

## Care of Homeless Oncology Patients

As nurses caring for oncological patients, part of a holistic assessment involves a review of the patient's psychosocial supports at home and in their community. For the cancer patient who is homeless, issues related to their unique social situation need to be understood and addressed by their health care providers.

Understanding of the issues confronting this population and careful reflection of one's own beliefs related to the homeless is imperative. Consideration needs to be given to the meaningfulness of the three dimensions of basic housing. These dimensions include a house as a physical structure, a home with its inherent social and psychological characteristics and neighbourhood, its physical location and available community supports. (RNAO Policy Statement).

The homeless are often isolated, without meaningful or trusting relationships. They are in need in ways that the general population who observe them in passing cannot even imagine – food, warmth, security and rest. Homelessness threatens the dignity of human beings, undermining or destroying their ability to be seen and to see themselves as worthwhile persons. (Seltser & Miller 1993) Homelessness has many complex causes and great potential for tragic consequences.

### *Who Are The Homeless?*

The United Nations describe "absolute homelessness" as the condition of people without physical shelter who sleep outdoors, in vehicles, abandoned buildings or other places not intended for human habitation. "Relative homelessness" is used to describe the condition of those who have a physical shelter, but one that does not meet basic standards of health and safety. (Hwang 2001).

The stereotypical view of a homeless person is generally thought to be someone who is single, an alcoholic, or drug-using male who is going through a "difficult period" and whose housing crisis and need for a shelter is a short term transition. Homelessness, however, affects men, women, women with children, men with children, adolescents and families. Poverty and homelessness are inextricably connected and it is on the rise. Homelessness is not an issue for large centres only. Within the City of Kingston, the In From The Cold Shelter reported the number of bednights in 2000-2001 at 1139. By 2003-2004 that number had risen to 2367 bednights. (IFTC Feb. 2005) The working poor live on a precipice that can tumble them into homelessness at any time. Illness or layoffs from the workplace can mean missed paychecks, which lead to skipped utility and rent payments, which result in utility shutoffs and eviction. These

circumstances leave them searching for accommodation, more often than not a homeless shelter, can pose threats of a different kind as shelters may be dirty, noisy and unsafe. (Plumb, 2000) Others who live in poverty and are at high risk for homelessness include people with mental disability, those who have been victims of domestic violence, those with addictions to drugs and/or alcohol, and people who lack sufficient social supports.

### *Health and Homeless Persons*

When affordable housing is below standard or absent, health is compromised. Homeless people devote tremendous energy to strategies for survival such as obtaining shelter, food and a place to rest. With the search for these necessities of life occurring on a daily basis, considerations related to their health become secondary to them. (McCormack & Macintosh) Homeless people suffer from a wide variety of medical problems with disease severity being remarkably high related to factors of extreme poverty, delays in seeking care, nonadherence to treatment regimens, cognitive impairment and the adverse health effects of homelessness itself. Medical problems prevalent among the homeless include seizures, chronic obstructive pulmonary disease, HIV, musculoskeletal disorders. Hypertension, diabetes and anemia are inadequately controlled or go undetected for prolonged periods of time. Respiratory problems are common. Tuberculosis (TB) is 20 to 300 times more likely to develop in the homeless with more than half being primary TB cases. (RNAO Policy Statement) Oral and dental health is often poor.

Skin and foot problems are common among the homeless. People who live on the street are particularly prone to the development of skin diseases. Cellulitis, impetigo, venous stasis disease, scabies and body lice are common. Despite best efforts and control measures, bed bugs are an ever-present threat in shelters thus increasing potential for skin infections, sleeplessness and psychological distress. Foot disorders such as onychomycosis, tinea pedis, corns, calluses and trenchfoot are usually the result of footwear that is inadequate, prolonged exposure to moisture, long hours of walking and standing and repetitive minor trauma. Proper foot care requires early detection of foot problems, education about foot hygiene and the provision of adequate shoes and socks. (Hwang, 2001)

### *Important Considerations for Caregivers of Homeless Persons*

During the assessment process, and regularly throughout the treatment of a homeless person, the following must be considered and monitored in order to manage and prevent further negative health consequences.

Nutrition – Is your patient aware of how/where to access meals of minimal cost/free in the community? If they are renting a room or are absolutely homeless and are staying in a shelter, refrigeration of fresh food will be difficult if

not impossible. As well, their food may be stolen by other people staying at the shelter. If they eat food from domestic, restaurant or hotel garbage their risk of food poisoning and/or other gastrointestinal problems is increased.

Acquisition of Medication/Storage of Medication – Ascertain from your patient whether or not they have a drug card. For patients receiving social assistance they are entitled to an Ontario Drug Benefits card (ODB). ODB cards and OHIP cards are frequently stolen or misplaced and applying for additional cards is a complex process for the absolutely homeless as they do not have a permanent address. Before prescriptions are given to patients, determine if the drug will be covered by ODB. If not, is there a substitute drug that ODB will cover? For patients whose condition requires them to use syringes, ie. diabetes, be aware that most shelters do not allow any syringes to be brought onto the premises. For medications that must be timed to be taken with meals, discuss with your patient strategies for taking medication related to when they eat and where/how they will be accessing food or meals.(Song, 2002) As part of your assessment it is important to ask your patient if they are using street drugs and/or alcohol and the frequency of use. Use of these chemicals may inhibit or enhance prescription medications.

Side Effects of Medication – The impact of side effects of diarrhea and/or nausea present particular problems for homeless people who share a bathroom with many others.(Song, 2002) As most shelters do not admit people to their beds, until late afternoon and most shelter rules insist the beds be vacated by 8 a.m. the following day, homeless patients suffering with these and/or fatigue do not have places to rest during the day.

Hygiene – Most shelters endeavor to provide showers for the occupants, but due to the number of people at a shelter, regular bathing may not be possible and the lack of privacy makes personal hygiene difficult. Often, rooming houses have showers that are not operational or barely operational, at best.

Safety – Not only are the homeless at increased risk of infection, but violence is a constant threat. In a survey done in Toronto 40% of homeless individuals had been assaulted and 21% of homeless women had been raped in the previous year. (Crowe & Hardill, 1993) Homeless men are about 9 times more likely to be murdered. (Hwang, 2000).

Unintentional death due to overdose of drugs or alcohol, or both, is common. Cold weather substantially increases the risk of frostbite and hypothermia. Deaths due to freezing are not uncommon. Severe sunburn and heatstroke occur during hot weather. (Hwang, 2000)

## End of Life Care

In the general population, control of physical symptoms, support of autonomy and “getting things in order”, are generally seen to help patients prepare for a good death.(Song, 2002) For many patients, dying at home in a responsive, respectful and personalized environment with friends and family close by is their preferred option at end of life. To date there have been no known studies done examining what is important to homeless palliative patients as the end of their life approaches. For the palliative homeless person there may be no family or close friends to provide care. The homeless person may be completely dependent on a health care provider they do not even know and who has no knowledge or understanding of their life before this point. (Song, 2002).

Miller and Keys (2001) undertook a study to look at dignity in the lives of homeless people. These researchers noted that while the majority of research on the homeless focused on examining structural causes of homelessness, their service needs and demographics. Very little was known about the inner lives of the homeless and how they experience their world. The outcome of the study revealed that receiving care, support or encouragement from others was most frequently described as being treated with dignity. Being able to have their basic needs met such as access to food, clothing, shelter, medical and hygiene needs were most frequently discussed in terms of dignity. Behaviours they found most dehumanizing were being ignored or avoided by people, being treated like a child or an animal and being yelled at with insults or stereotypes.

Homelessness is not an issue seen in “big cities” only. In January 2004 approximately 300,000 individuals were on waiting lists for social housing. Of that number 46.5% were families. In Ontario, approximately 390,000 children live in poverty. (RNAO Policy Statement).

Care of the homeless requires an understanding of the complex issues related to homelessness and how those issues impact on the health of this vulnerable population.

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### References

- Crowe, C., Hardill, K., Nursing research and political change:the street health report. *Canadian Nurse* 1993: 89
- Home Base Housing. In *From The Cold Shelter Statistics*.  
<http://www.kingstonhomebase.ca/IFTC.htm> Retrieved February 2005
- Hwang, S. (January 23, 2001) Homelessness and health. *Canadian Medical Association Journal* 2001, January 164 (2). Retrieved January 2003 from <http://www.cmaj.ca>
- Hwang, S., Bugeja, A.L. Barriers to appropriate diabetes management Among homeless people in Toronto. *Canadian Medical Association Journal* 2000. 163 (2)
- McCormack, D., Macintosh, J., Research with homeless people uncovers a model of health .*Western Journal of Nursing Research* 2001. Nov. 23 (7).Retrieved January 2003 from [www.ncbi.nlm.nih.gov/entrez/query](http://www.ncbi.nlm.nih.gov/entrez/query)
- Miller, A.B., Keys, C.B. *Understanding dignity in the lives of homeless persons*. *American Journal of Community Psychology* Vol. 29 (2). 2001
- Plumb, J.D. Homelessness:reducing health disparities. *Canadian Medical Association Journal* 2000, July 163 (2). Retrieved February 2003
- RNAO Policy Statement, Homelessness, [www.rnao.org/htmlpdf/rnao](http://www.rnao.org/htmlpdf/rnao), Retrieved February 2005.
- Seltser, B.J. & Miller, D.E. (1993). *Homeless families:The struggle for dignity*. Urbana, IL: University of Illinois Press.
- Song, J., Homelessness and clinical ethics, *H.E.C. Forum*, 2002. 13 (4)

