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Implications of the shifting landscape of residential care for volunteers' lived experiences and role involvement

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ABSTRACT

Volunteer contributions in residential care are viewed as an important way to meet older adults' psychosocial needs in the context of strained resources and increasingly complex resident populations. The implications of this context for volunteering experiences are rarely considered. This paper presents findings from interviews with 18 volunteers and 9 facility representatives in one Canadian city. Volunteers believed they made a difference through filling care and human resource gaps, helping both residents and paid employees. Organizational regulations at times limited their abilities to help residents, connect with residents relationally, and their integration within care teams. Organizational expectations could also pose a challenge for volunteers' autonomy, and some actively resisted a formal role. Interactions with residents with advanced dementia challenged volunteers' perceptions of effectiveness, appreciation, and emotional connection. Implications are discussed in relation to the needs of paid employees and care recipients, as well as training, regulating, managing, and retaining residential care volunteers.

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Older adults' psychosocial needs for informal social interaction, meaningful leisure or recreational activities, and emotional support in residential settings are frequently unmet (Harper Ice, 2002; Vourlekis, Gelfand & Greene, 1996). Social engagement and relationships are particularly important for the health and quality of care for nursing home residents (Coughlan & Ward, 2007; Leedahl, Chapin, & Little, 2015). However, residential care settings in Canada, as elsewhere, are increasingly challenged to meet these needs. Changes in older adult populations and health care system servicing and delivery have resulted in increasing proportions of residential care clients with high physical and cognitive impairment, without corresponding increases in staffing ratios. As such, paid care workers are less able to provide social and emotional supports or build relationships; this is exacerbated by a managerial focus on efficiency and physical tasks, and a devaluing (in practice if not philosophy) of psychosocial needs (e.g., Coughlan & Ward, 2007). Recreational aide staffing ratios can also be compromised over time, especially in for-profit care facilities (McGregor, Cohen, McGrail, Broemeling, Adler, Schulzer, et al., 2010).

Volunteers are widely touted as a way to meet the needs of older care facility residents in the context of strained resources and complex client populations, enhancing the feasibility of implementing wide-scale social supports (e.g., Thompson & Wilson, 2001; van der Ploeg et al., 2012). For example, one exploratory study of a friendly visitor program (Damianakis, Wagner, Bernstein, & Marziali, 2007) indicated that volunteers can help preserve personhood, build relationships, stimulate dialogue, and 'improve the quality of the moment' for cognitively impaired residents (p.348). Volunteers are often key components of non-pharmacologic,

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psychosocial interventions designed to enhance care facility resident quality of life (e.g., Culpepper Richards, Beck, O'Sullivan, & Shue, 2005; van der Ploeg, Mbakile, Genovesi, & O'Connor, 2012).

The mobilization of unpaid volunteer labour to meet residents' psychosocial needs aligns with the restructuring of health care more broadly, reflecting neoliberal value systems in which the appropriate role for publicly funded services is interpreted as only the most medical of needs. From a critical perspective, increasing reliance on volunteers (often, women) in the context of political and economic shifts in health and social care can inadvertently exploit volunteers' generosity, by positioning them primarily as a source of free labour that helps replace eroding public services (Martinson & Minkler, 2006).

Although there is a wide body of general research into the volunteer sector, the effects of volunteering within this context, in terms of subjective role experiences, are rarely examined in detail. For instance, analyses that connect volunteers' role interpretations to their personal frames of meaning and to broader social and political contexts are uncommon. One exception is a study by gerontologists Rozanova, Keating, and Eales (2012) who describe how a form of 'compulsory altruism' can emerge in volunteers in economically depressed rural areas with insufficient community services.

Moreover, we know little about how health care organizations use volunteer labour in supporting older residents (e.g., degree of role formalization and regulation; styles of management and training). For instance, some organizations support the use of volunteers not only in social engagement, but also in instrumental assistance – most notably feeding (Mellow, 2011). This may be less of an option for unionized facilities, or where safety concerns take

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precedence. Understanding how different organizations approach the use of volunteer labour is important for understanding how volunteer role expectations are structurally generated and negotiated, and then, in turn, experienced by volunteers themselves.

Our research addresses the following question: how are the role interpretations and experiences of residential care volunteers shaped by features of the broader context of residential care?

METHODS

Recruitment and Setting

In Canada, residential care homes are publicly funded and regulated facilities typically accessed through health agency assessment based on requirements for a certain level of care. In this paper, these are referred to as personal care homes (PCH), although they are known by other terms internationally (e.g., skilled nursing facilities, long-term care home, care home). Canadian PCHs operate either for-profit or not-for-profit. For this study, all PCH facilities and hospital long-term geriatric units in one medium-sized urban centre in central Canada were identified through an internet search, and these facilities (n=60) were asked to assist with recruitment through distributing information to their volunteers (11 facilities confirmed distribution). Participants were also recruited through a University-based Centre on Aging email list and local community papers and newsletters. Individuals currently volunteering with older adults in a care facility or hospital long-term care unit were eligible; including a broad range of volunteer positions facilitated examination of a spectrum of experiences. For additional information about the use of volunteers in long-term residential settings, facility managers, care directors, social

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workers, volunteer supervisors, and union representatives were also invited to participate (the request was made of all facilities who agreed to distribute the recruitment letter to their volunteers).

Participants

The final participant group (n=18) included 16 females and two males, ranging in age from 22 to 79 (average = 60), and including three participants of visible minority background. They had been volunteering between six months and 25 years (average = 6.64). Thirteen participants volunteered in one (or more) of thirteen different PCH settings; four volunteered in one (or more) of five hospital long-term care settings, and one volunteered in both hospital and PCH. Several participants helped with specific programs: spiritual care (n=2), music or pet therapy (n=3), and an end of life companion program (n=1). Four participants volunteered as a “friendly visitor” and three helped with various activities or tasks (n=3).

The remaining five participants (hereafter ‘informal volunteers’) characterized their volunteer role as informal - as a friend, unpaid companion or advocate. Although these participants represent the extreme periphery of volunteerism, they nonetheless self-defined their role as at least in part involving volunteering; this was a particularly noteworthy finding originating from this study, and will be discussed later in this paper. Two of these participants were family members of PCH residents, who befriended another resident; one was a bereaved family member who helped one particular resident; one participant became friends with a PCH resident after meeting her at a community event; and one other participant started out as a formal volunteer but due to work obligations had since ‘informalized’ his role (he had many friends in the facility).

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Two volunteers had some health and/or social care background. Eight participants (including five informal volunteers) reported receiving no formal training; and eight recalled an initial orientation outlining general guidelines (e.g., task boundaries, privacy, dress code, resident rights; personal safety; infection control).

Six additional interviews (individual and group) with nine organizational representatives from five PCHs were also completed, including five volunteer and/or recreation supervisors, a social worker, two directors of care, and one Chief Executive Officer. Demographic information was not collected for these participants.

Data Collection

Volunteer participants were interviewed in-person by either the first author or a research assistant between 2013 and 2014; interviews were digitally recorded and later transcribed verbatim. Transcripts averaged approximately thirteen pages in length (single-spaced). A question guide oriented the conversation to participants' understandings of their roles and responsibilities, as well as challenges and rewards associated with their experiences. Interviews with organizational representatives conducted by the first author included questions about the roles and regulation of volunteers in their particular setting as well as benefits and challenges of managing volunteers.

Data Analysis

After multiple re-readings, descriptive summaries were created for each transcript reflecting a preliminary coding or 'sifting' of the data focused on the nature of the work that participants described doing and their role interpretations. For instance, role interpretations

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included direct and indirect tasks descriptions (e.g., “I help to transport the residents”/”keep them in a healthy mood”/”I also assist the staff”;) and/or formal role descriptions (e.g., ‘friendly visitor’; ‘leads the music program’), provided either in response to particular questions from the interviewer or more generally within the interview.

As well as a substantive focus on ‘what’ participants said about their work, the analysis was in part guided by an interpretive, constructionist approach that considers participant talk as reflecting ongoing efforts to maintain and present meaningful identities (Gubrium & Holstein, 2000). For instance, when some female participants appeared reluctant to discuss aspects of personal benefit from their role, we considered that this may be connected at least in part to their desire to present themselves as a ‘good’ woman motivated by purely caring and altruistic motives.

Findings were compared and contrasted between participants, and between participants and facility representatives. Data from facility representatives was used to compare to, contextualize and extend the primary analyses of volunteer data. An additional analytic layer, informed by a critical sociological perspective, involved connecting individual-level role experiences, challenges, expectations and desires to the broader context of residential care, including facility approaches to volunteer labour as an extension of a broader neo-liberalism manifesting in health care for older adults.

FINDINGS

Making a Difference

A core, inductive theme among volunteers was a foundational need to believe they were making a difference through the provision of support to residents, including: facilitating

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involvement in recreational programs and events; visiting and social interaction; listening, companionship, and non-verbal communication; and developing friendships (especially for residents without family or friends). Volunteers sought to improve the quality of life and wellbeing of older adults, and derived purpose and satisfaction when they saw evidence of their effectiveness. However, the opportunities available to make a difference could be supported and/or challenged by certain organizational rules or regulations, including how volunteer positions are structured and managed. Throughout this section, we identify several features that supported or interfered with volunteers' opportunities and abilities to make a difference.

Opportunities to fill gaps: the impact of residential care resource pressures. Volunteers who believe they are filling an important gap feel they are making a contribution. As such, the context of residential care, although problematic in many regards, influences volunteers' subjective experiences. Health care resource constraints, low staff-resident ratios, and high workloads challenge the ability of paid staff to meet resident needs (psychosocial and other). Two PCH representatives expressed that workload constraints siphon recreational staff time into program planning at the expense of staff time for personal, social-emotional interactions with residents. One care director connected a lack of provincial funding for recreation to reliance on volunteers for social interaction and leisure activity:

We're doing a disservice to the elders ... by not providing them with more leisure activity, but we need volunteers to do that because it's an unpaid...and until we can lobby the government and have somebody somewhere recognize that [Provincial Ministry] needs to fund that; it's as integral to the lives of the people we're caring for as the hands on medical piece.

Facility representatives characterized the primary volunteer role as assisting recreational staff and supplementing recreational programming, enabling more residents to participate.

Volunteers are uniquely positioned to meet residents' needs in ways often unavailable to facility

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care staff faced with heavy workloads. Volunteers also fill other care gaps in PCH settings (e.g., cleaning, gardening, feeding). For example, one volunteer ensured that residents eat their meals:

Some [residents] I need two hours with. So everything in the dining room around me is cleaned up, and we are the only ones left, but I know that person gets their whole meal. Because [the healthcare staff] are usually understaffed, and they have to be fast, fast, fast. And they don't have that [time], so I sit until the person is finished or doesn't want to eat any more.

This volunteer explained that dieticians were formerly responsible for feeding, but the work was replaced by volunteers. Overall, however, there was between-facility variation in whether and how volunteers could be involved in feeding.

In contrast to gap-filling, in the following excerpt one informal volunteer articulated her role not as replacing the staff roles but as an important (non-professional) supplement that would otherwise be unavailable:

The fact that I'm there is a good thing. The fact that I touch [friend], I stroke her arm, I hold her hand, I give her a hug. Maybe I just am mirroring what I personally need, but I do think that everybody needs that. And it's not just the touch of a nurse. It's not the touch of a caregiver in the sense that somebody's putting on her stockings. It's somebody who's actually saying, 'You matter to me. I care about you.'

As well as helping residents, volunteers viewed themselves as filling a gap by directly and indirectly assisting facility staff. One volunteer spoke of her ability to sit with dying residents, adding: "there's never enough aides." Another informal volunteer helped with feeding a physically disabled resident: "it takes a bit of a load off of the workers, because they're free [to do something else]." When volunteers keep residents occupied, this creates opportunities for facility staff to focus on the care of other residents or other aspects of care. For example, one program volunteer elaborated:

While I've got a group of residents who are sitting ... and they're with me, almost like a class you're teaching, that's giving the staff other time to deal with some other people who may be in their rooms or are not well, where they've got other things to do. So I feel that what I do is provide a little bit of relief. One

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day I showed up when there was a flu outbreak...and the look on the staffs' face was, [relieved tone] 'you're still going to be here' because they just looked like they were run off their feet. So I felt what I did was give staff some support by engaging [residents] with me and then [staff] could do other things.

One volunteer supervisor expressed concern in this regard that employees may become dependent on volunteer labour. In describing how informal volunteers (family members of residents) help non-family residents, she added:

That's a little dangerous because we had two [family members] on one floor...and what we found out after was that they were helping the unit with [feeding] lunches, but then one of the residents passed away, and so that family is no longer there. So now all of a sudden the staff were complaining that they have got too much work to do because they were relying too much on these [family members].

Some volunteers also appeared to help minimize the effect of disruptive resident behaviours on facility workflow. For instance, one volunteer explained how she is sometimes asked to sit with and calm an agitated resident for several hours. A friendly visitor recalled similar situations:

Sometimes I'll come out of the elevators and the [care aides] will see me and go 'there's somebody that really needs you to sit with them.' Usually [residents] who don't really have a lot of awareness and they'll walk around and they just need somebody to walk with them just so they're not getting into trouble or anything.

With staffing constraints and workload pressures, paid employees are challenged to care for residents with disruptive behaviours associated with advanced dementia. Although volunteers in these situations may fill a facility human resource gap, they may at times feel ineffective, as detailed later in this paper; indeed, facility representatives appeared generally to view volunteers as less appropriate for this role (due to lack of training and safety concerns).

Opportunities to provide physical care. The nature of volunteer positions (and volunteer flexibility in tasks, time allocation and ability to advocate) is influenced by organizational

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approaches to volunteer labour as well as concerns about safety and liability. Most PCH volunteers have strict, clear task boundaries, reinforced by specific position descriptions, training, and volunteers' risk awareness. Facilities generally instruct volunteers not to physically handle residents or provide personal care. One formal PCH volunteer described how, over 10-15 years, her role has been increasingly more regulated, and she is no longer permitted to help with dressing, toileting or transferring (though she had previously done these tasks). In part she believed this is because residents are more physically dependent, generating safety and liability/legal concerns.

When residents or families ask a volunteer for help with physical care tasks, they must notify facility staff rather than act themselves. There was some indication, however, that role boundaries may generate discomfort or helplessness. For instance, one friendly visitor explained how she could not respond to resident requests, adding: "I guess I've kind of gotten used to that." Although conferring some relief from the burden of responsibility (as below), task and role restrictions, in the context of care gaps (and compounded by close relational bonds) may generate powerlessness, frustration and distress in some situations. These feelings may be particularly acute when a volunteer witnesses a resident suffering as a result of inattention to their needs and (as noted by one facility representative) when volunteers have health care training and backgrounds. One volunteer described her frustrations when she cannot respond to suffering (e.g., residents soil themselves while waiting to be toileted by care aides, and are upset). Further, one hospital friendly visitor explained that she could open up patients' food on their trays but not feed them even if they have difficulty, which she finds personally challenging. This participant also noted:

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In those everyday situations when they say 'can you get this' or 'can you help me' or 'why isn't anybody coming to help me' and then I just have to wait and we press a little button by their bed to ring for a nurse to come, so then I just sit there, like I'm useless...

The task involvement of informal volunteers appears to be less heavily regulated by organizations in contrast to formal volunteers, and the former may have greater control and autonomy over their tasks. For example, the voluntary contributions of family members in feeding non-family residents are not always viewed as problematic by organizations - as a CEO stated: "for them to be helping someone else, that's not something that we encourage but it happens. So until another family member complains or something actually happens, it happens."

Opportunities to advocate. Volunteers are most often excluded from the care team in residential care facilities, often because of privacy legislation but also because volunteers are frequently assumed to lack sufficient health care training or knowledge. From a facility perspective, volunteers' attempts to influence the care process tended to be characterized as well-intended 'over-involvement' (or 'meddling'). Some volunteers felt powerless to advocate for residents, or were uncomfortable when relaying simple resident requests to care staff, e.g., 'not wanting to rock the boat.' Feeling unable to advocate in some cases resulted in volunteers' feeling ineffective. For instance, one volunteer (a retired social worker) felt helpless to voice concerns about care (e.g., she had observed care aides shouting at, being rough with and neglectful of residents): "I don't know where to bring it up or how to, because I'm not in meetings or staff meetings or anything, I'm on my own. How can I bring those things forward?"

In another example, an informal volunteer's resident friend complained about being awakened for unnecessary diaper changes at night. This participant expressed: "I felt powerless to do anything about that." This volunteer also perceived that when she relayed the resident's

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concerns to staff, they were annoyed: "I got snapped at one day and I felt really awful, it left me feeling like I was bullied almost, very harsh." In a final example, a hospital volunteer stated her distress that she "cannot voice out" about situations where some care workers interact with older patients in a belittling or verbally abusive manner. She added: "as a volunteer I should say my position is also a dependent, less powerful person. So I find it very challenging when I saw some situation that I believe is abuse."

Opportunities for meaningful interaction. Certain features of volunteer positions can also influence volunteers' ability (and autonomy) to engage with residents socially and relationally. This may have a greater impact on perceived effectiveness, since social engagement is a predominant aspect of the volunteer role and its meaning. For instance, since non-verbal communication provides important comfort, one volunteer felt constrained by facility guidelines that discourage touch (to prevent virus spread). Friendly visitors also described helplessness when they have insufficient time to engage effectively with residents. For instance, one friendly visitor elaborated:

... the [residents] that I spend five minutes here, ten minutes here, and a few minutes there. There should be more that I can do with them. But [the facility staff] ... they say, "this one's available, and you can see this one, and this one" and I'm only there for two hours [*Laughs*].

Within some organizations, volunteers may even be viewed as inappropriate for individualized social connection. For example, one care director noted that volunteers "[are likely to be] volunteering for the facility or for a program" rather than "building a relationship with one resident over time."

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Volunteer positions can be structured or managed so as to promote relational distance. For instance, some friendly visitors were directed to spend only a small amount of time with a large number of residents (distributing their time equally between them). One friendly visitor has difficulty extricating herself when residents want her to stay longer; her approach is normally “a quick little hello, ‘how are you’ sort of visit.” Another friendly visitor (who characterized her role primarily as a friend) redirected her role in a way she perceived as more worthwhile (and personally rewarding). She had been initially assigned to visit a large number of people in succession, yet began to spend more time with fewer residents: “I don’t think I can see a lot of people in under an hour and be effective at actually really being present with them.”

Some volunteer positions are focused more on recreational engagement rather than personal connection. For instance, one music volunteer stated, “as a rule you don’t engage in [resident’s] names or their history,” and added, “it’s like being friendly to strangers, that’s the best way I can put it. So you don’t ask questions.” In contrast, one spiritual care volunteer specifically tried to build connections with residents; she contrasted her work against volunteers with more specific tasks: “it’s possible to do work like that by rote and not become very personal with people or very friendly with the people.”

In contrast, other features of the volunteer role facilitate relational closeness and social connection. As one volunteer suggested:

Because I don’t work there... [residents] like me very much because I can see their face is very happy and some even said that I am better than [laughs] the program recreational therapist. Because the recreational therapist, they have to give [residents] rules sometimes, so they have some power struggle between them. But as an impartial person, to go in as a volunteer, then I don’t have the power struggle with [residents], that’s why they like me better...

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Likewise, another volunteer believed residents are more open in communicating with volunteers than paid workers. Another explicated how privacy policies limiting volunteer access to information can facilitate social support: “in the beginning I wish I'd known what [residents'] medical problem was, but now I'm glad I don't know, because now I cater to the personality and not the medical problem. And that, to me, is what they need.”

Opportunities to help residents with advanced dementia. The nature of resident populations is another contextual feature indirectly influencing volunteers' perceived effectiveness. As one care director noted, the changing complexity of resident populations over the years (including more dementia-related aggression) is a key concern for PCHs. Since the work of many volunteers focuses on visiting and socializing, some participants expressed helplessness when interacting with persons with advanced dementia (or depression, or other conditions), with whom it is difficult to engage in normal social interaction. Participants spoke of discomfort or distress when dealing with behaviours such as screaming, agitation, mood swings, swearing and aggression. Residents' cognitive status can also make social engagement more challenging, as a music volunteer expressed:

I want them singing...there's one song and it has a nice storyline to it and I read it like a story to them each time and they seem to really enjoy it ... they're thinking and laughing. So I try to find ways to reach out...For some of them I get the impression it wouldn't make a difference, but there's other ones...But it's really hard to try and keep them, you want them engaged. I don't just want to play there and they're sitting there like bumps on a log, but at the same time, [their] capacity may be limited.

One friendly visitor explained why she stopped visiting a resident who started to exhibit increasing anger: “I'm not equipped to handle those kinds of situations... it's not my place. Somebody who can respond is, I felt, who I was there for.” She added: “[resident] wasn't getting anything out of it. And I would just feel frustrated and unable to do anything for her.”

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Other volunteers described difficulties mitigating negative resident emotions such as disappointment and anger. One friendly visitor reflected on the effect on her own wellbeing:

If people are upset, trying to console them...if they're really saying 'I'm so lonely in the hospital or I'm never going to get better' a lot of people because they're waiting for a placement they're always saying 'when am I going home? I want to go home, I'm stuck here, I don't want to go into a care home...' So that's just a personal thing, it's kind of hard.

In contrast, positive behaviours and reciprocal engagement provided evidence that volunteers were making a difference. One friendly visitor often worried about trying to cheer up residents. When asked how she knows when she has made a difference, she responded:

When they laugh. Or a smile, or they start expressing themselves, or family pictures or incidents that happen, or a joke that was given. Or so-and-so, can you believe what she just said? And the other will say, "yeah, I mean it" and we'll have a good giggle. I think then, when I come away feeling like that, then I know, I think I have [made a difference] for both of us, for them and for me.

Reciprocity provides an important signal function of feedback for volunteers, and is an expected feature of social interaction. Reciprocal interactions are also experienced as personally rewarding by volunteers, as described in the next section.

Recognition, Appreciation and the Rewards of Volunteering

A quote from one informal volunteer highlighted the challenges of working with residents with advanced dementia, who may not be able to express appreciation:

Some of them are with it enough to say 'oh thank you so much dear, that was so sweet of you to do that for me.' They probably wouldn't remember in 10 minutes what you've done for them [*laughs*], but that's ok. So there's some reward there sometimes, but not a lot.

A friendly visitor described her contrasting experience in her work:

There's so many times when people say 'thank you so much for coming, you're such a nice girl'. So it makes me feel good that I'm making them feel better. So I like that.

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As well as contributing to feeling needed, appreciation validates relational connections and reinforces one's sense of identity as a good person; here again, organizational regulations and policies related to volunteer management play an important role. For instance, facility policies usually prohibit volunteers from accepting gifts from residents. Although designed to prevent abuse, such policies constrain residents' abilities to reciprocate and convey appreciation; they may also create uncomfortable situations for volunteers. For instance, one participant explained that sometimes a resident will offer him small amounts of money and he will take it because he does not want them to feel rejected or disappointed; then he will inform the staff, and give them the money to return.

Being appreciated by facility employees could also be personally satisfying, and included but extended beyond expressions of gratitude. Although rare, a few volunteers were unhappy when they perceived they were unappreciated (e.g., bossed around, treated disrespectfully or 'like an idiot'). In contrast, one volunteer described a time she was out in public and was personally acknowledged by a former employee: "so, I feel what I'm doing here is recognized." Another program volunteer described feeling integrated into the care team, which connects to a desire to be appreciated:

You want [staff] to smile and say hello to you when you come in. You want to know what your parameters are when you're there. You want to feel that you're part of the team ... Not like you're almost an intruder coming in. I don't know who all the staff are, but they smile, they say hello, we're glad you're here, you feel like you're part of the team and I think that's really important.

Further, privacy policies that prohibit staff from communicating resident health information to volunteers could contribute to feelings of exclusion (as this symbolically conveys mistrust).

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Not all volunteers were comfortable with appreciation. One informal volunteer stated: “I don't need a certificate” and “that's not why I was doing it.” Although formal or public appreciation can convey recognition and approval, it may also generate discomfort for individuals who prefer to characterize they do as altruistic, or part of simply being ‘a good person.’ A similar sentiment was expressed by one participant who was reluctant to elaborate on any personal benefit from her role, perhaps because of a concern about appearing self-motivated.

Other participants were more willing to discuss personal rewards in their work. As well as making a difference and feeling appreciated, they cited the benefits of developing friendships and emotional connections. One friendly visitor notes how relationships are “the most interesting part of volunteering with older adults, for me.” For most informal volunteers, friendships with residents occurred serendipitously, and developed into what they viewed as a volunteer role. In other instances, formal volunteers developed friendships with particular residents over time; these friendships were clearly distinguished from their volunteer role.

Some participants expressed awareness of risks involved in friendships with residents, including feelings of guilt and responsibility, or emotional distress during bereavement or when the relationship otherwise ends. For instance, one friendly visitor feels guilty when she cannot see her friend: “She remembers. She'll say ‘I haven't seen you in a while’ and I feel terrible.”

Another friendly visitor was instructed by the hospital not to become too close to patients:

We're not supposed to tell them too much about ourselves and we're also not supposed to be around so much that they become dependent on us. I guess the worry is that they leave the hospital and they'll be calling and saying ‘where's so and so? I want to see so and so.’

She added: “we're not supposed to feel guilty if we can't go and visit them because it's just like, we're volunteering.” As noted in the previous section, such guidelines may inhibit the

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development of close friendships between residents and volunteers, yet these relationships may benefit residents and are an important component of reward and meaning for many volunteers.

Some facility representatives tended to characterize emotionally close friendships between volunteers and residents as risky from an organizational perspective. For instance, if a volunteer becomes friends with a resident, they may do things that exceed their role boundary (e.g., driving, purchasing items on behalf of the resident) and raise safety and liability concerns. Two representatives were also concerned about friendships between informal volunteers (family members of residents) and non-family residents, suggesting the resident might become dependent on that person, and that it raises boundary issues (e.g., “who are you here for?”). However, when facilities delineate boundaries between “friend” and “volunteer,” this may have implications for how the volunteer role is experienced.

With some exceptions, volunteers tended to experience appreciation, recognition and friendships as personally rewarding; this may draw them to the work. In this regard, we must consider the implications of increasing cognitive impairment among residents, and of facility policies that discourage emotional connections. Further, although appreciation from facility care workers was important, being integrated within the care team (e.g., access to information, valuing of input) also has an additional symbolic effect on volunteers' sense of recognition and appreciation that should not be underestimated.

Autonomy and Lack of Obligation in the Volunteer Role

Lastly, a third inductive theme arising from this study centred on the high value volunteers placed on preserving control and autonomy in their role, and minimizing obligation.

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The process of preserving autonomy could be shaped by personal interpretations and actions, the nature of role positions (e.g., informal vs. formal), and organizational expectations. For instance, when participants emphasized the mutual benefit and personal rewards they derived from volunteering in their interview talk, this may reflect an underlying desire for autonomy and to avoid 'feeling obligated.' One friendly visitor explained that her work is not an obligation because: "it's my choice to be there. I enjoy being there, it fulfils me too."

Volunteers generally valued low responsibility, derived from the unpaid nature of their work, the lack of sustained interaction with particular residents, and their autonomy in setting their own hours and being able to leave as needed. One friendly visitor contrasted her responsibility against that of paid professionals:

Just comparing it with how a nurse does it, I don't think it's a lot of responsibility for the patients. Like I'm not obligated to attend to their medical needs. I'm not obligated to stay if I don't want or if I think there's trouble that I'd be expected to leave so that the nurses or the [care aides] can attend to it. Just being a support or giving company to the patient is the most responsibility that we have.

Another informal volunteer contrasted the light responsibility of her volunteer role positively against her previous role as a family caregiver, which involved "the burden of being the sole person looking out for [my mother]." Other volunteers similarly liked the autonomy of their volunteer role, which protected against over-commitment and burnout. One PCH volunteer supervisor noted that volunteers tend to: "[want] to be part of it on their own terms, i.e., I only want to come Mondays from 10-11:30. That's it. I don't want to have to do anything more."

Some participants actively sought to protect their role autonomy. For example, one volunteer explained how she responds to requests from facility employees (e.g., to sit with an agitated resident): "on my terms, if I can. If I'm in the middle of feeding [another resident], I

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won't interrupt that. If I'm engaged with somebody else, I'll say 'well, in half an hour or so, I'll have time.' A desire to protect autonomy may also help explain why several volunteers emphasized the informal nature of their contributions. One informal volunteer explained that a staff member approached her about officially becoming a volunteer. Her reluctance, and resistance to role formalization, reflected her concern about becoming overcommitted to helping the recreational staff:

I know my own weaknesses and I'm more or less a people-pleaser and didn't want to be roped into where I would feel guilty saying no. So, as long as the understanding is that I'm the one visiting [resident]. And it's expanded into, when they take the bingo [program] to the Legion, then yes I will, if [resident]'s going I will go and help her. But I don't go to the mall with [residents/staff], I don't come in on other days.

Another informal volunteer once declined a request to work as a paid companion for a resident, to protect choice - payment would tie her to certain rules and expected time frames, which she has had enough of in her life. Another informal volunteer also explained:

I wanted to make sure that I was not a volunteer, I didn't want to be accountable to the care home ...and just be free to be [particular resident's] friend. I mean I have to pay attention to what the rules are there, but I wasn't accountable to [facility].

This participant referred to a time her friend wanted some local fish, which the staff prohibited because it might have bones. From the participants' perspective, the resident's wishes should take priority, so she sneaked it in: "If I was a volunteer I wouldn't be able to do that."

In a final example, a formal volunteer tailored her involvement to minimize obligation and guilt. She avoided hosting activities or helping recreation staff:

I want to have some flexibility if I can't make it, or if I go on holidays for several weeks or so, that the program doesn't suffer. That's why I ended up doing it this way. But that's to suit myself, and that way I feel like I don't let anyone down either.

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On a daily basis, this volunteer chooses to participate in what she enjoys and where she sees a need within the facility. Through self-defining their role, volunteers avoided feelings of obligation, set limits on their commitments, and maintained freedom which they believed helped them to meet resident needs while maximizing experienced rewards.

DISCUSSION

Social engagement and emotional connections are important for residents' personhood and wellbeing; this is no less the case for those with advanced dementia. However, paid care workers are increasingly unable to devote time and energy to this work. Embedded within a system that prioritizes only the most medical of needs, volunteers appear as one of few options for implementing wide-scale psychosocial supports. Yet our findings raise several important considerations in this regard.

Volunteers have a foundational need to know they make a difference. Ironically, the resource context that increasingly prevents paid staff from meeting residents' psychosocial needs creates a gap in which volunteers feel needed both by residents and employees. Yet when socio-emotional and relational aspects of care are viewed as more appropriate for volunteers, these tasks tend to be viewed as "extras," reinforcing the idea that paid care work is only about physical tasks. However, many paid employees view psychosocial care for others in a deepened relationship as important and rewarding components of their own role that they wish they had time for (Ball et al., 2009; Wilson & Daley, 1998). Furthermore, organizational reliance on volunteers can generate a burden of responsibility on the volunteer while simultaneously devaluing professional training. This reflects a broader context that obscures the need for psychosocial activities or well-trained professional care for older adults.

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Our findings raise concerns about work with more troubling resident behaviours— who should do it and how? When dealing with these behaviours volunteers tended to feel ineffective, and expressed distress or discomfort; some facility representatives also did not view volunteers as appropriate in this regard. This finding suggests concern for future volunteer retention and utilization, given that health care system shifts are resulting in larger proportions of residents with advanced dementia. Others have noted the potential for fear, hesitation and a lack of confidence among volunteers working with cognitively impaired residents (Davis, 2004; Robinson & Clemons, 1999; Steele, Rivera, Bernick, & Mortsensen, 2007; Touhy, 2004). Such effects may be partly mitigated through training (Damianakis et al., 2007; Steele et al., 2007), which could also help both paid staff and volunteers to better identify the difference they can make in the lives of residents with dementia. Volunteers and staff could also benefit from increased institutional support to address personal and emotional challenges related to this work. Further discussion is needed within and between health care organizations, however, regarding appropriate involvement for both volunteers and paid staff. For instance, participant comments about ineffectiveness when working with residents with advanced dementia may indicate the need for trained professionals with specialized knowledge.

Residential care organizations should contemplate the effects of their volunteer management approaches and policies on volunteer autonomy in terms of tasks, time allocation and ability to advocate. Increasingly regulatory limitations on volunteer involvement may meet institutional needs and address liability concerns in the face of increases in high-needs residents; protect resident and volunteer safety, and protect the rights of paid workers. However, the emotional impacts for volunteers need more attention. Although regulation may provide some

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welcome relief from responsibility, it may also restrain volunteers from some of the very aspects that make this work meaningful to them. In the context of significant care resource constraints, strong role boundaries and a lack of mechanisms for facilitating advocacy can generate distress when volunteers witness resident suffering but are unable to help.

Many volunteers value relationships with older adults; this orientation needs fostering within an overarching culture that continues to be quite ageist. However, many volunteers' abilities to develop relationships are limited, either by their placement in recreational support positions or by how their work is managed. Regulatory and structural constraints (e.g., discouraging physical touch, gift giving by residents, or personal relationships) can also constrain volunteers' connections with residents. Bureaucratic restrictions on affective labour and relational connections were also noted in research on hospital volunteers by Mellow (2011). Further, Damianakis et al. (2007) concluded that an unstructured friendly visitor program promotes volunteer freedom; however, it might also disadvantage residents with problematic social behaviours. Indeed, increasing proportions of residents with advanced dementia more broadly can further inhibit volunteers' perceptions of relationships. In contrast, other aspects of volunteer positions (an 'impartial' status; lack of access to medical information) can facilitate emotional connection. Other studies have identified additional features in this regard, including: the 'aura of domesticity' involved in the presence of visiting pets, for pet therapy volunteers (Savishinsky, 1992); and the unpaid nature of volunteering, in home-based palliative care (Sévigny, Dumont, Cohen, & Frappier, 2010).

When appreciation from residents is not obvious due to communication and cognitive challenges, appreciation from paid staff may be even more salient as a source of volunteer

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reward. However, appreciation may generate discomfort for some volunteers; for others, it may be equally if not more important to feel integrated within the care team (e.g., signifying recognition of their wisdom and experience).

Any potential future shifts towards increased regulation and formalization of the residential care volunteer role may have implications for volunteer experiences. Despite some role constraints, participants enjoyed the relative control, choice, autonomy and freedom they experienced in comparison to other aspects of their lives. They did not want to become over-committed, and some sought to protect their autonomy or avoid formalization. Likewise, Manthorpe et al. (2003) suggest: “volunteers may ... seek freedom to engage in activities that are mutually rewarding for themselves and the recipient of their time” (p.34). In some ways this fits with the image of the volunteer in ‘late modern’ society (Hustinx, 2010). However, Watts (2012) observed that that volunteer role is “now highly routinized and closely monitored in ways paralleling practices in the paid labo[u]r market...their activities are subject to significant management prescription” (p.101). Increased formalization and structuring may enhance a sense of obligation, discouraging some volunteers; it may also inhibit emotional connections between volunteers and care recipients (Guirguis-Younger, Kelley, & McKee, 2005; Sévigny et al., 2010).

In this context, the phenomenon of a ‘volunteer periphery’ needs to be more fully explored – those individuals (most often, friends or family) who are not officially sanctioned or regulated volunteers, but who nonetheless characterize what they do as, in part, a voluntary contribution. The reasons why such individuals may resist formalization should be more fully explored. More broadly, we need further research examining this particularly invisible form of

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labour within residential care facilities, especially since it is not normally accounted for within existing volunteer programs.

Although this study was not designed to assess volunteer motivations the findings suggest several recommendations in this regard. First, it is important to help volunteers feel useful and understand how they can make a difference, especially with residents with dementia. Further, it is important to dissuade volunteers from deriving a sense of purpose from completing care tasks; to encourage them to do so raises concerns for safety as well as the rights of paid workers. In addition, we should consider how to help volunteers maintain desired levels of autonomy, flexibility, informality and emotional connection; how to address their frustrations when they feel unable to help; and to provide options for their input and integration as part of the team (while considering privacy). The roles of volunteer coordinators, where they exist, may be particularly salient in this regard. Variations between available volunteer positions and their associated expectations and opportunities should also be clearly explained to volunteers during initial contact, to prevent disappointment in how volunteers experience their contribution.

Our sample does not include volunteers recruited through external community programs, such as high school students completing credit hours, new immigrants, or special needs persons in work experience programs. Additional research with these groups could explore the transferability of some of the themes raised herein. In addition, facility-level variation in policies and approaches to utilizing volunteers should be systematically documented on a larger scale. Ongoing dialogue between volunteers, policy-makers, administrators and practitioners about volunteer roles is also needed. More broadly, further research should continue to examine how demographic, political and economic trends will shape how care institutions utilize these often

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unrecognized workforces, how residents and paid employees may be affected, and how the work is experienced by volunteers.

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Ethical approval: All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent: Informed consent was obtained from all individual participants included in the study.

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