Nursing management of people experiencing homelessness at the end of life

Abstract
Homelessness is a complex and multidimensional issue often involving a combination of personal vulnerability, the limitations of social housing, and inadequacies in welfare support. Providing palliative and end-of-life care to people experiencing homelessness is challenging, both to individuals receiving care and nurses aiming to meet their complex needs. This article discusses what is understood by the concept of ‘homelessness’ and examines the barriers to accessing effective healthcare for people who are homeless and have life-limiting conditions. The authors review the research into end of life care for people experiencing homelessness and identify areas for further investigation, notably the lack of evidence regarding the end of life care priorities of these individuals. There is a focus on the availability of healthcare services for people who are homeless at the end of life, as well as the factors that should be considered if evidence-based healthcare services for this group of people are to be improved in the future.

Keywords
alcohol misuse, drug misuse, end of life care, healthcare inequalities, homelessness, inclusion, mental health, palliative care, social exclusion

Aims and intended learning outcomes
The aim of this article is to enable nurses to understand the complexities around providing end of life care for people experiencing homelessness. After reading this article and completing the time out activities you should be able to:
» Explain how homelessness affects people’s health and end of life care.
» Identify methods of supporting people who are homeless and may be approaching the end of life.
» Discuss the importance of interprofessional working when providing palliative and end of life care for people who are homeless.
» Recognise local and national resources to support nurses involved in the care of people experiencing homelessness who are approaching the end of life.

Relevance to The Code
Nurses are encouraged to apply the four themes of The Code: Professional Standards or Practice and Behaviour for Nurses and Midwives to their professional practice (Nursing and Midwifery Council (NMC) 2015). The themes are: Prioritise people, Practise effectively, Preserve safety, and Promote professionalism and trust. This article relates to The Code in the following ways:
» It states that nurses must consider the holistic end of life care needs of people experiencing homelessness. The Code states that nurses must ensure that people’s physical, social and psychological needs are met.
» The Code states that nurses should treat people as individuals and uphold their dignity. This article encourages nurses to reflect on the inequalities associated with...
The Code states that nurses should
Nurses are encouraged to practise
effectively by improving their
understanding of the challenges involved
in providing palliative and end of life
care to people who are homeless.
» The Code states that nurses should
act in partnership with those receiving
care, assisting them to access relevant
information and support when they
need it. This article encourages nurses
to reflect on local, regional and national
sources of support when caring for
people who are homeless and receiving
end of life care.

Introduction
Palliative care is a crucial element of
end of life care and involves a holistic,
multidisciplinary approach to the care of
people with life-limiting conditions such as
cancer or advanced liver disease. It focuses
on improving quality of life, the prevention
and relief of pain, and reducing the effects
of life-limiting conditions on people’s
physical, psychosocial and spiritual well-
being (National Institute for Health and
Care Excellence (NICE) 2004). People living
with progressive, incurable and life-limiting
diseases often require palliative care for
several years before they reach the end of life.
Mortality rates are significantly higher
among the homeless population and
research demonstrates a clear link between
chronic homelessness and complex health
needs, advanced illness and premature death
(Hwang 2001, Riley et al 2003, The Faculty
for Homeless and Inclusion Health 2013).
The average age of death is 47 years for men
and 43 years for women who are homeless and
die, it is often not as a direct result of factors
involved in homelessness such as exposure to
cold weather; research has found that death
among people experiencing homelessness
is often caused by advanced liver disease,
respiratory and cardiac disease, blood-borne
infections such as human immunodeficiency
virus and hepatitis, and alcohol and drug-
related complications (The Faculty for
Homeless and Inclusion Health 2013).

While it is acknowledged that there is
some debate around how best to refer
to the homeless population, this article
refers to both homeless people and people
experiencing homelessness for ease of
reading.

End of life care
There is debate around the exact
interpretation of end of life care. The
National Council for Palliative Care
(NCPC) (2011) describes end of life care
as that provided to people who are likely
to die within the following 12 months.
However, from the authors’ experience,
many healthcare professionals who provide
palliative care would argue that end of life
care usually refers to the last six weeks of
life, particularly when applying for
fast-track continuing healthcare funding
for end of life care in the community
(NHS Choices 2018a).

In recent years, national policy and
government funding have strengthened
the provision of dignity at the end of
life, promoting individual choice and
supporting advance decisions about people’s
end of life care preferences, for example
identifying the individual’s preferred place
of care (Department of Health (DH) 2011,
Hughes-Hallett et al 2011, The Choice in
End of Life Care Programme Board 2015).
Several palliative care guidelines have also
been developed, which focus on improving
choice and quality of care, enhancing service
provision and achieving positive outcomes
in terms of an optimal death for patients
receiving palliative care, wherever they
choose to die (DH 2008, 2009, 2010a, The
Choice in End of Life Care Programme
Board 2015). Furthermore, both palliative
and end of life care should be universally
accessible, inclusive and readily available
at the point of need wherever the person
may be and irrespective of socio-economic
deprivation (DH 2008, 2009). However,
some of the vulnerable and marginalised
groups of society, including homeless
people, do not access the palliative and
end of life care services they require.
Homelessness as a barrier to healthcare

While homelessness was previously considered a social welfare and housing issue, it is now understood to be a complex, multidimensional challenge, which, according to The Faculty for Homeless and Inclusion Health (2013), is ‘a community problem, needing a community solution’. The origins of homelessness are multifaceted and often deep-rooted; similarly, an individual’s route into homelessness can be diverse. However, most episodes of homelessness result from a combination of personal vulnerability, the limitations of social housing, and inadequacies in welfare administration and support. There are several risk factors for homelessness as identified in Box 1.

Despite statistics that indicate that the number of homeless people is rising, they are still described as ‘a hidden population’ (NHS Improving Quality 2014), who often report ‘feeling invisible’ (DH 2010b). While it is challenging to calculate exact figures for homelessness in the UK because of difficulty defining the term ‘homeless’, Crisis (2016), the national charity for homeless people, reports a 132% rise in the number of homeless people in England since 2010. However, this figure relates specifically to people who are sleeping on the streets and there are several definitions of homelessness, which adds to the complexity of providing accurate statistics. The media, for example, tends to equate homelessness with sleeping ‘rough’. However, homelessness includes those who are sleeping on the streets; squatting illegally; ‘sofa-surfing’; living in bed and breakfast accommodation, hostels, women’s refuges or other temporary accommodation; and those who are simply deemed to be unsuitably housed.

Marginalisation and social exclusion

Marginalised or socially excluded people are considered to exist outside the mainstream of society (DH 2010b). They have been described as individuals who ‘lack a voice or influence’ (Atkinson 2009), or who have a ‘limited “voice” that can be overshadowed by other, more vocal groups’ (DH 2010a). The DH (2010b) readily acknowledged that marginalised people, including those who are homeless, can have complex needs and unconventional lifestyles, which in turn can create significant barriers to navigating the healthcare system and accessing appropriate services (DH 2010a, 2010b, McNeil et al 2012a). The literature concerning healthcare provision for homeless people focuses primarily on perceived and actual barriers to accessing healthcare (DH 2010a, 2010b, Hewett and Halligan 2010, Elwell-Sutton et al 2016) (Box 2). Furthermore, there is a stigma concerning homelessness among healthcare staff, and it has been acknowledged that homeless people are frequently characterised as non-compliant and viewed as unreliable (NHS Improving Quality 2014).

Homeless people report to emergency departments on average five times more frequently than the general population (DH 2010b). They are also eight times more likely to have an acute hospital admission than the average person (DH 2010b). This is because homeless people often access emergency care rather than traditional primary and preventative healthcare services

TIME OUT 1
Reflect on your understanding of the term ‘homelessness’. Would you consider this to be a person who lives on the streets? Reflect on the wider definition provided in this article and how this may contrast with your definition.
because there are significantly fewer barriers to accessing emergency care. For example, emergency care is universally available and can be accessed at any time of the day or night, regardless of whether the individual has an appointment or documents such as personal identification or proof of address.

**TIME OUT 2**
Consider Box 2, which details various barriers to accessing healthcare for homeless people. Select four of these barriers and, using the information included in this article, explore the steps that could be taken to provide patients who are homeless with improved access to end of life care.

**Tri-morbidity**
Tri-morbidity is a commonly used term in the area of inclusion health and includes suboptimal physical health, substance misuse and mental health issues (DH 2010a, Webb 2017, Shulman et al 2018). Tri-morbidity is often the result of a combination of factors including a history of complex trauma, abuse, adverse childhood experiences and neglect. These factors have an effect on childhood developmental trajectories and mental health. Tri-morbidity is often associated with homelessness and has a significant effect on quality of life and life expectancy (The Faculty for Homeless and Inclusion Health 2013). In a survey of homeless people in England, complex or multiple needs, which include drug and/or alcohol-related issues, offending history, and mental health issues, affected 33% of the 321 respondents (Homeless Link 2016a).

For some people, mental health issues are the route into homelessness. Common mental health issues, such as depression, anxiety, obsessive-compulsive disorder and panic disorder, are twice as common in homeless people than in the general population, while homeless people are up to 15 times more likely to experience psychoses than the general population (Rees 2009).

Once people become homeless, they often develop physical illnesses such as chronic respiratory conditions, inflammatory skin conditions and musculoskeletal conditions, with homelessness frequently referred to as the ‘silent killer’ (Thomas 2011).

Drug and alcohol dependence can also lead to homelessness. The Homeless Link (2016a) found that 31% of the 312 respondents had drug-related issues, 23% of respondents had alcohol-related issues and 10% of respondents admitted to using so-called ‘legal highs’ such as Spice and Black Mamba; these are no longer legal substances (Homeless Link 2016a).

Homeless people are also often reluctant to access planned care, possibly because during previous clinical encounters they have experienced varying levels of suspicion, indifference and even hostility, rather than dignity or respect (The Faculty for Homeless and Inclusion Health 2013). As a result, homeless people may also experience a lack of self-worth and have minimal health aspirations. They may place a low priority on health when they also have to negotiate poverty and a day-to-day struggle for survival (Rees 2009).

**Challenges to the provision of end of life care**
In 2016, the CQC (2016a) produced a

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**KEY POINT**
In a survey of homeless people in England, complex or multiple needs, which include drug and/or alcohol-related issues, offending history, and mental health issues, affected 33% of the 321 respondents (Homeless Link 2016a).
report detailing the ongoing inequalities in end-of-life care experienced by some marginalised groups in society, including homeless people. The report acknowledged that healthcare services in the UK were not providing ‘the good, personalised care’ (CQC 2016a) that homeless people should expect at the end of life.

Meeting the end of life care needs of people who have higher-than-average prevalence of addiction and mental health issues, and who live in environments that are not generally considered to be conducive to palliative care, is challenging (Podymow et al 2006). There is substantial evidence of the complexities involved in providing palliative and end of life care to homeless people (CQC 2016a, 2017, Håkanson et al 2016, Hudson et al 2016). Some of these complexities are obvious, for example the lack of a postal address for letters to be sent regarding hospital appointments. Other complexities are less clear, for example low self-esteem preventing a homeless person seeking assistance with physical symptoms, or their chaotic lifestyles leading to missed appointments. However, these complexities must be addressed if person-centred palliative and end of life care is to be provided to homeless people (NHSE Improving Quality 2014, CQC 2016a, 2017).

Much of the research around the challenges of providing end of life care to homeless people relates to the barriers they experience in accessing healthcare services, for example the perceived prejudice of healthcare staff, homeless people’s mistrust of healthcare providers and inflexible policies regarding illicit drug use (Collier 2011, Krakowsky et al 2013, Hudson et al 2016). The most significant barrier is arguably the lack of awareness of the needs of homeless people with advanced ill-health (CQC 2017). However, specific research into the needs of homeless people and end of life care is sparse.

Song et al (2007) concluded that end of life care in the US could be perceived as paternalistic and unresponsive to the needs of homeless people, and identified several unique concerns of homeless people in the US, for example dying anonymously and what would happen to their body after death. Tobey et al (2017) also found that homeless people were anxious about dying anonymously; however, they also found that many homeless people in the US were concerned about the effect that care at the end of life might have on their freedom, and that they might find themselves ‘trapped’ in an inpatient facility. A study by Webb et al (2017) suggested that homeless people in the UK also have concerns about the disposal of their body, while Shulman et al (2018) revealed a dearth of specialist person-centred services for homeless people with advanced ill-health who misuse drugs and alcohol.

Shulman et al’s (2018) study outlined the requirement for specialist training, multidisciplinary working and collaboration between services to provide appropriate end of life care and support, including specialist drug and alcohol services, for homeless people with advanced ill-health.

TIME OUT 3
Consider the following case study. Bill is a 51-year-old man with alcoholism. He has no next of kin and is a resident in a local homeless shelter. He has become increasingly jaundiced, has been bedbound for the previous two weeks, and is complaining of a ‘sore bottom’. He is too unwell to attend a GP surgery and refuses to go to hospital. The GP reception staff will not book a home visit, saying Bill is not eligible. Bill’s support workers are concerned about the effect that care at the end of life might have on his freedom, and that they might find themselves ‘trapped’ in an inpatient facility. A study by Webb et al (2017) suggested that homeless people in the UK also have concerns about the disposal of their body, while Shulman et al (2018)

KEY POINT
Meeting the end of life care needs of people who have higher-than-average prevalence of addiction and mental health issues, and who live in environments that are not generally considered to be conducive to palliative care, is challenging (Podymow et al 2006)

Drug misuse and medicines management
The term drug misuse includes illegal drugs such as heroin or cocaine, as well as prescription and over-the-counter medicines used in palliative care such as opioids for analgesia (Public Health England 2017). The high incidence of drug misuse among homeless people compared with the general population results in specific medicines management
challenges as homeless people approach the end of life; for example, there is the risk that prescription medicines will be stolen from homeless people or medicines may be sold to pay for illegal drugs (McNeil and Guirguis-Younger 2012a, 2012b, McNeil et al 2012a, 2012b). The control of symptoms, such as pain, anxiety and breathlessness, using medicines is an important component of evidenced-based palliative and end of life care, and must be managed appropriately if homeless people are to access the same quality of healthcare as the general public (NICE 2004).

Public Health England (2017) outlined the considerable geographical variation in death rates from drug misuse, including illegal and prescription drugs, with the highest rates recorded in the North West and North East regions and the lowest rates in the East Midlands (Public Health England 2017). In England, health and social care providers in Newcastle have produced a comprehensive drugs management protocol that aims to ensure that all NHS, social care or police and probation staff working with homeless people understand how to manage medicines and any incidents involving drug misuse (Newcastle City Council 2015, Northumberland, Tyne and Wear NHS Foundation Trust 2017).

Given that hostel staff are not permitted to store or dispense controlled drugs, it is recommended that hostels provide either secure lockable cabinets in all bedrooms to prevent overdose or theft, or, where there are shared bedrooms and 24-hour waking cover, a bank of secure lockable cabinets in the main office with a digital key pad that only individual residents can access; it is recommended that a master key list is kept by the organisation but not in the same buildings (Newcastle City Council 2015). Newcastle City Council (2015) also provided examples of optimal practice such as hostel staff maintaining a record of the dosage of any drug that a resident tells them that they are taking, with the agreement of the service user.

Homeless Link (2016b) provided guidelines for managing medicines in homelessness services, which includes advice for nurses providing end of life care to people living in hostels, such as the use of lockable cabinets. Nurses must remember that each patient is an individual and, as such, the risks of prescribing controlled drugs in a hostel environment, such as theft or overdose, should be weighed accordingly. Open discussions between the GP, community nurses and hostel staff may be required when deciding how to provide the appropriate medicines to homeless people requiring end of life care.

Anyone using homelessness services may have a chaotic daily routine, or there may be significant issues within the service’s premises that prevent the storage or administration of controlled drugs. However, pharmacies may be able to assist with the supervised consumption of prescribed controlled drugs; for example, the use of monitored dosage systems and pill organisers with alarms are worth considering in this population group (Homeless Link 2016b).

Alternatively, transdermal patches such as fentanyl or buprenorphine patches can be considered for pain relief in hostel residents, negating the need for storage of controlled drugs. These can be dispensed one at a time, once or twice weekly, and transported and administered by a visiting community staff nurse. Registered nurses may legally transport medicines, including controlled drugs, where patients, their carers or representatives are unable to collect them ‘provided the registrant is conveying the medication to a patient for whom the medicinal product has been prescribed, (for example, from a pharmacy to the patient’s home)’ (NMC 2010). Local hospice teams will be able to advise nurses on the suitability of various immediate-release and modified-release analgesia preparations and the range of symptom-control medicines available.

Collaborative working
Hostel-based care, with input from palliative care and mental health teams, and, where necessary, harm reduction services (teams of healthcare professionals who work with individuals and their families to reduce the harm caused by drug or alcohol misuse), is recommended as an...
appropriate method of providing palliative care for homeless people (NHS Improving Quality 2014, CQC 2017, Hudson et al 2017a). Furthermore, hostel workers have been identified as resilient, creative, compassionate and resourceful advocates, who, with additional training, increased support from healthcare professionals in primary care and specialist palliative care, and improved access to medical information, are capable of coordinating the management of homeless people at the end of life (Webb 2015, CQC 2017, Shulman et al 2018).

Effective hostel-based palliative care requires clear communication between service providers if it is to be multidisciplinary and collaborative. It is also necessary for anyone working with homeless people at the end of life to be aware of the various services available in each locality and the important contacts within each service. Any health and social care staff should also receive training in sensitive end of life care issues, for example how to address homeless people’s concerns about end of life, or the management of toileting and personal hygiene when the individual becomes less able to mobilise independently (CQC 2016a).

Hospice education centres are specific teaching departments located within hospices and which provide educational courses for hospice and non-hospice staff. These centres are ideally placed to provide short courses on advance care planning (a care plan devised in collaboration with the family and health and social care staff, which details an individual’s future end of life care priorities), as well as communication skills for health and social care staff. There are also online resources that provide information on end of life care decisions; these do not require specialist training and can assist homeless people, family members, and health and social care staff who do not currently have access to a specialist palliative care nurse but would like to develop an advance care plan (Compassion in Dying 2014, CODA Alliance 2018, Macmillan Cancer Support 2018, NHS Choices 2018b). Russell (2017) also provided a comprehensive outline of online resources for advance care planning, which nurses can direct patients and social care staff to.

Staff working in hostels for homeless people could benefit from training in areas that usually fall within the remit of the specialist palliative care nurse, such as identifying deteriorating health and symptom control; similarly, primary care nurses and specialist palliative care nurses could benefit from training in drug misuse and mental health issues, as well as improving their knowledge of local drug and alcohol harm reduction services and mental health crisis teams. Willingness to work together and share expertise across professional boundaries is fundamental if homeless people are to receive person-centred palliative and end of life care.

**Parallel planning**

Hostels for homeless people usually operate a recovery-focused system and have a positive ethos, which promotes optimal outcomes. Because of this, conversations around end of life care can be particularly challenging for hostel staff and, in reality, they rarely take place (Hudson et al 2017a, Shulman et al 2018). The obvious result is that homeless people in hostels are rarely referred to palliative care services and have little opportunity to discuss their concerns and preferences for end of life care (CQC 2016a, 2016b). Shulman et al (2018) recognised that while arriving at a prognosis is challenging in any population, it is even more so with homeless people who often have coexisting mental health and addiction issues, which create further barriers to accessing traditional palliative care services.

One way to address this potential disconnect between services is the use of parallel planning. The Choice in End of Life Care Programme Board (2015), which was commissioned to advise the UK government on improving the quality and experience of care for adults at the end of life, described parallel planning as ‘greater joint working between palliative care specialists and other clinical staff, and between secondary care and primary care staff, to identify people who may need end of life care as early as possible’.

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**KEY POINT**

Staff working in hostels for homeless people could benefit from training in areas that usually fall within the remit of the specialist palliative care nurse, such as identifying deteriorating health and symptom control; similarly, primary care nurses and specialist palliative care nurses could benefit from training in drug misuse and mental health issues.
Parallel planning is specifically recommended for use with the homeless population and provides a useful way of addressing the uncertainty surrounding the health of homeless people (CQC 2017, Hudson et al 2017a). In practice, this involves triggering multidisciplinary support when concerns are raised about a homeless person’s advanced ill-health (CQC 2017). This bypasses the need for a formal terminal diagnosis and a rigid medical prognosis. Hudson et al (2017a, 2017b) outlined the various stages likely to be involved in parallel planning in the homeless population, including:

» Identify those who may be approaching the end of life.
» Collate information about the individual’s wishes, concerns and options.
» Provide multidisciplinary support and regularly review any care plans.

Box 3 provides a case study example of parallel planning in practice.

TIME OUT 4
Consider the following case study. Rosana is 47 years old and has been homeless for most of her life. She has a temporary bed at the local hostel where staff have noticed that she has an open sore on her right breast that she has been ignoring for months, but which is weeping significantly. The key worker took Rosana to the emergency department where she was told that she has a likely diagnosis of breast cancer, but Rosana refused any tests and left. The district nursing team has visited Rosana at the hostel and are dressing the fungating breast wound, but do not feel that the hostel is an appropriate place for her ongoing care. Rosana insists that she wants to die in the hostel. Consider the potential barriers that would prevent Rosana from being allowed to die in her preferred place of care. Can you think of a strategy that would overcome these obstacles?

**Future developments**

Hostel-based palliative care with input from other specialist services is recommended as the optimal strategy for the provision of culturally sensitive and accessible palliative care for homeless people (NHS Improving Quality 2014, CQC 2017, Hudson et al 2017a). However, the end of life care priorities of homeless people are not fully understood and it cannot be assumed that they reflect the priorities of the general population. Until further evidence is available, bringing outside expertise into hostels and primary care services remains the optimal method of reaching individuals in the homeless community who have advanced ill-health and require a palliative approach to care planning (Webb et al 2017). Over a decade has passed since St Mungo’s Hostel, a homelessness charity in London, pioneered the role of the palliative care coordinator for homeless people, which demonstrated improvements in the experience of care for homeless people at the end of life (Davis et al 2011).

Following the CQC’s (2016a) report into inequalities in end of life care provision for marginalised groups across the UK, healthcare providers and commissioners began to audit end of life care services in an attempt to address these inequalities. This led to several hospices employing community engagement officers, non-clinical staff responsible for engaging with community groups to widen access to services and encourage referrals from hard-to-reach groups such as homeless people. For example, St Luke’s Hospice in Cheshire employed a clinical nurse specialist to work on a joint project with
St Werburgh’s Medical Practice for the Homeless to install a room for respite care in the local homeless hostel (CQC 2017). In Manchester, the Urban Village Medical Practice provides specialist integrated care for homeless people based on the Pathway Model, an integrated practice model that puts the homeless person at the centre of care (The Health Foundation 2013, Dorney-Smith et al 2016). The practice also employs a specialist case manager who works across primary and secondary care services to coordinate and manage care across the multidisciplinary team.

The CQC’s (2017) follow-up to its 2016 report provided further examples of outstanding end of life care for homeless people. For example, the Anchor Centre in Leicester was commended for adopting a non-judgemental approach that respects homeless people’s individual decisions; this removes barriers to care by abandoning rules such as requiring clients to be free from alcohol or other substances before they are allowed to use certain services.

**TIME OUT 5**
Discuss the nursing management of homeless people with colleagues who work in palliative and end of life care. This might include a Macmillan specialist nurse covering your hospital ward or the hospice clinical nurse specialist attached to your local GP surgery. Collate their views and use them to provide a teaching session for your colleagues on how to overcome the barriers to providing end of life care to homeless people.

**Conclusion**
Homelessness is a complex multidimensional issue, which results in significant barriers to accessing healthcare. Furthermore, tri-morbidity – the combination of physical and mental ill-health and drug or alcohol misuse that is often associated with homelessness – has a significant effect on quality of life and life expectancy.

The lack of specialist services for homeless people with advanced ill-health who misuse drugs and alcohol is a major challenge in the provision of person-centred end of life care. In addition, rather than dignity and respect, homeless people can experience suspicion, ignorance, indifference and hostility from healthcare staff. This means they are often more comfortable in familiar hostel settings.

Collaborative working and holistic, person-centred care are essential to support and care for homeless people approaching the end of life. Nurses can make a significant contribution to this area by increasing their knowledge of the complex issues around homelessness and end of life care, and by working with other services that support homeless people. The provision of timely, accessible and culturally relevant end of life care for homeless people is challenging; however, with a willingness to work across disciplinary boundaries, the challenges can be overcome.

**TIME OUT 6**
Nurses are encouraged to apply the four themes of The Code (NMC 2015) to their professional practice. Consider how knowledge of palliative and end of life care for homeless people relates to The Code.

**TIME OUT 7**
Now that you have completed the article you might like to write a reflective account as part of your revalidation.

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**References**


Homelessness at the end of life
TEST YOUR KNOWLEDGE BY COMPLETING SELF-ASSESSMENT QUESTIONNAIRE 932

1. Palliative care involves the holistic management of people who:
   a) Have a long-term, benign condition
   b) Have been experiencing acute pain for up to three months
   c) Have life-limiting conditions such as cancer or liver disease
   d) Are due to undergo surgery

2. End of life care can be described as:
   a) Finding a cure for a person's palliative symptoms
   b) Care provided to people who are likely to die within the next 12 months
   c) Care of a person's body after their death
   d) Care of a dying person's relatives only

3. Which of the following are risk factors for homelessness?
   a) Alcohol misuse
   b) Child abuse
   c) Drug misuse
   d) All of the above

4. Marginalised or socially excluded people:
   a) Are fully engaged with society
   b) Do not have enough money to pay for food or bills
   c) Tend to have complex needs and unconventional lifestyles
   d) Are influential and vocal

5. What is one of the main barriers to homeless people accessing healthcare?
   a) Not speaking English
   b) Negative previous experiences of healthcare services
   c) Lack of an NHS number
   d) Suboptimal level of education

6. Tri-morbidity refers to which three issues?
   a) Suboptimal physical health, substance misuse and mental health issues
   b) Suboptimal diet, substance misuse and mental health issues
   c) Suboptimal physical health, lack of permanent address and mental health issues
   d) Suboptimal physical health, substance misuse and lack of family or friends

7. Which of the following is not one of the common conditions developed by homeless people?
   a) Chronic respiratory conditions
   b) Inflammatory skin conditions
   c) Musculoskeletal conditions
   d) Neurological conditions

8. Which statement is true in relation to hostels for homeless people?
   a) Hostels should provide secure or lockable cabinets in all bedrooms to prevent overdose or theft of drugs
   b) All drugs should be banned from hostels
   c) Only a registered healthcare professional should have access to the drugs in a hostel
   d) Hostel staff should administer over-the-counter and prescription drugs

9. Which of the following best describes ‘parallel planning’?
   a) Ensuring that homeless people at the end of life do not have access to drugs and alcohol
   b) Ensuring that family and friends are consulted on any clinical decisions
   c) Increasing joint working between palliative care specialists and other staff
   d) Involving the police in any clinical decisions

10. What is the recommended optimal strategy for the provision of palliative care for homeless people?
    a) Hostel-based palliative care with input from other specialist services
    b) Hostel-based palliative care with input from friends and family
    c) Inpatient palliative care with input from specialist services
    d) Inpatient palliative care with input from friends and family

This self-assessment questionnaire was compiled by Jason Beckford-Ball

The answers to this questionnaire will be published on 14 March

Answers to SAQ 930 on Blood components, which appeared in the 14 February issue, are:
1. a 2. c 3. b 4. d 5. c 6. b 7. c 8. a 9. b 10. d

How to complete this assessment
This self-assessment questionnaire will help you to test your knowledge. It comprises ten multiple choice questions that are broadly linked to the article starting on page 53. There is one correct answer to each question.
» You can test your subject knowledge by attempting the questions before reading the article, and then go back over them to see if you would answer any differently.
» You might like to read the article before trying the questions. The correct answers will be published in Nursing Standard on 14 March.

Subscribers making use of their RCNi Portfolio can complete this and other questionnaires online and save the result automatically. Alternatively, you can cut out this page and add it to your professional portfolio. Don’t forget to record the amount of time taken to complete it.

You may want to write a reflective account based on what you have learned. Visit rcni.com/reflective-account