotland and the Scottish Executive (Quiglar and Pleace, 2003), reviewed effective practice in meeting the health needs of homeless people and found that one of the main barriers to access to health care for homeless people, in the UK, was the administration of the NHS which requires people to have an address in order to access services such as registration with a general medical practitioner (GP). Furthermore, homeless people often encountered negative attitudes from health and social care staff and therefore were often reluctant to access mainstream health services. It is acknowledged, however, that due to the transient nature of the homeless population flexible models of service delivery need to be explored, incorporating an interdisciplinary approach to meet the diverse needs of this vulnerable group.

A number of nurse led primary care outreach services, for homeless people, are reported in the literature (Armstrong, 2001; Gaze, 1997; Hinton, 1994; Wilde *et al.*, 2004) but as Quiglar and Pleace (2003) point out many of these services are not fully evaluated. Nevertheless, facilitated by the Primary Medical Services (PMS) pilot projects in England (Department of Health & National Health Service Executive (NHSE), 1997) more innovative models of primary care have emerged over the last decade. An interim evaluation of first-wave pilots (National Primary Care Research and Development Centre, 2000) found that nurses had played a key role in increasing access to primary care. The evaluation gives an example of a nurse led pilot for homeless people, facilitating access to secondary care.

More recently, Pfeil and Howe (2004) developed a framework for the evaluation of a PMS for 'hard to reach' groups. They used a consultative approach and concluded that this was a useful case study approach as it involved diverse stakeholders agreeing to common evaluation criteria. The five criteria identified centred around: access, responsiveness,

overcoming barriers, user involvement, multi-agency approach and reintegration into mainstream services. Such a model of effectiveness is not dissimilar to the public health model of service provision (Skills for Health, 2004) which emphasizes needs assessment, partnership working, health promotion, health protection, influencing policy and strategy development with the overall aim of addressing inequalities in health.

Over the last two decades there has been a rapid increase in specialist and advanced nursing roles (Read *et al.*, 2001). In a systematic review and metasynthesis of such roles, Lloyd Jones (2005) concluded that key factors to success of innovative roles were: effective relationships with relevant personnel, a clear role definition, personal commitment of the post holder, relevant previous experience, appropriate educational preparation and a supportive organizational culture. In Northern Ireland McKenna *et al.* (2005) undertook a three phased study of innovative roles in nursing and midwifery incorporating: interviews with all Executive Directors of Nursing ($n = 18$), Chief Nurses ($n = 4$) and Directors of Primary Care ($n = 4$), a postal survey of 454 post holders and six in-depth case studies to explore innovative nursing and midwifery roles (McKenna *et al.*, 2005). This paper presents the findings of one of these case studies, investigating a nurse led homeless health care service as an example of best practice in meeting the needs of a vulnerable population. An in-depth analysis of this innovative role was conducted and a combination of the criteria derived from the literature (Pfeil and Howe, 2004; Skills for Health, 2004) used to evaluate the effectiveness of the role.

Aim

The overall aim of the innovative roles project was to conduct an exploration of innovative nursing and midwifery roles and associated levels of practice across Northern Ireland's Health and Social Services (HSS) Trusts and Boards. The purpose of this paper is to report the findings of one of the case studies in stage three of the project.

Method

Case studies use in-depth data collection techniques, allowing for the detailed study of all aspects of a

case and the exploration of a perspective that may have been missed in other methods. Mills *et al.* (2002) suggest that case studies are particularly useful where there is a dearth of research that considers the experience and difficulties faced by a specialist nurse providing a new service. This case study is one of six selected from a list of innovative post holders identified by Northern Ireland's Executive Directors of Nursing, Chief Nurses and Directors of Primary Care from stage one of the McKenna *et al.* (2005) study, as a nurse or midwife who they considered to be an outstanding exemplar of an innovative role holder. Their choice was based on the following definition of innovative roles:

Roles occupied by registered nurses or midwives that function outside the traditional hospital and community nursing and midwifery clinical structures (eg, Staff Nurse/Midwife, Ward Sister/Charge Nurse or other Ward Manager titles, District Nurse, Health Visitor, School Nurse, Community Psychiatric Nurse and also excluding Nurse Consultant positions).

(McKenna *et al.*, 2005: p. 11)

Six innovative roles were purposively selected as representative of an innovative role across different specialities (including midwifery, community, general practice, mental health, practice development and acute care) and across all four HSS Board areas. This paper relates to the community nursing speciality and involves a nurse practitioner working with the homeless population in an inner city area of Northern Ireland.

Purposive sampling is based on the belief that a researcher's knowledge about the population can be used to hand pick the cases to be included in the sample (Polit and Hungler, 1999), however, it is acknowledged that the innovative roles selected may not be representative and therefore generalizations weak.

Multiple data sources were used and data was collected via separate semi-structured interviews with the post holder and her line manager, a period of observation with the post holder and analysis of secondary data (eg, the post holder's job description). Interview schedules were adapted from those used in a similar project undertaken in the UK (Read *et al.*, 2001). Questions explored the background to development of the role, qualifications

and experience, management and support, and perceived impact of the role. Non-participant observation was undertaken over one working day, observing the post holder's interaction with homeless people in clinics and hostels. No existing template from which to develop an appropriate observational study was available, therefore, the observation was undertaken using an unstructured approach; the aim being to observe and record behaviour in a holistic way without the structure of a predetermined guide. The 'non-participant' observer wrote up field notes as soon as was possible following the observational period.

Ethical approval was granted by the Office for Research Ethical Committees for Northern Ireland (ORECNI). The post holder and her manager were contacted by letter and informed consent was obtained not only from interviewees but any clients involved in the observation study. With the permission of interviewees, interviews were audiotaped and transcribed.

Analysis

Interview tapes were transcribed verbatim and content analysed. Categories were initially identified from the semi-structured interview guide and further themes identified as they emerged. Interview data from the post holder interview and the manager interview were constantly compared to seek verification of the responses to similar questions. Field notes were fully completed and analysed after the observation allowing the emergence of case scenarios and themes used to illustrate, and verify the interview data.

Based on the literature and the themes emerging from the interview data a framework for evaluation is suggested and presented in Figure 1. The framework combines criteria adapted from the study by Pfeil and Howe (2004) and public health competencies recommended by the Skills for Health Project (2004). Results are presented using sub-headings derived from the evaluation framework.

Results

Addressing health needs

Responses from the post holder and her manager demonstrated that the role had evolved from an

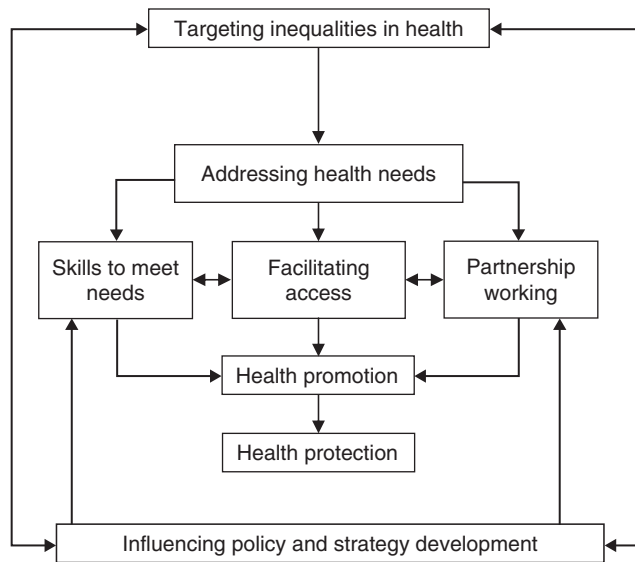


Figure 1 Public health framework for evaluation

identified need. Historically, limited district (home) nursing services were provided, as required, to single homeless people residing in a few hostels. In the mid-1990s the funding was granted for a pilot project to explore the health needs of the homeless population within the area. The funding allowed for the appointment of a dedicated district nursing sister who undertook physical health needs assessments within four hostels. The findings of the needs assessment were summarized as:

- The health needs of homeless people were much greater than that of the settled population.
- Approximately 25% of homeless people had spent significant periods in psychiatric care.
- Around 15% were young care leavers or children who had been in foster care.
- A number were adults with a history of foster care.
- It was estimated that 15% of the homeless population moved from hostel to hostel.

The manager made further comment:

The outcome of that (needs assessment) was, statistically, we were quite shocked when we saw the health needs of this group and we realized they were very vulnerable, possibly the most needy group out there, when it comes to the multitude of need they have and the

fact that they would not access services. Their health needs were appalling. The staff at the hostels were trying to do their best but I think you must accept the hostel staff had no training. As far as they were concerned they were providing a bed for these people and not an awful lot more.

The outcome of this needs assessment has been the development of a service delivered to 14 hostels in the catchment area and also to a number of clients who are not attached to a hostel and are homeless, living on the streets, because they have been unable to find a place in a hostel or have been excluded from the hostel for a variety of reasons. The required post holder was identified as a qualified nurse practitioner and by virtue of these skills was able to undertake a more detailed physical assessment with referral on to specialist services within the employing trust and outside agencies, as required. Observation of practice demonstrated an example of an individual needs assessment and this is depicted in Figure 2.

Skills to meet need

Following identification of the need for the role, a job description was drawn up. A summary of the job description is presented in Figure 3.

On a routine visit to one of the designated hostels the health care co-ordinator (nurse) is introduced to a new male resident. The resident is asked if he would like to see the nurse and on agreement, he is taken into a private surgery room. The extent of the service is fully explained to the client and he is assured of confidentiality. It emerges that as the client has come from another area he is not registered with a GP and the nurse assures him that she will organize this registration for him. Using a specially designed assessment sheet the nurse asks the client about his dental health and explains that there will be a dental screening clinic at the hostel the following week. As the client has had no recent eye test he is also offered this when the optician next visits the hostel. Similarly, podiatry will also be arranged. Having established trust with the client the nurse asks him if he would be willing to talk about the circumstances leading up to his homeless state. The client explains that because of a difficult family situation he developed an alcohol problem, which resulted in him spending some time in a rehabilitation unit in a psychiatric hospital. The client is also a smoker and his general health is poor.

The nurse checks on the client's immunization status and offers to give him a 'flu jab on her next visit.

Skills identified in the interaction

- Excellent communication
- Holistic assessment
- A non-stigmatizing approach
- Establishment of trust

Figure 2 Needs assessment

Job title Health care co-ordinator for the homeless population

Core purpose in relation to the homeless population

- Co-ordinate multidisciplinary health care
- Make referrals to appropriate agencies
- Assist in development of public health initiatives based on current health policy directives
- Plan and carry out training for hostel staff
- Promote a model of good practice by participating in relevant events to promote health care needs of this population
- Act as an advocate

Principle and professional responsibilities

- Assess needs, design, plan and deliver programmes to meet need
- Lead and co-ordinate programmes (e.g., dietetic, dental, ophthalmic)
- Establish collaborative working between statutory and voluntary services
- Act as representative on steering groups (e.g., Northern Ireland Housing Executive)
- Undertake research and audit
- Work to promote access and equity
- Work collaboratively with key stakeholders to develop patient group directives for immunization and prescribed medication
- Undertake appropriate clinical work
- Develop protocols for staff to ensure health and well-being
- Assist in further developing the service through funding bids
- Accept responsibility for own professional development based on changing needs of service

Figure 3 Job description

Both the post holder and line manager were asked to define the specific role. Additionally, the aims and objectives of the role were explored with the line manager. The post holder defined her role as:

health care co-ordinator/nurse practitioner to work with an identified population of single

homeless in XXX Trust and that can be anything from hands-on to referral. It's a nurse led service and I am the first point of contact for homeless people and rough sleepers.

The manager went on to talk about empathy and respect, but it became obvious from her discussion

that the personality of the present post holder was a key factor in the success of the role:

She is straight, honest and direct with them and they respect her for it, and they have such respect for her but then it is mutual. She shows them and treats them with respect and I think it is something, to be honest with you, that they have not been used to from service providers in the past.

Observation of the post holder demonstrated excellent communication skills, good rapport with clients and staff, delivering care and advice in a non-stigmatizing, non-judgemental and empathetic manner.

The job description indicated the minimum post-registration nursing qualification required for the role was a nationally recognized district nursing qualification, with four years experience as a district nursing sister. Additionally, a nurse practitioner qualification (or willingness to undertake the nurse practitioner course) was seen as desirable. The nurse practitioner qualification is a contentious issue, as at present this title is not formally recognized by the nursing regulatory body in the UK. Nevertheless, the Royal College of Nursing (RCN) developed a nurse practitioner programme at the beginning of the 1990s and the programme, now based on defined competencies (National Organisation of Nurse Practitioner Faculties, 2001; RCN, 2005), continues to run at various higher education institutions throughout the UK, including Northern Ireland.

The current post holder on taking up the post met the minimum requirements, holding a BSc in Community Nursing (district nursing option). However, it was evident from the interviews that not only has the service evolved during the six years since its inception but the post holder has undertaken ongoing professional and academic development to meet the ever changing demands of the service:

I went on to do my MSc in Advanced Nursing and that was the Nurse Practitioner Course. Basically, I did that because I thought there was a need not only to be able to assess this group, but also to be able to differentially diagnose the client group I was working with and to be able to refer them to appropriate services if I felt I couldn't handle it myself.

I have since completed my nurse prescribing and I am now an independent and supplementary nurse prescriber.

The post holder went on to discuss the experience required and the gaps in skills and knowledge that have been addressed:

Working with this group over the past six years has taught me an awful lot. I have also had to do a lot more courses like coping with aggression, around vulnerable adults, around drugs and alcohol because those were things that as a district nurse and during my nurse training I never did before. So there were a lot of gaps and to be honest every day is a learning experience because we get something new every single day.

As innovative roles usually involve the post holder working in an autonomous way it is important, in the interest of public safety, that the competency of the practitioner is ascertained. The post holder provided evidence of assessment of competency:

When I was doing my nurse practitioner course I did work for three years alongside the Trust medical director who is also a practising GP ... so certainly I was assessed then for my competence ... With nurse prescribing, first of all I was assessed as to how I assessed patients, came to a differential diagnosis and prescribing decision, this was the same medical director and then we did have our studies adviser who came out from the university.

It was clear from interviews with both the post holder and the line manager that the post holder had substantial autonomy within professional nursing boundaries and beyond. She has the authority not only to accept clients but also, following assessment, to refer on to other services as appropriate. Such referrals would be to a broad range of health and social care agencies, for example, mental health, podiatry and physiotherapy. Referrals do not appear to be related to any set of protocols and in some instances the post holder appears to be working very much on the boundaries of medicine and nursing. However, the post holder did not feel this was taking over medical responsibility:

... the GP would say himself, 'if you can get this sorted out better than I can, go ahead'.

I know that's like passing the buck from the GP but I suppose the GP has got a very big caseload and these people have multiple needs, very diverse needs.

In many circumstances GP consent would not arise, as many of the clients are not registered with a GP. Furthermore, autonomy allows the post holder to provide an opportunistic service:

It's an open access clinic and anyone's free to come in the door and in fact I would actively seek you out if I knew you were new in the hostel. You may not have a medical problem but just to see what your past background is to see if you are on medication and basically just to see if you are well.

The post holder clearly manages whole episodes of care, but given the multiple health needs of the client group and their transient way of life accepting and discharging from the case-load does not follow the usual pattern of care:

Invariably, your one assessment you have with me is the only opportunity I may have. You may have multiple things wrong with you – you may have mental health problems, you may have ulcers on your legs, you may also have hypertension. So those are the things I will try to deal with there and then. As well as that I will do the opportunistic health promotion bits with you, but I might never see you again, so this is the difficulty. It's not like you have a condition and you come back until you are well. For some they do but for a lot they don't, a lot just ghost into the system.

Protocols have long been seen as a way of negotiating role boundaries between professional groups, particularly in relation to the prescribing and administration of medicines. With the advent of nurse prescribing more formal patient group directives have been advocated (National Prescribing Centre, 2004). Due to the uniqueness of this post the post holder felt that too many protocols would be too restrictive. However, in the interests of safety and client convenience some have been developed:

I work under specific patient directives (for me) to give the 'flu vacc, because the criteria for the 'flu vacc is a little different for the

homeless, especially for the rough sleepers who have immune suppression because of their poor nutritional status and problems with their alcohol. Before when I first started the job I might have written out to 200 GPs – sent letters to say I'm a nurse practitioner and am willing to give this client a 'flu immunization, can I have your permission? Would you send me the script? Which they would have done, but there was often a mix up with this. So now we work under patient group directives, where the Trust supply me with the vaccine, so I'm not involved with the GP. If they have a GP I will send a letter and the batch number of the vaccine.

Observational and interview evidence suggests that the post holder is working at an advanced level as defined in a current Nursing and Midwifery Council consultation document (NMC, 2005), which identifies an advanced nurse practitioner as:

A registered nurse who has command of an expert knowledge base and clinical competence, is able to make complex clinical decisions using expert clinical judgement, is an essential member of an interdependent health care team and whose role is determined by the context in which s/he practises.

(Nursing and Midwifery Council, 2005: p. 6)

Facilitating access

A picture was painted of a highly vulnerable population, with a multitude of physical and mental health problems, and huge underlying social problems. Despite such health needs, as the line manager pointed out: 'They don't trust the system, they don't access the system, a lot of them haven't been registered with a GP.' For this reason one of the objectives of the post was to try to ensure that the majority of the homeless population in the area were registered with a GP and subsequently a dentist. Currently the post holder delivers services to homeless clients wherever they are, be it in one of the hostels or rough sleeper centres, but as stated:

The long term objective is to get homeless people into Trust services but that's a very, very slow process. Getting them to access our service has been successful as indicated by the

'One of the rough sleepers had fallen off a wall and broken his leg. He went to A & E, they put on a temporary cast and told him to come back on Monday. Now this is a rough sleeper who doesn't have a watch, whose head's absolutely pickled with alcohol, so he does not remember times for appointments. [When I saw him] he had a "mush" plaster on ... I took him to hospital. We waited for three hours. I actually stayed with him, it was important ... because he actually would have walked out. The young consultant ... said: "I'm putting on a long leg plaster and I want you to go home and put your leg up for the weekend" I said: "Can I just ask you to explain to X how he keeps his leg up outside XX (shopping centre) for the weekend, because that is where he sleeps." And then he (the consultant) asked me to come out and he talked to me in the office about the homeless and about rough sleepers.'

Figure 4 Advocacy role

uptake levels at clinic, screening and health promotion or health education sessions.

The post holder eloquently described overcoming homeless peoples' distrust of the statutory services:

You have to go out of your way to win them over and get their trust and be consistent about going back. It's not meant to be another tier of service but like meeting them there at their point of low self esteem, when really their [homeless peoples'] experience of health professionals has been marred by their [professionals'] attitudes and stigmatization of the homeless. So we are actually not in a clinical setting but out there with the people.

Measuring the impact of such a diverse and complex role is fraught with difficulties. However, in terms of service use the post holder reported that during the previous year she had logged 3000 contacts. In terms of impact on the client group the post holder described the need for continuity:

The client group I am working with, you as a person are very important to them because they need to identify with you. They need to trust you. The same person coming back time and time again, the same person turning up for the clinic, time and time again. That in itself attracts people to turn up because they can trust you.

The nurse manager also described the impact of the role in terms of client advocacy:

She has accompanied these clients to GPs, fought their battles and won ... I have watched some very senior people, other professionals' attitudes change dramatically after a conversation with her.... The clients would

say that was great, it's so much better the next time, that person's so much nicer the next time. So it's a whole advocacy role.

The post holder measured her own effectiveness in terms of three criteria. First in terms of the expansion of the service over six years: 'When I started in 1999 I had three hostels with 300 people and today I have 14 hostels and one centre for rough sleepers, and almost 2000 clients.'

Second, by developing a multi-agency approach to health care of homeless people and joining in shared responsibility for this client group with organizations such as the Housing Executive. Third, by raising awareness of the plight of homeless people the post holder feels she has developed an advocacy role, illustrated in the case study as presented in Figure 4.

Partnership working

Interview and observational data confirmed that the post holder works in partnership with professional colleagues, notably dentistry, podiatry, dietetics and general medical practice, voluntary agencies for the homeless, covering a range of religious and secular agencies; and, most importantly, in partnership with service users:

Although I am the first point of contact for the homeless with physical needs, I co-ordinate all the other services, it's very much a multidisciplinary, multi-agency working approach. I meet with my line manager on a regular basis for supervision and support, she is always at the end of the phone line if I do have a problem. Within the Trust I have a very good working relationship with the other disciplines who have been extremely empathetic and supportive of my role with the homeless.

On a visit to a hostel for recovering drug offenders the nurse works with a dietician to deliver a healthy eating session to interested residents. Following the session the residents discuss their dissatisfaction with the food given to them in the hostel. The nurse while offering to speak to the hostel staff on their behalf also discusses diplomatic ways they can present their case, in terms of suggesting menus and offering to be involved in the purchasing and preparation of the food within the constraints of the monetary budget of the hostel. The nurse also offers to run a Cook-it course for these residents and this suggestion is well received. Subsequently the nurse discusses the residents' concerns with the hostel staff and offers to work with them in remedying the concerns.

Skills demonstrated

- Multidisciplinary collaboration
- Health promotion
- Advocacy
- Collaborative working with voluntary agencies
- Excellent communication skills

Figure 5 Health promotion

A resident in the hostel attends the nurse's surgery for dressing of burns to his legs. This is ongoing treatment following discharge from hospital. The man tells the story of how he was sleeping rough and someone set fire to his sleeping bag. He sustained severe burns resulting in a prolonged stay in hospital. The nurse explains the dressings she is applying and why. She reassures the patient that the wounds are improving and the precautions he should take to ensure continued healing. She arranges to see the patient again at her next visit.

Another resident attends for a 'flu vaccination and the nurse follows the agreed patient group directive in the administration. She asks about general health and explains the possible side effects of the vaccination. She explains in detail the action of the vaccination and having administered the vaccination asks the patient to wait outside for the allotted time just to ensure that he has no immediate reactions to the vaccination.

Skills demonstrated

- Wound care
- Health promotion
- Using protocols to deliver immunization
- Excellent communication

Figure 6 Health protection

Health promotion

In spite of the broad remit of the role, which extends beyond the widely accepted scope of nursing practice, the post holder and her manager are firmly of the opinion that this remains a nursing role:

I see my role not just as nursing, I do a little bit of social work. The main part would be nursing. If you were to look at the whole person, then the whole person is not just nursing and if I am there as the first point of contact it can't be just nursing. There is a public health role; a very big teaching role around health education, health promotion. I've done a lot of hostel training to staff, because

don't forget the people who are looking after these hostel people are very often young people with very little life experience and they are dealing with huge multi-complex needs with such emotional baggage, it's quite difficult for them, so its training awareness for them – a counselling role.

Observation of the post holder quite clearly established her health promotion role as illustrated in the case study depicted in Figure 5.

Health protection

The nurse manager described the diverse nature of health problems picked up during routine

screening some of which are life threatening. She gave an example of a case of advanced mouth cancer being diagnosed following a routine dental screening exercise in one of the hostels. She pointed out that it was only due to efforts of the post holder that first, the dentist visited the hostel and second, that the residents presented themselves for dental screening. The post holder demonstrated her health protection skills within routine clinical nursing care as illustrated in Figure 6.

Influencing policies and strategies

There is no doubt from observation of the post holder in practice and her interaction with other agencies that this is an effective role. This has been acknowledged by the fact that the service has been identified as a model of good practice by the Northern Ireland Housing Executive, a view endorsed by other independent and voluntary agencies.

As a result of this acknowledgement the post holder has had the opportunity to be an active member of policy committees, which address the needs of the homeless. Such committee work affords an opportunity to influence policy:

... you are getting over the message of the homeless even to people who are talking about what homeless people need but they haven't a clue what they (homeless people) are like on the ground.

Discussion

Using the criteria for an innovative role, as defined in this study, there is no doubt that this post holder is working in an innovative way. Results demonstrate that the role fulfils the key criteria for success identified in the literature (Lloyd Jones, 2005), in that there is a clear role definition, effective relationships with key personnel and strong personal commitment from the post holder; there is a clearly identified client group, the single homeless population. This is a vulnerable population, with multiple health needs and this case study supports previous evidence, which demonstrates that this group feel stigmatized by health and social care staff and therefore are reluctant to access

mainstream, traditional primary care provision. (Quiglar and Pleace, 2003)

The innovative role depicted in this study has a clear evidence base for its inception and has patently evolved to meet the changing needs of the client group. Observational and interview evidence has been provided to demonstrate that the enacted role adequately matches the prescribed job description. The data suggests that not only is the post holder a health care co-ordinator, working in a well-developed interdisciplinary role, but she is also a hands on nurse practitioner meeting the NMC criteria for advanced practice (NMC, 2005). Additionally, the post holder demonstrates highly developed public health skills (Skills for Health, 2004) of needs assessment, partnership working, health promotion, health protection, influencing policy and strategy development, and addressing inequalities in health.

As other studies have shown (McKenna *et al.*, 2004) the success of the post is attributable, in no small way, to the current post holder. The personal attributes observed, and subsequently validated by the nurse manager interview, were those of advocacy, an excellent communication style, a non-judgemental approach; empathy; respect for the client group and fellow professionals, statutory and voluntary workers; excellent nursing experience and a well-developed sense of professional accountability.

There is clear evidence that although this is quite a unique post it is integrated into mainstream health and social care provision as at no stage did the post holder indicate that she felt isolated from her peers or other professional groups. On the contrary, her networking skills seem so well developed that she has built a multi-agency service from what is technically a singly funded post.

In terms of effectiveness the line manager had no hesitation in stating that the post is highly cost effective. It has clearly measurable outcomes in terms of increase in service users from a few hundred at the outset to 3000 during the last year. The service is on target to meet one of its key outcomes, which was to increase the number of homeless people, in the area, registered with a GP. Although user satisfaction was not specifically measured in this study it was clear from observing interaction between the post holder and clients that she is well respected and valued in her role.

Limitations of the study are that it is a single case study. However, this is a unique role and the lessons learned are that, in the right context, the public health skills of nurses can be enhanced and developed. Without the rigidity of a prescribed role nurses can truly assess need and target services accordingly, while maintaining quality and safety standards, in the best interests of the clients and communities they serve.

Recommendations

This was a single case study carried out in one area of the UK. There is a need to replicate the study in other areas and to develop a body of knowledge on which to plan future outreach services for the homeless. No true needs assessment is complete without listening to the users of the service and therefore user involvement is essential in developing any similar service of this nature. Finally, although this case study demonstrated effective interdisciplinary working, formalized multidisciplinary teams for the homeless population are probably required.

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