



## Evaluation of training on palliative care for staff working within a homeless hostel



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### ABSTRACT

**Background:** In the UK, many people experiencing homelessness whose health is deteriorating remain in homeless hostels due to few suitable alternative places of care. Hostel staff struggle to support residents with deteriorating health and palliative care services are rarely involved. There is recognition of the need for multi-agency working to support this group.

**Objectives:** To pilot and evaluate the impact of a two-day training course for hostel staff around supporting clients with palliative care needs, and increasing multi-agency working.

**Design:** Mixed methods evaluation using pre-and-post training data collection.

**Settings and Participants:** Frontline staff from two London homeless hostels.

**Methods:** Staff from two hostels attended a two day training course. Self-perceived confidence in supporting residents with deteriorating health, knowledge of palliative care, openness to discussing deteriorating health and work related stress were assessed at baseline and immediately after training using a novel questionnaire. Qualitative data was collected via focus groups immediately after and three months post-training.

**Results:** Twenty four participants attended at least one day of training, 21 (87%) completed the course. Training was reported to be useful and relevant. Modest improvements in self-perceived work related stress, knowledge, confidence and openness were observed following training. At three months, qualitative data indicated the beginnings of a shift in how palliative care was conceptualised and an increase in knowledge and confidence around supporting residents. Anxiety regarding the role of the hostel in palliative care, the recovery focused ethos of homelessness services and fragmented systems and services presented challenges to establishing changes.

**Conclusions:** Training can be useful for improving knowledge, confidence, openness and work related stress. Recommendations for implementing changes in how people experiencing homelessness are supported include embedding training into routine practice, promoting multidisciplinary working, incorporating flexibility within the recovery focused approach of services and recognising the need for emotional support for staff.

### 1. Introduction

Experiencing homelessness is associated with extreme health inequities across a range of health conditions (Aldridge et al., 2017). There is evidence of accelerated aging among people experiencing homelessness (Fazel et al., 2014) and the average age of death for this group is approximately 30 years younger than for people who are housed (Thomas, 2012). People who are homeless often face challenges in accessing health care, including difficulties navigating mainstream

systems (Davis-Berman, 2016), competing priorities (Rae and Rees, 2015), previous negative experiences and their impact on developing trusting relationships (Håkanson et al., 2016) and poorly managed addictions (McNeil and Guirguis-Younger, 2012).

Our previous research highlighted how these challenges in health-care access can be compounded towards the end of life (Hudson et al., 2016, 2017a, 2017b; Shulman et al., 2017). Many people who are homeless who may benefit from palliative care input but do not gain access to it for a number of reasons. Uncertainty around prognosis for

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many illnesses that are common among the homeless population makes it extremely difficult to know when and how palliative care might best be introduced (Shulman et al., 2017). There is also a lack of options regarding place of care for many people experiencing homelessness with advanced ill health, particularly those with active addictions (Giesbrecht et al., 2018). Therefore it is not uncommon in the UK for someone with complex health needs to remain in a homeless hostel (Webb, 2018).

Hostel staff are currently being placed in very difficult situations (Hudson et al., 2016; Shulman et al., 2017). Their remit is to help people move out of homelessness, rather than provide personal to support, such as assistance with medications or activities of daily living. Hostel staff describe challenges in accessing support from health and social care agencies for residents (Hudson et al., 2016, 2017a; Webb, 2015; Maguire, 2006) and are increasingly experiencing burdens and anxieties around the support of people with advanced ill health (Klop et al., 2018).

The emotional impact of working with people who are homeless and have multiple and complex needs has been recognized. Some hostels have adapted a “psychologically informed environment” model which uses psychological theories and frameworks to enable staff to understand and work creatively with behaviors that could be challenging (Breedvelt, 2016; Keats, 2012). Regular reflective practice or supervision for staff is a key element. Cognitive Behavioural Therapy in combination with clinical supervision may also be beneficial in reducing burnout for staff in this setting (Maguire et al., 2012).

Research exploring how other non-health care professionals involved in supporting people with advanced ill health (for example volunteers in hospitals) highlights how dealing with death, rather than recovery, can be difficult (Hulbert and Morrison, 2006) and stressful (Glass and Hastings, 1992). The perceived training needs of this group have been found to include communication skills, grief and bereavement support, spiritual diversity and self-care (Lisa Jane et al., 2017).

Until there are appropriate, well-resourced services that understand the complexity of need for people experiencing homelessness who may benefit from palliative care, health and social care services should explore how to work together to support people in their current environment. There is increasing momentum from the palliative care community to assist in the support of people with deteriorating health in hostels (HospiceUK, 2017), although how this can be incorporated into routine practice needs further exploration (CQC, 2017).

Using findings from our qualitative research (Hudson et al., 2016; Shulman et al., 2017), we built on the “end of life care and homelessness toolkit” developed by Marie Curie and St Mungo’s (Kennedy et al., 2013). A comprehensive package of training for staff working in homeless hostels was developed which aimed to increase staff’s knowledge of the support available when a resident’s health deteriorates, and when and how to access this. In addition, the training aimed to build staff’s confidence in supporting people with advanced ill health who are experiencing homelessness.

## 2. Aims

To pilot and evaluate the impact of a two day training course for staff who work in homeless hostels around supporting residents with deteriorating health who may benefit from palliative care.

## 3. Objectives

- Deliver a two day training course to two cohorts of hostel staff around supporting people experiencing homeless with advanced ill health.
- Collect mixed methods baseline and post training data around confidence, knowledge, attitudes towards palliative care and work related stress.
- At three months post training, conduct focus groups to explore the

potential impact of training on practice.

- Develop recommendations for future training for hostel staff.

## 4. Methods

### 4.1. Design

Mixed methods study including pre and post training data collection.

### 4.2. The Training Course

The findings from a large qualitative study (Hudson et al., 2016; Shulman et al., 2017) informed the development of the training, which was built upon the “end of life care and homelessness resource pack” developed by Marie Curie and St Mungo’s (Kennedy et al., 2013). The result was a comprehensive course for hostel staff (and an accompanying toolkit [www.homelesspalliativecare.com](http://www.homelesspalliativecare.com)), delivered by the current (NB) and former (PK) palliative care coordinators from St Mungo’s. The training included 7 sections which were completed by two cohorts of participants.

Given the uncertainty around the introduction of palliative care support for people experiencing homelessness (Hudson et al., 2017a; Shulman et al., 2017), the emphasis throughout the training was for staff working in homeless hostels to consider using ‘concern about a resident’s health’ as a trigger for action, rather than a palliative or terminal diagnosis (Hudson et al., 2017a).

The training contained information and practical tools and resources to help staff explore residents’ insights into their own health and their current needs and wishes. The training included information about palliative care services and tools to encourage the establishment and maintenance of multiagency working and self-care (Box 1). Day 1 contained information about common illnesses, red flags for deteriorating health and tools for developing person centered support and working with different services. Day 2 focused on engaging clients around their health, practical issues around end of life care and bereavement and self-care strategies for staff. Day 1 and 2 for each group were undertaken a week apart.

### 4.3. Participants and Recruitment

All staff working in two hostels for people experiencing homelessness (which provides temporary accommodation and key worker support) in one London borough were recruited. This borough was selected for its high recorded numbers of people experiencing homelessness and also homelessness services (CHAIN, 2017; Bhatti and Sapsaman, 2016). The hostels were selected as they had a high number of residents with poor or deteriorating health, and they did not have access to a dedicated palliative care coordinator. To ensure all staff had the opportunity to attend, the training was undertaken twice (i.e. 4 days in total). It was considered important that all staff were able to attend to increase the likelihood of the training resulting in lasting change. All hostel staff were invited to participate by hostel managers.

### 4.4. Data Collection

#### 4.4.1. Qualitative Data Collection

**Baseline:** participants were asked to consider a resident with advanced ill health, about whom they were concerned, and record the main challenges they faced in supporting them. The purpose of this activity was to help participants focus on a client whose health was concerning to them, rather than focusing on someone whom may have been formerly identified as requiring palliative care. Throughout the training, participants were asked to reflect on this client, so that discussions could be focused on real people and situations. Participants were advised to use pseudonyms for clients and ensure confidentiality

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