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 multiagency 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 multiagency 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 healthcare 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 dailty 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 avaliable when a residents' 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), 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 chaneg. 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

Box 1
Content of the training.
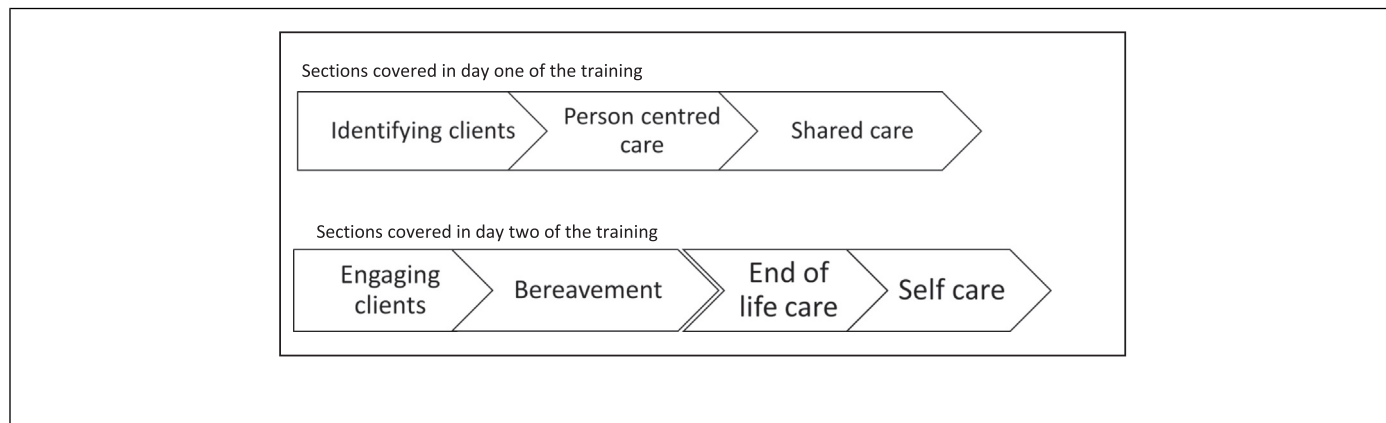
of residents was always maintained.

Immediately post training: focus groups were conducted to explore participants' views on the potential utility and relevance of training. The potential impact of the training on the four key outcomes (confidence, knowledge, openness and work related stress) was also explored. Participants provided feedback on how the training could be improved. The focus groups were conducted by researchers CS and BH, while the trainers (PK and NB) were not present.

Three months post training: BH and CS held focus groups during hostel team meetings to explore whether participants felt the training had influenced their practice, knowledge, confidence or access to services for residents with advanced or deteriorating health and/or how they managed work related stress.

4.4.2. Quantitative Data Collection

Baseline - Participants answered 14 Likert scale questions (1 - strongly disagree to 6 - strongly agree) that assessed their self-perceived confidence in supporting residents with deteriorating health, their knowledge of palliative care and available services, openness to discussing deteriorating health and work related stress (see Box 2).

During training - Immediately after each section, participants provided ratings of how interesting and potentially useful each module was (using Likert scale questions).

Immediately post training - participants repeated the 14 baseline Likert scale questions.

4.5. Analysis

4.5.1. Qualitative Data

Data from focus groups were transcribed verbatim. The transcripts and other written data were entered into NVIVO and analyzed using thematic analysis. BH analyzed the data in line with the guidance developed by Braun and Clarke (Braun and Clarke, 2006). Consensus was achieved through discussion with CS. Qualitative data from all participants was included.

4.5.2. Quantitative Data

Descriptive statistics summarized baseline and outcome questionnaire scores. The data were interrogated for changes pre and post training but given the low participant numbers, and the pilot nature of this evaluation, no statistical analyses were planned. Data were recoded where necessary. Mean scores were calculated for ratings of interest and potential usefulness for each section. Participants who did not complete the baseline or end questionnaires were excluded from the analysis of mean scores.

4.6. Ethical Considerations and Informed Consent

Ethical approval for this project was not required by the host university ethics committee. Written consent was collected from all participants and hostel managers.

5. Results

5.1. Participant Characteristics

Twenty four staff from 2 homeless hostels in London attended the training (Table 1). Twenty one participants (87%) attended both days while 3 attended a single day, due to prescheduled annual leave (n = 1) or being required at work (n = 2). Years of experience in supporting people who are homeless varied from less than 1 year to more than 16 years.

6. Qualitative Data

6.1. Characteristics of Clients Whose Health Was Concerning

All participants completing the baseline questionnaires (n = 23, 96%) provided a description of a client of concern. Physical health conditions reported included liver disease, hepatitis C, COPD, Korsakoff syndrome, kidney failure, cancer, HIV, frailty and mobility issues.

Three key themes were identified in hostel staff's descriptions of clients about whose health they were concerned (Table 2).

1. Alcohol and substance misuse

All participants mentioned concerns relating to alcohol or substance misuse in their description of clients of concern.

> "*Huge alcohol use, over 40 years old, multiple health issues… continued alcohol use is getting very dangerous, no intention to stop alcohol use. Doesn't want to engage with health services. No motivation*"

The impact of alcohol and substance misuse was related to three issues; falls and subsequent injuries (often including head injuries), infections related to injection drug use and failed detox and rehab attempts. Participants felt that these issues, either alone or in combination had a large negative impact both on clients' health and their ability to engage with services.

2. Mental health

The impact of poor mental health was cited often in hostel staff's descriptions of clients about whom they were concerned.

Box 2
Questions pre and post training evaluation questions.

1- Strongly disagree to 6- strongly agree

Confidence questions (high score = higher confidence)

1. *I feel confident discussing residents' symptoms with health professionals*
2. *I feel confident in supporting other residents following the death of a resident*
3. *I find it easy to talk to residents about their health when I feel they may be at risk of dying*
4. *I need more resources to help me talk to residents who are very ill about their future*

Knowledge questions (higher score = higher knowledge)

1. *I know <u>which</u> professionals could provide support for a resident whose health I am concerned about*
2. *I know which services provide end of life care*
3. *I know how to access services that provide end of life care*
4. *I don't know what to do when a resident dies*
5. *I know how to support colleagues following the death of a resident*

Openness to supporting residents with advanced or deteriorating health questions (willingness to talk about health and future care wishes, higher score = less open)

1. *It's important to have medical information that someone is very unwell before talking to them about insights into their health*
2. *It's important to have medical information that someone is very unwell before talking to them end of life wishes*
3. *It is not a hostel worker's role to talk about future care preferences with residents*

Work related stress (higher scores – better able to cope with stress)

1. *I find my work very stressful*
2. *I can manage the stress associated with my work*

Table 1
Participant characteristics.

Job title	Frequency (%) n = 24
Support worker	7 (29%)
Lead worker	5 (21%)
Trainee support worker	5 (21%)
Assistant support worker	4 (17%)
Senior practitioner	2 (8%)
Night support worker	1 (4%)

Years of experience	
Less than 1 year	4 (17%)
1–3 years	5 (21%)
4–6 years	6 (25%)
7–9 years	1 (4%)
10–12 years	1 (4%)
16 years plus	7 (29%)

"*Very low mood. Many years spent in hostels with repeated failure*"

Low mood, irritability, and uncertainty over mental capacity were described, in addition to self neglect and behaviour that was challenging. Participants noted that a lack of motivation to address physical health needs was a particular concern.

3. Access to health care and treatment

Another theme evident in participants' descriptions of clients about whom they were concerned related to limited or sporadic access to and engagement with health care services

"*Has Hepatitis C, not seeking treatment and does not talk about it. He denies it when doctor asks*"

Some participants described how clients did not want to talk about or address their physical health needs, refused to access health care or had been excluded from health care services due to behaviors they presented with. Furthermore, when clients did engage and were prescribed medication, their adherence to this was sometimes described as sporadic at best.

6.2. Main Challenges Identified in Supporting Residents With Advanced Ill Health

Participants also described challenges in supporting clients about whose health they were concerned. These were categorized into three themes: 1) challenges related to the hostel environment and system, 2) limitations of the role of hostel staff and 3) the impact of substances and alcohol (Table 3).

1. Limitations of the hostel environment and system

"*We are not the right place, but I don't know where else he could go.*"

Some participants felt that for clients with advanced ill health, a hostel environment may not be the most appropriate. They described struggling to support people with high physical care needs. They noted

Table 2
Key themes in descriptions of residents about whom hostel staff were concerned.

Code	Exemplar quote
1. Alcohol and substance misuse	
Falls related to alcohol use	When he is very intoxicated he struggles to keep his balance and falls a lot …
Failed detox/rehab attempts	Recent deterioration in behavior following a relapse, he had been sober for three months
Infections related to substance misuse	Substantial additional health needs, due to injecting abscesses
2. Mental health	
Low mood	Very low mood. Many years spent in hostels with repeated failure
Easily angered	Client gets irate very easily
Self-neglect	Double incontinence and refusing care - self neglect
Questions over capacity	Lack of capacity/understanding
3. Access to health care/treatment	
Avoidance of talking about or addressing ill health	Has Hepatitis C, not seeking treatment and does not talk about it. He denies it when doctor asks
Refusing medical care	Confining self to bed. Refusing GP interventions or to go to hospital
Poor adherence to medication	Not taking his/her medication even though health is at risk
Exclusion from services	Access to healthcare is limited due to exclusions because of behavior

that hostels were not designed for this purpose, but felt that currently there were very few other appropriate places of care for this group.

2. Limitations of the role of hostel staff

"*I don't know what to do – not sure what is right or wrong?*"

Participants described not having enough time to support clients with advanced ill health, given their high caseloads and the demands (both practical and emotional) of supporting clients with very poor health. This led to them feeling overwhelmed by the challenges and obstacles they faced and unsure about how best to support clients, or gain support from other services.

3. Challenges around substance and alcohol use

While substance and alcohol misuse were common characteristics of clients whose health was a concern, this presented specific challenges to supporting this group.

"*It's really hard to engage with him around anything when he's drinking, despite having a good relationship*"

Participants described how they struggled to manage the impacts of sustained drug and alcohol use, which included blackouts and overdoses, as well as consequences such as poor diet and malnutrition. Participants also described challenges around engaging with clients when they were intoxicated and the barriers this created for discussing client's insights and preferences into their health.

6.3. Immediately After Training

6.3.1. Potential Impact on Practice
Participants provided the following feedback in relation to the four areas assessed via questionnaires.

1. Confidence

Participants described how confidence in supporting clients with advanced ill health had improved following the training.

"*The training opened up how to bring death into conversations, so have some idea about what clients want. I will approach people early now. I feel more confident*"

This confidence related to not only having conversations with clients with advanced ill health, but also confidence in their ability to support clients with advanced ill health as a team and a greater awareness of sources of support for themselves and their clients.

"*It was helpful to have these discussions, this has previously felt taboo in work environment. I'm more confident about avenues of support. I have more confidence to speak to clients and more confidence to get support.*"

Some participants described how their previous fears about raising the topics of health and the future with clients about whom they were concerned had diminished, particularly in response to the question prompt tools which gave clients suggestions for ways to open conversations about client's insights into their health.

2. Knowledge

All participants described an increase in knowledge of what palliative care services are, what they may be able to support clients with and also how they could access this support.

"*To be honest, before this I didn't even know about palliative care. The extra funding [potential for continuing health care or fast track funding]*

Table 3
Main challenges identified by participants in relation to supporting residents with advanced/deteriorating health.

Code	Exemplar quote
1. The hostel environment and system	
Supporting residents with high personal care needs	Physical issues that are becoming too high needs for staff to deal with
Hostel environment	Influence from peers living in hostel and low motivation
2. Limitations of the role of hostel staff	
Limited time	Finding time for conversations and planning while working duty shifts and completing other responsibilities
Hostel staff unaware of appointments	Does not stay at the hostel each night which is partly why we are not informed about her appointments
Feeling overwhelmed	I don't know what to do – not sure what is right or wrong
3. The impact of substances and alcohol	
Engagement when intoxicated	It's really hard to engage with him around anything when he's drinking, despite having a good relationship
Poor nutrition	Not eating due to heavy doses of drug and alcohol
Becoming unwell after using	Blackouts from drinking, cannabis smoking

… I didn't know about that. That was definitely useful"

Participants felt that establishing multiagency meetings, where multiple clients about whom they were concerned could be discussed would be extremely helpful, both in terms of making sure the resident was receiving care that fitted with their wishes, but also to enable hostel staff to feel confident and supported.

3. Openness

Some participants described a shift in attitude regarding whether or not a client should be supported to die within the hostel with more openness to people with advanced or deteriorating health remaining in a hostel. Hostel staff described feeling more open to having conversations with clients about their health, and suggested that this could be something that would be useful for all clients, not just those about whose health they were currently concerned.

"Before the training I didn't think people should die in a hostel. Training has changed my view. I've got a better idea of the support available"

4. Self-perceived work related stress

The focus on self-care for hostel staff was very well received in the training. Hostel staff appreciated the emphasis on looking after themselves and their colleagues and the recognition of the potential impact of their role on their wellbeing.

"It's rare anybody bothers to find out how we are doing… Considering the incredible stress we're under… And we don't get clinical supervision. So, it was nice you bothered to find out how we cope, and how we can cope better."

6.3.2. Content and Structure of Training Course

All sections of the training programme were found to be interesting and relevant. Participants valued the practical tools and resources provided and appreciated the focus on the wellbeing of staff in addition to residents. A two day course was felt to be too long and concerns were expressed regarding releasing staff for this period, despite recognition of the training's importance. Changes to the training based upon this feedback included reworking the training into a modular format which could be delivered over a duration that suits hostel staff and including more group activities.

6.4. Changes in Practice at Three Month Follow Up

Three months after training, focus groups explored whether participants (n = 8) felt there had been any change in their practice since the training, whether they experienced any barriers when trying to introduce changes and what else would be required to support clients with advanced or deteriorating health. It was not possible to contact all participants who attended the training as many had moved to different hostels or different jobs.

6.4.1. Goal 1. Exploring Residents' Insights and Wishes

The first goal identified by participants during the focus group immediately following training concerned taking steps to explore the insights and wishes of clients whose health they were concerned about. This goal had two components 1) utilizing opportunities to have discussions with clients about their health, wishes and options and 2) utilizing the tools from the training.

A) Utilizing opportunities

"Since the training I have felt a little more comfortable talking about it [deteriorating health]. Maybe I'm getting used to it… yeah I think it's good, to talk about the forbidden subject"

Opportunities to engage clients about their health and wishes for the future, were increasingly being identified in response to events such as memorials for other residents. Staff described feeling more confident in raising these issues with clients.

B) Utilizing the tools from the training

"So you go on the training and you have all these great ideas from the training, but then they don't match the templates that you are using for the support plans…"

Staff described how the standard templates they were using within key working sessions with clients did not encourage them to explore issues such as client's insights into their health or their wishes for the future, and perhaps related to this, they described not having used the tools to a great degree following the training.

6.4.2. Goal 2. Shift in Approach to Supporting Residents With Advanced or Deteriorating Health

A) Incorporating parallel planning and working towards multiagency working

"I want all clients to have a conversation with their key worker about where they want to be, their health…even if they are OK at the moment… to get some wishes recorded. So if that sudden thing happens, as it does all the time, we are not left going 'what did they want? What are we going to do?'"

Elements of parallel planning (Hudson et al., 2017a) were beginning to be utilized by participants. An increase in discussions within hostel teams about supporting clients with advanced ill health was noted. In one hostel, a standing item had been added to the staff team meeting agenda to discuss clients about whose health staff were concerned.

In addition, discussions between hostel staff and health care professionals around how to work together to instigate multiagency meetings at the hostel had begun. Though these meetings were yet to be formally established, participants hoped they would be attended by a range of health and social care professionals and a number of clients about whom they were concerned would be discussed at each. Hostel staff also described increased attempts to develop relationships with hospital staff following client' admissions by discussing the difficulties they faced to increase mutual understanding and work towards appropriate solutions.

"I've been trying up at the hospital to get a bit more joined up working going on… I explained we'd tried to get social services to meet that clients' needs and how difficult we find it"

While some links were being established between hospices and hostels, participants described needing responsive, sustained access to specialist palliative care support, which had not yet been achieved. Being able to draw on specialist palliative care staff in times of need, crisis or bereavement was viewed as invaluable.

In summary, participants had been able to work towards the goals identified immediately after training, although a number of barriers to change had been encountered, which are outlined below.

6.5. Barriers to Implementing Changes and Goals

6.5.1. Anxiety About the Role of Hostels in End of Life Care

One hostel manager described concern from some staff that supporting clients who may be approching the end of life may become a more common aspect of their role. Some staff sought reassurance that their service wouldn't itself become a "hospice".

"One of the concerns that came up was…around were we going to become a hospice? Was that the direction we were going in?"

Hostel manager

The manager reassured staff this was not their aim, but due to the lack of alternative, appropriate places of care, they needed to consider how to support their existing clients with complex or advanced health needs by connecting with other services and utilizing the skills within their team. This anxiety and lack of clarity around the role of a hostel within the support of people experiencing homelessness requires further elaboration and discussion to ensure that staff are able to feel confident in their roles and know how to access support from other services.

6.5.2. Prevailing Focus on Recovery

Participants were cautious about how long knowledge gained from the training may be sustained with their services. Participants described how information about palliative care is absent from the core training curricula completed by new staff meaning that knowledge and learning may not be retained in the organization, given high staff turnover.

"*The training was great, but then there's new people coming in and it's hard. Our core key working training doesn't really focus on these issues*"

Participants described how the focus within homelessness services was on recovery-oriented options, such as employment or training, and that resources were limited for supporting clients who were unlikely or unable to pursue these options.

"*Erm, so you go on the training and you have all these great ideas, but then they don't match the templates that you are using for the support plans*"

In addition the systems within hostels were not conducive to implementing changes in supporting clients with advanced ill health. Support plans completed during the key working processes could be restrictive and not entirely relevant for clients with advanced ill health. Thus it was difficult for staff to explore issues highlighted in the training during key working sessions, as they were required to complete key working processes, even if they didn't match the client's needs.

6.5.3. Fragmented Systems and Services

The numerous systems different agencies used to record notes and care plans for clients were a further barrier to implementing change. The lack of a central hub of information that could be accessed by everyone was seen as a barrier to efficient, transparent multiagency working.

"*It's all very separate…when you've got an MDT or case conference, then everyone comes together. But the information…actions and plans that come from that need to be available to all the professionals involved, and it isn't, because it's all in different places.*"

This presented a challenge for hostel staff as they were unsure how best to access support from other organizations, and who to contact to arrange this support.

7. Quantitative Data

Twenty one participants (88%) completed the 2 day training course. Baseline and post training questionnaires were completed by 20 participants (1 participant did not complete the baseline questionnaire and another did not complete the post training questionnaire). Section specific feedback and overall impact of the training are outlined in Table 4.

Section specific feedback by participants indicated that all sections were found to be interesting and potentially useful. Immediately post training slight increases in mean overall ratings for knowledge, confidence, and openness were observed, although a ceiling effect (many participants scored at the higher end of the scale) may limit the extent to which changes can be assessed. The largest improvements were noted for participants' knowledge of palliative care.

Mean scores for items relating to work related stress reduced slightly following training.

8. Discussion

Participants described the training as useful and relevant. This study found that modest improvements in quantitative scores for staff self-perceived work related stress, knowledge, confidence and openness regarding palliative care were observed following training.

In this study, qualitative data indicated the beginnings of a shift in how palliative care was conceptualised by hostel staff, with the focus moving towards the consideration of clients whose health was a concern, rather those clearly identified as palliative. From this evaluation, 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.

8.1. Links to Existing Practice and Literature

There is currently limited literature exploring how best to meet the training needs of hostel staff around supporting people experiencing homelessness with advanced ill health and who may have palliative care needs. Some promising initiatives are in place across the UK that aim to provide training and support for hostel staff around supporting people experiencing homelessness who have palliative care needs. Importantly, within these initiatives, training is accompanied by continued support from palliative care professionals (Colclough et al., 2018; Garavelli, 2018).

The palliative care community recognizes that access to palliative care is currently inequitable (HospiceUK, 2017). The Hospice UK 5 year strategy includes an emphasis on tackling inequity and enabling hospice care to be delivered in any setting (HospiceUK, 2017). Innovative projects such as Project Echo (White et al., 2015), in which multidisciplinary support is accessed via virtual meetings, are being piloted by the hospice community as part of their commitment to "Open up hospice care" (HospiceUK, n.d.).

One barrier to referral to palliative care teams is the complexity and uncertainty around when someone should be considered palliative (Hudson et al., 2016; Shulman et al., 2017). For this reason, enabling hostel staff to consider when they are concerned about someone's health rather than them considering someone to have palliative care needs, is important (Hudson et al., 2016; Shulman et al., 2017).

Other approaches to building connections between homelessness and palliative care services could include the identification of champion/coordinators from within homelessness and palliative care services, such as the palliative care coordinator role from St Mungo's (Davis et al., 2011). These champions could take the lead in building relationships, facilitating multiagency working and sustaining knowledge gained from the training within organizations. Other strategies to extend the reach of palliative care expertise could come in the form of a "train the trainer" approach (Mayrhofer et al., 2016) or "integrated care leader" initiatives (to support people with dementia) (Moore et al., 2017) which have been found to be feasible in care home settings. These provide valuable lessons for the development of future interventions for homeless hostels which the authors of this paper intend to explore.

In this research, the self-care section of the training was valued by participants. The need for psychologically informed approaches to the support of people experiencing homelessness has been recognized and adopted by a number of hostels across the UK (Maguire, 2006). This research supports this approach and suggests that an ethos of self-care (and knowledge of the impact of vicarious trauma) should be embedded in the staffing culture of homeless services. As within the psychologically informed environment approach, this could be encouraged through reflective practice, mental health or emotional first aid

Table 4
Section specific feedback and overall impact of training using Likert scales from 1 (strongly disagree) to 6 (strongly agree).

Section specific feedback	I found this section interesting	I found this section useful
	Mean (SD)	Mean (SD)
Identifying residents (with advanced ill health) (n = 24)	5.17 (0.64)	5.38 (0.58)
Person centered care (n = 24)	5.29 (0.62)	5.33 (0.56)
Shared care (n = 23)	5.13 (0.78)	5.22 (0.60)
Engaging residents (n = 22)	5.27 (0.70)	5.27 (0.70)
End of life care (n = 20)	5.15 (0.56)	5.20 (0.52)
Bereavement (n = 20)	5.11 (0.90)	5.28 (0.58)
Self-care (n = 20)	5.30 (0.73)	5.35 (0.75)

Impact of training on four key areas	Baseline n = 20[a]	Post training n = 20[b]
	Mean (SD)	Mean (SD)
Confidence - overall	15.1 (2.9)	16.3 (2.4)
I feel confident discussing residents' symptoms with health professionals	4.6 (0.9)	4.95 (0.7)
I feel confident in supporting other residents following the death of a resident	4.6 (1.2)	4.7 (0.9)
I find it easy to talk to residents about their health when I feel they may be at risk of dying	3.5 (1.3)	4 (1.0)
I need more resources to help me talk to residents who are very ill about their future	2.3 (1.0)	2.7 (1.0)
Knowledge - overall	19.8 (4.5)	22.4 (2.8)
I know which professionals could provide support for a resident whose health I am concerned about	4.65 (1.5)	4.7 (0.8)
I know which services provide end of life care	3.3 (1.2)	4.6 (0.7)
I know how to access services that provide end of life care	3.3 (0.9)	4.35 (0.9)
I don't know what to do when a resident dies	4.2 (1.2)	4.1 (1.5)
I know how to support colleagues following the death of a resident	4.4 (1.2)	4.6 (1.0)
Openness - overall	11.0 (3.1)	11.3 (3.2)
It's important to have medical information that someone is very unwell before talking to them about insights into their health	4.5 (1.6)	4.6 (1.5)
It's important to have medical information that someone is very unwell before talking to them end of life wishes	4.4 (1.7)	4.4 (1.6)
It is not a hostel worker's role to talk about future care preferences with residents	2.10 (1.2)	2.3 (1.3)
Stress - overall	7.3 (1.5)	6.5 (1.8)
I find my work very stressful	3.0 (1.3)	2.3 (0.9)
I can manage the stress associated with my work	4.3 (1.1)	4.2 (1.2)

[a] One participant who attended both days did not complete the baseline questionnaire meaning their data was excluded.
[b] One participant who attended both days of the training did not complete the immediately post training questionnaire and their data was excluded.

following a death and optional compassionate leave when a resident dies.

8.2. Recommendations for Supporting People Experiencing Homelessness With Advanced Ill Health Within Hostels

1. Embed training and support into routine practice - Training alone is not enough.

This research suggests that standalone training is unlikely to be sufficient to effect and maintain change in this environment. In order to make training easier to embed within routine practice, future training could be developed in modular formats and delivered in response to the needs of a particular hostel or following an event or crisis. In this manner all staff, including those new to the service could have access to ongoing training. An interactive on-line toolkit has been created to support the modules taught in this pilot study, and easily assessable to frontline staff and others supporting clients with advanced ill health as and when required (www.homelesspalliativecare.com).

2. Promote multiagency working.

Supporting people who are homeless who also have advanced ill health is complex and challenging and requires the skills and resources of a range of professionals and teams (Hudson et al., 2016; Shulman et al., 2017). Through the promotion of multiagency working, the responsibility of supporting the wishes of the individual is shared, potentially reducing burdens experienced by hostel staff (Hudson et al., 2017a).

3. Incorporate flexibility within the recovery focused approach of services.

Systems and outcomes need to include more flexibility in determining what is a good outcome for an individual, so that "success" can be worked towards, measured and recorded in a way that is appropriate for each client.

4. Recognize the impact of stress and the need for emotional support for staff.

Feeling valued and finding ways to manage stress may help to reduce staff burnout. Commissioners and managers of homelessness services need to recognize the potential emotional impact for staff of supporting people with multiple and complex needs, who may be approaching the end of their lives.
Specialist in-reach services could provide some emotional support and future training should include an element of self-care.

8.3. Strengths and Limitations

This training was designed in collaboration with the present and former St Mungo's palliative care coordinators and was built using findings from a qualitative study exploring barriers to palliative care from the perspectives of people experiencing homelessness and those supporting them (Shulman et al., 2017).
This mixed methods evaluation provides useful insights into changes in working following the training and lessons for its further development. In recognition of the complexity and sensitivity of the issues, it was felt that to effect change, all staff from the service would

need to attend the training. Therefore the training was conducted twice to allow all staff to attend while maintaining adequate cover within the hostel. However, senior hostel managers were unable to attend.

Only modest change was observed at three months post training. This could be for a number of reasons; participant identified goals may take longer than 3 months to implement; hostel staff may also require support from other professionals and enthusiasm from high levels within organizations in order to effect changes in systems and ethos. In addition, by the three month evaluation there were a number of new staff and many participants had left the services.

The small sample size and lack of a 'no intervention' control group limit the generalizability of the findings and validated outcome scales were not used. However, the primary aim of this evaluation was to assess the feasibility of training hostel staff around supporting residents with advanced ill health and to gain knowledge to further refine this.

9. Conclusions

Training around how to support hostel residents with deteriorating health is currently largely absent from the training received by hostel staff in the UK. This study suggests that training can be beneficial for improving knowledge, confidence, openness and work related stress for hostel staff that support people with deteriorating health who are homeless. 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.

Based on our results, we suggest that training of this type should be made available to hostel staff and be accompanied by multiagency working to enable services to respond to the needs of people experiencing homelessness with poor health, and to support the people that provide this care.

Declarations of Interest

None.

Data Statement

No additional data is available.

Author Contributions

Caroline Shulman, Briony Hudson, Peter Kennedy, Niamh Brophy and Patrick Stone conceptualised the study.

Caroline Shulman, Briony Hudson, Peter Kennedy and Niamh Brophy collected the data.

Briony Hudson and Caroline Shulman analyzed the data.

Briony Hudson drafted the initial manuscript.

Caroline Shulman, Patrick Stone, Peter Kennedy and Niamh Brophy reviewed the manuscript, approved the final manuscript and agree to be accountable for all aspects of the work.

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