Caring for People Experiencing Homelessness or Housing Insecurity

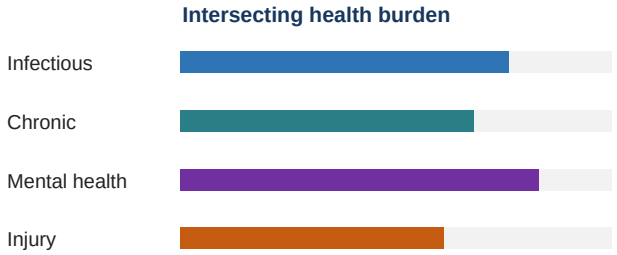
- A culturally responsive, trauma-informed nursing approach
- NURS-FPX4015: Pathophysiology, Pharmacology, and Physical Assessment
- Teaching goal: improve safety, trust, access, and continuity

Speaker notes

This presentation focuses on people experiencing homelessness or housing insecurity. The group includes people sleeping outdoors, living in shelters, staying temporarily with others, facing eviction, or living in unsafe and unstable housing. The purpose is not to define people by housing status. Instead, it is to show how housing conditions shape health risks, access to treatment, medication use, and the ability to follow a care plan. I will review common health needs, social and structural barriers, culturally responsive communication, trauma-informed assessment, practical nursing strategies, and a brief case example. The central message is that respectful care begins by asking what matters to the person, addressing immediate survival needs, and coordinating health and housing resources rather than assuming nonadherence or lack of motivation.

Population Characteristics and Healthcare Needs

- Housing instability exists on a continuum, including hidden homelessness
- Higher exposure to infection, injury, chronic disease, mental illness, and substance-related harm
- Health priorities often compete with food, safety, transportation, and shelter



(CDC, 2024; Lee et al., 2023)

Speaker notes

People experiencing homelessness are diverse in age, race, gender identity, family structure, disability, immigration history, and reason for losing housing. Some individuals are visibly unsheltered, while others stay with friends, live in vehicles, or move among temporary settings. Health risks arise from exposure, crowded environments, violence, limited sanitation, disrupted sleep, inadequate nutrition, and difficulty storing medication or medical equipment. Chronic conditions may worsen because follow-up is fragmented and emergency departments become the most accessible entry point. Nurses should avoid treating homelessness as a personal trait or a single diagnosis. The assessment should identify the person's immediate health concern, housing situation, safety, functional ability, mental health, substance use, and practical barriers that affect the plan of care.

Values, Beliefs, and Diversity Within the Population

- No single “homeless culture” exists
- Past discrimination may create mistrust of health and social systems
- Autonomy, privacy, dignity, family roles, faith, identity, and survival strategies vary

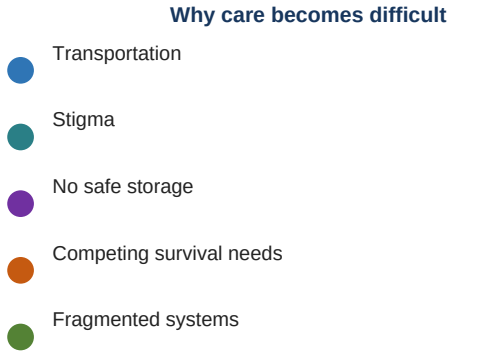
(Huo et al., 2023)

Speaker notes

Culturally competent care requires recognizing diversity within the population. A person’s beliefs and preferences may be shaped by race, ethnicity, language, gender, sexual orientation, disability, veteran status, family responsibilities, religion, and previous experiences with institutions. Repeated rejection or disrespect can make clinical environments feel unsafe. A nurse should therefore ask, rather than assume, how the patient describes their situation, who they want involved, what name and pronouns they use, and what concerns feel most urgent. Respect for autonomy is especially important because people without stable housing often have little control over daily circumstances. Flexible choices, private conversations, and transparent explanations can reduce power imbalance and demonstrate that the patient is a partner in care.

Healthcare Disparities and Access Barriers

- Transportation, identification, insurance, phone access, and appointment requirements
- Stigma and prior negative encounters
- No safe place for rest, wound care, refrigeration, hygiene, or medication storage
- Fragmented health, behavioral health, and housing services



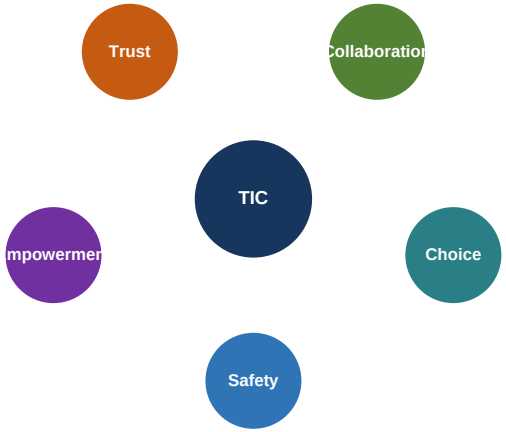
(Arbour et al., 2024; CDC, 2024)

Speaker notes

Many care plans fail because they assume stable housing, reliable transportation, a working phone, refrigeration, privacy, and the ability to return for appointments. For example, telling a patient to elevate a leg, keep a wound clean, or take a sedating medication at night may be unrealistic in a shelter or outdoor setting. Stigma can also delay care. A patient who expects judgment may withhold information or leave early. Nurses can improve access by simplifying referrals, confirming where and when services are available, providing written and verbal instructions, using low-barrier clinics, and connecting the patient with a case manager or housing advocate. Coordination is not an optional social add-on; it is part of safe clinical planning.

Trauma-Informed and Culturally Responsive Assessment

- Promote safety, choice, collaboration, trust, and empowerment
- Explain each step and ask permission before touch
- Screen privately for violence, exploitation, mental health, substance use, and suicide risk
- Prioritize the patient's stated concern and avoid retraumatization



(Huo et al., 2023)

Speaker notes

Trauma-informed care assumes that trauma may be present without requiring the person to disclose it. The nurse introduces themself, explains the purpose of questions, offers choices, and asks permission before physical contact. The patient should be told what information is confidential and what must be reported. During assessment, the nurse can ask, "What would help you feel safe during this visit?" and "Which problem is most important to address today?" Private screening is needed for violence, trafficking, exploitation, suicide risk, and substance-related harm. The nurse should not force disclosure, threaten loss of services, or use stigmatizing labels. Evidence on trauma-informed implementation highlights the importance of flexible policies, staff training, interagency collaboration, and service-user feedback.

Practical Nursing Strategies

- Address immediate needs first: pain, breathing, infection, exposure, safety, food, and shelter
- Design realistic medication and wound-care plans
- Use teach-back and plain language
- Provide warm handoffs to primary care, behavioral health, benefits, and housing services

(CDC, 2024; Lee et al., 2023)

Speaker notes

A practical plan starts with urgent clinical needs and the patient's immediate priorities. The nurse assesses for infection, uncontrolled chronic illness, withdrawal, overdose risk, pregnancy needs, exposure, injury, and mental health crisis. Medication teaching should include where the patient can safely store the medication, whether dosing fits shelter routines, and what to do if doses are missed. Long instructions can be reduced to a few clear actions and confirmed through teach-back. A warm handoff means contacting the receiving service, sharing necessary information with permission, and confirming that the patient knows where to go. When possible, the nurse provides supplies, written resource information, transportation support, and a follow-up option that does not depend only on a phone.

Case Example: Ms. R.

- 48-year-old woman living in a vehicle; diabetes and depression
- Foot blister, limited food access, lost glucometer, avoids shelters after assault
- Goal: prevent infection while respecting safety and autonomy

(Anderson et al., 2024)

Speaker notes

Ms. R. presents with a painful heel blister and reports living in her vehicle. A culturally insensitive response would focus only on “noncompliance” with diabetes care. A respectful assessment identifies her immediate concern, wound severity, glucose symptoms, medication access, food availability, trauma history, and preferred follow-up location. The nurse asks permission before examining the foot, explains findings, cleans and dresses the wound, and teaches warning signs using plain language. The plan includes replacement glucose-monitoring supplies, a medication review, food resources compatible with diabetes, a women-centered outreach clinic, and a housing advocate. Because shelters feel unsafe after an assault, the nurse offers alternatives rather than pressuring her. The strategy connects the clinical plan directly to her safety concerns and living conditions.

Patient Teaching: Prevention and Self-Management

- Seek urgent help for chest pain, severe breathing difficulty, confusion, high fever, suicidal intent, or rapidly spreading infection
- Keep medications together, dry, and away from extreme heat when possible
- Use low-barrier resources for vaccines, wound care, chronic disease follow-up, and mental health
- Identify one trusted contact and one realistic follow-up location

(CDC, 2024)

Speaker notes

Education should be brief, actionable, and adapted to available resources. The nurse explains emergency warning signs and checks understanding through teach-back. For chronic conditions, the patient is helped to identify the smallest realistic next steps, such as one follow-up visit, one safe medication-storage option, or one trusted outreach contact. Prevention may include vaccinations, foot checks, hydration, safer substance-use resources, naloxone, infection screening, and weather protection. The nurse should avoid giving advice that requires resources the patient does not have. Instead of saying “eat a healthy diet,” the nurse can connect the patient with meal programs and discuss affordable choices. Patient education is most effective when it respects the person’s goals and acknowledges the constraints of housing instability.

Resources for Further Learning and Referral

- Local 211 or coordinated-entry services
- Health Care for the Homeless and street-medicine programs
- Federally qualified health centers and mobile clinics
- Domestic violence, veteran, LGBTQ+, disability, and family-specific resources
- Naloxone, crisis, and behavioral health services

Speaker notes

Resources should be tailored to the patient's location and identity. In the United States, 211 can help identify local housing, food, transportation, and crisis services, but availability varies. Health Care for the Homeless programs, federally qualified health centers, mobile clinics, and street-medicine teams may offer low-barrier care. Some patients need specialized services, including domestic violence support, veteran programs, LGBTQ+-affirming services, disability advocacy, or family shelter resources. A resource list is only useful when it is current. Nurses should verify hours, eligibility, walk-in policies, transportation, and whether identification is required. Whenever possible, the nurse makes a direct referral instead of handing the patient a long list.

Key Takeaways

- Housing is a major determinant of health and treatment feasibility
- Respectful language and trauma-informed choices build trust
- Safe care plans must fit the person’s real environment
- Clinical care, behavioral health, and housing support should be coordinated

Speaker notes

In summary, people experiencing homelessness or housing insecurity have varied identities, strengths, and health priorities. Their outcomes are influenced not only by disease, but also by exposure, trauma, stigma, fragmented systems, and the practical realities of unstable housing. Culturally responsive nursing care uses respectful language, asks about preferences, protects autonomy, and recognizes diversity within the population. Trauma-informed practice promotes safety, choice, trust, collaboration, and empowerment. The strongest care plans are realistic: they address urgent needs, simplify medication and follow-up, use teach-back, and connect the patient with services through warm handoffs. Nurses cannot solve homelessness alone, but they can reduce harm, advocate for equitable care, and ensure that health recommendations do not ignore the patient’s living conditions.

References

- Anderson, J., Trevella, C., & Burn, A.-M. (2024). Interventions to improve the mental health of women experiencing homelessness: A systematic review of the literature. PLOS ONE, 19(4), e0297865. https://doi.org/10.1371/journal.pone.0297865
- Arbour, M., Fico, P., Atwood, S., Yu, N., Hur, L., Srinivasan, M., & Gitomer, R. (2024). Primary care-based housing program reduced outpatient visits; patients reported mental and physical health benefits. Health Affairs, 43(2), 200-208. https://doi.org/10.1377/hlthaff.2023.01046
- Centers for Disease Control and Prevention. (2024). About homelessness and health. https://www.cdc.gov/homelessness-and-health/about/index.html

Speaker notes

These sources are current scholarly or professional materials supporting the presentation. The reference list follows APA 7 style as closely as possible within a slide format. Learners should verify bibliographic details through the Capella Library and replace or add sources when the current courseroom instructions require a particular population, database, or source type.

References (continued)

- Huo, Y., Couzner, L., Windsor, T., Laver, K., Dissanayaka, N. N., & Cations, M. (2023). Barriers and enablers for the implementation of trauma-informed care in healthcare settings: A systematic review. Implementation Science Communications, 4, 49. https://doi.org/10.1186/s43058-023-00428-0
- Lee, J., et al. (2023). Addressing health disparities of individuals experiencing homelessness through community-institutional partnerships. Journal of Nursing Education and Practice. https://pmc.ncbi.nlm.nih.gov/articles/PMC10182242/
- Nichols, L., et al. (2023). Characteristics and effectiveness of co-designed mental health interventions in primary care for people experiencing homelessness: A systematic review. International Journal of Environmental Research and Public Health, 20(1), 892. https://doi.org/10.3390/ijerph20010892

Speaker notes

The presentation uses more than the minimum five recent sources. In a final course submission, every clinical or population claim appearing on a slide should have a matching in-text citation, and the spoken presentation should remain between five and ten minutes. The notes in this sample are written in complete sentences and are designed to produce an approximately eight-to-nine-minute presentation when delivered at a natural pace.