Palliative End Of Care Of Individuals Experiencing Homelessness In Canada

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Introduction

Palliative care entails helping individuals with terminal diseases to live comfortable lives. It generally focuses on averting pain and eliminating confusion among the patients, with special regard to the spiritual and emotional needs of the affected individuals as well as their families. It is therefore encouraged that individuals living with these patients ensure that they carry out early palliative care. Palliative care will help fight the stigmatization of the patients as well as the resultant homelessness. It should be noted that if these patients are left unattended, they may fall into depression or emotional instability, and this poses a risk factor for the subsequent effects of terminal diseases. Research has established that most of these patients wish to perish at home, and a few wish to die in health centres. This situation has revoked the issue of coming up with hospices and other palliative care units so that the patients can be well taken care of. In absentia of these units, it is established that the patients are more likely to experience more devastating health issues (Canadian Hospice Palliative Care Association, 2013).

Palliative and end-of-life care services continue to be more in demand with the increasing Canada's ageing population and as the rates of terminal and chronic illness rise. It is evident that people experiencing homelessness are more vulnerable to their health conditions in comparison to those who are under the best custody or house. It emerges that most patients are not in a position to access the palliative care unit services. Some relatives of these patients do run away since they fear seeing the patients die. The end result of this is that the patients end up dying anonymously or even undiscovered. There are various types of palliative care, namely shelter-based and mobile programs (Crane & Joly, 2014, p.259). The shelter-based program usually involves the use of hostels and shelters by medical staff and organizations to cater for these patients. There is normally a time frame for the visitors as well as time for the cleaning. During cleaning, the residents, particularly those who are not bedridden, are allowed to leave during the day. Mobile programs are rare but convenient. They do take care of the people who may be housed or on the streets. An example of such a program is the PEACH (Palliative Care Units for the Homeless). This paper seeks to discuss palliative end-of-life care for individuals experiencing homelessness in Canada.

Literature Analysis Of Palliative End Of Life Care

According to Morgan (2016), about 16%-30% of Canadians with chronic health conditions associated

with age receive end-of-life care utilities. It is devastating that only a few individuals get access to palliative care services. It is also reported that 75% of Canadians think about the end of life. This phenomenon has encouraged the majority of Canadians to support hospice palliative care. A good number of citizens have affirmed that hospice palliative care is within the reach of those at the end of life regardless of their ailments. A small percentage still believes that hospice care services are inaccessible to the right patients. Canadians firmly believe that palliative end-of-life care has brought up more merits that overshadow the demerits. The merits associated with palliative care include reduction of stress, life quality advancement, and family that the patients are less burdened. The citizens also want improvement or adjustment of the palliative end-of-life care. Such adjustments include the involvement of all stakeholders, the integration of all people with chronic illness, and also give the patient freedom of choice of a particular set up of utilities (Argintaru et al.2013, p.577).

Palliative end-of-life care should be accessible at the early stages of the disease. It also comes out that the Canadian families are so supportive of this service. This is evident by the fact that they contribute 25% of the total cost of the services of palliative care. The costs are normally associated with nursing and personal care in home-based programs. Canada ranks ninth best in the international quality of death index. Statistics reveal that a majority of Canadians would love to breathe their last at home in the presence of their relatives and best friends. This is quite contrary to the reality where a majority, like over 70%, do die in hospitals. This implies that a lot of effort has to be put in in ensuring that the palliative end of life care meets the expectations of these patients. Therefore, there should not be a big percentage of patients receiving palliative care in hospitals and at home (Fazel, Geddes, & Kushel, 2014).

It is established that charitable donations contribute up to 50% of the palliative care program funding. The provincial government is being criticized for little funding for palliative funding as well as general support for the program. The situation is further affirmed by the fact that only a small fraction of the Canadian provinces have put palliative care as a critical service under their provincial health plan. To make the situation worse, budget reduction is being witnessed where palliative care is incorporated into the provincial home care budgets and miscellaneous budgets. This increases the vulnerability of palliative end-of-life care to collapse. However, the Canadian government has put in place strategies to ensure that this service does not collapse (Hudson et al. 2016). It has established an integrated palliative approach to care, which gives a way forward for the utility. For instance, the federal government donated $ 3 million in 2014. This money was used to finance the study and create a framework of community integrative models of the palliative care hospices. The initiative did come up with two documents namely, The Way Forward National Framework and the Palliative Care in the Community.

The government also introduced advanced care planning. The care planning strategy involves a health professional engaging in the plan for making health care decisions in case the patient is unable to make informed decisions regarding his or her health condition. Such cases have been witnessed in advanced serious illness. The government has also rolled out awareness programs to emancipate the public on the value of supporting hospice palliative care units. The CHPCA normally hosts National

Hospice Palliative Care Week on the first week of May of each year. The themes of this event are extracted from the World Hospice Palliative Care theme. The sole mandate of CHPCA is to create an awareness campaign for informal caregivers and families every 5th April. This was an awareness campaign that was launched in 2012. One of the partnerships involved during the launch was We Care Home Health Services. Canada already has two hundred and fifty palliative care professionals who work on either a full-time or part-time basis (Hudson et al. 2016).

The Need And Means To Address The Palliative End Of Life Care

The ultimate goal of palliative care is to abate the agony of patients and families by assessment, which should be comprehensive, and treatment of the emotional, physical and spiritual symptoms. These are the major areas that have always to be addressed by stakeholders in ensuring that the patients die with dignity (Norman et al. 2015). Aggressive palliation is usually in demand, especially when the patient is almost dying. This measure of palliation should also be provided to the family of the dying patient. Should the patient die, one is required to majorly focus on the bereavement and the support of the family by whatever means they can. This aide involves intensified comfort measures for the bereaved family. Another significant role of palliative end-of-life is that the patients and their families are given the opportunity to make medically crucial decisions (Jaworsky et al. 2016). Therefore, palliative care should focus on more aggressive symptom management and social support. It also helps the victims understand the kind of illness. It also helps in predicting or taking the most appropriate medical care. This assists in aligning the patient's goals with those of the healthcare team.

Healthcare professionals can help in alleviating the pain experienced by patients by first acknowledging the pain and suffering. Clinicians are usually guided by their code of ethics to provide culturally competent palliative care to patients from all walks of life. The medical staff are expected to ensure that they avoid prolongation of the dying process, and that patient has full control of themselves, appreciate life by finding meaning in it, and also strengthen their relationship with their relatives. In situations where death becomes near, it is the general expectation that there is an increase in symptom burden and, at the same time, emotional and physical stress decreases (Morgan, 2016, p.35).

The ultimate goal of palliative care is to abate the agony of patients and families by assessment, which should be comprehensive, and treatment of the emotional, physical and spiritual symptoms. These are the major areas that have always to be addressed by stakeholders in ensuring that the patients die with dignity. There are a number of ways in which the patients facing homelessness do access palliative care. Access to palliative care depends on where the patients are situated. The two types of palliative care include shelter-based programs and mobile-based programs (Mundt-Leach, 2016).

In a shelter-based program, organizations and medical staff with hostels and shelter providers provide palliative care. There are a few shortcomings to what is to be provided by the owners of the hostels and shelters. During the cleaning process, the occupants of the premises are expected to leave, in particular those who are not very ill. The individuals visiting the patients are only allowed within specified time frames, though there are exceptions. The exceptions are usually at the discretion of the staff managing the shelter. This model is very instrumental and cost-effective. The model helps in reducing pain and providing comfort. This situation is in contrast to when the patients look for help elsewhere. Research in 2015 reveals that $ 1.39 million was saved since the commencement of patient care in hospices in comparison with other locations. The disadvantage of the shelter-based programs is that there is confusion between the health professionals and the shelter providers. There is also the enormous burden of work placed on the staff managing the shelter. The problem of unpaid overtime and emotional stress cannot be underestimated. Mobile-based programs are rare but more convenient and flexible. It basically targets the patients that are sheltered or on the streets. A perfect example is that of Toronto, PEACH (Palliative Education and Care for the Homeless). This program in Toronto gives homeless patients the dignity of deciding on how to die, henceforth reducing their pain. It is noted that both mobile-based and shelter-based programs are accessible to the urban population and in much smaller supplies in rural or remote areas (Morgan, 2016, p.36).

Psychosocial, spiritual and bereavement support forms an integral part of palliative near-death care. It is thus incorporated with physical support. This approach allows the professional team in palliative care to lay the foundation for the well-being of the patient and the family to adjust and support. It is instrumental in maintaining and upholding relationships. It also gives meaning to the dying process. It aids in gaining a sense of control during death confrontation as well as preparation. Clinicians, nurses, chaplains, social workers and psychologists are required to assimilate and negotiate the interpersonal skills and intimacy needed to elevate the patient’s peace and spiritual support (Mundt-Leach, 2016).

Impact Of Palliative End-of-life Care On The Client And Family

Nurses and other healthcare professionals are required to acknowledge the shortcomings of meeting the patients and families of those affected by a lack of end-of-life care. The clinicians are supposed to provide truthful information that is supposed to give hope to the victims. This will also help in sustaining their emotional and spiritual stability in the event that the patient is almost near death. Therefore, the caregivers are expected to embrace good communication strategies that would help spearhead realistic hope. The families of the patients are faced with the considerable burden of physiological and emotional stress by taking up the role of acting as surrogate decision-makers. It is advised that where a decision pertaining to the patient’s health condition is urgently required, the family can help in the process of decision-making (Webb, 2016). Therefore, the decision-making process should be consensual. It is noted that the decision-making process is largely influenced by religious, ethnic and cultural issues. These three aspects also affect the relationship between the

healthcare team and the family at large.

Cultural diversity may affect the decision-making process, thus posing a dilemma during the decision-making process. Cultural diversity may bring conflict and misunderstanding among the family members leading to delay in the actualization of a particular decision. It is also observed that there are extremities in the attitude to specific care systems. The care systems include life support withdrawal, active interventions such as analgesia, as well as fluids and feeding. The care systems are a target of criticism due to both religious and cultural differences, thus posing a setback to the provision of care. The families and caregivers also find it challenging to handle the patients who demand hastened death. This situation greatly destabilizes their emotions and spiritual beliefs. There are also some patients who feel that they are troublesome to the caregivers at the end of life and, therefore, they are more likely to stay in solicitude. These are the patients who end up dying undiscovered, as earlier discussed. The caregivers are advised to reach out to the patient who seems to be withdrawing from them and take care of them in a professional way. If left unattended, these patients' experiences are largely affected during their end of life. It also affects the decision they make at that particular moment just before death (Webb, 2016).

Impact Of Palliative End Of Life Care On The Nursing Profession

It is undeniable that nurses encounter patients in their day to day course of work. This experience enlightens them or makes them conscious of their mortality. These experiences instil unease and anxiety in the nurses and caregivers of those homeless patients. It is evident that not everyone is comfortable seeing someone die; thus, nurses who possess strong anxiety may be hesitant to care for these patients who are near death. These nurses, therefore, continuously develop a negative attitude while attending to the patients who are at the end of their lives. This observation does have a great effect on the well-being of the patients who require the care of these nurses. They may end up being neglected and thus accelerate their dying process. It is, therefore, important to take into consideration the emotional status of the nurses while caring for these patients. These three themes mentioned earlier are crucial in monitoring the patients in need of palliative care by the nurses (Tobey et al. 2017, 738). They include nurses' level of death anxiety, death anxiety and attitudes towards the dying and finally, death education. These three themes are crucial for the emotional functionality of health professionals. It is evident that the degree of anxiety of nurses working in the oncology and renal hospice is moderately low. It is also observed that there is an inverse relationship between nurses' attitudes towards care for the dying and their attitude towards death. The younger nurses are more fearful of death and possess a greater negative attitude towards dying patients. The nurses are expected to keep abreast of their personal beliefs to ascertain their level of fear towards attending the dying patients. The government has put up a worksite death education program. This has largely helped reduce death anxiety (Tobey et al. 2017, 738).

Evidence-Based Nursing Strategies Used To Address Homelessness In Canada

For the last two decades, numerous interventions and strategies to solve homelessness have emerged. While each intervention model is aimed towards transitioning people out of homelessness, different approaches are informed by different theoretical frameworks. These theoretical frameworks include personal responsibility and structuralism (Sumalinog et al. 2017). Some of the current models used to address the issue of lack of palliative care among the homeless population include shelters, treatment first, and housing first.

Shelter

Shelters play a significant role in alleviating the homeless and form essential transitional spaces because they facilitate interactions between the homeless population and resources. In 2010, the number of registered shelters in Canada was 1128, most of which were collected in large urban centres. One study, which was carried out in 567 shelters in the United States, identified four critical roles played by almost all of these establishments (Sumalinog et al. 2017). These roles were categorized into the following: specialized services for women and children, services enhancing self-sufficiency, treatment services, and services meeting basic needs. The study also added a fifth category, which included the provision of supplementary services such as legal aid. Shelters have a significant potential to help transition individuals out of homelessness. However, shelters have recently been criticized for not addressing the lack of palliative care among homeless individuals. Sumalinog et al. (2017) argue that the current models have changed and become more like long-term solutions to homelessness and less transitional spaces. This analysis stimulated the initiation of housing first with a solid idea that housing is a basic right for all people.

Treatment First

The framework for treatment first advocates for progression through a series of stages in preparing individuals for housing readiness. These stages include psychiatric treatment, a period of sobriety, and the development of unique important skills for independent living. The treatment-first model views permanent housing as an ultimate goal that must be attained through the realization of detail rather than as a priority (Rae & Rees, 2015). This aspect strongly corresponds with the conception of homeless that emphasizes individual limitations.

Housing First

The Housing First model was established in 1992 through a program known as Pathways to Housing. The aim of this initiative was to meet the basic needs of homeless people in New York. The

fundamental tenets of this model are that the first priority for the homeless population is housing. The definitional problem is that the homeless should not be dependent on sobriety or psychiatric treatment. This model is based on the ideologies of autonomy, consumer satisfaction, and self-control. Individuals are provided with services but not referrals but are not expected to adhere to medication to maintain their health status. It is also corresponding with a structural formation of homelessness (Rae & Rees, 2015).

The housing-first strategy perceives housing as a permanent and important intervention, while the treatment-first model views it as a desirable outcome. While there are studies which associate the treatment treatment-first model with increased treatment compliance and abstinence, there exists a considerable body of research showing greater efficacy with a housing-first strategy. For instance, the Housing First model has been associated with a reduced prevalence of psychiatric symptoms and shorter periods of homelessness. Besides, the Housing First model has been linked with housing stability and higher retention rates for individuals with chronic mental illnesses. One study on the effectiveness of the Housing First model confirmed that the approach is effective in reducing consumption among homeless persons with substance use disorders (Pineau, 2015). Also, studies have suggested that the Housing First model is more suitable for the homeless population.

Conclusion

Homeless people are faced with complex and unique advanced ill health conditions. Flexible services are, therefore, important in promoting coordinated and compassionate care among this population. The provision of palliative end-of-life care for the homeless population requires a joint approach from social, housing, and health services. At least, this should include support from all professional groups, provision of treatment and housing models and greater training, as well as increased collaboration between services. Palliative and end-of-life care services continue to be more in demand with the increasing Canada's ageing population and as the rates of terminal and chronic illness rise. The provision of palliative end-of-life care is faced with different barriers, such as lack of sufficient access to medical professionals and negative experiences in healthcare by the homeless population. Individuals experiencing homeless can get palliative care based on where they are located through various ways, such as shelter-based programs and mobile programs.

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