Trauma-Informed Wound Care in Street Medicine

Practical Strategies for the Certified Wound Care Nurse Advanced Practice

PORTFOLIO WORK SAMPLE

Liz Sahadi Smith

Collection	Institutional Voice
Engagement Type	Clinical Publication, Editorial and Communications Support
Organization	Healthcare Nonprofit, Arizona
Published	2026
Role	Editorial assistance — supporting the translation of advanced wound care science into publication-ready clinical prose for a specialist audience

How to Read This Piece

Work Submission

This is a portfolio work sample demonstrating editorial fluency in complex clinical content at the intersection of street medicine, trauma-informed care and public health communications. The manuscript was authored by the Associate Medical Director of Street Medicine, CWCN-AP. Liz Sahadi Smith provided editorial assistance acknowledged in the publication.

What This Shows

- Clinical communications fluency at the specialist level
- Editorial capacity across the full range of healthcare communication registers
- The ability to serve as a communications executive for organizations operating in complex clinical and policy environments
- The institutional depth required to support clinical staff in producing work that reflects both scientific rigor and organizational mission

Why Clinical Editorial Work Belongs in This Portfolio

A Comms Leader working with providers does not only manage external narrative. They also enable the clinician to translate their expertise into forms that reach the audiences who need it — researchers, funders, policy audiences and the clinical community.

> Editorial support for a clinical manuscript is a different discipline from writing one. It requires enough clinical literacy to understand what the science is saying, enough communications expertise to recognize when technical prose has become inaccessible and enough respect for the author's voice to improve clarity without displacing expertise.

This manuscript was published because those three conditions were met.

Clinical Literacy

Understanding what the science is saying

Communications Expertise

Recognizing when technical prose has become inaccessible

Respect for Voice

Improving clarity without displacing expertise

Publication Details

Title: Trauma-Informed Wound Care in Street Medicine: Practical Strategies for the Certified Wound Care Nurse Advanced Practice

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Conflicts of Interest

The author declares no conflicts of interest.

Funding

This work received no specific funding.

Acknowledgments

The author thanks this healthcare nonprofit for supporting the implementation of innovative wound care strategies in street medicine practice following wound care certification. Editorial assistance was provided by Liz Sahadi Smith.

Abstract

Background

Individuals experiencing homelessness face disproportionate wound burden due to environmental exposure, limited hygiene access and high comorbidity rates. Street medicine settings present unique challenges — no clean water, inconsistent follow-up and psychosocial barriers that standard wound protocols fail to address.

Purpose

This clinical review adapts evidence-based wound care principles to resource-limited street settings, emphasizing trauma-informed approaches that honor patient autonomy while managing complex wounds in uncontrolled environments.

Methods

Narrative review synthesizing wound care science, street medicine practice literature and trauma-informed care frameworks. The TIMERS framework (Tissue, Infection/Inflammation, Moisture, Edge, Regeneration/Repair, Social factors) is adapted for homeless populations with practical strategies for cleansing, debridement and dressing selection.

Results

Successful street-based wound management requires modified clinical decision-making. Go/no-go debridement criteria prioritize patient safety over optimal tissue preparation. Dressing selection balances moisture management with three- to seven-day wear time and environmental durability. Trauma-informed techniques — explicit consent, pain acknowledgment, patient choice — increase engagement among populations with healthcare system mistrust.

Conclusions

The Certified Wound Care Nurse Advanced Practice (CWCN-AP) role is essential to translating wound science into pragmatic street medicine applications. Excellence requires accepting that harm reduction, not complete healing, may be the appropriate clinical goal. This paradigm shift — prioritizing dignity and reduced suffering over wound closure — represents an ethical imperative for vulnerable populations.

Key Points

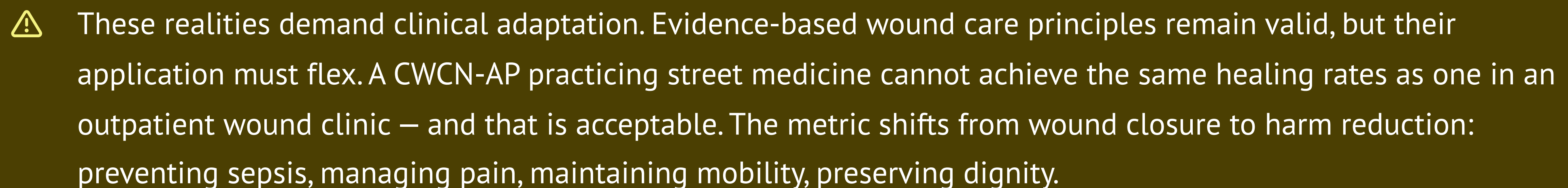
- The TIMERS framework adapts effectively to street settings when clinicians modify expectations and accept environmental constraints as fixed variables
- pH-balanced, noncytotoxic cleansers (normal saline, sterile water, hypochlorous acid) prevent healing delays caused by tissue-damaging agents
- Extended-wear dressings (hydrocolloids, foams, hydrofibers) must withstand heat, moisture and constant ambulation for three to seven days without clinical supervision
- Debridement requires explicit go/no-go criteria because complications in unsheltered populations can escalate rapidly without emergency access
- CWCN-AP expertise enables advanced assessment, evidence-based adaptation and advocacy that generalist providers cannot provide

Introduction

Wound prevalence among unsheltered populations has reached crisis proportions in urban centers nationwide. Chronic wounds affect an estimated **50 to 80%** of individuals experiencing homelessness, driven by prolonged standing, inadequate footwear, environmental trauma and delayed care access. These wounds generate preventable emergency department utilization, costly hospitalizations and profound quality-of-life impacts including immobility, social isolation and uncontrolled pain.

Traditional wound care methods assume clinical environments with clean water, temperature control, sterile supplies and reliable follow-up. Street medicine operates without these resources. Care occurs on sidewalks, in encampments, at mobile outreach sites — wherever patients feel safe enough to accept intervention. Water may come from bottles. Lighting depends on weather and time of day. Follow-up depends on finding the same patient in the same location days later.

Beyond environmental barriers lie psychological ones. Individuals experiencing homelessness report high rates of adverse childhood experiences, interpersonal violence and traumatic healthcare encounters. Many associate medical settings with coercion, judgment and loss of autonomy. Previous wound care experiences may include painful debridement without adequate anesthesia, dressing changes performed without explanation or discharge instructions impossible to follow without housing.



These realities demand clinical adaptation. Evidence-based wound care principles remain valid, but their application must flex. A CWCN-AP practicing street medicine cannot achieve the same healing rates as one in an outpatient wound clinic — and that is acceptable. The metric shifts from wound closure to harm reduction: preventing sepsis, managing pain, maintaining mobility, preserving dignity.

This article provides practical guidance for adapting wound care science to street medicine realities. It emphasizes trauma-informed approaches that rebuild trust, modified TIMERS framework application that accounts for social determinants and clinical decision-making that accepts environmental limitations as permanent rather than problems to solve.

Clinical Challenges in Street Medicine Wound Care

Wound Etiology and Presentation

Street medicine providers encounter wound complexity that exceeds typical outpatient caseloads:

Pressure Injuries

From sleeping on concrete, asphalt or hard surfaces create wounds in atypical locations — lateral feet, ankles, elbows, shoulders, hips. Unlike facility-acquired pressure injuries that develop in immobile patients, these occur in highly mobile individuals who cannot access soft sleeping surfaces.

Venous and Arterial Ulcers

Complicated by continuous ambulation. Patients with venous insufficiency cannot elevate their legs. Those with arterial disease walk miles daily to access food, shelter and services, worsening ischemia and delaying healing.

Neuropathic Ulcers

From uncontrolled diabetes progress rapidly when patients lack access to glucose monitoring, diabetes medications and protective footwear. Many present with wounds penetrating to bone, discovered only when pain finally forces care-seeking.

Injection-Related Wounds

Including those associated with xylazine (tranq), present with extensive tissue necrosis, high infection rates and challenging wound beds that resist standard debridement and dressing approaches.

Moisture-Associated Skin Damage

Occurs when limited access to showers, clean clothing and dry sleeping areas creates persistent skin exposure to urine, feces, sweat and environmental moisture.

Traumatic Injuries

Include burns from encampment fires, hot pavement contact in extreme heat, frostbite in cold weather and assault-related lacerations that go days without suturing.

Comorbid conditions including diabetes, peripheral vascular disease, malnutrition and anemia further impair wound healing and increase recurrence risk. The prevalence of MRSA and other resistant organisms in this population compounds infection management challenges.

Environmental and Resource Constraints

Care delivery occurs in conditions that would violate infection control standards in any facility. Street medicine teams adapt by:

- Using bottled water for irrigation when clean water access is unavailable
- Performing assessments in inadequate lighting, relying heavily on tactile examination
- Managing temperature extremes — freezing conditions that make wound exposure painful; extreme heat that compromises dressing adhesive and causes patient sweating that loosens dressings
- Carrying limited supply volumes, requiring careful resource allocation across multiple patients
- Accepting that sterility is aspirational rather than achievable

> These constraints force real-time clinical judgment: Is this wound clean enough to dress, or does contamination risk outweigh the benefit of coverage? Can this patient safely undergo debridement here, or does bleeding risk require hospital referral? Will this extended-wear dressing stay in place long enough to justify using it instead of reserving it for a more stable patient?

Psychosocial Barriers to Care Engagement

Trauma histories shape every patient interaction. Many individuals experiencing homelessness have survived childhood abuse and neglect, domestic violence and sexual assault, substance use disorders treated punitively, mental illness encounters marked by coercion and healthcare experiences involving judgment and stigma.

These experiences manifest as care refusal, anger during procedures, inability to follow instructions or sudden disengagement mid-treatment. Clinicians untrained in trauma-informed approaches may interpret these responses as noncompliance. In reality, they represent adaptive survival mechanisms developed through repeated harm.

Trauma Neurobiology

Understanding trauma neurobiology and its impact on patient responses

Avoiding Retraumatization

Recognizing provider behaviors that inadvertently retraumatize

Safety and Trust

Developing skills in establishing safety, building trust and honoring autonomy

Provider Wellbeing

Addressing provider secondary traumatic stress and burnout

Organizations deploying street medicine teams must invest in this training and create a culture that normalizes its application across every patient encounter.

Conclusion

Wound care delivery in street medicine settings demands clinical expertise, environmental adaptation and unwavering commitment to patient dignity. The CWCN-AP plays an essential role in translating evidence-based wound science into practical strategies that work within — rather than despite — the realities of homelessness.

The TIMERS framework provides valuable assessment structure when adapted thoughtfully. Wound cleansing, debridement and dressing selection require modified decision-making that balances optimal healing against environmental constraints and safety considerations. Trauma-informed approaches are not optional additions but fundamental requirements for engaging populations with extensive healthcare trauma histories.

Success in street medicine wound care requires redefining traditional metrics. When complete wound closure is unattainable due to circumstances beyond patient or provider control, harm reduction becomes the appropriate clinical goal. Preventing sepsis, managing pain, maintaining mobility and preserving dignity represent legitimate victories.

The CWCN-AP practicing street medicine operates at the intersection of advanced clinical science and profound social complexity. This work demands exceptional assessment skills, adaptive clinical judgment, cultural humility and systems advocacy. It requires accepting that the most technically perfect wound care plan fails if it ignores housing instability, food insecurity and safety threats.

> Ultimately, excellence in street medicine wound care rests on a simple ethical principle: every individual, regardless of housing status, deserves skilled, compassionate, evidence-based care delivered with respect for their autonomy and dignity.

About Liz Sahadi Smith

Strategic communications executive with 25 years of experience architecting institutional narrative, governing AI-era brand reputation and building resilience infrastructure for organizations operating under high public scrutiny.

Narrative Arbitrage — Category Engineering

Engineered the climate-adaptive healthcare category to bypass political friction and generate **$18M in earned media value**. The category was adopted by partner organizations statewide.

Algorithmic Brand Governance

Architects organizational Share of Model strategy, ensuring authoritative citation status in AI-generated outputs and governing how institutional reputation is synthesized across media and information platforms.

Resilience Architecture — Reputational De-risking

Designs crisis communications infrastructure that outlasts staff transitions and survives narrative hijacking. Built systems that achieved **143% positive sentiment** across 113 consecutive days of record heat and contributed to the first heat death decline in a decade.

Relational Capital Stewardship

Manages high-value media and institutional relationships as balance-sheet assets – PBS/WETA documentary feature, coverage in The New York Times, Reuters, AP, NPR, BBC and Politico. **91% award win rate** – 20 wins from 22 submissions.

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