VOLUNTEER MANAGEMENT IN LONG TERM CARE

A SOCIAL WORK INTERVENTION CONNECTING

THE RESIDENT WITH THE COMMUNITY

By

Judith M. D. Fijal

A Practicum
Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements
of the Degree of

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VOLUME I

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This volume is part of a two volume practicum report developed in partial completion of the requirements for the Masters of Social Work Degree Program (for volume II see "Volunteer Management Training Manual".)

Running head: VOLUNTEER MANAGEMENT IN LONG TERM CARE

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Abstract

Volunteer Management in Long Term Care, A Social Work Intervention Connecting the Resident to the Community, addresses the area of Gerontology as it relates to special issues in long term care. A model of volunteer program development is presented through the description of the establishment of a volunteer program in a personal care home which offered all levels of nursing care.

Special issues, such as creating supports in working with cognitive impairment (Alzheimer's), the role of social work in long term care, and the relationship of social work to volunteerism are addressed in this practicum report. The model of volunteer program development also examines such issues as staff-volunteer relations, quality assurance in evaluation, and special changes in volunteer management.

This practicum report concludes that the role of a professional, well trained coordinator providing volunteer management within a facility is essential to the success and continuance of the volunteer program. The report also concludes that volunteer management is a vital and legitimate administrative social work practice.

Volume II presents the model for the development of a volunteer program in a long term care facility, a practical "how to" guide for Coordinators of Volunteers.

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Chapter I

Introduction

The general focus of the study in this practicum has been on addressing the needs of the elderly in long term care. The social work intervention being presented in this project demonstrates the feasibility and circumstances under which a effective volunteer program could be mounted in a long term care facility. developed and structured volunteer program can meet some of the needs of the clients in long term care facilities, such as personal care homes.

One of the more specific hoped for outcomes of this practicum was a Volunteer Management Training Manual to be used to assist Coordinators of Volunteers in the development of volunteer programs in long term care facilities. This manual has been evaluated by community experts in volunteer management and gerontology.

Clients are most commonly referred to as "residents" in personal care homes and "patients" in extended care hospitals. For the purpose of this report, the elderly residing in long term care facilities will be referred to as residents.

The intervention was carried out in a personal care home over a six and one half month time period.

The facility provided all levels of care to two hundred and seventy-seven residents. Through the development of the volunteer program, volunteers were recruited and placed in ten different service areas. Most of the department heads, and several line staff were involved with the intervention.

The Resident's Council, whose interest and support were solicited early in the project, were also involved with the volunteer program.

Rationale for the Practicum

The demographic picture of our aging population is changing over the years. In 1981, there were 2,360,975 or 9.7% of the total population in Canada that was over sixty-five years of age. More than a third of the over sixty-five population was over seventy-five years of age.

Life expectancy for Canadians is changing over time. Presently, women are expected to live to the age of 78.7 years, and men are expected to live 71.5 years. There is a larger percentage of women widowed than men and a larger percentage of men are married than are women (Chappell, Strain, & Blandford, 1986).

About 61.8% of the elderly population have no functional limitation. Many of the people who are over

the age of sixty-five are fairly independent (about 85%), but have at least one chronic health problem. A total of 8.7% of the population over sixty-five are not able to do any major activity (Chappell, Strain, & Blandford, 1986, p. 35).

These facts lead to the realization that a large number of people are in need of specialized care, with percentages of elderly requiring long term care in institutions ranging from 5.8% to 8%, depending on the area. Even though the majority of citizens in this country over the age of sixty-five are independent, those who are not capable of caring for themselves are the most vulnerable, and in need of the support of the community in order to maintain an acceptable quality of life. This practicum report has addressed this fact.

The total number of personal care home beds in the province of Manitoba are 8,248. These beds are usually filled within two days of becoming vacant and there is a waiting period of approximately four months from the time an elderly person has been panelled for eligibility of placement and when the actual admission to a personal care home takes place. The number of personal care beds are equivalent to one bed per ninety

people over the age of seventy in the province of Manitoba.

As there is little consistency in terminology and reference to types of service across the country, it is very difficult to obtain figures or statistics of long term care on a national level. A personal care level 4 in one province would be considered extended care in another province.

Most residents are placed in a personal care home when the care level of residential home care exceeds the services that are available through community programs (Redston, M., personal communications, 1989).

In comparing the statistics of the present need of long term care, there is a far greater projected need in the future as indicated in the following statement:

> "It is estimated that by the year 2000, sixteen percent of Canada's population will be sixty-five years or older. The sixty-five or older age group which presently stands at 7.3% will double ... Today, 8.4% of that group are in long term care facilities. The "graying of Canada" will put an incredible stress on a system that is already breaking at the seams.

New approaches are needed in long term care including how facilities are built and organized" (France, 1986, p. 24).

If Dr. France's prediction is correct, and the need for personal care home placements grows at the same rate as the elderly population by the year 2000, there possibly could be a need for over 16000 personal care home beds in this province alone. When taking into consideration the skyrocketing health costs, the community will need to mobilize additional resources in order to support the residents in their emotional, physical, social and spiritual needs, as these needs have already surpassed the current limitations and resources of the staff working within the long term care facilities.

Residents in personal care homes, have experienced many losses and changes in their lives, i.e. spouses, health, mobility, residence, independency, which can also affect his or her sense of identity and self worth. The resident has to find a way to adjust to living within an institutional environment, probably for the rest of his or her life. They need to seek out a new sense of identity, of purpose, and of reality. Some residents enter a personal care home with a sense

that they are waiting to die, while others enter their new environment with a sense of hope, of new challenges, and new friendships.

In order to respond to the needs of residents in long term care, the practicum report presents a social work intervention which mobilized the special resources in the community to meet these needs through the development of an organized, structured volunteer program in a personal care home facility. As an outcome of this practicum, a training tool was being designed to assist Coordinators of Volunteers to develop volunteer programs specially designed as a support system in long term care and personal care home facilities. Coordinators using this training manual should already have a general knowledge of volunteer management.

Objectives of the Practicum

The first objective of this practicum was to facilitate the development of a framework for a structured, accountable volunteer program at a personal care home. This objective also included the creation and maintenance of a volunteer program, bringing about a community support for residents in that facility.

This objective differed from this author's previous experience in that a major purpose in the development of this program was to evaluate the experiences during the development of the program as to their usefulness and relevancy in establishing guidelines for a Coordinator of Volunteers to use in creating volunteer programs for long term care facilities. The experiences will be compared with management approaches, awarenesses, decisions, and outcomes of other programs coordinated by this author. (Previous volunteer program development was in long term care, probation and child welfare).

The second objective of this practicum was to produce a Volunteer Management Training Manual for the purpose of guiding Administrators and Coordinators of Volunteers in developing volunteer programs in long term care facilities. This report and manual are an outcome of the practicum.

The third expectation of the practicum was to arrange access to the training manual to the Volunteer Centre of Winnipeg for their use in training Coordinators of Volunteers in long term care health facilities.

Objectives for Learning

The first objective for learning was to acquire more knowledge about issues in gerontology as they relate to long term care. It was anticipated that some information would be incorporated into the training manual for the purpose of orienting and training volunteers working specifically with the elderly. Areas studied included society's attitudes toward aging, social services in long term care, family involvement in long term care, the approach of staff to working with terminal illness, and working with special issues such as cognitive impairment.

The second learning objective was to further understand and explore the components of a good volunteer program in the social service sector.

Summary of Chapters of the Report

Chapters I, II and III include an introduction to the practicum, providing the rationale for the project, information regarding society's view on aging, and a literature review on the topics regarding long term care. Previous knowledge and experience of the author in the development of other volunteer programs will also be included in this chapter and others in this report.

Chapter IV presents a review of literature and experience in volunteer management, as it relates to the social welfare sector. This chapter, identifying the development of a volunteer program as a social work intervention leads to Chapter V which is a description of the actual intervention carried out as a part of this practicum.

Chapter V presents the process of the development of the intervention undertaken, including all stages of volunteer management and specialization in volunteer training in working with residents in long term care. This section also covers such topics as Quality Assurance and Staff Orientation.

Chapter VI explores the intervention with some evaluative aspects while Chapter VII examines a special issue of volunteer management around the topic of volunteer-staff relations. These issues include problems encountered in working with other department heads.

Chapter VIII discusses issues around Staff-Volunteer-Union relations including the topic of the use of volunteers during a strike.

Chapter IX presents a summary of the findings of the practicum with recommendations and conclusions.

In order to be able to more fully understand how to meet the needs of the long term care resident, the next chapter will address several issues pertaining to society's attitudes and reactions toward the elderly.

Chapter II

North American Society's Views on Aging

The theme of this chapter is society's response to aging and how these belief systems affect the elderly population within our community.

When examining contemporary North American society, the strongest orientation of the people is toward the young, and there is a certain amount of ambivalence toward the elderly. The aged population are conceived as being either unproductive, inflexible, forgetful, confused and inattentive, or as serene, peaceful, relaxed, and contented with life. In either view, there is an assumption that aging is a uniform process (Rowlings, 1981).

Developmental and transitional theories address the belief that all people age and change in a uniform manner. The transition to old age is a very complex process because the rites to passage are "vague, amorphous, and unregulated." The individual cannot always control the common events in later life that have such a powerful impact on his or her existence (Hullsch & Deutsch, 1981). The developmental approach is one which assists the elderly to cope with these

events, and to understand them as a natural life span process.

The developmental approach views aging and death to be normal, with an adaptive resilience as in all stages of the life span. Rather than supporting a commonly believed assumption that aging is always a downhill process, research has proven that some developmental gains continue to be experienced in old age, along with some developmental losses that are experienced (Maas, 1984).

In experiencing new learning and developing new interests and relationships, much of what is used by the elderly person in learning is their past experience and knowledge. Whereas the young use memorization to learn, the older person falls back on their collection of knowledge and experience which allows them to connect the past with the present and continue to grow (Suzuki, 1989).

Roles play another important factor in the process of aging.

> "Recognizing the influence of social and situational factors on the biological and psychological conditions of aging, we must

> concern ourselves more specifically with position and role changes, notably family and peer roles, and with a relatively new role in the third part of life, that of the retiree. Position in the social structure affects the personality" (Lowy, 1985, p. 145).

The new role of retiree became more common after industrialization. Prior to that time, older people were often given less strenuous positions where they could share their experience, a position of honour, but after industrialization, older workers lost their power when management (varying positions of authority) levels developed and experience was less valued (Lowy, 1985).

Many existing roles begin to change and many new roles come into being. These changes of roles happen with ongoing life events in the later years of the elderly person's life. The work role diminishes in many cases with the oncoming role of retiree. This means making many new adjustments which also could affect the roles of spouse and parent. Grandparenting may also become a new role which often is challenging, exciting and rewarding. The spousal role ceases with the death of a husband or wife, and the widowed person

takes on the single person role of widow or widower, with many changing responsibilities and relationships within that role.

Economic status often changes in old age which also applies more pressure and limits opportunities. Many elderly fall below the poverty line when retiring.

Health factors often affect mobility, independence, relocation and quality of life. Many elderly in our society experience the major problem that "at the time they have earned the right to do what they want, they are often unable to exercise this right in formal ways. The majority of their roles exits or entries are not regulated by them, but rather by others - their families and society" (Hultsch & Deutsch, 1981, p. 344-345).

It is important for a person to have a defined function, as a loss of role would in some ways, be similar to death. Our role often helps to define our identity and sense of self worth.

Society's attitudes toward aging does not help the transition into old age. Advertisements that fill the television screens, radios, newspapers and magazines promote a healthier, younger look. Patricia Moore, in

her address at the Manitoba Health Organization Conference in November 1988, referred to the ageism mind trap of the young people in our society today. They will do anything to prevent the aging process from taking place. Her major concern is that in running from aging, people will not be in a position to identify the needs of the older population and respond to them. Moore compares ageism to Hitlerism where "if you don't meet the norm, you are out ... If your face doesn't meet the younger image, cut it up." Moore is referring to the numbers of people in our society that obtain plastic surgery to keep their "youthful" appearance.

There is a paradox in the approach or attitude society exhibits towards those who are under sixty-five and those who are over that age. Prior to legislation changing mandatory retirement laws, those who were considered to be making a valuable contribution prior to sixty-five were considered no longer capable of contributing valued efforts at retirement.

Society's views may be well rooted in the history of how various cultures reacted to their elderly in preindustrial times. In other societies the value of

an individual was assessed by how functional that person was in the community; the more functional person was respected and revered. Their influence and knowledge were seen as gifts from the spirit world. Once the older age began to take its toll, the elderly person's status and position would change, sometimes drastically (Beauvior, 1972). This historical reaction to the elderly is not unlike our society's reaction to the elderly today. There may be a significant connection.

One of the misconceptions of many members in our society is the belief that growing old is growing senile. This is not the case. However, there are larger numbers every year of residents in personal care homes who do suffer from neurological diseases that cause cognitive impairment. Redston (1989) reported that she believes as many as forty to fifty percent of personal care home residents are experiencing some degree of this type of illness, the major cause being Alzheimer's Disease. Our society tends to devalue victims of neurological conditions, and this practicum will address some aspects of this problem, which will also hopefully assist in changing attitudes in the community.

Our view of the world dictates to us how we respond to the world. Our view of the elderly also dictates how we respond to that segment of our population. Cultural beliefs and values play an important role in how we see ourselves and others in our society. The science of gerontology is a positive science. Steven H. Zarit states "Despite the predominantly negative feelings people have about old age, gerontology is an optimistic discipline. It separates myths of aging from what actually occurs as we grow older and considers both the potentials and the problems older persons have" (Zarit, 1982, p. 17).

Cowgill and Holmes (1972) and Cowgill (1974) state that modernization has caused a progressive decline in the status and social integration of older persons. They discovered that the introduction of modern health technology, modern economic technology, urbanization, and rising levels of education all have worked together to decrease the position for the elderly in this North American society. The existing work ethic and the cult of youth result in the elderly having no role (Chappell, Strain, Blandford, 1986).

Although many of our elderly citizens are discriminated against, the group suffering from cognitive impairment conditions, such as Alzheimer's, are particularly vulnerable in our society. They are exposed to dehumanization on the part of those in the community who believe if a person is old and/or confused, they have lost all value as a human being. In the case of conditions like Alzheimer's, where cognitive impairment and disorientation becomes fairly severe, these victims are prone to lose everything if responsible people do not take a stand.

For example, the Winnipeg Free Press reported on a case where a woman experiencing poor vision, confusion, and poor short term memory, being diagnosed with suffering from Alzheimer's Disease, was swindled out of her life's savings by her two sisters. Due to the amount of trust that she had placed in them, and due to her short term memory loss, she had inadvertently signed over most of her estate to her sisters. This action had left the woman in financial distress. Other concerned members of the family had requested the Public Trustee's office to take over the estate to protect the vulnerable sister's rights. This action

resulted in a court case, the finding of which ordered the sisters to return all the money.

This elderly victim of Alzheimer's Disease is still able to remain in her home with twenty four hour supervision. If her estate had not been retrieved, she would not be able to afford that level of care, which allows her to remain in her own residence.

Communities have the responsibility of ensuring that confused or cognitively impaired citizens are protected and cared for to ensure they do not fall victim to criminal activity and greed.

Another serious problem the elderly face at times is a very negative attitude on the part of the medical community. While treating a patient who had been diagnosed with Alzheimer's Disease, among other serious medical conditions including diabetes, a doctor informed the patient's family that an elevated blood test result indicated the possibility of a very serious medical problem, i.e. a tumor or cancer. When informing the family of these facts, he stated,

> "because this patient is so "old" and "demented", I have decided not to check out this situation any further. Because he is so

"old" and "demented" it would be a waste of time and money to run these tests" (personal communication, author, 1988).

In this case, the doctor was making the decision and a recommendation on the basis of the lack of value he held for the life of his patient rather than what would be in his patient's best interest. Because this patient was old and confused, he was seen as having no value nor worth, and therefore, no rights. He was in a very vulnerable position and he was not able to protect himself or insure he would get the best possible care available to him. With rising costs of health care and limited resources, priorities have to be made regarding service, but the quality of life of the resident should still be of major importance.

Although society's attitudes affect the elderly generally, the most vulnerable group among the aged population are the frail elderly. Those, who through physical and cognitive limitations, are unable to care for themselves, need the support and the involvement of the community to assist them in retaining their sense of self worth, dignity, and a quality of life in their remaining years. They are the least able to protect or

defend themselves against the hardships that may befall them. Within the field of gerontology, there is a need for an advocacy role to address this reality. Community services sponsored by government programs and private agencies attempt to address some of the needs of our frail elderly. However, with a problem of this magnitude, these services will not likely be able to meet the demands required to fulfill these needs alone. The community could take this opportunity to give back some of the contributions, talents, supports, and courage that the elderly exhibited in helping to build this country that they need to rely on in their later years of life.

Society's views on aging enter a long term care facility through the involvement of residents, staff, volunteers and family participation. These values can influence how these parties respond in meeting the needs of the residents. Through the development of a well structured, organized, and accountable volunteer program, orientation, training of volunteers and orientation of staff in volunteerism may give the opportunity to educate many members of our society as to the strengths, potential, and needs of the elderly in our community.

An example of the attitudes that may enter a facility would be a staff member, without proper training and orientation, creating dependency on the part of the residents rather than identifying the residents' need for a sense of independence, accomplishment and self worth. A volunteer could enter a facility with the belief the residents have come to a place to die rather than to start a new phase of their life. Residents also may have this belief until they begin to recognize the opportunities available to them.

Family members are often motivated or affected by the sense of guilt they feel in having a family member placed. They may also need assistance in realizing the potential of life and growth in this new situation.

The next chapter discusses service to the elderly in a long term care facility.

Chapter III

Service to the Elderly In Long Term Care

The theme of this chapter is the discussion and literature reference to several issues involving long term care services for the elderly. In part one of this chapter, the role of the social worker will be examined, discussing the response and attitudes of families of residents towards the long term care institution. The importance of an awareness in staff of special needs of residents and families in the event of terminal illness and death will also be addressed.

Part two of this chapter will focus on the affects of neurological conditions causing cognitive impairment, concentrating mainly on Alzheimer's Disease. This section will also discuss the possibility of the creation of a support system through the development of a volunteer program in a long term care facility.

Part I The Role of the Social Worker in Long Term Care

In examining the role of a social worker in a long term care facility, Roberta Greene (1986) made reference to a quote by B. Reynolds writing in 1942, referring to the function of social work: "The essential point seems to be that the function of social

casework is not to treat the individual alone or his environment alone, but the process of adaption which is a dynamic interaction between the two" (Greene, 1986, p. 175).

The role of the social worker appears to be a major role from the first contact with the elderly person requiring service in the community to the resident who has spent his or her remaining years of life in a long term care facility. The Social Worker and nursing department team up to meet the social, physical, medical, psychological and spiritual needs of a resident. The individual and the environment are important, as without responding to issues and drawing in resources from the environment, the needs of the individual will not likely be met.

In the province of Manitoba, a Single Entry Assessment and Placement Model is used to facilitate the processing of requests for service in a long term continuum of care. This model provides access to the long term care system through a single administrative structure with standardized methodology in identifying needs, planning and initiating service. Each person's case is coordinated by a professional to insure a

systematic approach to service delivery. The social worker's role begins in the pre-placement phase of this model. Often, the social worker takes on the function of a case coordinator, ensuring a systematic approach to service and ongoing communication. The worker ensures that clients' needs are assessed, with services being identified, provided and monitored. The social worker works as a part of a multi-disciplinary team in developing a service plan, requisitions for service and in monitoring service delivery. The social worker works closely with the client and his or her family, coordinating all services for implementation in the home until the client is panelled and placed in a personal care home. These services may include; homemaker service, meals on wheels, public health nurse, personal care attendant, and/or handi-transit for medical appointments. Adult Day Program, a service whereby a client attends a program for one or more days a week and Respite care, where a client is admitted to a personal care home on a temporary basis to provide relief to the caregiver are also services provided through a social worker/case manager (Minister of National Health and Welfare, 1988).

Clients in these types of programs (Respite and Adult Day programs) often make easier adjustments to permanent placement in long term care centres.

The function of a social worker in a long term care facility starts at the admission phase. Pope (1978) identified four phases in this process. The first of these phases is the preparation phase, which starts at the point of the resident making application for placement and ends at their being advised the application has been accepted. The next phase starts with the notification of acceptance and ends at the moment of admission. The transition phase starts upon arrival and lasts during the first day, and the incorporation phase lasts until the residents feels at home (Rowlings, 1981). Social workers are responsible for assisting the residents and their families throughout all of these phases.

Once the resident is admitted to a personal care home, information regarding all the services offered through the facility and the community should be available through the social worker. Another very important function of the social worker is to help the resident maintain previous roles and identify new ones.

A very important role for social workers in a long term care setting is to assist family members deal with feelings of separation, anxiety, guilt, and the concern and worry over their relative's care. The worker will work with other members of staff as well as collateral people in the community to help bring this about. This function of providing support to the resident and the family also relates to providing special care when the resident has a terminal illness and after the resident's death. Grief counselling is a very important role of a social worker in long term care (Lowy, 1979). This support could address losses in both function and role as well as death and dying for both the resident and family members.

In the ongoing involvement of a social worker, family problems and concerns become significant. Common problems encountered might be related to family members missing visits; or coming more often than the residents would like, or family concern regarding some aspects of the care the elderly person is receiving; or a deterioration in the resident's condition which may necessitate a transfer to another floor or facility. In the process of working with the family, the social worker will use

problem solving techniques in working with the family to identify the problem, clearly understand it, make commitments and make future plans with possible review of the process (Silverstone & Burach-Weiss, 1983).

In the role of a social worker in a long term care facility, the worker may seek to change the role of the family members to an auxiliary function, allowing the facility and other resources to lessen the physical and emotional pressure from those who had been the main caregivers. However, the role of the family still remains very important.

The type of relationship that was evident prior to the placement of a resident often dictates what the family relationship will be like after the placement; close positive relationships will likely remain so, while strained, distant relationships may not improve. The energy previously used by the Social Worker in the providing of care to the resident will now likely be directed to providing emotional and social support for the family member in the new environment. Family members attribute the responsibilities of the performance of most tasks to the nursing home staff, but they see themselves responsible for monitoring

and evaluating the efficiency and quality of the care tasks; including sharing with staff information about their family member that will assist the staff in giving quality care (Bowers, 1988).

The family is a very important part of the treatment team who work together with the resident to provide the best quality of care available within the resources at hand. Many staff may believe that after placement of the resident, the caregiver's well being could improve because of a lessening of the burden of care. This is not necessarily so, as the concern and worry may transfer to the welfare of the resident in the facility (Chappell, Strain, & Blandford, 1986). Possibly through establishing a workable partnership between the staff and the family, and giving the family an opportunity to take part in that care, the excessive burden may be lifted. This type of partnership could be coordinated by the social worker who is working with all parties concerned.

Some residents come to believe their usefulness is over by the time they have entered a personal care home. However, when the residents leave themselves open to new challenges and opportunities, they can

discover a whole new world of experiences, friendships and benefits.

For example, in a facility the author had previously worked, a resident in a personal care home was taking oil painting classes. Her work exhibited a lot of talent. When complimented on her painting, she replied "you know, I had thought I had come here to die, and now, at ninety-five years of age, I have discovered that I can paint. I have talent. I can now leave my oil paintings to my family as my legacy." This resident had decided to make the most of the time she had left even though she had already made many adjustments in her life style over the past few years (personal communication, author, 1980).

In another instance, a man in his late eighties entered a personal care home and seemed to have lost interest in life as his work had been so much a part of his identity. Upon taking a walk through the basement level of the facility, he discovered a woodworking shop. He asked if he could use the machines. After observing him at work, the staff realized he was a master carpenter and was very competent on the equipment. He was allowed to work in the shop whenever

he wished (which turned out to be five days a week, several hours each day). This resident's final years were very happy, fulfilling ones, where he felt useful, productive, and appreciated (personal communication, author, 1980).

A common view of a personal care home, or long term care institution is often that of a "place where you go to die." This view can sometimes be the residents' image of their new environment. For most residents, there is a realization that the facility will be their last home. There are two realities to consider here. Firstly, the quality of life may be closely tied into the resident's attitude as to how they use their remaining life while in the facility. The second reality is the truth around the fact that eventually the resident will die, and there are many special services and needs that must be addressed as personal care homes take on the role of hospices in our community.

Research was carried out regarding health care utilization of 4,256 elderly for a period of four years prior to their death. The findings showed that the use of hospital beds by nursing home residents declined as

the ages increased, and the overall use was much lower than the elderly from the community. Records showed that utilization of hospital beds were only increasing in the final year of life for those residents who were over 85 years of age. Otherwise, for the preceding three years, the residents, for the most part, were not closely associated with mortal illness.

Since more of the residents spend less of their time in acute care hospital beds than the elderly in the community, this would indicate the personal care homes or long term care facilities are also functioning as a hospice. With this fact in mind, other needs such as pastoral care should also be taken into consideration. Community churches often assist in volunteering to fulfilling this need (Montgomery, Kirshen, & Roos, 1988).

Katherine Karr, in her book What Do I Do? refers to aspects of caring for residents on a spiritual level. When the elder actually confronts death, in doing so, he or she is often affirming the meaning of life. This meaning may depend on our handling of life's challenges, including how we have loved others. She

states that persons die in nursing homes without being prepared for death because family members and staff, who have not dealt with their own fear of death, have not been able to assist the elder in their last transitional stage (Karr, 1985). Social workers may play a very necessary role in providing support to the dying resident and their family.

When social workers approach supportive involvement with a dying resident, they should consider that "human worth and dignity is extended to include death as a part of life, and dying with dignity is to be accorded a value commensurate to that of living with dignity" (Lowy, 1985, p. 144). In one personal care home, a resident had no remaining family or friends. She was dying and was terrified to be alone. Many staff volunteered their own time to sit with her so she would never be alone until after her death. They afforded her the dignity of dying not only with someone being present but with understanding and love.

Another role for the social worker in long term care is the area of volunteer management. Many social work skills are needed in developing and maintaining a volunteer program. Administrational skills studied in the Masters level can easily be applied to this area of

management, such as program development, evaluation, program planning, research, supervision, and the making of policy. The Volunteer Management Program (University of Colorado, Boulder, endorsed by the Association for Volunteer Administration) and the Canadian National Certificate program in Voluntary and Non Profit Sector Management (offering credit courses at various universities across Canada) are available for advanced training in volunteer management.

The information related in discussing the role of social workers in long term care points to the vast needs and challenges that exist in this type of a facility. However, it hardly begins to touch on the multitude of problems and needs that arise in working with the severely cognitively impaired.

The growing needs of this group of residents will be responded to by social workers, as well as other staff within a long term care facility. However, with the growing number of residents being affected by Alzheimer's, the problems become society's problems and the solutions must also be found within our community as well as in long term care facilities. Part two of this chapter will address this issue.

Part II

The Cognitively Impaired Elderly In Long Term Care

The theme of this section is the growing importance of neurological diseases causing cognitive impairment which, as previously mentioned, affects forty to fifty percent of residents in long term care institutions to varying degrees (M. Redston, personal communications, April, 1989).

This chapter will discuss some aspects of Alzheimer's Disease, the most common diagnosis of this group of neurological diseases, the effects of the disease on the residents, its impact on family members and caregivers, and the problems encountered by family members in trying to cope with the needs of the Alzheimer's victim. Suggestions are presented in the support of the resident as well as the family members.

If this society is going to begin to address the devastating effects of this disease on its victims and their families, the field of social work, along with the field of medicine, could assist with this challenge by educating those in the community about the facts of this disease and the needs of the people who have been touched by it. This fact also applies to the orienting

and training of staff and volunteers in long term care institutions. The purpose of this section is to review some of the literature that has been published about Alzheimer's illness, which also may apply to conditions caused by other neurological diseases.

Alzheimer's Disease

Alzheimer's Disease was originally identified by a German physician, Alois Alzheimer, who described the condition in 1906 (Channing Beti Co. Ltd., 1987). In Canada, 10,000 deaths are attributed to Alzheimer's Disease each year. It is estimated that 100,000 to 300,000 people are affected by this disease in varying degrees.

Alzheimer's Disease is described as a "inexorable, degenerative, neurological disorder for which there is no known method of prevention or cure. Plaques and neuro-fibrillary tangles develop in the cortex of the brain. The reason for this has yet to be determined (Birchard, 1985).

Early Symptoms of Alzheimer's Disease:

Early symptoms of Alzheimer's are almost imperceptible. The victims show common symptoms: They become more forgetful, especially of more recent events,

since the disease affects the short term memory; perhaps they forget to turn off burners or oven on the stove; they commonly misplace things, or lose money, and often will recheck to see if a task is done. These persons take longer to complete routine tasks, and will repeat already answered questions, show an inability to learn new things, and will use poor judgment. Victims of Alzheimer's Disease have difficulty in communicating with others, and may exhibit suspicious attitudes.

Midrange Symptoms of Alzheimer's Disease

These symptoms include a greater memory loss, changes in mood, confusion, irritability, restlessness, changes in personality and behavior, which eventually render the victims incapable of caring for themselves.

Final Stages of Alzheimer's Disease

During the final stages of Alzheimer's Disease, it becomes more apparent that this is a terminal illness. During this stage, the disease is often referred to as "the living death", which the symptoms support. The victim loses his or her ability to communicate, loses the ability to speak, experiences increased immobility, loses bowel and bladder control, exhibits twitching and jerking, and can experience seizures in some cases.

There is a complete absence of any spontaneous movement, and reflexes develop, such as sucking anything put in the mouth. During this time period, the Alzheimer's victim also is very prone to pneumonia and bed sores due to the immobility (Birchard, 1985).

Another reference, Aging, the Facts (Coni, Davidson, & Webster) report clinical information on Alzheimer's Disease:

> "Examination of the brains of Alzheimer's patients showed diffuse loss of the cerebral cortex (The Gray Matter). These patients pursue a progressive down hill course. The course remains obscure, although at a chemical level, there is no doubt that there is a deficiency of the enzyne choline acetyl transferase which is required for the production of the neuro-transmitter acetylcholine and which probably reflects loss of nerve cells in the cortex and in certain parts of the brain stem. This finding offers some hope that the course of this disease might be modified by the replacement of the deficient chemical, as was proven so

spectacularly possible in Parkinson's disease. Heredity may play a part and there is a familial tendency, although the disease is not directly inherited. The disease may be caused by a slow virus infection, and there is certainly a single recorded incidence of an exceedingly rare related disorder being transmitted from one human subject to another by comeal grafting from the affected donor" (Coni, Davidson, Webster, 1984, p. 85).

Chappel, Stain and Blandford reported the following information on diseases that cause cognitive impairment:

"The two most common causes of dementia are Alzheimer's disease, which affects more than 50% of all people with dementia, and vascular or multi-infarct dementia, accounting for another 20%. The remaining causes of dementia are Pick's disease, alcoholism, multiple schlerosis, Huntington's disease and others. Multi-infarct dementia is caused by strokes" (Chappell, Strain, & Blandford, 1986, p. 38).

When examining the total picture of Alzheimer's Disease, it is not hard to understand the great

difficulty that families and primary caregivers have in facing and accepting the reality of the disease afflicting their loved ones. The disease is a progressive disease, but often the victim is able to cover their limitations in such a way that it is difficult to determine whether there is a growing problem with that person, or whether it is the caregiver's imagination.

Oliver and Bock address this fact in their book Coping with Alzheimer's: A Caregivers Emotional Survival Guide. They stated that in dealing with family's responses, the most important key is to understand the family member's feelings.
An example of an important aspect of this disease to understand is how the family member views the actions of the Alzheimer's victim and what he or she told himself or herself about the behavior. Examples of such behavior would be when the inner dialogues don't make good sense, the victims make commands and demands rather than preferences, statements that don't square with reality and can't be supported by evidence, statements that are extreme or exaggerated with inappropriate feelings and behavior (Oliver & Bock, 1987).

Examples of this type of situation exist when a resident with Alzheimer's might relate an experience they believe had occurred earlier that day with someone who had been dead for twenty years. They may exhibit anger and annoyance because they believe someone has stolen a favorite sweater, with the item still in their room, but they no longer are able to recognize it. In the beginning, the family member may believe the resident out of habit and denial of the disease. However, as the behavior becomes more extreme and unexplainable through other means, the reality of the disease finally sets in. At that point, the rule of thumb is "to expect the unexpected".

The process for a family member to actually be able to understand and accept the disease may be lengthy. A frequent response of family members, who are the primary caregivers, is denial. Initially, denial can be adaptive giving the person the time to adjust to that reality. However, if the denial exists beyond the point in time when modifications are required to continue to cope, and there needs to be a realistic evaluation of the situation, the denial becomes maladaptive. Because of the fact that in the earlier

stages of the disease the victim can at times appear lucid and competent, it can be very confusing for the caregiver and make it easier for them to remain in the stage of denial, constantly looking for evidence of improvement.

Finally, the caregivers or family members come to the point where they have no other choice than to expect the unexpected. As Oliver and Bock point out, an Alzheimer's victim is not a person going through a second childhood. He or she is a person whose illness has severely limited them in being able to have access to their lifetime store of knowledge and experience (Oliver & Bock, 1987).

This is a very emotionally painful disease, both for the Alzheimer's victim as well as those who are a part of his or her life.

Problems Encountered by Caregivers of Residents with Alzheimer's Disease

The resident gains awareness of inabilities causing frustration, fear, tears, anger, embarrassment or humiliation and depression. The caregiver should give great reassurance and support with the message that the person is still loved.

Memory loss brings about a need for consistent daily routines, requiring patient and frequent reminders in the form of spoken words, calendars, clocks, diagrams, lists and schedules. The caregiver must show patience, as these reminders will have to be repeated continuously.

Poor judgment and erratic thought processes bring about the need for the caregiver to try to identify certain changes in decision making, as previous good judgment skills may become poor judgment skills as the disease progresses. At this point, the caregiver may find it advisable to take over some of the legal responsibilities of the Alzheimer's patient.

Wandering is a problem with many Alzheimer's victims. The caregiver, upon discovering the resident who is wandering, should be careful not to startle or frighten the resident, but to gently guide her or him back to familiar surroundings. Identification bracelets or labels on clothing can assist in locating the wanderers.

The Alzheimer's Association has a wanderers registry for those people in the city who are affected with this type of condition, and a search procedure is

activated upon receiving word that the person is missing.

Repetitive behavior, such as repeating questions and pacing is also a common symptom. Answering questions with short simple answers may help and otherwise, it is suggested that caregivers can try to ignore repetitious behavior whenever possible or appropriate.

Residents with Alzheimer's may have difficulty sleeping at night, may wander in the night, may have severe nightmares, and hallucinate. They also appear to be fearful of the dark. Caregivers can assist by helping the resident to be more active during the day. Night lights may also help the resident to settle for the night.

One of the most severe emotions of an Alzheimer's victim is fear, creating extreme anxiety. The resident has difficulty recalling her or his surroundings, and misconstrues objects or events. Caregivers can respond to this fear through gentle reassurance, touch, hugs, and supportive words. The caregiver or volunteer's presence also helps to lessen the level of fear being experienced by the resident.

One of the more difficult problems for caregivers to deal with is aggressive behavior. This behavior constitutes mood swings, quick changes of mind, angry outbursts, which are all due to the resident's damaged grasp of reality. The resident reacts to misperceived threats, dangers or insults. The outbursts may be from misconceptions which the resident may have believed for sometime. It is not always effective to use logic or to try to reason with a resident with Alzheimer's, as they do not always have an accurate perception of reality.

Communication becomes an increasingly serious problem as the disease progresses. Some suggestions to assist in communication with a resident suffering with Alzheimer's Disease includes:

As the ability or capacity for communication decreases on the part of the resident, other forms of communication become important, such as stance, tone, or facial expressions.

Understanding and responding to body language may prove very helpful to caregivers, family members and volunteers.

It is helpful to use short simple sentences, spoken slowly and clearly. It is recommended that one

should present only one statement or question at a time, allowing plenty of opportunity for a response. Affirmative statements work better than questions.

When speaking to a resident with Alzheimer's, remain in front of that person to maintain eye contact, always remembering to call that resident by name. Also, it is advised to reinforce the spoken word with objects or demonstrations.

The visiting of residents with Alzheimer's Disease is very important for additional stimulation, thus giving the resident an opportunity to use whatever social skills are still remaining. Many of these people are still social by nature and enjoy the contact. This stimulation enhances communication.

Promoting Independence

Residents with Alzheimer's Disease gradually lose their ability to care for themselves. Caregivers can use the following steps to encourage the resident in self sufficiency for as long as is possible.

Give simple reminders to brush hair and teeth. Consider that tasks may need to be broken down into smaller steps that are within the capability of the resident so he or she can still take some responsibility in taking care of themselves.

Caregivers should assist with tasks no longer within the capability of the resident. During some of the programs this author has coordinated previously, volunteers have assisted the hairdresser, and have applied make-up and manicures to the residents. This often picked up their spirits and provided a service that residents, staff and families, alike, really appreciated.

Diet and eating presents a problem when the resident forgets that he or she is on a special diet, forget to eat, or eats several times daily, forgetting that they have already eaten previously. For example, prior to admission to a personal care home, one Alzheimer's victim would eat everything in sight, including high sugar content foods. With uncontrolled Diabetes, he was admitted to hospital after losing consciousness in a neighbourhood grocery store. With the constant monitoring of his diet and other activities to divert his attention away from eating between meals, his diabetic condition is now stabilized.

The families of residents with Alzheimer's often feel guilty because they were unable to cope with the

needs of their loved one, and had to arrange for placement in a long term care facility. One of the statements made by Fraser and Thornton in their book Understanding Senility was that people experiencing Alzheimer's Disease become unrealistically demanding, and the main caregiver must learn to put themselves first at times, after all reasonable needs have been met (Fraser & Thornton, 1987).

Families of Alzheimer's victims may act out the concern they have regarding their family member's care, which may explain their reaction to the facility, e.g. expressing anxiety, criticism, or worry (Fraser & Thornton, 1987). If all people, staff and volunteers alike, can view the family as an integral part of the care system, the family would feel a sense of contributing, which could relieve guilt they may be feeling.

Legal issues are important issues to deal with when a diagnosis of Alzheimer's have been made. Marvin Ross, who wrote the Silent Epidemic presents several suggestions that families should follow, including arranging for a power of attorney to take over financial and legal affairs, having the family member with Alzheimer's make out a will before total cognitive

impairment occurs, and canceling any credit cards, or drivers licence, that may exist (Ross, 1987).

Once the Alzheimer's victim is admitted to a long term care facility, they still remain very vulnerable. Policies regarding accepting gifts, money, or signing legal documents should be established for the purpose of protecting volunteers, staff, and residents, alike.

Clark and Lennox in their article "Family Supports" stress that education is a vital tool in improving the quality of care to the Alzheimer's family member, while at the same time, minimizing the burden of the caregiver. Emotional acceptance of the disease will come more easily with gaining an intellectual understanding of the situation. Specific information as to the medical diagnosis, medications, and the prognosis of the resident will assist the caregivers in caring for the resident (Clark & Lennox, 1987).

Education regarding this type of disorder or disease is also essential for volunteers who will be personally involved with residents suffering from this type of condition. It can be very frightening to a volunteer or a new staff member to work with a very

disoriented resident if they have no knowledge of what to expect or how to react to the resident. The training package in the volunteer manual addresses this issue. Nancy Peppard (1986) reported when the facility counselled and supported families, resident's functioning levels improved, as well as the satisfaction levels for families (Peppard, 1986).

According to the Winnipeg Free Press, N. Mace who was co-author to The 36 Hour Day, stated "tender loving care, not sedation, is the prescription for Alzheimer's patients. Staff have to learn how to incorporate patience and gentleness into the regimented pace of most nursing homes. What is very important now is that while we can't cure the disease, we can change the quality of life for the patients and their families" (Winnipeg Free Press, 1989).

There is a great sadness when it comes to the later stages of the disease. A time usually comes when the resident will not know their own family members. However, it is believed that emotional memories of relationships are the last to go. Dorothy Coons referred to seeing family members coming to visit their parents, and their parents would respond. They would

not know who their visitors were, but would know the person was one he or she had been devoted to in a very special relationship (Kattermen & Lee, 1983).

It is often during this later stage, just prior to death that the social worker and the rest of the staff should become sensitive to the needs of the resident and family in dealing with the pending death of the resident. The stages of grieving, such as denial, anger, depression, bargaining and acceptance (Kubler-Ross, 1969), are stages that many family members have already experienced through the course of their loved one's illness.

Often, by the time the disease has affected the resident to the degree that mentally and emotionally that person no longer appears to exist, the family have already mourned their loss. However, this, too is a issue that family members may want to work out. Some may also experience these stages again, and will need assistance to deal with the reality of the loss. The death of the resident also changes the focus of attention of the caregiver in the family. The facility, staff and volunteers have often become a very large part of that person's life and their role as a

family member of a resident no longer exists. Often, after an appropriate time, that family member may want to volunteer in the facility to keep up the contact and help with the adjustment. Several family members did volunteer after the death of their loved ones, which provided an opportunity to use the skills learned and give something of themselves.

In summary, when taking into consideration the vast needs of the elderly resident in long term care, and the functions and responsibilities of staff to assist in meeting those needs, the facilities require assistance in attending to the quality aspects of the lives of their residents. As was earlier suggested, a well developed volunteer program can be created as part of a social work intervention to assist in adding to the quality of the lives of residents and their families.

In the next chapter, the topic of the relationship of volunteerism to social work will be discussed, revealing the important connection in the history of the social welfare system of today.

Chapter IV

The Relationship of Voluteerism to Social Work

This chapter will examine the history of volunteerism and how the private efforts of volunteers evolved into the present social welfare system. In actual fact, social work and volunteerism are very closely connected. Examining the beginnings of a social welfare system on the North American continent will help to clarify how the development of a well structured volunteer program can be seen as a social work intervention.

The original conception of volunteerism, as a required formal practice, emerged out of "the social contract of 1620", which was the covenant entered into by a group who migrated to North America known as "the pilgrims". This covenant as stated in Old English, presented that the people were "strictly tied to all care of each other's good and of the whole by everyone and so mutually" (Ellis & Noyes, 1978, p. 15). The value system came out of their belief that all men were evil and it was through good deeds that man could obtain grace. This belief was also basic to Puritanism, which presented that each member of the

community would take the responsibility for different aspects of community life (Ellis & Noyes, 1978). This belief system is still central to many main line churches today in our society.

The social service sector began to grow through the volunteer movement, and during the colonial period, the charities of that time were not highly organized. Society's value system did not endorse giving something for nothing. However, it was recognized that there were people, who could not care for themselves, and needed help. Almhouses were established for that purpose. Workhouses were established to assist able bodied men.

As time passed, the needs of the community grew to the extent that they would no longer be addressed privately through the volunteer efforts of individuals or church groups. Finally, the government had to take responsibility for meeting some of those needs, while paying for those costs through taxation. This began the establishment of the institutionalized social welfare system.

Jackie Wolf, in her study of the voluntary role in Canada and the United States, presented that where

there was a view of church and state being one entity, integration existed between the church, state, the economy, and the private sector. This came about through the religious and political views of the settlers being infused with the Spirit of Enlightenment (Wolf, 1985). The Spirit of Enlightenment is a philosophical movement of the 18th century, characterized by rationalistic methods and skepticism about established dogmas (Funk & Wagnall, 1980).

In the United States, as this new republic developed and matured, they began to take on the Federalist direction politically. They believed "the rich are stewards of the souls and bodies of the less fortunate, or those known as the "not chosen" from a Calvinist perspective" (Wolf, 1985, p. 5).

In the southern colonies, the church and state were seen as separate organizations, and there society developed along the more traditionalist lines. Their government or service department was growing in a parliamentry direction, rather than an ultra democratic or populist format. The southerners were becoming Jeffersonian Democrats, following more closely

to the British Parliamentry style. During the earlier years, the main strength in their system of charity seemed to be in the strong one-to-one relationship between the donor and the recipient. This was considered the first stage of volunteer development in the United States.

Samual Martin describes Canada's first stage of volunteer sector development in the same way: "Stage one is individual to individual. Society is characterized by a high degree of personal involvement, interaction, and responsibility for the delivery and receipt of humanistic services" (Wolf, 1986, p. 10).

The second stage of the development of the voluntary sector was from 1870 to 1920 which was known as "The Golden Age." Philanthropy, defined as the disposition or effort to promote the happiness or social elevation of mankind in general (Funk & Wagnall, 1980), began to develop due to a desire to change society by ridding it of all the ills that charity sought to lesson. Charity would provide the "hands-on" care to tend the sick, while philantropy would work to try to eradicate the virus or eliminate the conditions causing the illness. Also, a view of

the Social Psychology of Benevolence became a factor with volunteers providing more specialized professional services and taking on more essential services.

In Canada, the second stage, "Individual to Institution", was marked by the institutions beginning to provide more of the services required. Hospitals, museums and schools became the projects of some philanthropists in the country.

During the 1920's there was an enormous increase in human need as well as an increased social awareness of that need. This became even more apparent during the 1930's and the great depression, when Franklin D. Roosevelt's "New Deal" was introduced. The needs of society had grown beyond the capacity of the voluntary sector to meet them. Governmental programs had to be developed to address this new social challenge.

Martin relates Canada's third stage of development of the Voluntary sector as "Collected Individuals to Institutions." Organizations that were meeting society's needs became inundated with requests and demands of increasing social problems, and had to request additional funding to supplement their own resources which no longer could meet the need. As

these demands increased, it was recognized that demands for services funded from Voluntary financial resources must be balanced against the need for financial resources to sustain the organizational infrastructure so the need for public support was acknowledged (Wolf, 1985).

As a continuation of the growth of the Canadian Voluntary Sector, stage IV is reported by Wolf as being Society to Institution: As the whole topic of human rights emerge, and as society develops a keener sense of their responsibilities toward human need, it decrees that its members shall be provided with an appropriate level of health care, education, cultural enjoyment, and the social well being which now falls under the jurisdiction of public fundings and programs not private goods. Martin sees Canada as presently being in stage IV which is consistent with this nation (Martin, 1985).

The historical content of the development of the Volunteer sector between the United States and Canada is very similar. There is an indication that where the church and state is seen as one, there was a different pattern of development than where the two were seen as

separate organizations. The changing roles and responsibilities are developing at a similar rate.

One theme that is common in both countries is that volunteerism appears to be the backbone of our social order as it presently exists. The entire social welfare system was born out of a tradition of charity and the belief that all have a responsibility to the less fortunate.

Margaret Mead once stated:

> "We live in a society that has always depended on volunteers of different kinds, some who can give money, others who can give time, and a great many who give freely of their special skills. If you look closely you will see that almost everything that really matters to us - anything that really embodies our deepest commitment to the way that human life should be lived and cared for depends on some form of volunteerism" (Coutts, 1984, p. 28).

Volunteerism and the social welfare system appears to have evolved at the same time. The original volunteers were non professional workers. In this practicum, addressing the topic of long term care in the area of Gerontology, social work and

volunteerism are brought together in a intervention which addresses the need of our elderly in long term care. Many of the elderly being served in the personal care home settings were the volunteers of yesterday, actively helping to create the social welfare system they have come to rely on to meet their present day needs.

Through the organization of volunteers by professionals, service agencies are being supported in providing the care required within this society. The pattern appears to be moving toward both the society and individuals picking up the slack for institutions, rather than the institution taking over from individual volunteer efforts.

Volunteer Management in Long Term Care in Winnipeg

As the need for long term care placements increased in this province, there was a greater awareness of the role that community supports would have to play in order to address the special services provided to the residents. One possible answer to this need was the development of structured, professionally directed volunteer programs to recruit, supervise, and evaluate the community assistance to residents in the

personal care homes. These programs began to emerge in the very late 70's and when the author was hired as a Coordinator of Volunteers for a personal care home in 1980, this position was only the third of its kind in Winnipeg. More personal care homes began to establish Coordinator of Volunteer positions, and in 1981, a group, known as Volunteer Administrators of Long Term Care was formed (V.A.L.T.C.). In 1982, the organization established its by-laws and began to grow in numbers and activities. At one point, the organization was representing a total of approximately fourteen programs, which gave the members an opportunity to see the various patterns that emerged.

One reality that was very apparent was that these positions, and programs, were on a pilot project basis, with no real security and in a constant fight for survival and recognition. Although anyone directly involved in decision making and evaluating the services of a facility could see the value of such programs, the funding bodies would usually not fund Coordinator of Volunteers positions. On the one hand, the personalized services that were being provided through the volunteers were seen as essential and very

valuable. On the other hand, they were not accorded financial and administrative support, as a result, many programs were curtailed. As Coordinator positions were discontinued, the volunteer programs themselves disappeared even though efforts were made by other staff to ensure their continuance.

The setting where this practicum took place is a good example of this type of situation. There had been a full time Coordinator previously in that personal care home but at the start of the practicum, there was little or no volunteer program in evidence. This was the fact even though the Director of another program area was also designated responsible for the volunteer program. The experience of the V.A.L.T.C. organization was that when the Coordinator of Volunteers responsibility was taken over by the Director of Activities, the program usually didn't survive, partly due to a conflict of interest (with Activities often being the only department to receive volunteers), and because the pressure to respond to the needs of the Activity Department usually required all the time or energy available.

Presently, there are fewer professionally coordinated programs in personal care homes than there

were four years ago, even though the programs which do exist have become more advanced, creative, and address the needs of personal care homes more extensively than in the past (Putz, personal communication, 1989).

The potential of a volunteer program can be outstanding, when properly coordinated and supported. This author previously developed a volunteer program in a personal care home that recruited over 20,000 volunteer hours of volunteer services a year. There were over two hundred and fifty volunteers involved in the facility, with literally every department being supported by volunteers. The position was replaced by a part time Coordinator, whose position was brought down to less than half time, and within less than two years the total number of volunteer hours was only around 7,000. This facility has since given the responsibility to a staff person who is not only responsible for the Volunteer Department, but two other departments as well.

When the volunteer program was operating at its fullest capacity under one full time Coordinator, the Board of that facility determined that the program was

providing a minimum of $100,000.00 a year to the facility in specialized services. However, as this position was not funded by the major funders, and as the facility came under a financial crunch, the full time Coordinator position was the first expense to be eliminated. One would have to question the wisdom in that type of decision. However, it seems that the direction the facility took is not an uncommon one.

There are still several programs leading the way in volunteer management in the long term care facilities, but more work must be done to ensure their existence and their growth.

The next chapter will describe the intervention taken in this practicum, the development of a volunteer program in a long term care facility.

Chapter V

The Intervention

The major part of the activity for this practicum was the development of a volunteer program in a personal care home. The facility, where the intervention took place, serves well over two hundred residents, providing all levels of care, ranging from residents requiring assistance with medications, bathing, meals and laundry to residents needing twenty-four hour medical supervision due to severe physical or cognitive impairment.

The Setting

This specific setting was chosen due to the fact that the organization was in need of the development of a volunteer program to meet accreditation standards through the Canadian Council of Health Facilities Accreditation.

The Director of Nursing had previous experience working in long term care facilities and strongly believed in the benefits and value of a volunteer support system in a personal care home.

This facility is owned privately by a large corporation which acquired real estate property across

the United States and Canada, with many of the properties being retirement homes and personal care homes. The building was originally built about twenty years ago as a retirement home, and has since been changed to a personal care home.

A wide variety of services are offered for the benefit of the residents. These services include medical services such as medical doctors, chiropodist/ podiatrists, denturists, dentists, an optometrist, audiology, and transportation for medical appointments.

Full nursing services include registered nurses, registered psychiatric nurses, licensed practical nurses, and nursing assistants. Nursing services are available twenty four hours a day.

Other services offered are pharmacy, laboratory, physical therapy, occupational therapy, dietary, activity and recreation services, social services, pastoral care, and physical plant services (to ensure the operation of the building, heating, plumbing and maintenance), housekeeping and laundry.

The rooms for residents vary from single deluxe to rooms shared by four residents. The majority of the rooms are semi-private, shared by two residents.

Approximately one hundred residents take their meals in the large dining room, while the remainder eat in small lounges on the floors.

The facility's layout is not very conducive to a personal care home, as it was not originally designed for that purpose. Multi floor levels can create transportation problems for the severely disabled and for the residents in wheelchairs. This factor became important when assessing the need for volunteer supports later in the program.

The Time Frame

Negotiations for this intervention took place between the Director of Nursing, the School of Social Work, and this author in early October, 1988. Initial contacts were made with the manager and the department heads regarding planning for the implementation of the program and the coordination and support of the Lodge's Annual Tea prior to the official practicum placement. This author started the development of the intervention on a thirty-two hours a week basis in mid October, 1988. The last formal date of this intervention was April 21, 1989.

The Activities

Prior to the official start of the practicum placement, a meeting took place between the staff member who had the responsibility for coordinating volunteers and directing activities, the Director of Nursing, and the author to discuss the implementation of the practicum project in the facility. The main concern expressed by the permanent staff members at that time was the annual tea scheduled to take place at the facility in less than two weeks. No planning had taken place and no volunteers had been recruited. The Director of Nursing suggested that as the author had coordinated this type of event many times in the past, the author commenced by coordinating the tea and recruiting volunteers for the dining room to serve in the event, would be a very positive way of introducing the program in the facility. The program would become visible in a very helpful manner. This arrangement was agreed upon, and there were eight outside volunteers recruited to assist in serving tea while the regular staff concentrated on running the remainder of the activities. Besides the volunteers, there were a few staff and department heads assisting with the event,

which ran very smoothly. Staff gave positive feedback about both the coordination of the tea serving, as well as the extra assistance they had received from the volunteers.

Program Planning

A meeting took place between the Director of Nursing and the author during which historical and current information was shared about the facility and previous volunteer activities that had taken place. Issues that were discussed included staff experience in their present situations, staff morale, some political issues, staff-management relations, and how a volunteer project would fit into the picture at the facility. An agreement was made between the Director of Nursing and the author that all department heads would be interviewed with the objective of obtaining information as to what knowledge the department heads have of previous volunteer involvement at the facility, if they ever worked with volunteers in the past, whether they were in favour of the development of a volunteer program at the facility, if they aware that the previous accreditation survey evaluators recommended that a volunteer program be redeveloped before the next

accreditation survey takes place, and what roles or functions would they see volunteers fulfilling in their departments.

The history of the facility and the previous volunteer involvement in the centre played a large part in the feedback received from these departments in response to the questions asked. General response to the first question was that a previous coordinator had been hired on a term basis for a period of one year. Any previous involvement with volunteers had been seen with skepticism, mistrust, and a belief that a volunteer program would not work at that facility due to the following reasons:

A. The volunteer program would not be viable due to the downtown location of the facility.

B. A lack of parking space would prevent people from volunteering.

C. As the volunteer department fell under the supervision of another department, the department head would have difficulty coordinating both programs at the same time.

D. There were communication problems between some departments that would make working cooperatively with

the volunteer department and Coordinator difficult.

E. The previous Coordinator who had worked between two facilities had tried to build a program and had not succeeded as the program was non-existent shortly after her term had finished, and therefore it was tried, and didn't work, so why try again?

One factor that did stand out was that no person who had held the responsibility of coordinating volunteers in that facility, past or present, was properly qualified. There had never been a sound foundation developed for the program.

A consideration in determining whether a program can be evaluated is a synthesis of the information which has been collected resulting in the development of a "rhetorical program model" which is a flow model or models depicting intended resource inputs, intended program activities, intended impacts, and an assumed causal link (Rutman, 1977, p. 23). The information gathered was a starting point in determining what was required in the way of inputs, activities, needed resources, and what type of outcome would be feasible and desirable.

A further awareness was reached through the contact with the department heads that also affected the development of the volunteer program. This awareness was the fact that other than the Director of Nursing, few of the department heads had experience in working with volunteers in the past and they readily admitted that they knew very little about working with volunteers, or volunteerism generally. Most of the department heads were recently hired into their own positions, so they also did not feel they could take a very active role in assisting to build the volunteer program's framework.

The response of line staff to the proposal of a volunteer program was not unlike the department heads. However, several staff did indicate it would be nice to have a good volunteer program operating in the facility. Residents in the facility did indicate an interest in having a volunteer program and were able to suggest several duties that could be fulfilled by volunteers.

Susan Ellis suggests that training should be supplied to staff in working with volunteers, the degree of acceptance of volunteers on the part of staff

should be monitored, staff should be asked about their own experience with volunteerism when being interviewed, and when the staff should be responsible for supervising volunteers that responsibility should be included in this job description (Ellis, 1986).

Developing the Framework of the Volunteer Program

Due to the information received from the staff related in the previous section, the framework of the program, which consisted of the mission statement, the philosophy, goals, objectives, and policies and procedures, would have to be developed by the author. The department heads, who ideally should have been involved in the development of the structure of the program in order to gain a sense of ownership, were unable to handle this responsibility, due to a lack of expertise, time, and experience.

The author developed a mission statement, which was a brief description of the purpose or intent of the program. The philosophy was then written, which presented the principles of operation in general. The philosophy can also present the general laws through which the program could function.

Goals are defined as "statements, usually general and abstract of desired states in human conditions and social environments (Rossi & Freeman, 1985, p. 60). The author developed goals in response to the identified needs for the program in the facility.

Objectives were also identified and developed in relative terms. They were also stated specifically in order to be able to measure them in the future. Rossi and Freeman describe objectives as "specific and operational statements regarding the desired accomplishment of the social intervention programs" (Freeman & Rossi, 1985, p. 60).

The author developed these statements with the values of the organization and the existing conditions and limited resources in mind.

The Director of Nursing reviewed and approved the statements of mission, philosophy, goals and objectives. The next plan was for the author to create the volunteer policy and procedure document. These policies were to be developed using a similar model of policies and procedures for other personal care home volunteer programs.

After developing the policy and procedure document, and having it reviewed by the Director of Nursing, the author established a committee of volunteers to review and give feedback on the policy and procedure guidelines. The recommendations were incorporated into the document. Establishing methods for volunteers to express concerns and offer suggestions is one way of assuring ongoing volunteer motivation and appreciation (Ellis & Noyes, 1981).

In order to ensure that all administrative and department head personnel were aware of the structure of the program and were able to take some ownership of the responsibility for the volunteers, a staff meeting was called, the statements were circulated and the staff group approved the structure with a few minor revisions.

A policy was developed that policy and procedure documents would be signed by the volunteers signifying that they have read the guidelines, understand them and are in agreement with them. These policies would be circulated to all volunteers and staff so that all parties concerned would have an understanding of what volunteers are allowed to do and the roles they should

not fulfill in the facility. The policy and procedure statement helps to protect the facility from legal action in the event that the volunteer does not operate within the guidelines. A voluntary organization should provide very specific job descriptions and guidelines to ensure the volunteer is aware of the rules for functioning within the facility (Clark, 1988).

The next step in the development of the framework of the program was the creation of forms used within the facility to aid in the communication between the various departments and the volunteer department. These forms included volunteer request forms, data information forms, monthly statistical forms, volunteer application forms and a job description format.

The reason for the importance of this part of program development is that good communication is essential for the successful operation of a volunteer program in any facility. As communication within this setting was already poor, the author felt the development of a structured communication format would be very beneficial to the survival of the program both during the project, and after the practicum was completed.

For further detail on how these responsibilities ideally should be completed, see Volume II under "Developing a Framework of a Volunteer Program", completed as part of this practicum by this author.

Developing a Budget for a Volunteer Program

The process of developing the budget for this program did not match the usual situation as the Coordinator, in this case the author, was not a paid staff person. All typing, production of forms, invitations, postage, and office supplies came out of the general budget. Funding was provided for special expenditures such as volunteer name tags, recognition certificates, badges, and posters. For the most part, whatever supplies were required were provided through the use of other accounts. The facility also provided a recognition dinner for volunteers which was prepared and served by the food services department. That department provided refreshments for many of the meetings, orientations and training sessions that took place. Much of the money that would have been required by this program was provided to the volunteers through the Food Service Department.

For further information on developing budgets for volunteer programs, see Volume II under "Developing a Budget for a Volunteer Program".

Staff Orientation

The staff orientation would usually take place at this point in the development of the program. It was at this point when the author began to negotiate for a staff orientation of department heads and nursing team leaders within the facility. Several attempts were made to find a date acceptable to all concerned, but months passed before a date was agreed upon. Finally, one half hour before the orientation was to take place it was discovered that over half the staff were not going to be available. It was cancelled. Another attempt was made a few weeks later. Most attended but were preoccupied or concerned about getting back to the floors. It was not a very fruitful meeting. The volunteer program did not appear to be a priority to many staff on the department head/team leader level. As the staff all had other pressures, scheduling problems and priorities they were asked to read the information packets when they had time and to make them available to staff in their departments.

The Coordinator of the Activity Department, who was also responsible for volunteers, requested to have a staff orientation session held for her department. This orientation took place and staff indicated that the session was very helpful, and they found it enjoyable and beneficial.

The staff orientation packets were developed by this author and included the volunteer program's mission statement, philosophy, goals, objectives, volunteer policy and procedure guidelines, request for volunteer form, volunteer log sheet, monthly statistical sheet, facts on volunteerism, and fire and safety rules for volunteers.

Several staff orientation packets were given to the staff person responsible for volunteers at the end of the practicum, to be distributed to present and new staff who will be working with volunteers. For further information on staff orientation, see Volume II under "Staff Orientation to the Volunteer Program".

Developing Job Descriptions and Negotiating Job Placements for Volunteers

The definition of a job description in Basic Steps in Volunteer Management is "a written report outlining

the duties, responsibilities, and accountabilities of a job within an organization" (Thomson, 1981).

While creating the Request for Volunteer form, the author requested enough information on that form to be able to develop a job description for the prospective volunteer required. The job description acts as a guideline of what the volunteer is expected to perform and forms a part of the verbal contract between the volunteer and the facility.

To get the program off the ground, the author met with the Director of Nursing and the Coordinator of Activities, and filled out Request for Volunteer forms, for them (recording required information to develop a volunteer job description) during a meeting to discuss various needs for volunteers in their departments. They reviewed the forms and signed them, passing the forms back to the author in order to develop job descriptions for the volunteers. In the initial stages, approximately sixteen different job descriptions were developed by the author. These job descriptions were reviewed by the supervisors, confirmed, and passed back to the volunteer department for recruitment. Normally, the request forms would be

made out by staff, but as time was limited in the practicum, a faster process was initiated.

The job descriptions developed provided assistance in Activities, Special Events, Medical Escort, Nursing, Office, Medical Records, Baking program, Crafts, Bingo, Carpet Bowling, Volunteer Department, Food Services, Elevator Operator, Shopping Trip Escort, Birthday Party and one-to-one resident visiting. The information presented in a job description included the job title, purpose of the assignment, an itemized list of responsibilities, time requirements (time of day, days per week, total number of weeks, months or year), and skills and qualifications, including any special qualifications that may be required. Orientation and training available would also be listed, as well as the line of accountability and authority. Sue Vineyard stated that job descriptions should be flexible, practical, honest, and designed with input from others (Vineyard, no date published).

A meeting between the potential volunteer, the supervisor and Coordinator of Volunteers to discuss the job description helps to clarify points for all concerned. When all parties are aware and in agreement

of the content, the placement usually runs more smoothly.

Upon receiving the requests for volunteers, the author would screen them to make sure they were appropriate requests to be filled by volunteers (were the requests within the realm of ability and skill level of volunnteers, challenging, creative, and offering a rewarding experience). Legal issues need to be taken into consideration as well as whether the request is going to negatively affect staff or residents in the facility. During the process of negotiating the placements for volunteers, the author would also try to assist to broaden the vision of staff in the ways volunteers could be utilized within their departments. This was also done during the staff orientation sessions. For further information on this topic, see Volume II under "Developing Job Descriptions and Negotiating Job Placements for Volunteers".

Recruitment of Volunteers

The recruitment carried out by the author in this practicum setting was limited, compared to full time, ongoing volunteer programs. As was mentioned earlier,

volunteers were recruited from personal contacts for the Annual Tea in October, 1988. Due to staff morale and staff resistance difficulties, recruitment started slowly, with the Christmas programs being supported by about eight volunteers in total, covering four different special events. Regular recruitment began in January, 1989. About sixteen separate job descriptions were registered through the local volunteer centre, some churches and community centres were approached, and word of mouth by volunteers and staff also was effective in recruiting volunteers. Posters and pamphlets were developed. Advertisements appeared for our job descriptions in the media through the coordination of the volunteer centre.

Many volunteers want opportunities to participate in problem solving and significant decision making. Volunteer opportunities should relate to the interest, needs, and aspirations of the volunteer (Fisher, 1986).

A total of about thirty-two volunteers were recruited. However, it was decided between the author and the administration that further recruitment efforts would stop due to the fact that a full time staff Coordinator would not be available to take over the

program at the end of the practicum placement. The present staff person who would inherit the responsibility of the program, and who was already running another department, would not likely be able to carry more than this number of volunteers. For further information on recruitment, see Volume II under "Recruitment of Volunteers".

Interviewing, Screening and Assignment of Volunteers in Long Term Care

After prospective volunteers showed an interest in the volunteer program, this author arranged to interview the applicant with the following goals in mind:

A. To share information about the facility and the volunteer program.

B. To gain more knowledge about the applicants and their motivation for volunteering at the facility.

C. To evaluate their suitability for acceptance into the volunteer program.

D. If suitable, and interested, to provide a brief orientation to the facility. This orientation would include a short tour, printed information on the program and introduction to staff and other volunteers.

E. To discuss various opportunities available within the volunteer program and if possible agree on one of these job descriptions as a job assignment.

When interviewing applicants for long term care volunteer programs, the following issues were discussed: the reality of working in a health care centre, where policies, schedules, and routines are very important in providing good care to residents. Even though special rules governing possible medical complications and conditions appear in the volunteer policy and procedure guidelines, adherence to those rules can not be overstated.

Mason sees organizational volunteers as both workers and hobbyists, with varying expectations of functioning on the part of both volunteers and staff. Workers are assumed to work for instrumental benefits, in exchange providing sustained reliable job performance, while hobbyists do what is enjoyable when and how they wish (Mason, 1979). These motivations should be taken into consideration during the interview and job placement.

Another issue often causing problems with volunteer applications in long term care is for those

who are applying to volunteer but have the intent of obtaining paid employment. There were many persons who were applying that were not interested in volunteering (working without pay, using the volunteer program to get in the door) and once they discovered that there were no jobs available, they would leave, often without any notice. Time and energy spent on training these people were wasted and staff were annoyed by this practice. This author recommended a policy, and instituted it, to counteract this practice. All volunteers being accepted in the program had to agree to volunteer for a minimum of three months before submitting an application for paid employment. This policy was instrumental in lessening this problem considerably.

A third concern discussed during the interview process is another issue of motivation. Some applicants become involved in personal care homes because they have recently lost a relative through death. They may be trying to resolve their own grief, or their own fear of aging. This fact does not automatically make the person unsuitable, but could indicate a need for

additional supervision and support in the program.

Job assignments took place jointly between the volunteer, the staff person requesting the volunteer and the author. The volunteer was introduced to the staff supervisor, and a review of the duties of the job description would take place. In the case of the one-to-one visiting assignments, the staff member who had requested the volunteer would usually introduce the volunteer to the assigned resident.

Overall supervision of the volunteer assignments remains with the Coordinator, or in this case with the author until the completion of the practicum project. For further information on this topic, see Volume II under "Interviewing Screening and Job Assignment of Volunteers" in the Volunteer Management Training Manual in Long Term Care.

During this project, this author interviewed approximately fifty people indicating an interest in volunteering at that facility. A total of thirty-two applicants were accepted and assigned to volunteer positions in the facility. The majority of the remaining applicants were either seeking employment, obtained a full time job elsewhere, or decided they

could not work in an environment with confused residents.

Orientation of Volunteers

Okin (1972) identified that a major problem in training volunteers was the wide varieties of applicants' backgrounds, knowledge, and ability to change. Due to this observation, she suggested that principles of curriculum planning for adult learners should be used. Becker (1964) stated that the process of situational adjustment is one of the most common mechanisms in the development of the person in adulthood. This concept suggests that "a person moving into a new situation learns the requirements of remaining in it and of being successful. If he wishes to remain in it, he must access accurately what is required and learn to deliver the required performance. We may assume, in other words, that a major motivation of the population under discussion in seeking training is the wish to succeed" (Okin, 1972). This fact was taken into consideration in the preparation of the orientations and training sessions planned in this practicum.

Brief orientations were carried out following all initial interviews when the applicant had indicated a

desire to volunteer by the end of the meeting. Formal orientations were developed by the author and held twice during the recruitment phase of the volunteer program, approximately one month apart.

One of the first tasks this author undertook was the creation of the Volunteer Orientation Session packet. This packet included the mission statement, philosophy, goals, objectives, policies and procedures of the volunteer program, as well as the organizational chart of the facility. Information on aging and communication skills with the sight, hearing and speech impaired resident was also included. The log sheet for keeping records of volunteer hours was included with a request for volunteers to sign the main log book in the office area as well as keeping their own personal records. These packets also included the agenda for the Volunteer Orientation Session.

The sessions were held in the facility's boardroom. Approximately seven to ten volunteers were invited to each session. The Administrator attended the first orientation (held on a weekday afternoon), to give a message of welcome. The Director of Nursing gave a brief history and philosophy of the organization

and discussed custodial and therapeutic treatment approaches of care toward the residents. The social worker presented services provided through that department as well as admission procedures.

The staff development officer presented educational and library opportunities for volunteers and demonstrated how to use a wheelchair. A questionnaire on aging was completed by the participants with the opportunity for questions and answers to follow. A tour of the facility was given to the participants, along with information about volunteer benefits such as complimentary meals and beverages.

Coffee and refreshments were provided by the food services department, which gave the participants and staff an opportunity to communicate and get to know each other. General information about volunteerism and the specific volunteer program were presented by the author, in this case, acting as the Coordinator of Volunteers. Volunteer program policies and procedures were thoroughly discussed with clarification made, where necessary. The Fire and Safety Officer also presented fire and safety regulations and demonstrated the use of a fire extinguisher.

A second orientation was held during an evening. The Director of Nursing and the Social Worker participated. A resident was asked to assist with the demonstration of the proper use of a wheelchair during the second orientation meeting. It is advisable to have residents involved to assist in connecting the residents to the volunteers.

This author used the volunteer orientation sessions as a vehicle to involve staff members so they could become connected to the volunteer program. An experienced volunteer was also asked to share her experience as a volunteer with the group of participants. All participants of the Volunteer Orientation were thanked for attending the session. For further information on Volunteer Orientation and a sample of a Volunteer Orientation session packet, see Volume II under "Orientation of Volunteers".

As the volunteers had received mini-orientations upon coming for their first interview, many had started volunteering before their Volunteer Orientation session. They reported that the Orientation session made more sense and was more beneficial to them, as they were already involved in the facility, and had

questions relating to their functions that were answered at the orientation meeting. Each volunteer was invited to an Orientation session within two weeks of starting to volunteer at the facility, whenever possible.

A total of thirty-two volunteers received brief orientations and about fourteen volunteers attended the full Volunteer Orientation session. An additional ten volunteers received orientation packets and had some orientation at a special volunteer training session. Due to the lack of time, there were only two general Volunteer Orientation sessions held during the project. They were identical sessions, one held during an afternoon for daytime volunteers and one held in the evening for the evening and weekend volunteers.

Specialized Training for Volunteers

In a personal care home, or long term care institution, there may be many needs for specialized training. One of the most obvious needs that existed in the practicum setting was in the area of working with the cognitively impaired resident. Many of the residents in long term care facilities, especially personal care homes, are suffering from varying degrees

of confusion. Volunteers often feel lost in working with a resident who is not oriented to reality.

The author undertook the study of Alzheimer's Disease as well as information on other conditions which cause cognitive impairment in order to develop a training package for volunteers in working with the confused resident. During the past two years the author has also been involved with three different relatives who have been sufferers of Alzheimer's and have required services ranging from home care to institutional placement. The combination of the study and the relatives' illness, brought about a greater awareness of this topic.

Two special volunteer training sessions were held at the practicum setting with a total of fourteen volunteers in attendance. Two films were shown. The Portrait of Grampa Doc, a film representing a very positive view of aging and the special relationships between an elderly person and the people involved in his life, presented a good introduction to a healthy productive and happy existence. The film gives an example of a healthy and more normal existence of the elderly. The second film, Looking for Yesterday, was a

film that presented a comparison of approaches to working with cognitive impairment, one using reality orientation and the other Validation/Fantasy. Reality orientation involves informing or correcting the resident of the real facts within their existence. With reality orientation, a worker would inform the resident that a spouse or parents of the residents were dead if the resident had forgotten that fact.

Validation/Fantasy uses empathy to connect with the disoriented resident. Building a relationship of trust is important, a caregiver could try to imagine walking in the shoes of a disoriented resident. If a resident had forgotten that a spouse had died, the worker would encourage that person to talk about their spouse until the memory of the death returned. This approach is believed to be more gentle and appropriate for the severely confused resident. The worker enters the resident's fantasy and validates his or her feelings (Feil, 1981). The understanding gained by this film helps to make the exhibiting of bizarre behavior easier to understand.

Using the two films together in a training session on Gerontology and cognitive impairment also offers a look at the continuance of aging as a developmental

process. The Looking for Yesterday film helped to explain some of the confused behavior of residents, and how respect and dignity for these residents is still so essential for their well being.

Information was presented on Alzheimer's Disease by the author and several questions were answered. Refreshments were served during the program. Due to other priorities within the facility, most staff were not available to assist with the training program. The staff person who was to continue with the coordination of the volunteers attended the afternoon session. This meeting gave her the opportunity to meet more of the volunteers and get to know them. No staff were available for the evening session. (The facility had a standards visit by the Manitoba Health Services Commission).

The volunteers who attended the training session had a discussion following the information presented and felt it was a very beneficial and informative meeting. The volunteers stated that they now understood more clearly some of the behaviors and feelings of the residents they had contact with in the facility. For

information on training volunteers in long term care, see Volume II under "Specialized Training of Volunteers".

Supervision of Volunteers

Alfred Kadushin (1976), in discussing supervision, states that

> "the ultimate objective of supervision is to offer the agency's service to the client in the most effective and efficient manner possible. It is toward that goal that the supervisor administratively integrates and coordinates the supervisee's work with others in the agency, educates the workers to a more skillful performance in their tasks, and supports and sustains the workers in motivational performance of these tasks" (Kadushin, 1976, p. 2).

The supervisory functions within a volunteer program were fulfilled in the practicum setting by this author in the role of the Coordinator of Volunteers. Activities performed were the administrative functions listed in Basic Steps in Volunteer Management (1981). These functions included the developing of job

descriptions, contracting with volunteers, establishing goals and objectives of the placement with the volunteers, developing an evaluative process for the volunteers, and for the program, data collection and record keeping, managing volunteer benefit programs, expenses, and redirecting or terminating of volunteers in their positions.

As the acting Coordinator, the author coordinated educational functions and led training sessions, where appropriate. The main role in the educational function of supervision was in facilitating and coordinating the educational opportunities, by arranging for staff to attend and present information regarding their specific speciality of service.

In the supportive supervisory role, factors that were taken into account were the psychological status, physiological status, abilities, limitations, modes of action, and personality characteristics of volunteers. These were highlighted in negotiating supervision supports with other staff and were considered in supervising volunteers working in the Volunteer Department. For example, a volunteer, who was under psychiatric supervision, was assigned to a ward whose

head nurse was trained in psychiatric nursing. She was able to give appropriate support and the volunteer match worked out well.

As acting Coordinator, the author had the responsibility of the overall supervision of the volunteer program.

In order to ensure that staff members requesting a volunteer would follow through in the supervisory responsibilities toward the volunteer: the staff person, when completing the Request for Volunteer form, was requested to sign the form as the acting supervisor, and a supervisor or department head signature also appearing on the form. With this procedure in place, both staff persons had signed their names signifying that the request was made and the department head was aware of the request and supporting the use of that volunteer. This procedure is especially helpful in health care facilities where there are frequent changes of shifts and varying working hours for staff.

In any situations where there was a problem between a volunteer and the staff member/department head, the author would be available to mediate the

situation. There was always an "open door" policy in the volunteer department.

The manner in which this program was developed and supervised is not the ideal method of creating and maintaining a volunteer program. This approach did establish the program initially, but the long term possibilities for this program in this facility are questionable. Even though the departments had been asked to participate in the development of the framework of the program and to participate in orientations and training sessions, the author had to take more of the responsibility than would be beneficial to the facility in the long term approach.

The staff, through this process, did become more positive toward volunteers and the concept of a volunteer program, however, they did not gain the type of knowledge or experience necessary to ensure continuity in the program at the completion of the practicum.

> "Social workers have often greatly overpromised what they could deliver with respect to the impact and its outcomes for their services. Evaluation findings

> generally indicate that few startling results can be achieved. As a result, administrators need to be cautious about the quality of service that can be routinely delivered and about the utility of arbitrary standards set up by external bodies on the basis of some consensus about desired results" (Sarri, 1985).

This statement could be applied to the purpose originally given by the Administrator for this program to be developed.

For further information on supervision of volunteers, volunteer burnout, or how to fire a volunteer, this material is presented in Volume II under "Supervision of Volunteers".

Developing an Evaluation Package for the Volunteer Program

The purpose of developing an evaluation package for any volunteer program is to create a "systematic application of social research procedures in assessing the conceptualization and design, implementation, and utility of a program," which in this case is a social work intervention (Rossi & Freeman, 1985, p. 19). In

this project, the author wanted to develop the evaluative tools that would measure both quantative and qualitative aspects of the program. Volunteer performance and effectiveness were only two of the measurements needed to evaluate the practicum project. The program supports provided through the actions and functions of staff, the responses and attitudes of residents, and the attitudes and experiences of volunteers in working within the facility also needed to be measured.

To obtain further understanding of the depth of evaluation and develop the method to be used in adequately evaluating the program, the author researched such topics as quality assurance and the requirements of the Canadian Council of Health Facilities Accreditation survey evaluation. This study was done to ensure that the expectations of these evaluation methods and tools were built into the framework of the program, using the accreditation survey as a check point in developing all aspects of the program to be evaluated. The reason of going this route was that most health care facilities in this province apply for accreditation through the Council,

and quality assurance is a large part of the accreditation survey. This method of evaluation proved to be helpful as a guideline on directing what forms or types of information, statistics, and questionnaires were needed. The accreditation guideline also encouraged the participation of all parties, staff, residents, volunteers and the public at large to be incorporated into the facility's program. For further information on quality assurance and accreditation in long term care, see Appendix I under "Quality Assurance and Accreditation as Evaluative Measures in Volunteer Programs".

As was earlier mentioned, during the development of the framework for this program, this author created several forms requesting information relating to volunteer applicants, residents' needs, job descriptions, and volunteer log sheets for recording statistics that were reported in the form of a monthly statistical sheet. Evaluation questionnaires were also developed for the purpose of evaluating a volunteer, for a volunteer to evaluate the program, and for obtaining residents' feedback on their impressions and experiences with the volunteer program, when

appropriate. Residents are asked to give feedback when they are in a one-to-one match with a volunteer, or when they are a participant in a program assisted by volunteers.

As an ongoing evaluation of orientation and training sessions, evaluation forms are also included in the packets provided to participants in Volunteer Orientation sessions, Staff Orientation sessions, and special volunteer training program.

The program was not in place for a long enough period of time to implement many of the evaluation methods, but the total package is in place and could be used by the organization after the practicum was completed. The Manager of the facility had requested that the author ensure that accreditation standards be met through the development of the program. Upon completion of the practicum, the program elements were compared with the accreditation survey and all of the criteria according to the survey were met (see Appendix VII in training manual). However, there is no guarantee that the program will still meet accreditation criteria when the evaluation takes place, as there has not been a full time Coordinator in place since the practicum was ended.

At the completion of the project, or as of April 15, 1989, according to the statistics gathered by the author through the data collection system developed for the program, a total of thirty-two volunteers contributed 1187.0 hours within a period from December, 1988 to April 15, 1989. During December, 1988 and January 1989, one hundred and sixty-two hours were given by volunteers, with February's contribution being two hundred and fifty-eight, and March's volunteers' contribution totaling four hundred and nineteen and one half hours. April's statistics only represented one half of the month, and the hours contributed were three hundred and forty-seven and one half hours, almost as much for the total for the month of March. These figures show a consistent growth, as did the numbers of new volunteers coming into the program each month.

Although the method of evaluation used in this program was quality assurance through its Accreditation survey, many other volunteer programs in non-health care agencies would possibly approach evaluation differently. In volunteer programs evaluating quantity is an easier task than evaluating quality of service. Questionnaires are subjective in nature, giving

personal opinions that could be influenced by personality clashes, lack of understanding of the purpose or role of volunteers, and in a facility responding to severe cognitive impairment, obtaining feedback may be difficult.

Benefits derived from the practicum for the facility involved the creation of a volunteer program which would assist the administration in meeting the requirements for accreditation. However, there is also an element of loss to consider. Due to the expedient manner in which the program had to be put in place, the lack of involvement on the part of staff, and the inability of the facility to offer continuity through the hiring of a full time Coordinator, this program may be more potentially destructive than helpful due to the experience adding to a history of failure in the volunteer program area.

Benefits of the practicum to the author involve giving the author the opportunity to learn more about gerontology, volunteer management and long term care to apply to the Volunteer Administration Training Manual. However, from the more negative perspective, the time being so limited was found to be very frustrating.

Timing of the practicum, as a whole, worked against the project. The program was implemented at a point of low staff morale, staff cutbacks, and poor management-staff relations. While developing a volunteer program fully often takes about two years, the process of this project took a little over six months.

The author also had concerns regarding the longevity of the program due to the conditions earlier described. Timing or lack of time played an important role in the inability of staff to take part or responsibility for the volunteer program. After several attempts, meetings still would not be productive or fruitful due to time restraints of staff.

The first involvement the author had in the facility was assisting in coordinating the Annual Tea. Time restriction was an issue as there was very little left to pull the arrangements for volunteers together. Time started out as an issue and remained a major concern throughout the entire practicum.

In comparison with the single department receiving service from three semi-active volunteers providing approximately ten hours of volunteer service per month,

prior to the start of the practicum, at the end of the project a total of thirty-two volunteers provided services to ten different service areas in the facility (see statistical information on program - Appendix I).

Recognition of Volunteers

Recognition should be a built in policy of daily activity on the part of staff in the facility of long term care. Every time a volunteer contributes their time, energy, talent and love, they should be thanked by someone in the facility besides the resident and the Coordinator of Volunteers. In this practicum project, volunteers were given certain benefits such as complimentary meals and beverages when working a specified number of hours. This is also a form of recognition. Reference letters were written by the author and signed by the Director of Nursing upon request. This is another form of recognition.

A major recognition event was planned and coordinated by the author and sponsored by the facility. All registered volunteers as of the beginning of April were invited. Certificates of Appreciation were prepared by office staff. The recognition dinner was prepared and served by the food

services staff. The activity staff and their Director assisted with setting up the furniture and decorating the facility for the recognition event. The Manager gave a speech of welcome and appreciation to the volunteers in attendance. The Staff Development Officer, Social Worker, and Director of Activities/ Volunteers assisted in presenting the certificates and volunteer pins. The representatives of Residents' Council also gave a speech of appreciation. Regrets were made on behalf of the Director of Nursing who couldn't attend, due to family illness. Indeed the volunteers, having heard about the Director of Nursing's family situation, left an arrangement of flowers and a card for her in her office. The night nursing supervisor attended the banquet in her place.

One of the maintenance staff volunteered his time to assist with the event and in cleaning up the dining room after the event. Those volunteers who could not attend received certificates and pins in the mail.

The reason for presenting this detailed account of the event was to present the cooperation and team work that was needed to make this event successful. The quality of the program was beginning to emerge.

During the time of the development of this project, the staff and the volunteers became a team, and the real potential of the program became evident. This was also a sad reality as the likelihood of the volunteer program ever reaching its potential is very questionable without a full time specially trained Coordinator to facilitate the program's growth.

For further information on volunteer recognition, see Volume II under "Recognition of Volunteers".

In the period of time this project took place, there were many problems encountered, some of which will be discussed in the next chapter dealing with volunteer-staff relations. However, there were also many achievements made on personal as well as program levels. The practicum project did provide material and awarenesses that guided this author in the development of the Volunteer Management Training Manual in Long Term Care.

This intervention provided supports and rich experiences to many people, residents, staff and volunteers, as well as this author.

Chapter VI

Observations of Experiences During the Intervention

As was indicated in the previous chapter, there were many activities carried out in the completion of this intervention. This chapter will discuss some of the observations and learnings of this author during the six month period of this practicum project.

The Program Planning and Developmental Phases

In the initial planning stage of this practicum intervention, a question existed for this author as to whether this project should take place in this specific facility. The conditions were not conducive to volunteer program development, staff resistance was high, staff morale was low, and there was no guarantee of permanence for the program. If the only goal was to develop the project for the purpose of meeting accreditation standards, this author would likely not have completed the intervention at this site. However, as one of the hoped for outcomes was a training manual for Coordinators of Volunteers in long term care facilities, and as this facility exhibited many of the management problems commonly found in developing

volunteer programs, the site offered an appropriate and a challenging opportunity for the completion of this practicum.

Because this author had worked over the past several years with staff persons who had some knowledge of volunteerism and volunteer management, and had forgotten, to a certain degree, what working with staff members with little or no knowledge in that area was like, the challenge was even greater than anticipated. The first attempt to organize the department heads in the development of the framework of the volunteer program was frustrating and fruitless for all concerned. There existed two conflictual realities. One was that these staff needed to be involved in this process in order to gain any sense of ownership. The opposing fact was that there would be no way the department heads could get involved on that level, due to their own priorities and problems. This meant the program would not develop further if the author did not take on that responsibility.

A decision was made between the author and the Director of Nursing that this author would develop the framework of the volunteer program, and present it to

the department head group for approval. In this situation, the program was developed and did have an impact on the facility while the author was still directing the activities, but it is this author's belief that the department head group never did really buy into the program or into the concept of volunteerism. This fact could strongly affect the future existence of the program. However, several of the department heads that were involved have since left the facility. The majority of present department heads were not involved in the facility at the time of the practicum.

Developing Job Descriptions

Initially, to assist in getting the program off the ground, the author, rather than waiting for the key staff members to submit written requests for volunteers through the use of the Requests for Volunteer forms, assisted in completing these requests during interviews with the staff persons involved. These staff members were informed that they would have to submit their own forms in the future. Although these staff members did obtain more volunteers in the future, neither of these department heads used the request forms other than for

short term - one time volunteer assignments.

One question this author asks is if there would have been a program had the author not completed approximately sixteen request forms and developed job descriptions to use in the project? The problem was that in another situation, where the program would have grown larger in size, the Coordinator would not have the time available to take the responsibility of completing these forms. This action included interviewing the department heads, assessing needs, establishing tasks and developing a job description as a volunteer contract. The two department heads, for which the author completed request forms, did not submit further request forms in writing during the entire length of the practicum placement.

Recruitment of Volunteers

Due to the fact that a full time Coordinator was not going to be hired to continue on with the volunteer program, a large scale recruitment campaign never took place. The staff person taking back the responsibility of coordinating volunteers on a part time basis could not have handled a larger workload. This author believes that recruiting more volunteers than the facility could effectively support would be unethical,

and unfair to the volunteer contributing their time and talent to the facility. The Director of Nursing and the Administrator both agreed with this decision.

In actual fact, the real potential of this program has not been realized. The only way the volunteer project could develop to its full potential would be under the direction of a full time, trained Coordinator of Volunteers.

Specialized Training for Volunteers

The topic covered in this special training session was cognitive impairment in the elderly.

The author had attempted to obtain two films for the training session and was informed the films would not be available until after the end of the practicum project. Toward the end of the practicum, the author mentioned this fact to a staff member, who informed the author that she had the films in her possession for almost one month (which no one else in the facility was aware of), and the films would be available for volunteer training, if the sessions were to take place in the next week.

The sessions were quickly arranged. The problem was that an external evaluation was being completed in the facility, so that staff (other than one department head) could not be available to attend and help direct the sessions as resource people. The author had completed some research on the topic of cognitive impairment and was able to respond to questions. However, it would have been desirable to have other staff with more experience in attendance to facilitate the training sessions.

Other Observations

One of the most significant differences this author recognized between this project and previous programs developed and coordinated by this author was in the author's managerial approach to problems encountered during the development of the intervention. In previous programs, if staff were unsupportive or uncooperative, this author, at times, would respond in a confrontational manner. This would often make a bad situation worse as it would further drive a wall between the parties involved, creating a further breakdown of communication. Instead of confronting the staff person directly, the author worked around that

person, providing evidence of the value of the program through more supportive staff members.

In some instances, the hurdles within this practicum were even more severe; with problems actively working against the development of the intervention. An example of this situation was the frustration encountered in trying to arrange for a staff orientation for department heads. The same staff person who was assisting in setting up the first meeting had forgotten that more than half of those staff were involved in a program she was directing with residents, causing the session to be cancelled.

The second orientation for department heads was a very frustrating experience with very inappropriate behavior on the part of a staff person who had a very disturbing effect on the session. Rather than trying to force the group to continue in a situation that had become very uncomfortable for all concerned, the author brought a close to the meeting.

The author realized that some of the actions brought about by problems of staff were not directed personally at the volunteers or herself. Rather than confronting these issues, it was decided to work around

them, gaining the positive supports that were available through other sources, more specifically, the Director of Nursing and some members of the nursing staff.

One of the considerations that could have had an impact on the outcome of the practicum, as well as the problem within the facility that affected the development of the volunteer program, was the fact of the facility being a for-profit health care centre. This issue has been a confusing aspect of this experience for this author. All previous experience in volunteer coordination had been in non-profit organizations. This author had entered the for-profit facility with certain misconceptions commonly believed in the non-profit sector of the social welfare field.

Varying attitudes exist among authors re the profit versus non profit service. Larry D. Gamm (1983) presented distinctive features about voluntary versus nonvoluntary organizations identified by Mason. He stated that to the non-profit facility, diplomacy is more important in achieving objectives, responsibility for the production of resources and provision of service are more clearly separated, measurement of market value of service is less precise, and more diversity in purpose is typical in a voluntary organization (Gamm, 1983).

Gillingham and Zanibbi (1987) found that success and failure were measured in profit oriented organizations by a financial criteria, which was not an appropriate measure for non-profit organizations. To assess any organization's performance one could measure: overall goal attainment, strength of financial resources, strength of human and physical resources, overall market performance, as well as specified criteria established as significant to the organization (Accreditation Survey Questionnaire; Gillingham & Zanibbi, 1987).

In a facility (non-profit) where the author was previously employed, the food services department cut expenses considerably when funding became tight. There was less variety of food, it was less appetizing, and not as enjoyable than prior to the budget cuts. In the profit home, the menu was superior, had more variety, was more appealing, and was a highlight in the daily lives of the residents. However, this service was visible to the public, the families and the residents. Financial limitations were responsible for a lack of other types of services that were less visible to the public eye, i.e. supplies, equipment, etc., which can be frustrating for the staff.

The bottom line in this author's experience is that staff attitudes and commitment levels dictate the quality of care more than the profit, non profit question. This factor is often influenced by the quality of management at the head of the organization, whether profit or non profit.

Volunteer management was not a fiscal priority to this organization, and coupled with the changes in staffing and function to increase profits, these issues may have had an impact on the development, maintenance and future of the practicum project.

This intervention became a learning experience for many people involved in the program. Staff learned more about volunteers and volunteering, volunteers learned more about working with the elderly, and gained specific skills in their job training. Residents learned more ways in which they could be still connected with members of the community. The author learned more about gerontology and volunteer management.

The next chapter will address special issues of volunteer management, especially as they relate to the working relationships between volunteers and staff.

Chapter VII

Special Issues of Volunteer Management

Relations between Volunteers and Staff

In developing and managing volunteer programs, one of the most important factors to consider is the working relationship between volunteers and staff in the facility. Staff's attitudes toward the volunteers working in the program can make or break the project. Linda Graff (1983) states in her discussion paper that paid staff accepting the involvement of volunteers and productive working relationships between paid and unpaid workers are crucial in the successful management of volunteer programs. She also states that even the suggestion of replacement of paid staff by volunteers introduces suspicion, mistrust and antagonism among the workers (Graff, 1983).

The method of introduction of a volunteer program to paid staff may powerfully affect the staff members reaction to the project. In the case of this practicum project, the proposal for the program's development came from the administration, with the realization that the formation of such a project was an expectation of the Canadian Council of Health Facilities

Accreditation. Most of the staff were unimpressed with the idea of the volunteer program initially, and were surprised to see the program taking effect.

Change: The Ultimate Threat

Several years ago, the author was hired as a full time Coordinator of Volunteers for an innovative probation program. The purpose of this position was to develop a highly specialized volunteer support service. This was an experimental project, in which volunteers were to be recruited to offer every type of support the probation clients may need.

This program, conceived by the administrative offices of the organization, had not been discussed or shared with the line workers expected to train and work with the volunteers. The lack of consideration and communication on the part of the management level of that office brought about a reaction of hostility, suspicion, and resentment on the part of several staff members to the volunteers. The author chose to develop the program through two probation officers who were supportive of the project. As other staff discovered how the extra support were bringing better results on the part of those two staff members' caseloads, they

finally also came on board and started incorporating volunteers into their caseloads.

Two factors affecting staff with the introduction of a volunteer program (without that staff's consultation or involvement in the decision making process) are as follows:

1. The sense of a loss of control or rights to participate in decision affecting their future.

2. The reaction to change itself.

Donald Schon (1973) states that "Belief in the steady state is belief in the unchangeability, the constancy of central aspects of our lives, or belief that we can attain such a constancy" (Schon, 1973, p. 9). According to Schon's theory, belief in stability is the means of maintaining stability, with radical change bringing about a more radical defense (Schon, 1973).

The example of the Probation Officer's response to the volunteer program supports Schon's theory. The fear of change was so great that some workers would refuse to participate in the program, and some staff members even sabotaged the project. For example, they were telling volunteers to pick up participants and

transport them to their work experience sites, and at the same time, these staff members were telling the clients they did not have to go with the volunteers. By the end of the first year, the staff members had adjusted to the change that had taken place and recognized the benefits gained by both staff and clients alike.

In a response to change, constructive outcomes can occur. Within the practicum placement, the original response to placing a volunteer in a specific department was one of severe negativity. Under no circumstances would volunteers be allowed to work in that area. However, after gaining experience in working with volunteers in another section of that department, the department head agreed to having a professional volunteer with university qualifications gain work experience in the original section that had been "off limits".

Schon advocates that a constructive response to the loss of the steady state is

> "to invent and bring into being new or modified institutions capable of confronting challenge to their steady state without

> freezing or flying apart at the seams. If we are losing stable values and anchors for personal identity, we must find a way to maintain a sense of self respect and self identity while in the very process of change" (Schon, 1973, p. 29).

In the practicum setting, some staff members originally saw the volunteers and the program as a threat to the steady state of the conditions of survival in the job at that time. However, once the staff had an opportunity to observe benefits to residents and their fellow staff members, these volunteers who were previously seen as threats became valuable resources. The extra support received from volunteers began to enhance the staff members' role rather than to threaten the role's existence. In encouraging staff members to instigate many of the volunteer roles by suggestions and requests, giving the staff person more control over how volunteers are used, the steady state becomes an ongoing creative involvement in directing human resources.

The Impact of History

Another factor to be taken into consideration in the successful development of a volunteer program is

the history that had taken place prior to the implementation. In the case of the practicum's project, the development of volunteer support services in the personal care home previously played a fairly important role in the staff reaction to the new project. The responsibilities of running a volunteer program had been passed from staff person to staff person over the years, but with no continuity to allow the program to grow or stabilize. The only full time Coordinator responsible for a volunteer program had been hired on a one year term career training program to work at developing programs in two different facilities at the same time. This person was inexperienced and untrained. That position ended approximately three years before this practicum took place. Staff members had reported that the program had diminished to the point of being almost non-existent before the Coordinator had left the facility.

The department head that had taken on the responsibility of the volunteer program was also directing another department. This person also doubted whether a volunteer program could be developed in that specific location with parking restrictions, a

central area neighbourhood, and whether the program would be feasible.

There also had been a lack of follow-up on most of the new applications that had been completed by prospective volunteers, and a lack of follow-up of volunteers who had stopped coming to the facility. The record keeping system (data collection of statistics) was very poor, providing few clues as to why previous attempts of program development had not been very successful. Part of the reason for this fact is that the staff person who was responsible for this program was fully occupied with another department and the supervision of several staff members.

The various experiences with the previous volunteer efforts were considered by many staff member too negative in nature, and these experiences were still well remembered by some of the more experienced staff persons.

Personality Conflicts and Natural History

Sarason (1972), in his book The Creation of Settings and the Future Societies, related

> "a major obstacle in our understanding of the creation and development [of settings or

> programs] is the surprising lack of detailed description of their "natural histories". This may attribute to a tendency to see the problem in terms of the personality of a single person or the characteristics of a small group putting the problem in the realm of personality and the idiosyncratic, and therefore, not making it a general problem" (Sarason, 1972, p. 26).

As with this practicum setting, many times, where there are difficulties in developing a sound foundation for a program, personality issues will overshadow the general management problems that contribute to the failure of a program. The theory that Sarason has presented applies within the practicum project. There seemed to be a general attitude on the part of many of the staff members and the administration that certain personality traits and conflicts on the part of staff members responsible for the volunteer program were causing the program to fail. In actual fact, the general problems, or natural history of this facility, namely, a lack of adequate funding for a full time trained Coordinator of Volunteers; job allocation, for

example giving a staff member the double responsibility of two departments at one time; and a lack of professional training in volunteer management all played an important role in the history of this facility.

In the beginning of the practicum, personality clashes did exist between different personnel, but this problem was not the only factor affecting the volunteer program. These relationships did appear to improve considerably during the course of the practicum project, partly due to the Director of Nursing's influence, and partly due to the staff witnessing a more helpful, committed, and supportive function that volunteers were beginning to demonstrate in the facility.

Given the history of this facility, the practicum's volunteer program had to be approached carefully. Sarason (1972) addresses this issue in relating that proposed new settings or programs are always in some relation to existing settings bringing about a possibility of conflict in opposing ideologies, and concern for resources, which is bound to effect the parties involved (Sarason, 1972). In creating this

program, such aspects as strength of motivations, values, personalities, and who holds or abuses the power had to be taken into consideration.

It is very helpful to compare the "actual" managerial structure with the written organizational chart for the facility, as the written chart does not always represent what is happening in real life. However, unless the historical, sociological, developmental, and longitudinal context are taken into consideration, not all the facts surrounding the facility or program may be realized (Sarason, 1972). For example, within the practicum setting, the organizational chart presents an order of accountability that does not match the reality, with the Director of Nursing being responsible for more of the departments than is indicated on the chart. From the perspective of developing the volunteer program, this is an important fact as the Director of Nursing strongly supports the development of the program and could influence the other departments in that direction.

Some Sources of Difficulty in Volunteer Management

Sarason (1972) points out several sources of difficulties between a leader and core group in program management.

1. The first source of Volunteer Management difficulty is the basis and order of recruitment. Several of the department heads had been recently recruited. They did not feel comfortable or confident in their job roles, were threatened by any additional responsibility or expectation, and indicated clearly that they expected the foundation work of the volunteer program to be completed by this author. Most of the department heads were unable to take on any further pressures as they already felt overloaded.

2. The absence of problem anticipating and problem solving vehicles. In this case, as there was no sense of ownership and no desire to take responsibility, the group did not feel it was their need or responsibility to create such a system, except for giving some direction for the policy and procedure for volunteers guideline. For example, policy was established stating that volunteers must report to or answer to a staff person regarding a complication with a resident (e.g. resident falling, becoming ill, or erratic behavior). Problem solving vehicles within an organization are essential.

3. Sarason's third source of difficulty is the

myth of unlimited resources and untroubled futures. Within this practicum, originally, during the earlier stages of development, the staff population generally felt that volunteers could not be recruited for that facility. However, once the program became more active and visible, the staff members began to expect volunteers to materialize whenever there was a need. This reaction is typical of many volunteer programs. Limited resources are as much a problem as unrealistic expectations for the future.

4. Sarason's fourth difficulty source, the difficulty of specialization of function also relates to volunteer programs. One area that touches on this topic is the use of volunteers in the less traditional roles. Many staff would not have a problem with volunteers visiting residents, but would question volunteers working with speech therapy, physiotherapy, or sensory stimulation. There are many well trained, professional volunteers that are willing to offer their talents, but staff members can react territorially and resist using volunteers in creative ways.

This problem of specialization of function can also refer to staff resisting training or taking

responsibility for supervising volunteers if they do not see that role as a part of their defined speciality. An example of this situation was when a staff person who was responsible for training paid staff personnel took exception when she believed she would be expected to train and orient volunteers. She did not see "unpaid" staff as her responsibility.

5. Sarason's fifth difficulty listed was the competition among staff members for resources and influence on the Coordinator, where possible, to allocate resources inappropriately. In a previous program coordinated by this author, all the volunteer resources needed for a dining room Annual Tea had been recruited and assigned. The author, who was recovering from surgery, was not present to direct volunteers to the tea area. Later, reports were received that there was a serious lack of volunteers to serve tea, as they had not reported to the dining room. Upon further investigation, it was discovered that other staff persons, who were responsible to recruit volunteers for their own areas in the Bazaar, had not done so, and had re-directed the tea volunteers to their own areas.

One of the most frustrating experiences of a volunteer is being asked or "ordered" to do several different tasks by a number of staff persons at the same time. For this reason, specific job descriptions for volunteers as well as assignment of a staff supervisor is imperative to the well being of that volunteer.

6. Sarason's sixth difficulty in working within a group of department heads would be the pull of present realities and the ignoring or postponement of dealing with the crucial future or past. In this practicum, the fact of the past history had a very heavy impact on the program, but the future was even a more serious problem. During the development of the program, the author was working in the project almost full time, and was bringing expertise to the facility through many years of experience and training regarding volunteer management. The program was not to be taken over by a full time professional Coordinator, but arrangements for monitoring the volunteer was to revert back to the conditions that were similar to those existing prior to the practicum taking place. The Administrator, who wanted the program developed to meet accreditation

standards stated he did not have the funding to hire a Coordinator, and realized it was not likely that the facility's contingency plan for the support of the volunteer program would prove to be very successful. Again, time limitations and timing of the program fell into this category.

The department heads were not apparently willing to see that ownership of the volunteer program had to be shared by them. However, once the practicum was completed, they would have to take up the extra responsibilities.

An Approach to Enhance Volunteer-Staff Relations

The approach used in developing the volunteer program for the practicum was similar to that which the author used in developing volunteer services in a Probation program. The road chosen was the demonstration program. A lot of time was devoted to getting to know the various department heads, and introducing the volunteer programs in the areas that were the least threatening to the staff. Feedback from staff indicated there was little belief that this program would get off the ground, because they did not believe volunteers would be willing to come to this

setting, with a downtown location and poor parking facilities.

As was previously mentioned in this report, the support given by the author and eight volunteers to the Annual Tea before the official start of the practicum placement was the beginning of disproving the belief that volunteers could not be recruited for this facility's location, demonstrating that a volunteer program was possible.

As the recruitment of volunteers increased and the program became more visible, a larger number of volunteer requests were being submitted by staff members.

There are many political elements involved in developing a volunteer program in a long term care facility. Generally many of these problems existed prior to the entry of the Coordinator of Volunteers who had not created them. Special analysis, consideration, public relations, and finesse may be required to address these situations. Rossi and Freeman (1985) suggests that in the program evaluation the key stakeholders motivations or goals are very important considerations. In this practicum, there were many key players or stakeholders

with varying motivations. The responsibility of the author, or in other programs the Coordinator, is to balance or juggle the various stakeholders motivations for wanting the program with the motivations of the volunteers for being involved with the program. In the centre of these considerations is the care and the welfare of the residents.

Accreditation was the motivation for this organization to have the volunteer program developed. There was no intention of placing a full time Coordinator at the completion of the practicum. If this author had been asked to coordinate this program with no other benefits to be derived, this volunteer project would not have taken place. This facility did not present a positive political climate for the development of a good long term volunteer program.

The next chapter will address issues involving the relationships between volunteers, staff members, and unions.

Chapter VIII

Relations Between Volunteers, Staff and Unions

This chapter will discuss issues and concerns involving unions and the effects of these issues on working relationships between volunteers, staff members, and unions working in a facility. There are two main concerns that union leaders have expressed regarding the use of volunteer supports in an organization. These concerns are as follows:

1. Displacement of paid staff with volunteers. Displacement of paid staff takes place when staff are laid off even when funding is still available for their positions, but the money is allocated elsewhere. Volunteers are placed in the paid staff's position to carry out those functions.

2. Replacement of paid staff.

Replacement of paid staff takes place when a program has lost its funding, and there is not money available to pay staff positions. Volunteers are used to carry out the functions within the program rather than cancelling the service. The difference between displacement and replacement is that with displacement, the funding was not lost and the workers would not

otherwise be out of a job, whereas with replacement staff have already been laid off due to a lack of funds.

The volunteer sector's positions on displacement is as follows:

> "It is generally held by leaders in the field of volunteerism that it is unethical to displace paid workers. The volunteer movement strongly holds that while volunteers have a place in the delivery of service, it is a supportive role and should not be substituted for that of paid staff" (Graff, 1983, p. 25).

When addressing the topic of replacement, most union leaders believe that where an organization will replace paid staff with volunteers because the program funding has been pulled, the use of volunteers may "buffer" public reaction to the loss of funding because the service still appears to be provided. The program may not be operating with the same level of consistency or expertise, but the public may not be aware of that fact due to the program still being in operation.

A point that cannot be overstated in the successful coordination of a volunteer program is the importance of good working relationships between staff and volunteers. If staff are hostile or suspect the motivations of volunteers, or the management's reasons for using volunteers, the volunteer program could be in jeopardy. One way this situation can be prevented is in the development of the guidelines, policies and procedures for the volunteer program which are clear about purpose. These can be presented during staff orientations on volunteerism.

In times of fiscal restraint, however, the facility may be faced with making decisions to use volunteers to provide service which was previously funded, rather than to withdraw the program altogether. In making such a decision, a clear understanding on the part of the participants in the program is necessary. To continue the program may address one social need, but by doing so, ultimately, that decision could be creating another, possibly a much larger problem (Campbell, 1985).

When taking into consideration what functions volunteers should fulfill, there are many factors to

consider. It is difficult to delineate appropriate volunteer roles in the abstract. Each facility will define an appropriate volunteer role differently. For example, one facility might define a particular responsibility as a paid staff function, while in another facility, a similar responsibility would be defined as a volunteer function (e.g. transportation drivers of vans). McCurley (1981) and Duncan (1982) both suggest that a volunteer role should be determined by the actual nature of work to be completed, and who could achieve the most in doing the task. For example, nonvoluntary clients or hospital patients who are admitted against their will, may respond more positively to a volunteer than to a paid staff person, as the volunteer is not seen by the patient as a part of the system (Graff, 1983). These volunteers could assist paid staff in gaining information, providing service, and alleviate loneliness.

Unions sometimes connect the cutbacks in funding of human service sectors as government divesting agreement of responsibility for the provision of vital human services, with the expectation of low paid and nonpaid staff picking up the slack. This may

contribute to souring of the attitudes of the unionized members toward volunteers working in their workplaces, which has been reported by C.U.P.E. (Rose, 1986).

According to John Calvert (1985) who wrote the article "Volunteers and the Unionized Workplace: Problems and Prospects", the Coordinator of Volunteers is simply a vehicle of the management to force volunteers to take on whatever responsibility the management wishes. From this and other statements made by Calvert; it appears that he has several misconceptions about volunteerism.

One of the most important responsibilities of a Coordinator is to ensure that the assigned duties of volunteers are appropriate, acceptable, and in no way abusive to the volunteer. Indeed, the competition for the use of volunteers may become so strong that a program could fail quickly if volunteers are not the main consideration of the Coordinator and treated with consideration, respect, and dignity.

Calvert (1985) stated:

"Looking at the matter from the viewpoint of volunteers, if the employer chooses to exploit them or ask them to do work normally

done by members of a bargaining unit they cannot, in any collective or organized sense, refuse such assignments. Obviously an individual may choose not to do such work. But the employer is quite free to replace any volunteer with another volunteer who does not share these reservations" (Calvert, 1985, p. 26)

Volunteers are a far more powerful group than Calvert realizes. Most volunteers will not willingly allow themselves to be exploited. For example, there are over one hundred and fifty volunteer programs in Winnipeg, all of whom are competing for the same volunteer market. The grapevine in the volunteer community is so well developed that if an organization does try to exploit volunteers, they will have great difficulty in successfully continuing to recruit volunteers. Many volunteers work in more than one location and several know others volunteering in various programs in the city. Many volunteers have contact with the Volunteer Centre who records complaints or concerns about poor volunteer placements or problematic volunteers reported to the centre by various program personnel.

The functions assigned to volunteers should be clearly stated in job descriptions. Job descriptions could be reviewed by union representatives to ensure there is no problem with the proposed volunteer role. The majority of requests in a large volunteer program often come from unionized staff members. Even many of the requests presented by department heads or management level personnel were originally suggested by the union members in the facility. However, staff may request a volunteer for a function that may be against their own interests, or many people may be unaware of complications (legal issues) that could arise out of a volunteer request.

The fear many staff members have of volunteers taking the place of full time staff may be somewhat unrealistic. The consistency provided by full time staff in a program cannot usually be provided through volunteers, as many people are only available for a few hours at a time. Provincial standards hopefully prevent facilities from overloading employees by cutting staff with the assumption that volunteers will lighten the load.

Another statement made by Calvert (1985) was that volunteers were replacing or threatening most of the

occupations and functions where women are predominant. In most volunteer programs coordinated by this author, around forty percent of the volunteers were male. In this practicum project thirteen of the thirty-two volunteers were male, equaling about 43.5 percent. The majority of these volunteer roles were not traditional female roles, and no staff were replaced by volunteers.

Volunteerism apparently has changed over the years in gender, age, motivation, and cultural makeup (from the earlier stereotype). A more enlightened approach on the part of organizations and unions towards volunteerism would assist greatly in improving relationships between all parties concerned.

Graff (1983) recommends that clear policies are required and should be determined tri-laterally among management, staff (or their bargaining agent) and volunteer delegates. All three parties should be consulted in the process of adding volunteer positions within an agency or in changing existing job descriptions. (Graff, 1983).

The Use of Volunteers During a Strike

During the period of a strike, whether a volunteer should cross a picket line could be determined by whether a pre-arranged agreement of volunteers working

during a strike was made by the joint team of staff (union representatives), management, and volunteers. For example, some unions might agree to volunteers entering a facility during a strike to continue giving emotional support to residents to lessen the tension, worry and discomfort that residents may be experiencing.

Volunteers should be allowed to make their own decision as to whether they would want to work during a strike even if an agreement is in place. However, if volunteers do work during a strike, they should not take any other responsibilities than volunteers would normally carry out in a volunteer position.

If an agreement does exist regarding volunteers working during a strike, all staff and volunteers should have complete knowledge of the terms of that agreement prior to the strike taking place.

Terms of a strike agreement should be kept and honoured closely. The most important position for a volunteer to take during a strike is neutrality (Graff, 1983).

In concluding this chapter, Campbell (1985) relates a stand that is very appropriate when looking

at the question of the relationship of the labour movement and the volunteer sector:

> "The volunteer sector must realize the legitimate concerns of the labour movement in seeking to protect the jobs and improve the working conditions of its members and of others in the labour force. The labour movement, for its part must acknowledge that the use of volunteers is not a short term expedient during hard times, but an honourable and long standing practice which has many social benefits and that voluntary agencies must be preserved and strengthened so that the range and diversity of service available in the community are not reduced. The labour movement and the voluntary sector must see each other as allies to ensure that adequate services are provided in the community" (Campbell, 1985, p. 22).

Chapter IX

General Overview and Recommendations of this Practicum

The objectives of this practicum were as follows:

1. To facilitate the development of a framework for a structured, accountable volunteer program at a personal care home. This objective also included the creation and maintenance of a volunteer program, bringing about a community support for residents in that facility.

2. To produce a Volunteer Management Training Manual for the purpose of guiding Coordinators of Volunteers in developing volunteer programs in long term care facilities. This document was a proposed outcome of the practicum.

3. To arrange access to the training manual for the Volunteer Centre of Winnipeg for their use in training Coordinators of Volunteers in long term care health facilities.

This author has arranged to obtain evaluative feedback from community experts on the training manual; one of these is the Executive Director of the Volunteer Centre. In reviewing the manual, the Director will

also be able to ascertain its value as a training tool in that agency.

Learning objectives were to acquire a greater knowledge in issues of gerontology, as they relate to long term care, as well as gaining further knowledge on the topic of volunteer management.

Chapter II presented information regarding society's attitudes toward the aged population. One of the most important aspects of aging is the changing roles and functions that take place in the aging process. These are often changes brought about by family's and society's value system rather than the actual condition the elderly person finds themselves responding to in their lives.

Consideration should be given by all people involved with the person requiring service to the importance of roles and identity when trying to assist the elderly in the community or in long term care to retain their self respect and dignity. Recognition of the person's wishes, needs, desires, and knowledge assit in this task.

Chapter III presented the role of the social worker in long term care, both in the community and in the

facility. The role of the social worker as a facilitator in organizing supports of both residents and their families is highlighted. The ability of that worker in a long term care facility to be an effective support in providing service with terminally ill residents and these families is a very important role in the responsibility in that position. This role requires special skills on the part of the social worker, which should be obtained through courses on issues in gerontology and grief counselling. The social worker also requires knowledge in pastoral care and would work with the pastoral care workers.

All social workers working in long term care facilities would benefit by receiving training in grief counselling, gerontology, and working with volunteers.

Part two of Chapter III was a discussion on working with residents who are cognitively impaired. Research shows that the majority of residents suffering from cognitive impairment or severe confusion have been diagnosed as having Alzheimer's Disease. Because this fact, this section presented information on Alzheimer's Disease, and a training package was developed from the information for the Volunteer Management Training

Manual to be used in training volunteers in working with the cognitively impaired resident.

According to the research referred to in this report, the care levels for residents in long term care institutions are very high, both for physical needs and emotional support. Paid staff in these settings would probably not have the time or energy available to provide personal one-to-one contacts for Alzheimer's victims. Facilities that are providing care to this type of resident should try to institute a properly coordinated program of support through trained volunteers working with residents suffering from Alzheimer's Disease. Family members may either require support from volunteers, or provide service as a volunteer.

Chapter IV reviewed the history of volunteerism and social work and how they are connected in their development. This chapter also shows the pattern of varying areas of support, whereby originally government and private agencies were required to take over some of the functions of volunteer efforts when the needs outweighed the volunteer resources. However, today, volunteer inputs are required to assist agencies and

government departments to meet the needs of our communities. This chapter leads into the introduction of volunteer management being proposed as a social work intervention.

The social welfare system would be greatly benefited by the recognition and development of the available human resources in the volunteer community. Social work institutions, including schools of social work, should take the function of volunteer management more seriously and train social workers how to develop and work within the volunteer programs that can assist in meeting the needs of their clients.

Chapter V was a description of the intervention introduced during this practicum. The development of a volunteer program is described in the Volunteer Management Training Manual. Highlights of activities carried out in the project at the practicum setting are described in Chapter V and further analyzed in Chapter VI.

The role of a Coordinator of Volunteers uses a range of social work skills throughout the entire process of the development and maintenance of a volunteer program: program planning, evaluation,

supervision, counselling skills (in the case of volunteers, in the event of a resident's death, or personal problems affecting its volunteer's functioning), public relations, recording and data collection, group work techniques, and coordination and administrative skills are all used to varying degrees in this position. The social work community would assist greatly in the further development of the volunteer sector in a professional manner if the social work community would recognize the position of Coordinator of Volunteers and assist in lobbying for funding in health care facilities for that position. One of the reasons this author is making this recommendation is because many of the problems this program, and others have encountered were caused by the lack of funding or loss of continuity of service due to limited commitment to a professional role in volunteer coordination.

Chapter VII included literature on the topic of issues affecting working relationships between staff and volunteers. This section presented positive relationships between these two groups as imperative in a successful volunteer program. The author recommends

that: (A) Administration deciding to have volunteers supervised, trained, and supported by staff should recognize that their staff members and their volunteers may need training, support and recognition for their efforts. (B) Also, very clear standards and guidelines to protect both staff members and volunteers should be put into place during the developmental stages of the volunteer program. This action should assist in lessening staff resistance. (C) Staff orientations to volunteerism becoming a part of the initial orientation for all new staff would assist in strengthening the relationships between staff members and volunteers.

Chapter VII responded to concerns and issues of many unions and union members regarding volunteerism.

Wherever possible, a joint committee represented by staff members, union representatives, management, and volunteers should be established in order to oversee any agreements or policies regarding volunteer activities in the facility. If a cooperative team working relationship could be developed, all participants, especially the residents (who could also be represented on that committee) would benefit.

Program Outcomes

This summary has presented general information for the practicum, but for further information, the volunteer program's specific outcomes are detailed:

Before the practicum began in the personal care home, there were only three semi-active volunteers involved at the facility. These volunteers were assisting with some special event recreational programs, and two of these people were relatives of one of the residents. The only department being supported by these volunteers was the Activity Department.

At the completion of the project, there were a total of thirty-two active volunteers that had contributed a total of 1186 recorded hours in the duration of the practicum, with volunteers working mainly from December 7, 1988 to April 15, 1989. These hours were given in ten different areas of service including activities, nursing, food services, housekeeping and laundry, medical escorts, special events, friendly visiting, volunteer department, office, and staff library.

The volunteer program became more active and visible in the facility. Some of the volunteer roles

moved from the more traditional, like friendly visiting to the more creative, like nursing assistant and administrative assistant.

This practicum was a demonstration project and within the narrow time frame it took place, the program was fairly successful. The following accomplishments were made:

A. Over a period of about five months, there were a total of thirty-two people contributing time and talent to the residents that would not have existed if the project had not taken place.

B. Through the exposure and relationships formed between staff and volunteers, the staff members attitudes toward volunteers and a prospective volunteer program did improve as was shown by the increasing numbers of volunteer placements being made by over that time period. Staff became more positive toward the volunteer's involvement as more volunteers contributed an increasing number of hours.

As there was a fairly comprehensive orientation and training program for volunteers, many of the people investigating the opportunities at the Lodge received some education regarding different aspects of aging and

long term care that they may otherwise not have received.

D. The process of bringing volunteers into the facility did act as a vehicle to reconnect the residents with members of the community in very positive ways.

E. The author has created many volunteer programs in the past, but never with the purpose of identifying what new Coordinators should know, and training they should have in developing volunteer programs in long term care facilities. This project has proven a valuable experience in developing a Volunteer Management Training Manual that deals with many issues relating to the elderly and long term care. This manual also confronts issues of volunteer management that have not been widely published and are still considered to be in the pioneering stage of development, such as staff-volunteer-union relations and quality assurance/ accreditation.

From a research perspective, this project was completed in a facility that was experiencing a number of managerial problems, such as insufficient funding, new staff with little or no knowledge of volunteer management, negative history toward volunteerism, and

at times, conflicting motivations regarding the volunteer program. This was an excellent setting for this demonstration project as many of the problems experienced were found in other facilities, but not necessarily all at one facility at the same time. This experience gave the author many aspects of volunteer management to consider while developing the program and selecting information for the Volunteer Management Training Manual.

This model of this intervention was developed in a structure that is transferable to other long term care facilities. However, the author recommends that for the purpose of the quality and duration of the program, long term funding should be provided for a Coordinator of Volunteers position to develop and maintain the volunteer program. This refers to any long term care facility that may be considering the creation of this type of service. The method described of this program's development is not recommended. The training manual presents a more appropriate model for volunteer management.

The intervention carried out in this practicum did provide a valuable service for the time period the

project existed. The possible outcome of the development of the volunteer program in the facility, beyond the completion of the practicum, will be determined by those staff and volunteers who were involved in the Lodge upon this author completing her responsibilities with the volunteer project.

Volunteer management is a vital and legitimate administrative social work practice. It facilitates the discovering, training, education, supervision, evaluation and recognition of human resources being applied to human need.

This practicum report has addressed many issues of working with the elderly, long term care, and volunteer management. The Volume II, the Volunteer Training Manual, addresses the specifics of developing a volunteer program in a long term care facility (see evaluation Appendix II). This practicum proposes that by the joining of volunteer management to the needs of long term care, the quality of the lives of our elderly in these types of facilities can be enhanced through the coordination, commitment, caring, and love of the people of the community.

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APPENDIX I

Summary of Volunteer Program Statistics

<u>December 1989, and January, 1989</u>:	
Total number of active volunteers	12.0
Total number of volunteer hours	162.0
Total number of areas served	5.0
Number of existing volunteers prior to to the practicum	3.0
Number of volunteers recruited through the practicum	9.0
Number of new volunteer requests (December)	16.0
Number of new volunteer requests (January)	5.0
<u>February, 1989</u>:	
Total number of active volunteers	14.0
Total number of volunteer hours	258.0
Total number of areas served	7.0
Number of new volunteers	6.0
Number of new volunteer requests	2.0
<u>March, 1989</u>	
Total number of active volunteers	28.0
Total number of volunteer hours	419.5
Total number of areas served	9.0
Number of new volunteers	13.0
Number of new volunteer requests	3.0

April, 1989 (from April 1 to April 15 only):

Total number of active volunteers	21.0
Total number of volunteer hours	347.5
Total number of areas served	10.0
Number of new volunteers	4.0
Number of new volunteer requests	0

Total practicum program statistics:

Number of volunteers pre practicum	3.0
Number of volunteers recruited through the practicum	32.0
Total number of volunteer hours contributed through the practicum	1187.0

Services area breakdown:

Department	Hours
Activities	186.50
Nursing	106.00
Food Services	57.00
Office	405.50
Laundry	24.00
Friendly Visiting	76.75
Med. Escort	6.00
Volunteer Dept.	47.75
Library	80.00
Special Events	72.00
Total	1061.50

Volunteer Support Program:

Program	Hours
Volunteer Recognition	60.00
Volunteer Orientation	29.50
Volunteer Training	36.00
Total	125.50

Volunteer hours contributed to service departments	1061.50
Volunteer program supports	125.50
Total volunteer hours	1187.00

Gender breakdown of volunteers recruited through the program:

Percentage of female volunteers	56%
Percentage of male volunteers	44%

Note: New volunteer requests refers to volunteer job descriptions that had not been previously registered. The request could refer to a specific task to be completed by one volunteer, e.g. Library Assistant, or a program requiring the support of several volunteers, e.g. activity programs, special event programs.

Note: Due to the fact that not every registered volunteer contributed time each month and that not every specialized program was carried out each month, it may appear that there had been a decline in numbers of volunteers and/or volunteers' hours. This, in fact, was not the case. April, 1989 statistics represented

only the first half of the month. The total number of volunteer hours from April 1 - April 15, 1989 being 347.5 hours represented a large increase in hours in comparison to the full month of March which totaled 419.5 hours. There was a steady increase in both numbers of volunteers registered with the program as well as the total number of volunteers contributed consistently throughout the project.

STATISTICAL REPORT DEC & JAN. 1988/89

ACTIVITIES	NURSING	FOOD SER.	OFFICE	SPECIAL EVENT	FRIENDLY VISITING	ESCORT MED.	VOLUNTEER DEPT.	PUBLIC RELATIONS	SPECIAL EVENT GRP	ORIENT.	VOLUNTEER TRAINING PROGRAM	TOTAL VOLUNTEER HOURS
							12.5					12.5
				18.0								18.0
				8.0								8.0
	2.0			14.0								16.0
	2.0			14.0								16.0
2.5												2.5
			61.0									61.0
							6.0					6.0
				8.0								8.0
				5.0								5.0
				5.0								5.0
	4.0											4.0
2.5	8.0		61.0	72.0			18.5					162.0

ACTIVITIES	NURSING	FOOD SER.	OFFICE	SPECIAL EVENT	FRIENDLY VISITING	ESCORT MED.	VOLUNTEER DEPT.	PUBLIC RELATIONS	SPECIAL EVENT GRP	ORIENT.	VOLUNTEER TRAINING PROGRAM	TOTAL VOLUNTEER HOURS
5.5							8.75			2.5		16.75
7.0										2.5		9.5
										2.5		2.5
5.0										2.5		7.5
5.0	2.0											7.0
10.0												10.0
			112.25							2.5		114.75
2.0					19.0		6.0			2.5		29.5
										2.5		2.5
			18.0							2.5		20.5
18.0		6.0								2.5		26.5
					4.0					2.5		6.5
	3.0											3.0
										1.5		1.5
52.5	5.0	6.0	130.25		23.0		14.75			26.5		258.0

MARCH, 1989

ACTIVITIES	NURSING	FOOD SER.	MED. REC. LIBRARY	SPECIAL EVENT	FRIENDLY VISITING	ESCORT MED.	VOLUNTEER DEPT.	PUBLIC RELATIONS	SPECIAL EVENT GRP	ORIENT.	VOLUNTEER TRAINING PROGRAM	TOTAL VOLUNTEER HOURS
2.0	3.5										3.0	3.0
	3.5										3.0	8.5
	3.5										3.0	6.5
	3.5					4.5					3.0	6.5
5.0											3.0	11.0
2.5			93.5		2.0							5.0
					20.0		8.5				3.0	101.0
					6.0						3.0	31.5
1.5			36.0								3.0	9.0
54.0		18.0										37.5
	3.5										3.0	75.0
	3.5											3.5
	3.5											3.5
	3.5											3.5
	3.5											3.5
	3.5											3.5
	8.5											3.5
	5.0											8.5
	3.5											5.0
	3.5											3.5
			20.0									3.5
												20.0
												356.0

ACTIVITIES	NURSING	FOOD SER.	OFFICE	SPECIAL EVENT	FRIENDLY VISITING	ESCORT MED.	VOLUNTEER DEPT.	PUBLIC RELATIONS	LAUNDRY HOUSEKEEP.	ORIENT.	VOLUNTEER TRAINING PROGRAM	TOTAL VOLUNTEER HOURS
					8.5					3.0	3.0	14.5
	3.5											3.5
7.5											3.0	10.5
8.0									8.0			16.0
		16.0										16.0
											3.0	3.0
80.5	63.5	34.0	149.5		36.5		8.5		8.0	3.0	36.0	419.5

ACTIVITIES	NURSING	FOOD SER.	OFFICE	LAUNDRY	FRIENDLY VISITING	ESCORT MED.	VOLUNTEER DEPT.	RECOGN	LIBRARY	ORIENT.	VOLUNTEER TRAINING PROGRAM	TOTAL VOLUNTEER HOURS
								3.0				3.0
								3.0				3.0
								3.0				3.0
						6.0		3.0				9.0
3.0			40.75		2.0			3.0				48.75
					4.0		6.0	3.0				13.0
					3.0			3.0				6.0
			24.0					3.0				27.0
27.0		9.0						3.0				39.0
					5.25							5.25
								3.0				3.0
								3.0				3.0
5.0								3.0				8.0
16.0				16.0								32.0
		8.0										8.0
					3.0			3.0				6.0
	14.75											14.75
	14.75											14.75
								3.0	80.0			83.0
								15.0				15.0
								3.0				3.0
51.0	29.5	17.0	64.75	16.0	17.25	6.0	6.0	60.0	80.0			347.5

APPENDIX II

Volunteer Management Training Manual Evaluation

Specialists in Gerontology and Volunteer Management were asked to give evaluative feedback on the Volunteer Training Manual. These experts were active in the area of Volunteer Management consultation consisting of two members of a volunteer centre with backgrounds of executive experience in Volunteer Agency Boards, adult education, national voluntary organization administration, public relations and Board management, specializing in the non profit sector. Another specialization of one of the evaluators was the development of geriatric services and lecturing in a School of Social Work, as well as volunteer management.

The respondents identified several important issues addressed in the Manual: cognitive impairment (Alzheimer's) communication, the need to improve the quality for peace of mind of all concerned, special skills required in a long term care facility and unique relationships of volunteers. The need for strong management in volunteer programs with good feedback and adequate recognition was also sighted.

The main strengths of the Manual included the information, or content in, clarity, definitions, and

excellent appendixes providing samples of specific needs in volunteer management.

The evaluators indicated a need for more discussion on quality assurance and accreditation. The format and flow could be improved for publication, and a larger, more specific table of contents would be helpful.

Suggested uses, according to the evaluators, are as a reference for developing an institutional manual, a chapter in a organization's policy and procedure manual, and a training tool for Coordinators of Volunteers in long term care.

All of the evaluators believed the Manual would be very useful, but went far beyond the purpose of a manual in its content and should be considered a Volunteer Management Training Handbook. This Manual has been identified as incorporating all the steps of volunteer management and could also be used as an evaluation tool for volunteer programs.

VOLUME II

Volunteer Management Training Manual for Long Term Care

Judith M. D. Fijal

University of Manitoba

Running head: VOLUNTEER MANAGEMENT TRAINING MANUAL

Volume II

The Volunteer Management Training Manual is Volume II of a School of Social Work Practicum Report entitled "Volunteer Management in Long Term Care a Social Work Intervention connecting the Resident with the community."

The Practicum and the report have been developed in partial completion of the requirements for the Master of Social Work Degree program.

Although the report and the Manual are related, they can be read separately or alone. The Manual offers guidelines in the development of a volunteer program and several examples of the framework for that project in the appendix.

TABLE OF CONTENTS

Introduction

This training manual has been developed for the purpose of assisting Coordinators of Volunteers to develop volunteer program support systems within long term care facilities.

Many of the increasing demands for specialized services to be provided in the area of Gerontology, relates to these needs in long term care. The members of the community will need to be mobilized in order to assist in meeting the needs of our elderly citizens.

This manual refers to a general guideline of the steps to developing a volunteer program, but relates mostly to issues involving volunteers working in long term care facilities. The reader of this manual should have a general understanding of volunteer management prior to using the publication.

This manual relates to special issues of volunteer management in long term care, specialized training for volunteers in working with the cognitively impaired, staff-volunteer relations, and staff orientation. Other aspects of volunteer coordination and orientation are included in relation to long term care volunteers.

The format of this training manual works from the development of the framework for the program through to recognition of volunteers.

Section I

Developing the Framework of the Volunteer Program

The framework for a volunteer program represents the structure from which it is built. The structure of a volunteer support system should include the following:

A. Mission Statement and/or Philosophy: a brief general statement describing the purpose of the program. The philosophy could also represent the general laws through which the program would function.

B. Goals of the Program: are defined as statements, usually general and abstract, of human conditions and social environments (Rossi & Freeman, 1985, p. 60). For the purpose of evaluation, goals should be operationalized into measurable objectives.

C. Objectives: defined as specific and operational statements regarding the desired accomplishment of a social intervention program (Rossi & Freeman, 1985, p. 60). Objectives can be stated in absolute or relative terms. Relative objectives are usually more realistic to accomplish as a Coordinator doesn't always have total control over circumstances to ensure all volunteers attend a training session, whereas

a general percentage increase of attendance is usually more reachable.

Goals and objectives should be established to take into consideration the values of the organization and the existing conditions and limitations through which the program has to be developed.

D. Volunteer Program Policies and Procedures: are developed as guidelines for both volunteers and staff. They address specific issues of direct care of residents, confidentiality, volunteer benefits, legal and insurance issues, staff-volunteer accountability, direct lines of communication and authority, and emergency procedure information (see samples of long term care facility policies and procedures in Appendix 1).

These policies and procedures should be written clearly with relevance to both volunteers and staff. All parties concerned should have access to copies of the policies and procedures. With staff, volunteers, and where appropriate, residents, having copies of the volunteer program policies and procedures, all parties will have a clearer understanding of what role volunteers are expected to fulfill.

A signature of the volunteer on the policy and procedure document, ascertaining that the applicant has read, understands, and agrees to the policies - helps to insure the facility against liability cases if the volunteer breaks the rules.

E. Fire and Safety policies should be developed that would apply to the volunteer program.

Ideally, the framework of the volunteer program should be established jointly between the Administration, Department Heads, line staff, union representatives, Coordinator of Volunteers, volunteers, if they are already in place, and where possible, residents, such as representatives of Resident's Councils. This procedure assists all involved parties to acquire a sense of ownership of the program.

Where this is not possible, Administrators and Department Heads should have the opportunity and the responsibility of affirming this framework, for the same reason.

Developing a Record Keeping System

As a part of the foundation of the program, a record keeping system should be developed. The

following are suggested questions to consider in preparing guidelines for record keeping in any program or agency:

1. What are the functions of these records? How will information in the record be used? What content and what structure will fulfill these functions best?

2. How can the record best meet accountability requirements? What information should be included in the record to achieve accountability to the client, to the organization, to the profession, to the community, and to the funding and accrediting agencies?

3. How can the record best represent the essential elements of service, such as its purpose, plan, process, and progress? How can it best represent the practice modality or service approach?

4. Who will have access to the record or to the information in the record? What do privacy laws, regulations, and policies require of records in our agency? How can the content, access, and use of the record be limited to protect client privacy? How will the record affect the client if the client gains access to it?

5. Is there a customary form or structure for the record? Are there established standards or formats for recording in the field? Will use of the record be facilitated by adhering to common format, e.g. the problem-oriented recording in health organizations?

6. How can the cost of recording be minimized? Can the cost in time, personnel, and commodities for preparing, transcribing, storing, retrieving, and using the information in the record be limited while the record still fulfills its functions? (Doner-Kagle, 1984, p. 12).

In taking these questions into consideration, the following are suggestions of the types of forms that could be developed in a long term care volunteer program:

1. Request for Volunteer Form: to be completed by staff when requesting the volunteer department to supply a volunteer for a specific task. This information would be sufficient to develop a job description for the perspective volunteer.

Information required would be:

A. specific tasks to be carried out by volunteer

B. qualifications required

C. line of accountability

D. time commitment

E. program or resident information as to the location, frequencies and circumstances of contact

The Request for Volunteer form should be signed by both the staff person making the request and the supervisor/department head of that staff person. This process should help to insure that there will be supervisory follow-up to the volunteer assignment (for sample see Appendix 2).

2. Data Collection Forms:

A. Volunteer Log Sheet: signed by all volunteers, providing their name, the date, time of arrival, time of departure, and assignment or resident. This documentation provides the following information:

- total number of volunteer hours
- total number of volunteers
- total number of volunteer hours per department
- total number of hours contributed by each volunteer
- total number of volunteer hours contributed mornings, afternoons, evenings and weekends

- total number of departments receiving volunteer services
- total number of residents receiving one-to-one volunteer contact.

This information may be communicated by the use of a monthly statistical data sheet (see Appendix 3).

3. Volunteer Application Forms: to be completed by volunteer applicants identifying their name, address, telephone number, interests, educational background, hobbies, other languages, motivation for volunteering, time commitment, future plans or career aspirations, and references. In a long term care facility, such information as experience in working with the elderly, working in health care centres and recent or unresolved deaths of parents, grandparents, etc. should also be included. Unresolved grief can sometimes present a problem in a long term care volunteer assignment.

Information as to how the volunteer learned of the program will also assist the Coordinator in knowing the more effective ways of recruitment.

Section II

Quality Assurance and Accreditation as Evaluative Measures in Volunteer Programs

In considering the establishment of a evaluation procedure in volunteer supports for long term care facilities, these programs usually come under the evaluative unbrella of the facility in which the program operates.

As the evaluation of facilities became more structured and of a higher profile, such measures as quality assurance became the criteria through which the various programs within the institution were assessed. The Canadian Council of Health Facilities Accreditation is responsible for assessing or evaluating each health care facility who wishes to be accredited. Quality assurance is the form of evaluation the Council uses and supports within the facilities.

The basic steps in developing a quality assurance program are similar to the steps made to ensure that a program is measurable, and can be evaluated.

1. There should be a clear statement of the program's mission, and/or philosophy, stating the beliefs of the program and these should be in writing

and made available to staff, volunteers, etc. They should be reviewed on a regular bases to ensure they match or appropriately address, the current picture of the organization. Goals and objectives should be clearly stated with time frames assigned to them.

Volunteer policies and procedures should refer to the expected levels of service or performance of both volunteers and staff. These standards should be established utilizing such factors as accreditation standards, provincial and municipal legislation and professional standards of practice. They should be in writing and be measurable.

2. Each evaluative mechanism, although being developed with standard evaluation guidelines, should also be unique to this specific program or facility. These mechanisms should evaluate all aspects of the program, volunteer functioning and satisfaction, staff functioning and support system to volunteers, as well as resident's experiences and impressions of the program (see samples of evaluation questionnaires, Appendix 4, 5, and 6).

A part of the process is to determine, through the development of evaluative instruments or tools and man power available, how well a quality assurance program can be managed. Are there adequate questionnaires? Do staff have time to keep records, etc.? Also to be considered is which are the most important variables to measure, what changes are required, which are the most reliable measurement tools, and which of the available tools are the easiest and most meaningful for staff to use.

3. The data is gathered and analyzed; problems are documented and recorded for corrective action. Corrective action should be taken within specified time limits.

A well developed evaluation model helps to establish creditability of the program for its facility as well as the funders. This procedure will also indicate patterns of growth and development as well as weaknesses in the program. When developing an evaluation package for a volunteer program, that package should address all of the questions on its Canadian Council of Health Facilities Accreditation survey to insure the program meets their criteria (see Canadian Council of Health Facilities Accreditation question survey,

(Appendix 7). All workshops such as orientation sessions, staff orientation to volunteerism sessions and specialized training seminars should also have an evaluation questionnaire in the participant's packets.

Section III

Developing a Budget for a Volunteer Program

It has often been stated that volunteer programs provide free labour. This, in fact, is not true. A viable volunteer program requires a budget in order to operate successfully. The types of expenses incurred in a volunteer program are as follows:

A. Personnel - Direct and Indirect Costs

1. Coordinator of Volunteers' salary should be based on similarity with other department head or key administrative positions in the facility.

2. Support staff - clerical worker - full time or part time depending on the size of the facility.

3. Space - office space, private interviewing space, and facilities for meetings, orientations and training sessions, volunteer lounges and storage, volunteer log book location, bulletin boards, rest rooms, and space for volunteer's coats and boots. All appropriate furniture and equipment will be required in these areas.

4. Office supplies, printing, reproduction, and postage.

5. Insurance coverage for liability for all volunteers working in the program.

6. Recognition including out-of-pocket expenses for volunteers.

7. Travel reinbursement for recruitment campaigns, workshops and conferences for the Coordinator of Volunteers and other program personnel.

8. Professional development, association fees, subscriptions to journals and registrations for workshops (Ellis, n.d.).

Factors that may have an impact on the budget required for a volunteer program are as follows:

1. Rural versus urban setting of facility would possibly effect transportation costs.
2. Projected size of program.
3. The extent to which volunteers require training.
4. Standard and variety of recruitment and publicity materials.
5. Skill level and expertise required of coordinator affects salary levels.
6. Availability of staff resources for training volunteers.

7. Ability of agency to absorb office, clerical, telephone costs in the general operating budget.
8. Number, type and quality of recognition to volunteers (Thomson, 1983).

Due to a lack of financial resources in many facilities providing long term care, volunteer programs are often developed with very limited financial support. This fact may affect the ability to compete for volunteers in recruiting volunteers in a community that has many organized volunteer programs that are well funded.

Section IV

Staff Orientation to the Volunteer Program

Staff members are often assigned to supervising and supporting volunteers. These staff members may have never been trained in the art of supervision and may have little or no knowledge of volunteerism. The quality of the experience of volunteering relates as much to the relationship between the volunteer and the staff supervising them as it relates to a sense of satisfaction of providing assistance to someone or learning a new task or skill.

The motivation that a volunteer may have for contributing their time and talents is an important factor for staff members to consider when they are supervising or supporting volunteers in their facility. The Basic Steps in Volunteer Management (1981) includes an article entitled "Volunteer Viewpoint." This article relates the points of view of a volunteer, as follows:

"If you want my loyalty, interests, and best efforts, remember that:

A. I need a sense of belonging, a feeling that I am honestly needed for my total self, not just for my

hands nor because I take orders.

B. I need to have a sense of sharing in planning our objectives. My need will be satisfied only when I feel my ideas have had a fair hearing.

C. I need to feel that the goals and objectives arrived at are within reach and that they make sense to me.

D. I need to feel that what I'm doing has real purpose or contributes to human welfare - that its value extends beyond my personal gains, or hours.

E. I need to share in making the rules by which, together, we shall live and work toward our goals.

F. I need to know in some clear detail just what is expected of me, not only my detailed tasks, but where I have opportunity to make personal and final decisions.

G. I need to have some responsibilities that challenge, that are within range of my abilities and interests, and that contribute toward reaching my goal, and that cover all my goals.

H. I need to see that progress is being made toward the goals that we have set.

I. I need to be kept informed. What I am not up on, I may be down on (keeping me informed is one way of giving me status as an individual).

J. I need to have confidence in my superiors confidence based on assurance of consistent fair treatment, or recognition when it is due, and trust loyalty will bring increased security.

In brief, it really doesn't matter how much sense my part in this organization makes to you. I must feel that the whole deal makes sense to me. I would add, hopefully, the whole deal makes sense to everyone involved - the client, staff volunteer ... and you" (Campbell, 1981).

A staff orientation provides information to staff members about volunteerism in general, the volunteer program within the facility, and the volunteers working in the organization and how their services may be used more appropriately.

The Staff Orientation to Volunteerism Session

The orientation program should be presented with the knowledge and support of the Administrator. If that support is made clear, the session may be accepted as being more creditable.

The sessions would last approximately two and one half to three hours, but in a long term care facility, due to staff scheduling, the orientation often is presented in two separate sessions.

The attendance of the supervisor and/or department head is usually helpful as both middle management and line staff know the information being presented, and the staff's response to the orientation.

A suggested format of the orientation is as follows:

A. Chair Exercise (assists in determining why people don't volunteer, who among staff do volunteer, and allows staff to get to know each other from a different perspective) (see Appendix 8).

B. Job Description Exercise (encourages staff to identify more useful roles for volunteers within their own department. Also assists staff in identifying how the volunteer program may personally assist or benefit them).

C. Examining all the forms and documents provided in a Staff Orientation to Volunteerism package, such as:

1. A copy of the session agenda
2. Volunteer program mission statement
3. Volunteer program philosophy
4. Volunteer program policies and procedures
5. Fire and safety regulations affecting volunteers
6. Information on volunteerism
7. Sample forms to be used in the facility:
   - A. request forms for volunteers
   - B. evaluation forms
     - for the evaluation of volunteers
     - for the evaluation of the volunteer program
     - for feed back from residents
   - C. data collection forms
   - D. monthly statistical sheet

   (see Appendix 9).

When possible, volunteers could be involved in presenting information about the volunteer program and his/her own personal experience working as a volunteer within the facility.

Information regarding the supervision of volunteers is referred to in section 10.

Section V

Developing Job Descriptions and Negotiating Job Placements for Volunteers

A job description is defined as "a written report outlining the duties, responsibilities, and accountability of a job within an organization ... " (Thomson, 1981, p. 28). A task analysis, which can be included in a job description, provides a list of the detailed responsibilities to be carried out by the volunteer.

The job description acts as a contract and provides very specific information regarding the volunteer placement and the purpose of job assignment. A written job description is a reference point for both staff and volunteers in determining the role and the activity of the volunteer in the department.

Written job descriptions are an excellent tool in volunteer recruitment as they provide a very detailed account of the opportunities available for volunteers, but also assist the Coordinator to plan what areas the recruitment campaign must approach to gain appropriate volunteers (Thomson, 1984).

Job descriptions should include the following information:

A. Job title

B. Purpose of the assignment

C. An itemized list of responsibilities

D. Time requirements (time of day, day of week, total number of weeks, months, year)

E. Skills and qualifications required (including special qualities that may be required)

F. Orientation and training required

G. Accountability and line of authority

The volunteer, the assigned staff member, department head or supervisor, and the Coordinator of Volunteers would be benefited by all having a copy of the job description. Prior to the volunteer starting in his or her new assignment, a meeting between the staff member, Coordinator and the volunteer to review the job description could be helpful (see samples of job description in long term care, Appendix 11).

The Coordinator's role in job placement of volunteers is to insure that job assignments are appropriate and do not conflict with legal issues, lack challenge, have unrealistic expectations, or are

not meeting the motivational need of the volunteer. The Coordinator may also broaden the facility's vision of what roles volunteers can have with that type of treatment facility. The Coordinator's role in this area is also an educational role.

Section VI

Recruitment of Volunteers

The key to volunteer recruitment is in the marketing of the volunteer program. Marketing is "the analysis, planning, implementation, and control of carefully formulated programs designed to bring about voluntary exchange of values with target markets for the purpose of achieving organizational objectives" (Campbell, 1981, p. 55).

With volunteerism becoming a highly competitive field, with far more need for volunteers than people to fill them, the presentation of the need for the volunteers and the opportunities being made available is very important. As motivation for volunteering is so closely linked to recruitment, the target groups approached and the type of opportunities offered should be closely linked.

A good recruitment strategy would probably include creating opportunities that would not only fulfill the needs of residents, but also direct consideration to the following types of motivations for people volunteering:

A. Career exploration

B. Work experience

C. School course credit

D. To re-enter work force

E. To establish new friendships

F. To obtain opportunities to practice new language skills

G. Personal interest in a special area of service

H. Religious commitment to serve

I. Community service commitment

J. To develop new skills

Recruitment Materials

Pamphlets and posters from long term care centres should present a bright, clear, brief display of the opportunities available to volunteers in the facility. These materials should be colourful and be attractive to the prospective volunteer's eyes.

The following are helpful hints that the Volunteer Centre of Metropolitan Toronto referred to in the publication of their manual:

1. Do specific, rather than general recruiting whenever possible.

2. Choose appropriate audiences whose interests, priorities and skills match your needs.

3. Be as specific and honest in your appeal as possible.

4. Have a year around recruitment plan: e.g., early fall and January for the general public, late spring, for summer students, and other kinds of recruitment for the remaining months.

5. Use a variety of recruitment techniques ... newspapers, radio, TV, speeches to clubs, person-to-person (effective!), flyers, brochures, posters in libraries, hairdressers, and doctor's offices, and volunteer fairs.

6. Use services of Volunteer Centre/Bureau.

7. Recruit by inviting people to respond to the opportunity to volunteer, and the benefits available to them, not only by telling them they ought to be concerned.

8. Be enthusiastic!

Additional areas of recruitment may be university departments in the Humanity fields, high school life skill programs, churches, community centres, a day care

program for special contact between the children and the residents.

Recruitment, as a public relations tool, brings information to the community about the facility, its services, and through the awareness gained by the recruitment campaign, the community becomes more informed and educated regarding residents' needs in the facility.

One major area of growing interest in the health care field is the area of Gerontology. When recruiting for volunteers, offering career exploration in the area of aging may be a powerful drawing card.

Section VII

Interviewing, Screening and Job Assignment for Volunteers

Volunteer selection is the process whereby the Coordinator searches out the right volunteer for the job and the right job for the volunteer. Interviewing is the instrument or tool used to assist in making the appropriate selection. The job assignment is the meeting of the minds of the Coordinator and the volunteer where both parties with an exchange of information could agree on a particular job description for the volunteer (Putz, 1981).

The Interview

The following points should be considered:

A. The interview should take place in a private, quiet, clean environment, preferably without a desk separating the interviewer and the interviewee.

B. The Coordinator opening the interview by providing the applicant with information about the facility, offering a cup of coffee, and using open ended questions will often assist the applicant to feel more at ease. The Coordinator can switch to closed

questions or direct questioning if the applicant seems to prefer that approach.

C. Body language is a form of communication that can assist the interviewer to gauge the comfort level of the interviewee.

Special issues that could be addressed during the interview in a long term care facility are as follows:

1. Issues regarding working within the structure and expectations of a health care facility such as schedules, policies, and routines being very instrumental in providing good care to residents.

2. Applicants actually looking for paid employment and having very little interest in volunteering: Establishing a policy that all volunteers who are accepted into the program and trained will not be considered for a specified period of time for paid employment will screen out these applicants.

3. Recent death of parent, grandparent, or unresolved grief on the part of the volunteer: These experiences may interact with the relationships between the resident and the volunteer. More support or closer supervision may be required.

4. Dealing with cognitive impairment/confusion and severe medical problems: Prospective volunteers can be assisted in examining these areas of concern and be better prepared to cope with the reality of such illnesses.

Introducing the applicant to active volunteers helps the prospective volunteer to see him/herself in a helping role within the facility. Other volunteers are usually very receptive and supportive, and the applicant may feel reassured by that contact.

Job descriptions can be presented to the applicants which will not only identify the specific responsibilities required in the position applied for, but will also inform the new volunteer of other opportunities available. The volunteer may have some of the skills required for opportunities they would be interested in, but did not know had existed.

A meeting should take place between the staff supervisor, the volunteer and the Coordinator before finalizing the assignment to ensure there is total clarification and agreement between all parties.

The Coordinator has the responsibility of following the progress of the assignment to insure that

both the volunteer and the staff member are satisfied with the job assignment. This process helps to promote a successful volunteer program.

Every step of the development of a volunteer program represents public relations between the facility and the community. The interview - placement role is an important part of this process.

Section VIII

Orientation of Volunteers

Orientation session for volunteers provides an opportunity for new volunteers to learn general information about the organization they have chosen to serve. A suggested orientation package to be provided to participants would include the following:

A. The mission statement/philosophy of the volunteer program.

B. The goals and objectives of the volunteer program.

C. Volunteer program policy and procedure document.

D. Fire and safety regulations.

E. Volunteer log book form for recording volunteer hours contributed to the facility.

F. Information on aging.

G. Information regarding communication skills with the hearing impaired, sight impaired and speech impaired.

H. An organizational chart showing the various departments and services and line of accountability/communication.

The orientation session provides an opportunity for new volunteers to meet staff members who would be presenting information at the session. An example of those staff persons that could contribute are as follows:

A. The Administrator/Manager - to provide a message of welcome and history of the facility.

B. The Director of Nursing - to describe the treatment approaches (custodial or therapeutic approach), nursing department and general information about resident's care.

C. The Social Worker(s) - to provide information as to admission policies and procedures, services provided within the facility, and to discuss one to one type job assignments.

D. Staff Development Officer - to discuss educational and training opportunities for volunteers, staff library, and give instruction on such issues as handling a wheelchair.

E. Food Services Representative - discuss food services in the facility, special event programs requiring volunteer assistance, volunteer benefits regarding complementary meals, and to provide refreshments for the orientation participants.

F. Fire and Safety Officer - demonstrate how to use a fire extinguisher and review regulations.

G. Active Volunteers - who would assist in describing the volunteer program, giving a personal account of their experiences.

H. Resident Council Representatives - to extend welcome.

The Coordinator can provide a general overview of the volunteer program, number of volunteers, types of opportunities, and volunteer benefits.

Discussion could also take place regarding participants views on aging and perceptions of long term care.

A tour of the facility should also be arranged. The information contained in the orientation package should be reviewed with the participants with an opportunity for questions and answers to follow (see sample package, Appendix 12).

Mini-orientations can be provided by the Coordinator of Volunteers upon the first interview, however the volunteer should be invited to a general orientation meeting within two to three weeks of being accepted.

Specific specialized training for volunteers in relation to special job assignments would be provided at a different time.

Section IX

Specialized Training for Volunteers

In comparison to volunteer orientation, volunteer training is the "systematic process by which the volunteer is permitted to learn the skills and acquire the knowledge and attitudes necessary for the performance of the assigned tasks" (Simmons, 1981, p. 90).

Four steps in training are:

1. Learning needs must be accurately and specifically determined.

2. Appropriate learning objectives must be defined in terms of expected changes in performance.

3. Learning experiences must be designed so that they can take into account the practical considerations of cost, scheduling, and achievement of objectives.

4. An honest evaluation must be done to determine whether or not the outcomes are as predicted in the objectives (Simmons, 1981, p. 92).

Learning needs are deficiencies and learning objectives are what one should know or achieve out of the learning experience.

Other considerations to keep in mind when planning special adult training programs are:

1. Adults enter learning activities with an organized set of descriptions (self-concept) and feelings (self esteem). Both are based on how the learner interpreted and valued past experiences.

2. The adult learner needs to feel their past experience is respected and valued by others, otherwise he/she feels devalued. He/she needs to respect their own past, to value its potential for learning and its potential for hindrance to further learning.

3. When past experience as applied to current experience learning is facilitated.

4. The most important component of its self concept relevant to learning is past experience attached to the role of the learner and the resulting meanings, values, skills, and strategies. The learner learns best when he/she values the role of learner for self, experience competence, can manage his/her own learning, processing facts through many channels, values and uses past experience for current learning, values his/her status as a learner, utilizes others resources and values himself/herself as a resource

for others (Brundage & MacKeracher, 1980, p. 97-101).

These learning principles point out the importance of the Coordinator to provide solid supportive, organized training programs with trained, competent instructors for the well-being of the volunteers.

The role of the Coordinator is to facilitate and coordinate the training sessions, providing instructors to present their expertise in a specific topic.

Structured training programs often fail due to:

A. When the model, as outlined, is truncated or abbreviated or when it is inadequately implemented by the facilitator.

B. Previously ineffective training experiences brings about resistance on the part of its participant in future training programs (Simmons, 1981; Pfeiffer, 1975).

Volunteer training programs provide opportunities for staff members to share their expertise with volunteers involved in special assignments. With conditions causing cognitive impairment appearing in increasing numbers, volunteer support in personal care homes will be vital to assist in providing the high level of care that will be required for these affected residents. The staff and volunteers will have to act

as a team meeting these resident's needs. Specialized training responding to conditions such as Alzheimer's Disease will be required for volunteers working with the cognitively impaired (see sample training package, Appendix 13).

Specialized training not only provides the tools with which the volunteer is able to complete the assignment, but also offers a valuable volunteer benefit.

Section X

Supervision of Volunteers

The ultimate objective of supervision is to offer the service of the program in the most effective and efficient manner possible. The supervisor administratively integrates and coordinates the volunteer's work with others in the facility, assists in educating the volunteer to a more skillful performance, while supporting and sustaining the volunteers in their motivational performance (Kaduskin, 1976).

Supervisory tasks in working with a volunteer program have the following functions:

A. Administrative functions:

1. Developing job descriptions
2. Contracting a work assignment
3. Establishing goals and objectives for that particular volunteer
4. Evaluating the volunteer and the program
5. Data collection and record keeping
6. Managing volunteer benefit programs
7. Redirecting or terminating volunteers in their positions

B. Educational Function:

1. Providing orientation and training programs
2. Ensuring on the job training
3. Providing access to off the job site workshops and training seminars
4. Providing specialized training and in-service education

C. Supportive Function:

When developing supportive supervision, the following factors should be taken into consideration:

1. Psychological status
2. Physiological status
3. Abilities
4. limitations
5. modes of action
6. personality characteristic
7. individual needs and aspirations of the volunteer

(Itzkow & Hurtado, 1981, pp. 112-113).

The overall administrative function of the volunteer would fall under the responsibility of the Coordinator. Educational functions are organized by

the Coordinator, in conjunction with the Staff Development Officer if one is in place, and are facilitated by various staff members or outside resources with the appropriate expertise.

The supportive role in supervision is the responsibility of all staff within the facility. The Coordinator ensures that volunteers are receiving supportive supervision through evaluations and feedback but "hands-on" supervisors are the staff members who will have the major role of supporting volunteers.

Some facilities tend to expect the Coordinator to personally supervise all volunteers, which is very unrealistic as well as unwise. No department head or supervisor in any facility are expected to supervise that large a number of staff. There are highly specialized areas of service in a long term care facility requiring special supervision, as in the nursing department. Most Coordinators would not be qualified to provide that area of supervision. However, when problems arise in supervision, the Coordinator acts as the negotiator and insures the problem is solved to everyone's satisfaction.

There is a facilitative process of supervision that is known as impact supervision. This approach is a problem solving method with both a facilitative and an active component. The facilitative component includes such qualities of the supervisor as empathy, respect, genuineness, and concreteness.

The action component is the problem solving role:

A. indentifying the problem

B. determining the need

C. establishing the goals and priorities

D. devising the methods

E. evaluating the results

Clarifying the problem by properly defining it is solving at least half the problem, and is necessary in order to complete the other steps.

In determining the need, the following questions could be asked:

1. What are needs lying behind the problem being identified?

2. Why does the problem arise or exist?

3. What are the needs that are causing this person to behave in this manner?

Establishing goals and priorities is determining the desired end result. In order to do this effectively, goal statements should be clear and concise, with built in indicators of achievement that can be measured. Goals should also be listed in priorities.

In order to adequately devise methods of problem solving, all previous steps should be completed.

To evaluate the problem solving, one should measure the effectiveness of the action, the impact of the method and its correlation with the outcome, measuring both efficiency and effectiveness of the problem solving method used in the process of supervision (Clarke, Shaw, & Weinstein, 1984, pp. 39-58). When supervisory methods are not adequate and support systems are not effective, the result is often volunteer burnout.

Volunteer Burnout

A definition of "Burnout" is "someone in the state of fatigue or frustration brought about by devotion to a cause, way of life, or relationship that failed to produce the expected reward" (Kennedy & Zauhar, 1982, p. 2).

Volunteers commit themselves with caring, devotion, and purpose, offering their time, talents and resources with little or no expectation of material gain. When volunteers drop out of programs, it is often due to burnout and job dissatisfaction.

Reasons for volunteer burnout are as follows:

1. felt services no longer needed
2. felt contribution was no longer appreciated
3. had conflict with organizational goals
4. had conflict with others in the organization
5. had not recently received a request to serve (Howell, 1986).

Other reasons for volunteers leaving programs are:

1. a lack of proper attention by volunteer coherts, volunteer organizers, or administrators.
2. excessive responsibility beyond the individual's capabilities and/or activities.
3. exhorbitant expectations on the part of clients participants, organizers, overseers.
4. client dissatisfaction with results and unmet needs, wants, and desires (Kennedy & Zauhar, 1982, p. 6).

It is not an uncommon practice for staff members to overload volunteers with requests for their assistance when the volunteer has proven to be an excellent worker. Having each volunteer assigned to a staff person to oversee these demands and work on a "Buddy" system helps to alleviate this concern. However, there are times when volunteers don't work out in the placement or violate the guidelines to the degree of putting the resident at risk. Under these circumstances, it can become necessary for the Coordinator of Volunteers to fire the volunteer.

Firing a Volunteer

When a volunteer has not met the expectations or standards of a job assignment, and further training and support has not proven to be effective, the volunteer could be transferred to another department for a more appropriate assignment or referred to the Volunteer Centre/Bureau for reassessment and redirection. How this is done is very important, as the experience of failure within a volunteer position can be very devastating to a volunteer. All attempts should be made to redirect the volunteer into another position

rather than leaving them feel that they have failed and are being rejected.

However, when a volunteer repeatedly breaks rules, ignores guidelines, breaks the law or puts residents at risk, the Coordinator not only has the authority to fire that volunteer, they also have the responsibility to do it swiftly and quickly. If the Coordinator does not act in a situation where the volunteer is showing no respect for the guidelines of the home or will willingly put residents at risk, the Coordinator and the volunteer program will lose all creditability. It is also suggested to inform any central volunteer registry, like a Volunteer Centre of the action taken so the volunteer is not referred elsewhere.

Section XI

Recognition of Volunteers

Recognition is a vital part of any volunteer program. According to the Webster's New World Dictionary, "recognition" is defined as:

1. to be aware of
2. acknowledgment and approval
3. gratitude
4. to notice, as in passing

Sue Vineyard, author of "Beyond Banquets, Plaques and Pins - Creative Ways to Recognize Volunteers and Staff", suggests that recognition should be "user-oriented" to be effective. The volunteer's motivations for volunteering should be closely tied into the style or form of recognition that takes place within any organization.

Recognition should be personalized to be effective. Certificates and pins can be given out during a recognition event, but in introducing the volunteer individually, an account of each of the volunteer's activities, responsibilities or contributions can be presented, highlighting them on a personal basis. In this manner, the recognition,

although general in design, is also personalized in nature.

In evaluating the recognition event and trying to determine if it is accomplishing what it was supposed to accomplish, the volunteers and staff can be questioned regarding their feelings or ideas about the event. Constant consideration should be given as to the effectiveness and appropriateness of the event.

Although most organizations or volunteer programs recognize their volunteers through a major event each year, that is only one method of recognizing the contributions that are made. Daily, ongoing acknowledgment of volunteer contributions should be a program policy. Every time that a volunteer provides a service, that volunteer should be thanked verbally. Recognition is a very important part of an ongoing management process, helping to ensure that volunteers are not taken for granted, are appreciated for their efforts and are feeling positively about their role within the organization. These feelings are often taken back to the community by the volunteers, which also provides an excellent public relations service to the organization.

Other tangible ways of recognizing volunteers can be arranged through the organization of the volunteer program. An article presented by the Volunteer Centre of Metropolitan Toronto suggests that ongoing training and educational programs also act as a form of recognition. Evaluations of volunteers are vehicles that can also be used. Staff/volunteer meetings and workshops provide for opportunities of recognition.

A promotional system of assigning volunteers responsibilities also provides for recognition of work well done and outstanding talents or contributions.

The following are additional suggestions of how volunteers can be recognized on an ongoing basis:

1. Providing complimentary meals and beverages
2. Out-of-pocket expense coverage
3. Highlighting volunteers in organizational newsletters
4. Establishing a "Volunteer of the Month" award
5. Occasional letters of appreciation being handed to volunteers or mailed out to their homes
6. Sending birthday cards if month of birthday is known

7. Cards and/or flowers if volunteer is ill or in hospital
8. Ask volunteers to take part in orientations or training session events as training leaders
9. Provide small token gifts or cards for special occasions, e.g. Christmas

In long term care facilities the Resident's Council or resident's representative may be invited to join the recognition event and be asked to say words of welcome and appreciation.

Section XII

Special Issues of Volunteer Management

A. Staff-Volunteer Relations

One of the most important determining factors in a successful volunteer program is positive staff-volunteer relations. Paid staff's acceptance of the volunteer program and productive working relationships between the staff members and the volunteers are critical to the successful operation of a volunteer program (Graff, 1983).

Factors that the Coordinator usually has to confront in developing good working relationships are as follows:

1. The history of the facility and/or program:

Attitudes of paid staff toward volunteer involvement are often influenced by the history of the facility and of whatever type of volunteer activity may have been present in the past. If the staff had a history of negative experiences in either that facility or in previous positions, that history may have an affect on their attitude of the present program.

2. Staff's reaction to change:

The implementation of a volunteer program may be threatening to staff who had not experienced working with volunteers in the past. Beyond the Stable State confronts the topic of the concept of change. Schon states "Belief in the steady state is belief in the unchangeability, the consistency of central aspects in our lives, or the belief we can obtain such consistency" (Schon, 1973, p. 9). He believes we want to be protested by the threats inherent in change.

Institutions may respond constructively to change by maintaining a sense of self identity while in the process of change.

Change is seen as something that happens to organizations as a result of outside pressures or forces rather than as a result of active efforts of forces coming from outside. A healthy organization acts and responds continually in a forward direction to fulfill its ais, making room for change and improvements through planning, evaluation and feedback (Love, 1980).

3. Proposed new settings for programs are often established within existing settings bringing about a possibility of conflict in opposing ideologies, and a concern for resources, which is bound to affect all parties involved (Sarason, 1972).

In analyzing the political make-up of the facility, comparing the written organizational charts with the actual line of authority and command, may assist the Coordinator in what direction, and with what staff members the development should be concentrated.

However, unless the historical, sociological, developmental, and longitudinal context is taken into consideration, not all the facts surrounding the facility or program may be realized. These facts may be instrumental in the successful development of the program (Sarason, 1972).

Problems that can enter into the development of a program and affect staff-volunteer relations are as follows:

1. Recruitment of the Coordinator and the capability of the other department heads working with their program.

2. The absence of problem anticipating and problem solving vehicles.

3. The myth of unlimited resources and an untroubled future.

4. Specialization of function - are the staff willing to train and supervise volunteers in specialized job assignments? Are the staff territorial or threatened by professional, well trained volunteers working in their facility? (Sarason, 1972, p. 91).

Many of the political situations that exist within facilities prior to the Coordinator being hired to develop a volunteer program may challenge the Coordinator in his/her position. Staff lay-offs, low staff morale, poor relationships between the administration and the staff or, a lack of commitment toward the program that has been ordained from "on high" may all play a negative role in the formation of the volunteer program. The Coordinator may not have created them, but through public relations, education, special analysis, consideration, and finesse, these influences could be successfully resolved. One way to approach the staff-volunteer relation context is

through working toward positive Volunteer-Staff-Union relations.

Volunteer-Staff-Union Relations

Two major concerns unions express regarding the use of volunteers within the unionized facility are as follows:

1. Displacement: member staff being laid off when money is available, and volunteers are used to complete the tasks of staff members, with the allocated funds for that program being diverted elsewhere.

2. Replacement: occurs when funding for the position is lost, and there is no way for the program or activity to continue without maintaining it on a voluntary basis. Unions feel this practice may "buffer" the large scale reaction to diminished funding for the programs (Graff, 1983). Volunteers should never be used to displace paid staff members, and the replacement of previously funded positions with volunteers may have to be assessed individually.

There are many considerations in defining what roles volunteers should fulfill in a long term care facility. A lack of similarity between facilities as to what are appropriate volunteer roles lead to a wide

variety of volunteer functions in the field. What one facility identifies as a staff role, other facilities may identify the same task as a volunteer role. McCurley (1981) and Duncan (1982) both suggest a volunteer role should be determined by the actual nature of the work itself and who could achieve the most by doing the task, e.g. a volunteer providing time consuming one-to-one support to a resident who is hostile toward staff.

In working out the issues that union members, staff and volunteers have toward their involvement in the facility, the role of the Coordinator is to maintain the balance between the needs of the institution and the needs of the volunteer (Hickerson, 1988).

The main key in addressing issues of volunteer, staff, union relations is teamwork and communication. A tri-lateral committee made up of management, union representatives and the Coordinator of volunteers (with volunteer representation), could work on establishing clear guidelines together. All job descriptions could be confirmed, with keeping in mind the majority of

suggestions of roles for volunteers are made by staff union members.

The same committee that oversees the volunteer part in the facility could also establish a policy agreement on volunteers' involvement in the facility in the case of a strike. Volunteers should be allowed to make their own decision as to crossing a picket line, but the decision could be more easily made if there were a printed agreement on what all parties believed volunteers should be allowed to do in the process of a strike. This agreement should be distributed prior to any threat of strike action.

Strike agreements should be kept and honoured closely, allowing the volunteer to maintain a position of neutrality.

> In concluding this section, Campbell (1985) stated "the volunteer must realize the legitimate concerns of the labour movement in seeking to protect jobs and improve the working conditions of its members and of others in the labour force. The labour movement, for its part, must acknowledge that the use of volunteers is not a short term expedient during hard times, but an

honourable and long standing practice, which has many social benefits, and that voluntary agencies must be preserved and strengthened so that the range and diversity of the service available in the community is not reduced. The labour movement and the voluntary sector must see each other as allies to ensure the adequate services are provided in the community" (Campbell, 1985, p. 22).

Summary

This manual has been created to assist Coordinators of Volunteers in developing a volunteer program in a long term facility. The information touches on all aspects of volunteer management, but emphasizes issues dealing with volunteers working in long term care, management requirements such as evaluation and quality assurance/accreditation, and volunteer/staff/union relations. Areas that were not fully addressed have already been published in many forms. Several of the publications listed in the reference section discuss other issues of volunteer management in a more general manner.

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VOLUNTEER PROGRAM
POLICIES AND PROCEDURES

1. Volunteers will be recruited through the Volunteer Centre of Winnipeg, educational programs, work experience placement programs, the media (television, radio, newspapers), community posters and pamphlets, community organizations, churches, and through volunteer contacts. Qualifications for volunteers include the following:
   an interest in working with the elderly, dependable, consistent, willing to work under the policy and procedure guidelines, neat in appearance, etc. Specific qualifications are described in the individual job description for each volunteer responsibility.

2. All volunteers are to be registered in the volunteer program.

3. All volunteers are requested to wear volunteer name badges and to leave the badge at the facility upon leaving the building.

4. All volunteers are requested to sign the Volunteer Log Book at the reception desk before leaving the building.

5. Orientation programs for <u>new</u> volunteers will be held on a monthly basis, alternating between day and evening programs and all volunteers are requested to arrange to attend an orientation meeting.

6. If a volunteer is unable to attend the facility or keep an appointment with a resident or a program, the volunteer is requested to phone the charge nurse or program supervisor, to inform them the volunteer will not be in. If a resident is ill and does not want to see the volunteer or if a program is cancelled, the Coordinator of Volunteers should be informed as well as the volunteer assigned to the resident or the program.

7. Volunteers are requested to respect the resident's privacy and rights. All volunteers are requested to knock on the resident's door before entering their room, introduce him/herself, and explain the reason for being in the room.

8. Volunteers are requested to wear appropriate clothing while in the facility. All clothing should be washable, neat in appearance, and comfortable. Any volunteers handling wheelchairs are requested not to wear open toed shoes or sandals.

9. All volunteers are requested to check with a charge nurse before running an errand for a resident. A volunteer could be requested to purchase food or items that the resident is not supposed to have or use, and checking with the nurse would prevent further problems in the future.

10. All volunteers are requested to inform the charge nurse before taking a resident off her/his floor.

11. Volunteers are requested to smoke only in lounges where ashtrays are provided, in smoking cafeterias or other designated areas.

12. No volunteers are allowed to accept money or valuable gifts from residents or resident's family members for services rendered. The only exchange of gifts should be token gifts at Christmas, etc. Token gifts would be candy bars, a greeting card, etc. Volunteers are encouraged to check with the charge nurse before giving a resident a gift due to concern re health, mental confusion, or other legal issues.

13. All volunteers should refuse to sign any legal documents for residents. Any such requests should be directed to the social worker, the director of nursing, or the manager of the facility.

14. Volunteers are requested to avoid lifting or transfers of residents under any circumstances. Volunteers are not covered by the facility's insurance for lifting and transferring.

15. If a resident falls, volunteers are to seek help from a registered nurse and are not to attempt to move the resident under any circumstances. The volunteer is encouraged to sit by the resident and try to comfort the resident while waiting for assistance. The volunteer is requested to fill out an incident report on the fall if the volunteer had witnessed the fall.

Incident reports are forms that are available through the Director of Nursing and/or the Coordinator of Volunteers. The form should be completed, signed, dated, and submitted to the charge nurse.

If the resident should fall away from the facility while out with a volunteer, and is experiencing pain from the fall, the resident should not be moved. The volunteer should ask anyone who is available to phone for an ambulance, stay with the resident until help arrives and notify the charge nurse at his/her earliest opportunity

16. If a volunteer witnesses an action, ie. falling resident, one resident pushing another, questionable behaviour on the part of other volunteers or staff, the volunteer is requested to submit an incident report to the Director of Nursing and/or Coordinator of Volunteers. Volunteers are encouraged to use this procedure in relating conflict that may occur between the volunteer and a staff person as well, if it cannot be worked out privately.

17. All volunteers are requested to respect a code of confidentiality. Any personal information learned about residents should be kept within the facility and should be shared only with the volunteer's supervisor. Medical charts and care plans are not available for public viewing. However, volunteers are encouraged to share information or knowledge they have of the resident, either verbally or in writing to assist with the review of the care plan.

    Staff are encouraged to share with the volunteer any information about the resident that could have an impact or effect on the relationship or activities between the volunteer and the resident ie. diabetes, alzheimer confusion, seizures.

Would all volunteers please sign this Policy and Procedure document to indicate that you have read and understand these policies. Also, your signature indicates you are in agreement with these policies.

Dated: _____ Volunteer Signature: _____

VOLUNTEER REQUEST FORM

DATE _____ REQUESTED BY _____

PHONE _____ POSITION _____

DEPARTMENT _____

NUMBER OF VOLUNTEERS REQUESTED

(Please complete seperate form for each Job Description/in case of a friendly visitor request form please coplete Friendly Visitor Information form.)

DESCRIPTION OF VOLUNTEER'S DUTIES

A _____

_____

B _____

_____

C _____

_____

D _____

_____

E _____

_____

SKILLS REQUIRED FOR THIS VOLUNTEER POSITION

1 _____ 4 _____

2 _____ 5 _____

3 _____ 6 _____

ANTICIPATED START DATE _____

#No. OF HOURS PER WEEK OR EVENT _____

DAYS OF WEEK VOLUNTEER REQUIRED

MON TUES WED THURS FRI SAT SUN

TIME OF DAY VOLUNTEER REQUIRED

MORNING AFTERNOON EVENING

TIME COMMITTMENT SHORT TERM ☐ 3 MONTHS ☐ 6 MONTHS ☐ 1YEAR ☐

LINE OF ACCOUNTABLILITY:

VOLUNTEER'S SUPERVISOR _____

DEPARTMENT HEAD _____

DATE OF ORIENTATION

REQUIRED TRAINING OF VOLUNTEER _____

_____

_____

BY WHOM _____

SIGNATURE OF STAFF REQUESTING VOLUNTEER

_____

SIGNATURE OF SUPERVISOR/DEPARTMENT HEAD

_____

FRIENDLY VISITOR INFORMATION

NAME OF RESIDENT _____

ROOM NUMBER _____

PHONE NUMBER _____

MALE OF FEMALE _____

LANGUAGES SPOKEN _____

REASON FOR REQUEST _____

SPECIFIC INTERESTS OF RESIDENT _____

SPECIFIC PROBLEMS OR NEED OF RESIDENT _____

HAS RESIDENT AGREED TO THIS VOLUNTEER BEING ASSIGNED? _____

WOULD A MALE OR FEMALE VOLUNTEER BE MORE APPROPRIATE FOR THIS RESIDENT? _____

TIME COMMITTMENT 3 MONTHS 6 MONTHS 1 YEAR

VOLUNTEER REQUEST FORM

Has patient agreed to this service - Yes ☐ No ☐	Date:

Referred by:- Name & address agency:

Patient's Surname	First Name	Sex	Date of Birth

Address: Postal Code:

Phone Nos. Home:	Business:
Other contact person:	Address:

Phone No. Home:
Business:

Other known services being provided:

Nature of request:- (Simple description and intended goal(s) set)

Background information:-

Signature:- Date:

For Office Use Only

Name of Volunteer Assigned: Signature:

Date:

VOLUNTEER REQUISITION FORM

REQUESTED BY _____ DATE _____

DEPARTMENT _____

NUMBER OF VOLUNTEERS REQUESTED _____ (COMPLETE SEPARATE FORM FOR EACH DIFFERENT JOB)

DESCRIPTION OF VOLUNTEER DUTIES _____

_____

_____

_____

NATURE OF REQUEST (GOALS AND/OR OBJECTIVES) _____

_____

_____

PLEASE ANSWER FOLLOWING IF REQUESTING VOLUNTEER FOR ONE-TO-ONE RELATIONSHIP.
IF NOT APPLICABLE, PROCEED TO FOLLOWING PAGE.

HAS THE RESIDENT AGREED TO THIS SERVICE? _____

RESIDENT's NAME _____ PHONE # _____

ROOM # _____ SEX _____ AGE _____

GIVE PARTICULARS OF RESIDENT (EMOTIONAL, SOCIAL DIFFICULTIES AND NEEDS) _____

_____

_____

_____

PHYSICAL DIFFICULTIES AND NEEDS _____

HEARING _____ HEARING AID _____ LEFT EAR _____ RIGHT EAR _____

EYSIGHT _____ BLIND _____ GLASSES _____

SPEECH _____

PARALYSIS _____ TOTAL _____ PARTIAL _____

WALKING _____ WHEELCHAIR _____ TRI-POD _____ CANE _____

MOTORIZED WHEELCHAIR _____

REQUEST FOR VOLUNTEERS Updated

Date _____ Agency _____

Address _____

Contact _____ Phone _____

Job Title _____

Job Description _____

Qualifications (age,sex,skills,etc)

Date to Start _____

Length of Commitment _____

No. of Volunteers needed _____

Orientation _____

Training _____

Days & Hours of Work _____

DO YOU WANT THIS OPPORTUNITY ADVERTISED IN THE NEWS MEDIA?
(agency name will not be printed) Yes _____ No _____

ADDITIONAL COMMENTS:

APPENDIX III

MONTHLY VOLUNTEER PROGRAM STATISTICAL REPORT MONTH: ____________

NAME OF VOLUNTEER	ACTIVITIES	NURSING	FOOD SER.	OFFICE	SPECIAL EVENT	FRIENDLY VISITING	ESCORT MED.	VOLUNTEER DEPT.	PUBLIC RELATIONS	SPECIAL EVENT GRP	ORIENT.	VOLUNTEER TRAINING PROGRAM	TOTAL VOLUNTEER HOURS

VOLUNTEERS DEPARTMENT

MONTHLY REPORT FOR _____

VOLUNTEER WORK	# OF VOLUNTEERS	# OF VOLUNTEER HOURS
1. FRIENDLY VISITING		
2. ACTIVITIES		
3. DINING ROOM / COFFEE SHOP		
4. HOUSEKEEPING		
5. MAINTENANCE		
6. CHURCH SERVICES		
7. CLERICAL		
8. CANTEEN / MILK BAR		
9. ESCORT SERVICES		
10. ENTERTAINMENT		
11. INDUST.WORKSHOP		
12. PLACE FOR CRAFTS		
TOTAL	*	

TOTAL NUMBER OF HOURS WORKED BY VOLUNTEERS THIS MONTH _____

TOTAL NUMBER OF VOLUNTEERS WORKED THIS MONTH _____ *

NEW VOLUNTEERS:

* These totals do not match because some volunteers work in more than on department.

VO-3 April/84

VOLUNTEER RECORD

Number of hours volunteered

ınteer's ıme	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Total

-4 Rev. April/84

REPORT OF VOLUNTEER VISIT

DATE	TIME OF ARRIVAL	TIME OF DEPART.	NEEDS	HOW NEEDS WERE MET	REMARKS

APPENDIX IV

VOLUNTEER EVALUATION FORM

(TO BE COMPLETED BY SUPERVISING STAFF)

NAME OF VOLUNTEER _____

VOLUNTEER ASSIGNMENT _____

SUPERVISOR OF VOLUNTEER _____

DEPARTMENT _____

DATE OF LAST EVALUATION _____

TERMINATION DATE (IF APPLICABLE) _____

VOLUNTEER PLACEMENT OBJECTIVES _____

VOLUNTEER JOB TASKS _____

TRAINING RECEIVED BY VOLUNTEER: _____

ADDITIONAL TRAINING REQUIRED _____

VOLUNTEER'S SKILLS UTILIZED: _____

VOLUNTEER'S SKILLS DEVELOPED _____

PLEASE ASSIGN THE FOLLOWING AREAS WITH A RATING:

1 - UNSATISFACTORY
2 - SATISFACTORY
3 - GOOD
4 - VERY GOOD
5 - EXCELLENT

PUNCTUALITY: _____
TRUSTWORTHY: _____
COMMUNICATION SKILLS: _____
WORKING RELATIONSHIP WITH STAFF _____
WORKING RELATIONSHIP WITH RESIDENTS _____.
GENERAL APPEARANCE (APPROPRIATE DRESS, ETC.) _____
ABSENTEEISM _____
DEPENDABILITY _____

DIFFICULTIES IN VOLUNTEER PLACEMENT _____

STRENGTHS OF VOLUNTEER _____

STAFF COMMENTS _____

VOLUNTEER'S COMMENTS _____

SIGNATURE OF SUPERVISOR/DEPARTMENTAL HEAD _____
SIGNATURE OF VOLUNTEER _____
SIGNATURE OF COORDINATOR OF VOLUNTEERS _____

VOLUNTEER EVALUATION FORM

NAME OF VOLUNTEER _____

ASSIGNMENT _____

DATES OF ASSIGNMENT _____

	Above Average	Satisfactory	Below Average
1. Personal appearance			
2. Co-operation			
3. Initiative			
4. Dependability			
5. Emotional stability			
6. Enthusiasm			

Major strengths (if any) _____

_____

Major weaknesses (if any) _____

_____

Other comments (if any) _____

_____

_____

_____

_____

_____ _____

DATE SUPERVISING STAFF

01 - April 1983

PROGRAM EVALUATION QUESTIONAIRE

APPENDIX V

(TO BE FILLED OUT BY THE VOLUNTEER)

NAME OF PROGRAM/DEPT/RESIDENT _____

_____

_____

VOLUNTEER'S RESPONSIBILITIES _____

_____

_____

_____

NAME OF VOLUNTEER'S SUPERVISOR _____

START DATE OF VOLUNTEER'S ASSIGNMENT _____

PLEASE RATE THE FOLLOWING QUESTIONS	1 POOR	2 FAIR	3 GOOD	4 EXCELLENT	5 EXCEPTIONAL
SUPERVISION PROVIDED TO VOLUNTEER					_____
TRAINING PROVIDED TO VOLUNTEER					_____
EXPECTATIONS OF PLACEMENT REALIZED BY VOLUNTEER					_____
OPPORTUNITY FOR VOLUNTEER'S TALENTS & SKILLS TO BE USED					_____
RECOGNITION FROM STAFF OF CONTRIBUTION BEING GIVEN BY VOLUNTEER					_____
EXPERIENCE IN WORKING WITH OTHER STAFF IN DEPARTMENT					_____
LEVEL OF SATISFACTION IN VOLUNTEERING AT FACILITY					_____
AMOUNT OF GENERAL SUPPORT BEING PROVIDED TO VOLUNTEER					_____

MAJOR CONCERNS OF VOLUNTEER RE: JOB PLACEMENT/REASON FOR LEAVING THE PROGRAM (IF APPLICABLE) _____

_____

_____

ADDITIONAL COMMENTS, SUGGESTIONS, OR NEW EXPERIENCES DESIRED BY VOLUNTEER:

_____

_____

_____

ADDITIONAL TRAINING BEING REQUESTED BY VOLUNTEER: _____

_____

_____

VOLUNTEER'S SIGNATURE _____

STAFF SUPERVISOR'S SIGNATURE _____

COORDINATOR OF VOLUNTEER'S SIGNATURE _____

Thankyou for completing this form.

APPENDIX VI

RESIDENT VOLUNTEER EVALUATION QUESTIONAIRE

NAME OF RESIDENT _____

ROOM NO. _____

NAME OF VOLUNTEER _____

HOW LONG HAS THIS VOLUNTEER BEEN INVOLVED WITH YOU _____

_____

DO YOU ENJOY YOUR EXPERIENCE WITH THE VOLUNTEER _____. WHAT DO YOU ENJOY/ NOT ENJOY ABOUT YOUR EXPERIENCE WITH THE VOLUNTEER ? _____

_____

_____

_____

ARE YOU SATISFIED WITH THE SERVICES THE VOLUNTEER IS PROVIDING TO YOU ? _____

ARE THERE ANY PROBLEMS YOU ARE ENCOUNTERING WITH THE VOLUNTEER MATCH AND IF SO, WHAT ARE THESE PROBLEMS ? _____

_____

_____

_____

ARE YOU HAPPY WITH THE VOLUNTEER ASSIGNED TO YOU ? _____ DO YOU WANT THE MATCH TO CONTINUE ? _____ IF THIS VOLUNTEER LEAVES THE PROGRAM, WOULD YOU WANT ANOTHER VOLUNTEER ASSIGNED ? _____

HOW OFTEN DOES THE VOLUNTEER SEE YOU PER WEEK (OR MONTH) ? _____
HOW MANY HOURS DOES THE VOLUNTEER VISIT ON EACH OCCASION ? _____

WHAT IS THE GREATEST STRENGTH OF YOUR VOLUNTEER ? _____

_____

WHAT IS THE GREATEST WEAKNESS OF YOUR VOLUNTEER ? _____

_____

Thankyou for completing this form.

SIGNATURE OF RESIDENT _____

WITNESS _____

YES NO

STANDARD I

THERE SHALL BE CLEARLY STATED GOALS AND OBJECTIVES FOR THE VOLUNTEER SERVICES THAT ARE IN ACCORD WITH THE OVERALL GOALS OF THE CENTRE.

1.1 The use of volunteers is encouraged by the centre. ___ ___

1.2 The activities of volunteers are appropriate to the size, location and nature of the centre. ___ ___

1.3 There are clearly delineated goals and objectives for the volunteer services. ___ ___

1.4 These goals and objectives are consistent with the overall goals and objectives of the centre. ___ ___

STANDARD II

THERE SHOULD BE A COORDINATOR OF VOLUNTEER SERVICES WHO SHALL BE RESPONSIBLE FOR INTERRELATING THE VOLUNTEER SERVICE WITH THE VARIOUS GOALS AND OBJECTIVES OF THE CENTRE.

2.1 The coordinator of volunteer services is:

- full-time employee of the centre. ___ ___
- part-time employee of the centre. ___ ___
- a volunteer. ___ ___

Name, title and qualifications of coordinator of services:

_____

Responsible to: _____

2.2 To provide a link between residents and community, there is:

- planning of volunteer activities so they complement the centre's program. ___ ___
- definition of volunteers' role in the centre's total program with delineation of activities permitted. ___ ___

2.3 The role of volunteers at the centre is understood by all staff and volunteers. ___ ___

2.4 The volunteer organization is broadly representative of the community. ___ ___

YES NO

2.5 Specify the type of activities in which the volunteers are involved:

2.6 There are community groups and/or service clubs that contribute their services voluntarily to the centre. ___ ___

Specify the groups and how often they attend the centre:

2.7 The residents are encouraged to participate in volunteer programs if they so wish. ___ ___

2.8 There is an auxiliary organization in addition to the volunteer services. ___ ___

The primary purpose of this auxiliary organization is:

2.9 There is an established means by which volunteers communicate their concerns to administration. ___ ___

STANDARD III

THERE SHALL BE ADEQUATE SPACE, FACILITIES, EQUIPMENT AND SUPPLIES TO CARRY OUT THE ACTIVITIES OF THE VOLUNTEER SERVICES.

3.1 Space, facilities, equipment and supplies allocated are adequate to carry out the objectives of the volunteer program. ___ ___

3.2 There is appropriate administrative and clerical assistance for the volunteer organization to provide its services effectively. ___ ___

YES NO

TANDARD IV

THERE SHALL BE CURRENT WRITTEN POLICIES AND PROCEDURES GOVERNING ALL VOLUNTEER SERVICES.

4.1 There are written policies and procedures that outline the scope and limitations of the volunteers in the centre. ___ ___

4.2 The policies and procedures are developed by representatives of the volunteer services together with representatives of administration and other related services/ departments. ___ ___

4.3 The policies and procedures are in manuals that are available to volunteers and to all appropriate staff. ___ ___

4.4 The policies and procedures are reviewed annually, revised as necessary, and the date of review or revision is noted. ___ ___

Give date of latest review/revision _____

4.5 The policies and procedures include the following:

- the recruitment of volunteers, including necessary qualifications. ___ ___
- the orientation of volunteers. ___ ___
- the limitations and responsibilities of volunteers. ___ ___
- contribution of data by volunteers to the care plan for individual residents. ___ ___
- lines of communication. ___ ___

4.6 The duties of the volunteers are planned so to be rewarding to both volunteers and residents. ___ ___

STANDARD V

THERE SHALL BE OPPORTUNITIES FOR VOLUNTEERS TO PARTICIPATE IN EDUCATIONAL PROGRAMS RELATIVE TO THEIR ROLE.

5.1 There is an organized orientation program for all volunteers. ___ ___

5.2 The volunteers are trained and supervised in those activities that are permitted. ___ ___

5.3 Volunteers are invited to participate in staff development programs when appropriate. ___ ___

YES NO

STANDARD VI

THE CENTRE SHALL ESTABLISH AND IMPLEMENT PROCEDURES TO EVALUATE THE QUALITY OF VOLUNTEER SERVICES AND THE PERFORMANCE OF THE VOLUNTEERS.

6.1 There are written procedures outlining the methods of evaluating the volunteer services provided to residents. ___ ___

6.2 The evaluation processes include:

- screening of volunteers for suitability. ___ ___
- assessment of orientation programs. ___ ___
- ongoing review of goals and objectives. ___ ___
- ongoing review of policies and procedures. ___ ___
- review of job description of coordinator. ___ ___
- resident questionnaires. ___ ___
- other (specify) _____ ___ ___

6.3 Volunteers:

- receive the results of these evaluations. ___ ___
- participate in plans to overcome any deficiencies. ___ ___

6.4 There is documentation of actions taken as a result of quality assurance activities. ___ ___

6.5 All documentation is available to the CCHA surveyor(s) for review. ___ ___

QUESTIONNAIRE SECTION COMPLETED BY:

_____

Name Title

Staff Orientation Package

Chair Exercise

Purpose: To assist staff in recognizing the reasons why some volunteer programs are not successful, and to allow the participants opportunities to share their own volunteer experiences.

A. Place two empty chairs in front of the group. Place a number on each chair. Ask the group for volunteers to sit in the chairs. Give no instructions, reasons, and answer no questions. Wait for the chairs to be filled.

B. Ask the two participants why they volunteered to sit in the chairs and write their answers on a flip chart. The two most common answers are: "I was curious and no one else volunteered" and "As no one was responding I felt sorry for you, so I did."

C. Ask all remaining participants why they did not volunteer, recording their responses as given. These responses usually match many of the reasons why volunteer programs do not succeed. They include: "I didn't know what was expected of me. I didn't what to be embarrassed. I was too shy to do what you asked. I am always the one to volunteer, this time it was someone else's turn. I was not told why you wanted me

to sit in the chair, I did not know the purpose. I didn't know enough about the situation to trust it."

At this point, the Coordinator invites the participants to share with their fellow staff their own experiences as volunteers. All participants are asked to indicate by raising their hands if they do now or have ever volunteered. Several usually raise their hands and the participants usually indicate surprise that so many people among them volunteer. The staff who have volunteered are asked to share their most positive and their most negative experiences with the group. This exercise usually raises the awareness level of staff toward the volunteers working in the program as the participants begin to see the program from the volunteer's points of view as well as their own interpretation.

APPENDIX IX

STAFF ORIENTATION
TO VOLUNTEER PROGRAM
AGENDA

****

1. Welcome
2. Chair Exercise
3. Myths and Concerns Regarding Volunteers
4. Volunteer Program Description
5. Request for Volunteer Forms
6. Friendly Visitor Information Form
7. Volunteer Program Mission Statement, Philosophy and Goals
8. Volunteer Policies and Procedures
9. Volunteer Log Book and Sheets
10. Monthly Statistical Report
11. Volunteer Evaluation Form (To Be Completed By Staff)
12. Resident's Questionnaire
13. Program Evaluation Form (To Be Completed By Volunteer
14. Question Period

MYTHS AND CONCERNS REGARDING VOLUNTEERISM

- Gail Thomson, VIPS

There are many myths and concerns that can create stressful situations between volunteers and agency staff, such as:

1. Volunteers replace staff - There is a concern that the present government is supporting volunteer programs in order to reduce the number of staff in agencies. Firstly, there is a place for volunteers both in times of restraint and in times of affluence. Secondly, volunteer programs and volunteers require staff involvement in order to provide continuity, guidance and direction to and evaluation of the volunteers and volunteer program. Volunteers supplement and compliment the work of staff, bring in "specialized" skills for short periods of time, allow agencies to catch up on things that are backlogged, and extend the services that an agency can provide. Volunteering has sometimes led to the development of new services which prove so valuable that employment positions are created to guarantee that the new services will be available full time.

2. Volunteers are free labour and therefore not important - Volunteer programs cost money in terms of staff time, recruitment costs, office supplies, the cost associated with expanded or specialized programs provided by volunteers, out-of-pocket expenses. Consequently, volunteers should be utilized in important and responsible ways and their time should probably be considered more valuable since it is freely given.

3. Volunteers can do anything paid staff can do - You probably can find a volunteer who can perform part of the same functions of staff since all kinds of people volunteer. However, volunteers make a limited time committment as compared to staff and therefore cannot provide the on-going continuity of services that staff provide. Also, volunteers do not have the same mandate as staff and consequently should not be given inappropriate responsibilities.

4. Volunteers will scrutinize programs with a critical eye and embarass paid staff -

More often than not, volunteers become strong advocates for an agency. Those staff that are trying to provide the best services they can, will get the acknowledgement and support from the volunteers they deserve.

5. Volunteers are unreliable and irresponsible - We all know of the volunteer who comes a few times and then never shows up again. There can be several reasons for this including:

- volunteer arrives to volunteers his/her time and no one is there to welcome him/her
- volunteer is not told what he/she will be doing, what is expected of him/her, what the policies and rules of the agency are
- volunteer gets little direction from agency, no feedback from staff as to his/her work and accomplishments and little thanks for her/his efforts
- volunteer not invited for coffee or to lunchroom with staff
- volunteer given very little responsibility
- staff are defensive and resentful towards volunteers and behave as if all volunteers are irresponsible (self fulfilling prophesy)

All these factors lead volunteers to believe that they aren't really required by the agency, they aren't appreciated by the staff, and the skills and abilities they can offer are unrecognized. No one who is freely giving their time will continue for long under those circumstances. However, just as there are some unreliable and irresponsible staff, volunteers aren't immune from this and some need to be let go.

6. Volunteers get too emotionally involved - Staff feel volunteer may become too involved and do too much; volunteer feels that staff is too caught up in bureaucratic procedures. Usually this can be avoided by staff developing an open relationship with

volunteer; setting priorities and guidelines for the volunteer; monitoring the volunteer; and providing feedback to the volunteer on the tasks and accomplishments of the volunteer (changes in client, changes in staff workload, impact on agency). Should a volunteer become too involved, the Coordinator of Volunteers should be informed in order to terminate the volunteer or place elsewhere.

7. Volunteers require too much staff time - The initial time required by staff is the most demanding. Staff must meet with the Coordinator of Volunteers to plan the volunteer component, approve volunteer job descriptions, assist the Coordinator of Volunteers determine necessary characteristics for volunteers, decide on placement and plan volunteer training programs. When the volunteer is first placed the staff must meet with the volunte to set objectives, provide guidelines, train volunteer and introdu the volunteer to client. Once the volunteer has begun working the staff should only have to meet with the volunteer every four to six weeks for thirty minutes to an hour to review the volunteer work, and meet with the Coordinator of Volunteers periodically in order to evaluate and document the performance of the volunteer. It is crucial that staff be involved in the planning and evaluatin of the volunteer project in order that the project can respond appropriately and effectively to agency and staff needs and require ments. Hopefully, the time staff put in will be returned in full through better and more individualized services to clients, fewer crises for staff to deal with, improved sense of well being and functioning of the clients.

8. Staff are the experts and professionals - People with professional backgrounds and expertise in areas are involved in volunteer work and have a very valuable resource to offer agencies and staff. Also, most volunteers have a professional attitude to their work; they take their responsibilities seriously and honour the policies of the agency such as confidentiality.

9. Volunteers can't be fired or evaluated - Volunteers are involved in an agency to assist that agency with its services. If volunteers are not fulfilling their responsibilities, the Coordinator of Volunteers should terminate them. Most volunteers want to be evaluated on their work performance and view this as recognition of their importance to the agency.

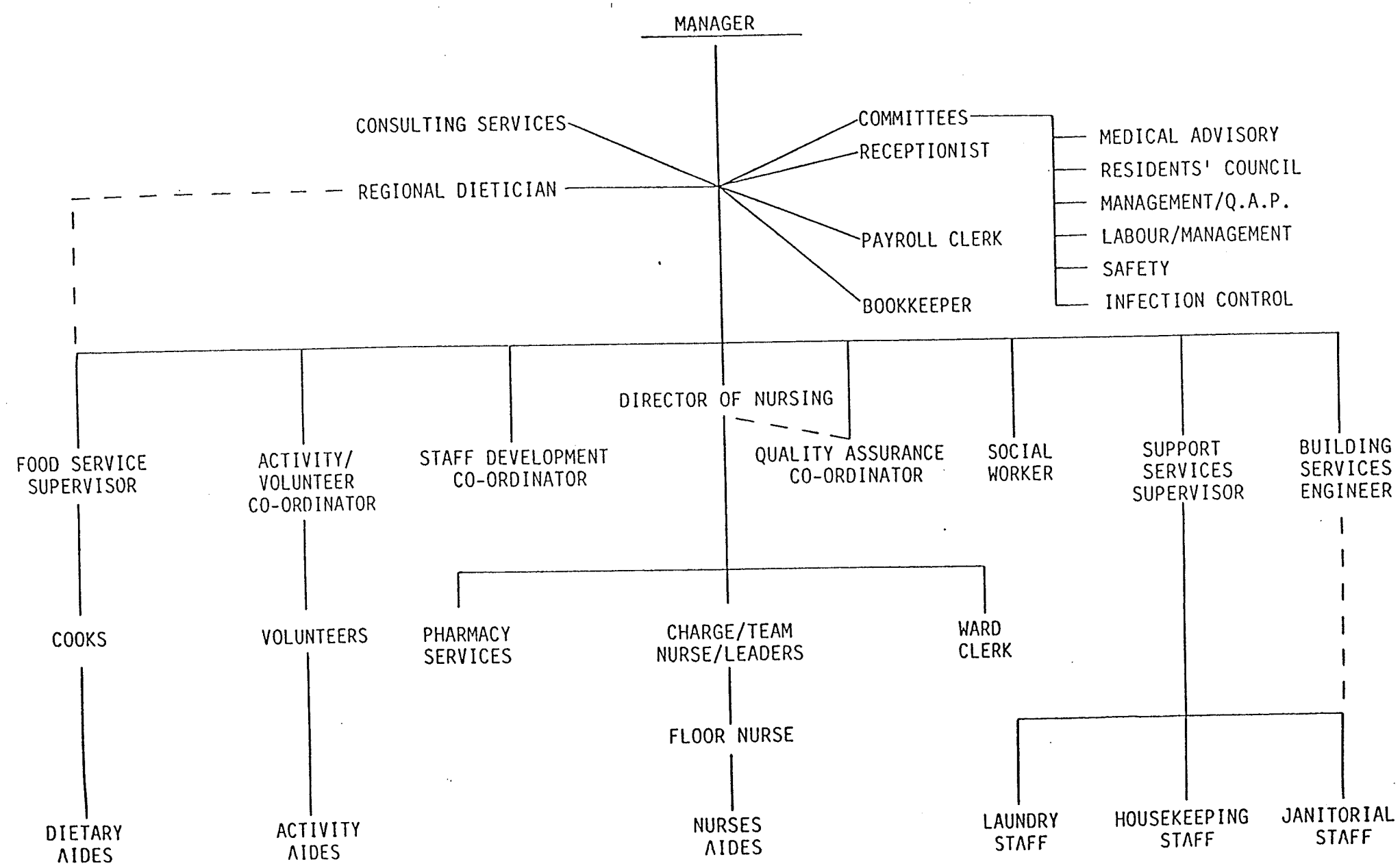
16. If a volunteer witnesses an action, ie. falling resident, one resident pushing another, questionable behaviour on the part of other volunteers or staff, the volunteer is requested to submit an incident report to the Director of Nursing and/or Coordinator of Volunteers. Volunteers are encouraged to use this procedure in relating conflict that may occur between the volunteer and a staff person as well, if it cannot be worked out privately.

17. All volunteers are requested to respect a code of confidentiality. Any personal information learned about residents should be kept within the facility and should be shared only with the volunteer's supervisor. Medical charts and care plans are not available for public viewing. However, volunteers are encouraged to share information or knowledge they have of the resident, either verbally or in writing to assist with the review of the care plan.

    Staff are encouraged to share with the volunteer any information about the resident that could have an impact or effect on the relationship or activities between the volunteer and the resident ie. diabetes, alzheimer confusion, seizures.

Would all volunteers please sign this Policy and Procedure document to indicate that you have read and understand these policies. Also, your signature indicates you are in agreement with these policies.

Dated: _____ Volunteer Signature: _____


MANAGER
CONSULTING SERVICES
REGIONAL DIETICIAN
COMMITTEES
RECEPTIONIST
PAYROLL CLERK
BOOKKEEPER
MEDICAL ADVISORY
RESIDENTS' COUNCIL
MANAGEMENT/Q.A.P.
LABOUR/MANAGEMENT
SAFETY
INFECTION CONTROL
FOOD SERVICE SUPERVISOR
ACTIVITY/ VOLUNTEER CO-ORDINATOR
STAFF DEVELOPMENT CO-ORDINATOR
DIRECTOR OF NURSING
QUALITY ASSURANCE CO-ORDINATOR
SOCIAL WORKER
SUPPORT SERVICES SUPERVISOR
BUILDING SERVICES ENGINEER
COOKS
VOLUNTEERS
PHARMACY SERVICES
CHARGE/TEAM NURSE/LEADERS
WARD CLERK
FLOOR NURSE
DIETARY AIDES
ACTIVITY AIDES
NURSES AIDES
LAUNDRY STAFF
HOUSEKEEPING STAFF
JANITORIAL STAFF

VOLUNTEER REQUEST FORM

DATE _____ REQUESTED BY _____

PHONE _____ POSITION _____

DEPARTMENT _____

NUMBER OF VOLUNTEERS REQUESTED

(Please complete seperate form for each Job Description/in case of a friendly visitor request form please coplete Friendly Visitor Information form.)

DESCRIPTION OF VOLUNTEER'S DUTIES

A _____

_____

B _____

_____

C _____

_____

D _____

_____

E _____

_____

SKILLS REQUIRED FOR THIS VOLUNTEER POSITION

1 _____ 4 _____

2 _____ 5 _____

3 _____ 6 _____

ANTICIPATED START DATE _____

#No. OF HOURS PER WEEK OR EVENT _____

DAYS OF WEEK VOLUNTEER REQUIRED

MON TUES WED THURS FRI SAT SUN

TIME OF DAY VOLUNTEER REQUIRED

MORNING AFTERNOON EVENING

TIME COMMITTMENT SHORT TERM ☐ 3 MONTHS ☐ 6 MONTHS ☐ 1YEAR ☐

LINE OF ACCOUNTABLILITY:

VOLUNTEER'S SUPERVISOR _____

DEPARTMENT HEAD _____

DATE OF ORIENTATION

REQUIRED TRAINING OF VOLUNTEER _____

_____

_____

BY WHOM _____

SIGNATURE OF STAFF REQUESTING VOLUNTEER

_____

SIGNATURE OF SUPERVISOR/DEPARTMENT HEAD

_____

FRIENDLY VISITOR INFORMATION

NAME OF RESIDENT _____

ROOM NUMBER _____

PHONE NUMBER _____

MALE OF FEMALE _____

LANGUAGES SPOKEN _____

REASON FOR REQUEST _____

_____

_____

_____

_____

SPECIFIC INTERESTS OF RESIDENT _____

_____

_____

_____

_____

SPECIFIC PROBLEMS OR NEED OF RESIDENT _____

_____

_____

_____

_____

_____

HAS RESIDENT AGREED TO THIS VOLUNTEER BEING ASSIGNED? _____

WOULD A MALE OR FEMALE VOLUNTEER BE MORE APPROPRIATE FOR THIS RESIDENT? _____

TIME COMMITTMENT 3 MONTHS 6 MONTHS 1 YEAR

MISSION STATEMENT
VOLUNTEER PROGRAM

The mission of the Volunteer Program in a long term care facility is to enhance the quality of the lives of residents being served under the organization's mandate. This mission is accomplished by creating a linkage between the residents in the facility and members of the community who contribute their time and talent through the structure of the volunteer program.

The Volunteer Program is to compliment the work of staff of the facility in providing a high level of quality in the care of the residents.

PHILOSOPHY OF A VOLUNTEER PROGRAM
IN LONG TERM CARE

A long term care facility has the responsibility of providing service to all areas of need of the elderly who fall within their mandate. The volunteer program within a long term care facility is responsible for enhancing and enriching the lives of the residents by complimenting the efforts and duties of the staff and the supports of family members of residents.

It is the belief of the volunteer program that residents have the right to the personal relationships, time, talent and creativity provided by the volunteer. It is also the belief of the volunteer program that volunteers have the right to sufficient orientation training, supervision, support, evaluation and recognition that may be required in the carrying out of their duties.

GOALS FOR VOLUNTEER PROGRAMS
IN LONG TERM CARE

1. To provide a well developed, accountable volunteer program through which the lives of the residents would be enhanced and enriched.

2. To bring about a more conscious awareness on the part of the community regarding the needs of the elderly through the process of recruitment, orientation, and training of volunteers.

3. To create a linkage between the residents in the facility and the members of the community through the volunteer program to reduce isolation on the part of the resident.

4. To provide a variety of work experiences to volunteers who wish to investigate or explore various career options in the field of gerontology as it relates to long term care facilities.

5. To provide positive educational and training opportunities for volunteers who provide services within the long term care facility.

6. To provide proper evaluation procedures to ensure that volunteer services are being appropriately delivered and evaluative feedback is being given to volunteers and facility alike.

7. To provide recognition for volunteer efforts and contributions being given to the facility.

OBJECTIVES FOR THE VOLUNTEER PROGRAM

1. To develop a volunteer program by completing the following tasks.

   a. Complete a needs assessment of the various types of volunteers and volunteer functions that are required within the Lodge.

   b. Develop a referral system through appropriate forms to be used for staff to request volunteers. Set up a data collection system for the gathering of information regarding the volunteer program.

   c. Using feedback from staff, develop job descriptions for volunteers.

   d. Develop a recruitment campaign for the purpose of bringing volunteers into the facility.

   e. Set up interviewing and screening procedures to facilitate proper assignment of volunteers within the facility.

   f. Develop a comprehensive volunteer orientation for new volunteers to orient them to the philosophy, objectives, policies and procedures of the volunteer program.

   g. Arrange the policy for the job assignment for the volunteer.

   h. Follow up supervision of volunteer.

   i. Develop required volunteer training packages regardin special education volunteers would need to complete their tasks.

4. Continued

Also, providing for education program placements through schools and college work experience programs eg. Kildonan Regional Tech School, Red River Community College.

5. To provide positive educational and training opportunities for volunteers who provide service in long term care facilities by

a. Making staff development programs available to volunteers who have an interest in the topic being presented.

b. Creating educational programs on issues that relate to long term care, but also related to other types of circumstances volunteers deal with eg. bereavement, stress, communications skills, etc.

6. To provide proper evaluation procedures to ensure that volunteers services are being appropriately delivered and evaluation feedback is being given to volunteers and facility alike by:

a. Developing a questionnaire for volunteers to complete re their experience in volunteering at the facility.

b. Developing a questionnaire for staff to complete on volunteers working under their direction.

c. Developing a questionnaire for residents to complete on their experience and knowledge of the volunteer program.

6. Continued

   d. Ensuring all stages of the volunteer program meet the criteria of the Council of Accreditation's survey.

7. To provide recognition for volunteer's contributions being given to the facility by

   a. Encouraging all staff to thank volunteers daily for their contribution of time to the Lodge.

   b. Providing services to volunteers in recognition of their efforts, eg. free coffee, meals (when time contribution warrants a free meal), letters of reference, etc.

   c. Planning yearly major recognition events to formally recognize volunteers contributions to the Lodge.

VOLUNTEER PROGRAM
POLICIES AND PROCEDURES

1. Volunteers will be recruited through the Volunteer Centre of Winnipeg, educational programs, work experience placement programs, the media (television, radio, newspapers), community posters and pamphlets, community organizations, churches, and through volunteer contacts. Qualifications for volunteers include the following:
   an interest in working with the elderly, dependable, consistent, willing to work under the policy and procedure guidelines, neat in appearance, etc. Specific qualifications are described in the individual job description for each volunteer responsibility.

2. All volunteers are to be registered in the volunteer program.

3. All volunteers are requested to wear volunteer name badges and to leave the badge at the facility upon leaving the building.

4. All volunteers are requested to sign the Volunteer Log Book at the reception desk before leaving the building.

5. Orientation programs for <u>new</u> volunteers will be held on a monthly basis, alternating between day and evening programs and all volunteers are requested to arrange to attend an orientation meeting.

6. If a volunteer is unable to attend the facility or keep an appointment with a resident or a program, the volunteer is requested to phone the charge nurse or program supervisor, to inform them the volunteer will not be in. If a resident is ill and does not want to see the volunteer or if a program is cancelled, the Coordinator of Volunteers should be informed as well as the volunteer assigned to the resident or the program.

7. Volunteers are requested to respect the resident's privacy and rights. All volunteers are requested to knock on the resident's door before entering their room, introduce him/herself, and explain the reason for being in the room.

8. Volunteers are requested to wear appropriate clothing while in the facility. All clothing should be washable, neat in appearance, and comfortable. Any volunteers handling wheelchairs are requested not to wear open toed shoes or sandals.

9. All volunteers are requested to check with a charge nurse before running an errand for a resident. A volunteer could be requested to purchase food or items that the resident is not supposed to have or use, and checking with the nurse would prevent further problems in the future.

10. All volunteers are requested to inform the charge nurse before taking a resident off her/his floor.

11. Volunteers are requested to smoke only in lounges where ashtrays are provided, in smoking cafeterias or other designated areas.

12. No volunteers are allowed to accept money or valuable gifts from residents or resident's family members for services rendered. The only exchange of gifts should be token gifts at Christmas, etc. Token gifts would be candy bars, a greeting card, etc. Volunteers are encouraged to check with the charge nurse before giving a resident a gift due to concern re health, mental confusion, or other legal issues.

13. All volunteers should refuse to sign any legal documents for residents. Any such requests should be directed to the social worker, the director of nursing, or the manager of the facility.

14. Volunteers are requested to avoid lifting or transfers of residents under any circumstances. Volunteers are not covered by the facility's insurance for lifting and transferring.

15. If a resident falls, volunteers are to seek help from a registered nurse and are not to attempt to move the resident under any circumstances. The volunteer is encouraged to sit by the resident and try to comfort the resident while waiting for assistance. The volunteer is requested to fill out an incident report on the fall if the volunteer had witnessed the fall.

Incident reports are forms that are available through the Director of Nursing and/or the Coordinator of Volunteers. The form should be completed, signed, dated, and submitted to the charge nurse.

If the resident should fall away from the facility while out with a volunteer, and is experiencing pain from the fall, the resident should not be moved. The volunteer should ask anyone who is available to phone for an ambulance, stay with the resident until help arrives and notify the charge nurse at his/her earliest opportunity

16. If a volunteer witnesses an action, ie. falling resident, one resident pushing another, questionable behaviour on the part of other volunteers or staff, the volunteer is requested to submit an incident report to the Director of Nursing and/or Coordinator of Volunteers. Volunteers are encouraged to use this procedure in relating conflict that may occur between the volunteer and a staff person as well, if it cannot be worked out privately.

17. All volunteers are requested to respect a code of confidentiality. Any personal information learned about residents should be kept within the facility and should be shared only with the volunteer's supervisor. Medical charts and care plans are not available for public viewing. However, volunteers are encouraged to share information or knowledge they have of the resident, either verbally or in writing to assist with the review of the care plan.

    Staff are encouraged to share with the volunteer any information about the resident that could have an impact or effect on the relationship or activities between the volunteer and the resident ie. diabetes, alzheimer confusion, seizures.

Would all volunteers please sign this Policy and Procedure document to indicate that you have read and understand these policies. Also, your signature indicates you are in agreement with these policies.

Dated: _____ Volunteer Signature: _____

VOLUNTEER EVALUATION FORM

(TO BE COMPLETED BY SUPERVISING STAFF)

NAME OF VOLUNTEER _____

VOLUNTEER ASSIGNMENT _____

SUPERVISOR OF VOLUNTEER _____

DEPARTMENT _____

DATE OF LAST EVALUATION _____

TERMINATION DATE (IF APPLICABLE) _____

VOLUNTEER PLACEMENT OBJECTIVES _____

VOLUNTEER JOB TASKS _____

TRAINING RECEIVED BY VOLUNTEER: _____

ADDITIONAL TRAINING REQUIRED _____

VOLUNTEER'S SKILLS UTILIZED: _____

VOLUNTEER'S SKILLS DEVELOPED _____

PLEASE ASSIGN THE FOLLOWING AREAS WITH A RATING:

1 - UNSATISFACTORY
2 - SATISFACTORY
3 - GOOD
4 - VERY GOOD
5 - EXCELLENT

PUNCTUALITY: _____
TRUSTWORTHY: _____
COMMUNICATION SKILLS: _____
WORKING RELATIONSHIP WITH STAFF _____
WORKING RELATIONSHIP WITH RESIDENTS _____
GENERAL APPEARANCE (APPROPRIATE DRESS, ETC.) _____
ABSENTEEISM _____
DEPENDABILITY _____

DIFFICULTIES IN VOLUNTEER PLACEMENT _____

STRENGTHS OF VOLUNTEER _____

STAFF COMMENTS _____

VOLUNTEER'S COMMENTS _____

SIGNATURE OF SUPERVISOR/DEPARTMENTAL HEAD _____
SIGNATURE OF VOLUNTEER _____
SIGNATURE OF COORDINATOR OF VOLUNTEERS _____

VOLUNTEER HOURS LOG

DATE	NAME OF VOLUNTEER	TIME IN	TIME OUT	TOTAL HRS	DEPT.

RESIDENT VOLUNTEER EVALUATION QUESTIONAIRE

NAME OF RESIDENT _____

ROOM NO. _____

NAME OF VOLUNTEER _____

HOW LONG HAS THIS VOLUNTEER BEEN INVOLVED WITH YOU _____

_____

DO YOU ENJOY YOUR EXPERIENCE WITH THE VOLUNTEER _____. WHAT DO YOU ENJOY/ NOT ENJOY ABOUT YOUR EXPERIENCE WITH THE VOLUNTEER ? _____

_____

_____

_____

ARE YOU SATISFIED WITH THE SERVICES THE VOLUNTEER IS PROVIDING TO YOU ? _____

ARE THERE ANY PROBLEMS YOU ARE ENCOUNTERING WITH THE VOLUNTEER MATCH AND IF SO, WHAT ARE THESE PROBLEMS ? _____

_____

_____

_____

ARE YOU HAPPY WITH THE VOLUNTEER ASSIGNED TO YOU ? _____ DO YOU WANT THE MATCH TO CONTINUE ? _____ IF THIS VOLUNTEER LEAVES THE PROGRAM, WOULD YOU WANT ANOTHER VOLUNTEER ASSIGNED ? _____

HOW OFTEN DOES THE VOLUNTEER SEE YOU PER WEEK (OR MONTH) ? _____
HOW MANY HOURS DOES THE VOLUNTEER VISIT ON EACH OCCASION ? _____

WHAT IS THE GREATEST STRENGTH OF YOUR VOLUNTEER ? _____

_____

WHAT IS THE GREATEST WEAKNESS OF YOUR VOLUNTEER ? _____

_____

Thankyou for completing this form.

SIGNATURE OF RESIDENT _____

WITNESS _____

PROGRAM EVALUATION QUESTIONAIRE

(TO BE FILLED OUT BY THE VOLUNTEER)

NAME OF PROGRAM/DEPT/RESIDENT _____

_____

_____

VOLUNTEER'S RESPONSIBILITIES _____

_____

_____

_____

NAME OF VOLUNTEER'S SUPERVISOR _____

START DATE OF VOLUNTEER'S ASSIGNMENT _____

PLEASE RATE THE FOLLOWING QUESTIONS	1 POOR	2 FAIR	3 GOOD	4 EXCELLENT	5 EXCEPTIONAL
SUPERVISION PROVIDED TO VOLUNTEER					_____
TRAINING PROVIDED TO VOLUNTEER					_____
EXPECTATIONS OF PLACEMENT REALIZED BY VOLUNTEER					_____
OPPORTUNITY FOR VOLUNTEER'S TALENTS & SKILLS TO BE USED					_____
RECOGNITION FROM STAFF OF CONTRIBUTION BEING GIVEN BY VOLUNTEER					_____
EXPERIENCE IN WORKING WITH OTHER STAFF IN DEPARTMENT					_____
LEVEL OF SATISFACTION IN VOLUNTEERING AT FACILITY					_____
AMOUNT OF GENERAL SUPPORT BEING PROVIDED TO VOLUNTEER					_____

MAJOR CONCERNS OF VOLUNTEER RE: JOB PLACEMENT/REASON FOR LEAVING THE PROGRAM (IF APPLICABLE) _____

_____

_____

ADDITIONAL COMMENTS, SUGGESTIONS, OR NEW EXPERIENCES DESIRED BY VOLUNTEER:

_____

_____

_____

ADDITIONAL TRAINING BEING REQUESTED BY VOLUNTEER: _____

_____

_____

VOLUNTEER'S SIGNATURE _____

STAFF SUPERVISOR'S SIGNATURE _____

COORDINATOR OF VOLUNTEER'S SIGNATURE _____

Thankyou for completing this form.

Staff Orientation Package

Identifying Volunteer Tasks Exercise

Purpose: To assist staff in identifying tasks within their own job descriptions that could be completed by volunteers, while enhancing staff functions in the facility.

A. Participants of the staff orientation to volunteerism session are divided into groups of approximately four people.

B. One member of each group is asked to write out specific tasks in their jobs on a large piece of paper, e.g. flip chart. This staff person is asked to mark a check beside every task that could be completed or assisted by a volunteer.

C. The rest of the groups are requested to mark a check beside any remaining tasks they believe could be completed by volunteers.

D. The first staff person who wrote the tasks is now asked to write a "Dream List" of what they would like to do in their jobs, but they do not presently have time to complete. This usually involves quality issues in the job rather than quantity items. The participant then is asked if volunteers were to assist with the

items on the task sheet, how much of that worker's time would be freed to apply to completing the "Dream List" functions?

The staff would begin to understand how volunteers would compliment their involvement and add quality to their own roles. Rather than being considered a threat, the volunteer could be seen as a supportive enabler.

VOLUNTEER PROGRAM
JOB DESCRIPTION

DEPARTMENT : Activities

JOB TITLE : Woodworking program assistants

PURPOSE : To enhance the life of residents by assisting them to participate in a creative stimulating activity.

DUTIES AND RESPONSIBILITIES:

1. To assist in setting up materials for the program.
2. To assist in transporting residents to the woodworking program.
3. To assist residents in working with their projects.
4. To assist in serving refreshments after the program.
5. To assist in transporting residents back to their floors.
6. To assist in cleaning up the work area.
7. To sign the volunteer log book before leaving the facility.

QUALIFICATIONS :

Some knowledge of woodworking. Must like working with the elderly, pleasant personality, good communication skills.

TIME REQUIREMENT :

THURSDAY 1:00 - 3:30 P.M.

LENGTH OF COMMITMENT :

6 MONTHS

ORIENTATION :

General Orientation. Communication skills, working with the confused resident.

ACCOUNTABILITY :

Volunteer will be supervised by Activity Staff and/or supervisor of Activities.

VOLUNTEER DEPARTMENT

JOB DESCRIPTION

DEPARTMENT : Activities

JOB TITLE : Shopping Trip Escorts

PURPOSE : To enhance the lives of the residents by assisting them to function in the community while on shopping excursions.

DUTIES AND RESPONSIBILITIES:

1. To assist residents to the boarding area for transit to the shopping center.
2. To assist the resident to gain access to the shopping center - push wheel chair or assist in walking, etc.
3. To assist resident in shopping for needed articles.
4. To assist resident back to boarding area for ride home.
5. To assist resident to his/her own room.
6. To sign the volunteer log book before leaving the facility.

QUALIFICATIONS :

Must enjoy working with the elderly. Must have physical strength to push a wheel chair, should enjoy shopping malls, must enjoy being with people and have a friendly and pleasant presonality.

TIME REQUIREMENT :

- day to be determined
- shopping trips will be once per month - depending on availability of volunteers.

TIME COMMITMENT :

6 MONTHS TO 1 YEAR.

ACCOUNTABILITY :

To be supervised by the Activity Staff assigned to the program.
Supervisor of activities has responsibility for the program.

ORIENTATION :

General Orientation.

TRAINING :

On the job training also how to use wheelchairs, communication skills etc..

VOLUNTEER DEPARTMENT

JOB DESCRIPTION

DEPARTMENT : Activities

JOB TITLE : Woodworking Co-ordinator

PURPOSE : To enhance the lives of the residents by assisting them to participate in a creative and stimulating activity.

DUTIES AND RESPONSIBILITIES :

1. To prepare materials for the woodworking program.
2. To teach and assist residents during the woodworking projects.
3. To assist in serving refreshments after the program.
4. To keep inventory on supplies and notify activity staff of what additional materials may be needed.
5. To clean up woodworking area after the program is completed.
6. To assist in planning the activities or projects of the woodworking program.

TIME REQUIREMENT :

THURSDAY AFTERNOON 1:00 - 3:30

TIME COMMITMENT :

6 MONTHS

QUALIFICATIONS :

Must enjoy working with the elderly.

Good woodworking skills and knowledge. Able to direct and teach woodworking skills, patient , pleasant personality, good organization skills.

Able to direct other volunteers.

ORIENTATION :

General Orientation

TRAINING :

Self motivated - trained on the job.

Also training in how to work with the confused resident.

ACCOUNTABILITY:

Volunteer is responsible to Activity Staff assigned to program and Supervisor of Activities.

VOLUNTEER DEPARTMENT

JOB DESCRIPTION

DEPARTMENT : Activities

JOB TITLE : Activities Assistant

PURPOSE : To enhance the resident's lives by assisting in providing a specia variety of activity programs adding an extra interest and excitement to the lives of the residents.

WEDNESDAY AFTERNOON PROGRAMS :

2 WEDNESDAYS A MONTH..... Glee Club

1 WEDNESDAY A MONTH..... Bonanza Bingo

1 WEDNESDAY A MONTH..... Birthday Party (in conjunction with food service in dining room).

DUTIES AND RESPONSIBILITIES :

1. Assist in setting up for Wednesday afternoon program.
2. Assist in transporting residents to the activity room.
3. Assist with the program, e.g.: turning pages for sing-along, assist with Bingo cards, etc.
4. Assist in serving refreshments after the program or during the Birthday Party.
5. Assist residents back to their rooms.
6. Assist in cleaning up activity room.
7. Sign volunteer log book before leaving the facility.

QUALIFICATIONS/SKILLS REQUIRED :

Must enjoy working with elderly, good communication skills, be able to take direction from staff, pleasant personality, enjoys music and has some knowledge of Bingo.

TIME REQUIREMENT :

WEDNESDAY 1:30 - 4:30 P.M.

LENGTH OF COMMITMENT :

6 MONTHS

ACCOUNTABILITY :

Volunteers will be supervised by activity staff assigned to the program.

Supervisor of Activities is responsible for program.

VOLUNTEER PROGRAM

JOB DESCRIPTION

DEPARTMENT: Nursing

JOB TITLE: Friendly Visitor

PURPOSE: To enhance the quality of life of the residents of the lodge by providing a special friendship through visiting and communication.

DUTIES AND RESPONSIBILITIES:

1. Report to the Charge Nurse at the Nursing Station before visiting resident.
2. Visit resident, supporting resident by conversation, reading, letter writing, assisting resident to an event, being the resident's connection with the outside world.
3. Report any concerns or appropriate information to the Charge Nurse before leaving.
4. Sign Volunteer Log Book before leaving the building.

TIME REQUIREMENT: 2-3 hours a week

Mon	Tues	Wed	Thurs	Fri	Sat	Sun
		Morning		Afternoon	Evening	

LENGTH OF COMMITTMENT: 6 months

QUALIFICATIONS OR SKILLS: Must enjoy working with the elderly; good communication skills, patience, pleasant personality, consistance in work habits.

ORIENTATION: General Orientation
Orientation Program reworking with confused residents, communication skills.

TRAINING: on the job - ongoing - special learning programs provided as required.

ACCOUNTABILITY: Volunteer is supervised by Charge Nurse on floors, who is accountable to D.O.N. - Director of Nursing

VOLUNTEER DEPARTMENT

JOB DESCRIPTION

DEPARTMENT: Activities

JOB TITLE: Church Service Volunteers

PURPOSE: To enhance the Residents lifestyle by assisting them in participating in workshop services they choose to attend.

DUTIES AND RESPONSIBILITIES:

1. To assist in setting up for THE church service.
2. To assist in transporting residents to THE service.
3. To assist residents in finding correct songs during the hymn singing.
4. To help supervise residents that tend to wander away from the area.
5. To assist transporting residents back to their rooms.
6. To assist in cleaning activity area after the service.
7. To sign the Log Book before leaving the facility.

TEAM REQUIREMENTS: Thursdays 10:00 - 11:30A.M.

TIME COMMITTMENTS: 6 months

QUALIFICATIONS OR SKILLS REQUIRED: Must enjoy working with the elderly, feel comfortable in church service environment, pleasant personality.

ORIENTATION: General Orientation

TRAINING: on the job - additional training provide as required.

ACCOUNTABILITY: Volunteers are supervised by its activity staff assisting with the church service. The Director of Activities is responsible for its overall program.

VOLUNTEER DEPARTMENT

JOB DESCRIPTION

DEPARTMENT : Activities

JOB TITLE : Baking Program Assistant

PURPOSE : To enhance the quality of life of the residents by assisting in a baking program that would give residents the opportunity to participate in a previously enjoyed experience.

DUTIES AND RESPONSIBILITIES:

1. Assist in setting up supplies for baking program.
2. Assist in transporting residents to the baking program.
3. Assist residents with the baking activities.
4. Assist in serving refreshments after program.
5. Assist in transporting residents back to their rooms.
6. Assist in cleaning of the baking area.
7. Sign volunteer log book before leaving the facility.

TIME REQUIREMENT:

THURSDAYS 6:15 - 8:30 P.M.

LENGTH OF COMMITMENT :

6 MONTHS

QUALIFICATIONS :

Must enjoy working with residents. Good communication skills, must enjoy baking and helping to facilitate baking, pleasant personality.

ORIENTATION :

General Orientation.

TRAINING :

On the job training, with further training as required.

ACCOUNTABILITY:

Volunteer is supervised by the activity staff person assigned to the program. Charge nurse has overall responsibility for the facility.

JOB DESCRIPTION

DEPARTMENT : Activities

JOB TITLE : Carpet Bowling Assistant

PURPOSE : To enhance the quality of life of the residents by assisting in providing a carpet bowling program in the Activities Department.

DUTIES AND RESPONSIBILITIES :

1. Assist in setting up carpet bowling equipment in the activity room.
2. Assist in transporting residents to the carpet bowling program.
3. Assist residents in participation of the carpet bowling game.
4. Assist in serving refreshments after the carpet bowling game.
5. Assist in transporting residents back to their rooms.
6. Assist in cleaning up activity room after the program.
7. Sign volunteer log before leaving the facility.

TIME REQUIREMENT :

FRIDAY EVENINGS 6:15 - 8:30

LENGTH OF COMMITMENT :

6 MONTHS

QUALIFICATIONS OR SKILLS:

Must enjoy working with the elderly, good communication skills, good organization skills, patient, pleasant personality.

ORIENTATION :

General orientation.

TRAINING :

On the job training - ongoing training programs as required.

ACCOUNTABILITY :

Volunteer is supervised by Activity Staff assigned to the program, and in case of emergency.

Charge nurse has ultimate responsibility.

VOLUNTEER PROGRAM

JOB DESCRIPTION

DEPARTMENT : Nursing

JOB TITLE : Elevator Volunteer

PURPOSE : To enhance the quality of the lives of the residents by facilitating a more enjoyable and organized transfer for the residents from their rooms to the dining room and from the dining room to their own floors during meal time, by ensuring their safe transportation.

DUTIES AND RESPONSIBILITIES :

1. Assist in organizing the transportation of residents by gathering residents one floor at a time for the elevator and assisting the resident on and off the elevator.
   This would be done repeatedly until all residents have been transported from the dining room back to their floors.

TIME REQUIREMENT : 7 days a week

MORNING 8:30 - 9:30

AFTERNOON 12:30 - 1:30

Evening

LENGTH OF COMMITMENT:

6 MONTHS TO A YEAR

QUALIFICATIONS :

Pleasant personality, good organization skills, good communication skills, able to work under stress, enjoy working with elderly.

ORIENTATION :

On the job training and on-going as required.

ACCOUNTABILITY :

Charge nurse would have the responsibility of supervising the volunteer.

VOLUNTEER DEPARTMENT

JOB DESCRIPTION

DEPARTMENT : Activities

JOB TITLE : Craft Program Assistant

PURPOSE : To enhance the lives of the residents by assisting them in using their creative skills to participate in stimulating activity.

DUTIES AND RESPONSIBILITIES :

1. To assist in setting up the craft materials for the craft program.
2. Assist in transporting residents to the craft program.
3. Assist residents in participating in the crafts projects: e.g. making flowers, liquid embroidery, ceramics.
4. Assist in serving refreshments after the craft program.
5. Assist in transporting residents back to their rooms.
6. Assist in cleaning up the craft area.
7. Sign the volunteer log book before leaving the facility.

TIME REQUIREMENT :

TUESDAYS 1:30 - 4:30 P.M.

LENGTH OF COMMITMENT :

6 MONTHS

SKILLS REQUIRED :

Must enjoy working with elderly, enjoy craft activities, good communication skills, pleasant personality.

ORIENTATION :

General Orientation

TRAINING :

On the job training - ongoing training programs as required.

ACCOUNTABILITY :

Volunteers will be supervised bv Activity Staff assigned to the program. Director of Activities is responsible for the department.

440 EDMONTON STREET

WINNIPEG, MANITOBA

JOB DESCRIPTION - VOLUNTEER DEPARTMENT

DEPARTMENT : Activities and/or Food Services

JOB TITLE : Special Event Program Volunteers

PURPOSE : To assist with Special Event Programs coordinated by Activities Department and The Food Services Department.

DUTIES AND RESPONSIBILITIES :

1. Assist staff in setting up special event area in preparation for the special event.
2. Assist in transport residents to the special event area.
3. Assist in serving refreshments to residents and guests at special event program.
4. Assist in transporting residents back to their areas at completion of the program.
5. Assist in clean up of special event area after completion of the special event program.
6. Sign volunteer log book before leaving facility.

TIME REQUIREMENT :

3 - 4 hours when events are scheduled.

LENGTH OF COMMITMENT :

Open

QUALIFICATIONS OR SKILLS :

Must enjoy working with the elderly, be able to accept direction in working in a group of volunteers, pleasant personality.

ORIENTATION :

Volunteers will be included in on-going orientation program.

TRAINING :

On the job training by staff and/or coordinator of volunteers.

ACCOUNTABILITY :

Supervisor of Activities or Supervisor of Food Services and/or Coordinator of Volunteers.

VOLUNTEER DEPARTMENT

JOB DESCRIPTION

DEPARTMENT : Activities

JOB TITLE : Bingo Program Assistant

PURPOSE : To enhance the quality of the life of the residents by assisting with a recreational program to add stimulation, interests and activity to their lives.

DUTIES AND RESPONSIBILITIES :

1. Assist in setting up activity room for Bingo.
2. Assist in transporting residents to the activity room.
3. Assist the residents in playing Bingo.
4. Assist in serving refreshments after the Bingo game.
5. Assist in taking residents back to their rooms.
6. Assist in cleaning up activity room.
7. Sign volunteer log book before leaving the facility.

TIME REQUIREMENT:

SATURDAY 6:15 - 8:30 P.M.

LENGTH OF COMMITMENT :

6 MONTHS

QUALIFICATIONS :

Must enjoy working with the elderly, pleasant, friendly personality, and have some knowledge of bingo.

ORIENTATION :

General Orientation.

TRAINING :

On the job training by staff assigned to the program.

ACCOUNTABILITY :

Volunteers will be supervised by assigned activity worker.
Charge nurse has the over all responsibility.

Special Volunteer Training Package on Working with Cognitive Impairment

As the largest percentage of residents who are suffering from cognitive impairment have been diagnosed with Alzheimer's Disease, this training package will refer mostly to this disease.

Alzheimer's Disease: History and Current Status

This disease was originally identified and named by Alois Alzheimer, a German physician in 1906. Between 100,000 and 300,000 people are believed to be affected with this disease currently (Channing Beti Co. Ltd., 1987). There is no known method of prevention or cure. Diagnosis of this disease can take up to eight years form the inception of the disease. This is a neurological disease that causes plaques and neuro-fibrillary tangles to develop in the cortex of the brain (Birchard, 1988).

In the early symptoms of Alzheimer's Disease, the victim:

1. becomes more forgetful, especially of recent events
2. forgets to turn off burners or ovens on stoves
3. will misplace things
4. will recheck to see if task is done

5. takes longer to complete routine tasks
6. will repeat already answered questions
7. be unable to learn new things
8. show poor judgment
9. will have difficulty communicating with others
10. will have a suspicious attitude

In the midrange stage of the disease, the victim will experience:

1. more severe memory loss
2. confusion
3. irritability
4. restlessness
5. changes in mood, personality, and behavior
6. the disease rendering her/him totally incapable of caring for self.

The final stages of Alzheimer's includes:

1. loss of ability to speak or communicate
2. increased immobility
3. loss of bowel and bladder control
4. twitches and jerking
5. seizures in some cases
6. complete absence of any spontaneous movement
7. reflexes develop such as sucking anything put in the mouth

8. prone to pneumonia

9. vulnerable to bed sores due to immobility

(Birchard, 1988).

Symptoms of Alzheimer's Disease are in many cases not unlike those of other neurological diseases. Although Alzheimer's accounts for over fifty percent of diseases causing cognitive impairment, other causes are vascular or multi infarct dementia, accounting for about twenty percent of the residents suffering from confusion, with the remaining thirty percent of residents suffering from Pick's Disease, Alcoholism, Multiple Sclerosis, Huntington's Disease and others (Chappell, Strain &, Blandford, 1986, p.38).

Family's responses to Alzheimer's Disease:

Due to the fact that in the earlier stages of the disease the victim is able to cover their confusion and have periods of lucidity, the family members can enter a denial stage. Initially, the denial can be adaptive as it gives the family members time to adjust to the reality of the disease, however, it becomes maladaptive when it still exists at the point of the disease where modifications are required to continue to cope and there needs to be a realistic assessment of the situation.

The next stage the family enters is to expect the unexpected. The Alzheimer's victim will react and behave irrationally due to the fact of the disease severely limiting them in having access to their life time store of knowledge and experience (Oliver and Bock, 1987).

This disease is a very emotionally painful disease for both the Alzheimer's victims as well as their family members. By the time the person afflicted is placed in long term care the family are often exhausted, depressed, and feeling very guilty because they can no longer cope with caring for their loved one. They also may be going through a grieving process as this person no longer represents the mother, father, husband, wife, grandparent they had known. Family members need support and involvement in the care of their family member as well as reassurance that they have acted in a responsible manner.

The following are problems encountered by the caregivers of residents with Alzheimer's Disease:

1. Resident's awareness of inability causing frustration, fear, tears, anger, embarrassment or humiliation and depression. The caregiver must give great reassurance and support with the message that the person is still loved.

2. Memory loss brings about a need for consistent daily routines, requiring patience and frequent reminders in the form of spoken words, calendars, clocks, diagrams, lists, schedules, etc. The caregiver must show patience as these reminders will have to be repeated continuously.

3. Poor judgment and erratic thought processes bring about the need for the caregiver to try to identify certain changes in decision making as previous good judgment skills may become poor judgment skills as the disease progresses.

4. Wandering is a problem with many Alzheimer's victims. The caregiver, upon discovering the resident who is wandering should be careful not to startle or frighten the resident but to gently guide them back to familiar surroundings. Identification bracelets or labels on clothing would assist in locating wanderers.

The Alzheimer's Association of Winnipeg has a Wanderer's registry for those people in the city who are afflicted with this type of condition, and the procedure is activated upon receiving word that the person is missing.

5. Repetitious behavior, such as repeating questions, pacing, etc., is also a common symptom.

Answering questions with short simple answers may help, and otherwise, it is suggested to try to ignore repetitious behavior whenever possible or appropriate.

6. Alzheimer's victims may have difficulty sleeping at night, may wander in the night, have severe nightmares, and hallucinate. They also appear to be fearful of the dark. Caregivers can assist by helping the resident to be more active during the day. Nightlights also help the resident to settle for the night.

7. One of the most severe emotions of an Alzheimer's victim is fear, creating extreme anxiety. The resident has difficulty recalling their surroundings, and misconstructing objects or events. Caregivers can respond to this fear through gentle reassurance, touch, hugs, and supportive words. The caregiver or volunteer's presence also helps to lesson the level of fear being experienced by the resident.

8. One of the more difficult problems for caregivers to deal with is aggressive behavior. This behavior constitutes mood swings, quick changes of mind, angry outbursts, which is all due to the resident's damaged grasp of reality. The resident reacts to mispercieved threats, dangers, or insults.

The outbursts may be from misconceptions the resident has believed for sometime. It is not always effective to use logic or to try to reason with the Alzheimer's victim as they do not always have an accurate perception of reality.

9. Communication becomes an increasingly serious problem as the disease progresses. The following are suggestions to assist in communication with an Alzheimer's victim:

- as the ability or capacity for communication decreases on the part of the resident, other forms of communication become important such as stance, tone, or facial expressions.

- always look for the meaning behind the behavior that is puzzling.

- use short, simple sentences, spoken slowly and clearly.

- present only one statement or question at a time, allowing plenty of time for a response. Affirmative statements work better than questions.

- when speaking to an Alzheimer's victim, remain in front of the resident to maintain eye contact, and you should always call the person by name.

- reinforce spoken words with real objects or demonstrations.

- visiting a resident with Alzheimer's is very important for additional stimulation, giving the Alzheimer's resident an opportunity to use whatever social skills are still remaining.

10. Alzheimer's victims generally lose their ability to care for themselves. Caregivers and volunteers can use the following steps to encourage the resident in self sufficiency for as long as possible:

1. To give simple reminders to brush hair and teeth.

2. Tasks may be broken down into smaller stages that are within the capability of the resident so that he or she could still have some responsibility in taking care of themselves.

3. Caregivers should assist with tasks no longer within the capabilities of the resident.

11. Diet and eating presents a problem when residents forget that they are on a special diet or eat several times daily, forgetting they had already eaten (Oliver & Bock, 1983).

An article quoting Mace, author of the Thirty Six Hour Day, dealing with Alzheimer's stated "tender

loving care, not sedation, is the prescription for Alzheimer's patients. Staff have to learn how to incorporate patience and gentleness into the regimented pace of most nursing homes. What is very important now is that while we can't cure the disease, we can change the quality of life for the patients and their families" (Winnipeg Free Press, 1989). With the help and support of volunteers, specially trained for this type of responsibility, hopefully the quality of lives of residents and their families would improve.

VOLUNTEER TRAINING SESSION EVALUATION FORM

DATE: _____ AM: _____ PM: _____

TOPIC: _____

Please answer the following questions by writing the appropriate number in the space beside the question:

(1) Unsatisfactory	(2) Somewhat Satisfactory	(3) Satisfactory	(4) Very Good	(5) Excellent
Not Helpful	Somewhat Helpful	Helpful	Very Helpful	Extremely Helpful

How helpful did you find the information presented about the topic in question? _____

How well did the training program meet the expectations of fulfilling your needs for knowledge in this topic area? _____

How helpful have you found this session in relation to your role as a volunteer? _____

How would you rate the environment for the training session? _____

How would you rate the presentation of the training session? (Was it well organized, etc.)

_____

How satisfactory was the length of the orientation session? _____
Remarks:

Please answer the following questions:

1. Was there further information you feel would have been helpful to include in the training session? _____

   _____

   _____

2. Were the refreshments that were served adequate? _____

   Suggestions: _____

3. What was most helpful in the training session? _____

   _____

   _____

5. General Comments: _____

   _____

   _____

Thank you for completing this form.

Volunteer Orientation Agenda

Welcome

History and Philosophy

Question Sheet on the Facts of Aging

Description of the Volunteer Program

Tour of the Facility

Coffee and Refreshments

Communication with Residents who are Hearing Impaired

Communication with Residents who are Sight Impaired

Communication with Residents who have Impaired Speech

Skills in handling a Wheelchair

Volunteer Program Policies and Procedures

Fire Safty Policies and Procedures

Questions and Answer Period

THANKYOU FOR COMING

VOLUNTEER APPLICATION FORM

NAME _____ DATE _____

ADDRESS _____ POSTAL CODE _____

TELEPHONE (HOME) _____ (WORK) _____

LANGUAGES SPOKEN _____

VALID MANITOBA DRIVERS LICENSE YES _____ NO _____

USE OF CAR YES _____ NO _____

PLACE OF EMPLOYMENT _____

PREVIOUS WORK EXPERIENCE _____

_____

_____

SPECIAL SKILLS, HOBBIES, INTERESTS _____

_____

_____

_____

PLEASE LIST PREVIOUS VOLUNTEER EXPERIENCES _____

_____

_____

_____

TYPE OF VOLUNTEER POSITION BEING APPLIED FOR _____

_____

REASON FOR VOUNTEERING FOR THIS FACILITY/POSITION _____

_____

_____

NAME, ADDRESS, AND PHONE NUMBER OF PERSON TO NOTIFY IN CASE OF EMERGENCY:
NAME _____ ADDRESS _____ PHONE NUM _____

TIME AVAILABLE FOR VOLUNTEERING _____

NUMBER OF HOURS PER DAY _____

NUMBER OF DAYS PER WEEK _____

PREFERRED DAYS (PLEASE CIRCLE)

MORNING AFTERNOON EVENING

MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY SATURDAY SUNDAY

LENGTH OF COMMITTMENT (WEEKS, MONTHS, YEARS) _____

REFERENCES (UPON REQUEST)

	NAME	ADDRESS	PHONE	RELATIONSHIP
1.				
2.				
3.				

PLEASE CHECK AREAS OF INTEREST:

___ ACTIVITIES (GAMES,CRAFTS,BOOK CART)
___ NURSING DEPARTMENT
___ FRIENDLY VISITING
___ SPECIAL EVENTS
___ HOUSEKEEPING/LAUNDRY
___ FOOD SERVICES
___ OFFICE ASSISTANT
___ TUCK SHOP/BAR
___ ESCORT FOR MEDICAL APPOINTMENTS
___ MANICURES/MAKEUP
___ READING TO RESIDENTS
___ SHOPPING OUTINGS
___ SMALL GROUP ACTIVITIES
___ CHURCH PROGRAMS
___ LIBRARY/STAFF/RES.
___ BIRTHDAY PARTY
___ PUBLIC RELATIONS
___ WEEKEND EVENTS
___ VOLUNTEER COORDINATION/ADMINISTRATION
___ OTHER _____

FOR VOLUNTEERS UNDER THE AGE OF SIXTEEN YEARS, A SIGNATURE OF PARENT OR GUARDIAN WILL BE REQUIRED:

DATE: _____ SIGNATURE: _____

FOR OFFICE USE ONLY

DATE OF INTERVIEW: _____

INTERVIEWED BY: _____

JOB ASSIGNMENT: _____

DEPARTMENT: _____

SUPERVISOR: _____

STARTING DATE: _____

EVALUATION DATE: 1. _____
2. _____
3. _____

TERMINATION DATE: _____

REASON FOR LEAVING: _____

THE "AGED" AND "OLD PEOPLE" ARE DEFINED AS THOSE OVER AGE 65

FACTS ON AGING

Mark "True" or "False"

T F 1. The majority (more than half) of old people are senile (Defective memory, disorientated, demented, etc.)

T F 2. All five senses tend to decline in old age.

T F 3. The majority (more than half) of old people have no capacity for sexual relations.

T F 4. Lung capacity tends to decline in old age.

T F 5. The majority of older people say they are happy most of the time.

T F 6. Physical strength tends to decline in old age.

T F 7. At least one-tenth of older persons are living in long-stay institutions (nursing homes, mental hospitals, homes for the aged)

T F 8. Drivers over 65 have more accidents than drivers under 65.

T F 9. Older workers cannot work as effectively as younger workers.

T F 10. About 80% of older people say they are healthy enough to carry out their normal activities.

T F 11. The majority of older people are unable to adapt to change.

T F 12. Older people tend to take longer to learn something new.

T F 13. The reaction time of older people tends to be slower than the reaction time of younger people.

T F 14. In general, older people tend to be pretty much alike.

T F 15. The majority of older people say they are usually bored.

T F 16. The majority of older people say they are lonely.

T F 17. Older workers have more accidents than younger workers.

T F 18. The majority of medical practitioners give low priority to older people.

T F 19. The majority of older people say they would like to have some kind of work to do.

T F 20.. Older people tend to become more religious as they age.

T F 21. The majority of older people say they are usually irritated or ang

T F 22. The health and socioeconomic status of older people (compared to younger people) in the year 2000 will probably be about the same as now.

DOCUMENTATION:

1. The majority of old people are not senile (i.e. defective memory, disoriented, or demented). Only about 2 or 3% of persons age 65 or over are institutionalized as a result of psychiatric illness (Busse & Pfeiffer, 1977). A series of 8 community surveys found the prevalence of psychosis of all types to range from 4 to 8% (Riley & Foner, 1968). Thus, all the evidence indicates that there are less than 10% of the aged who are disoriented or demented. It is more difficult to get accurate estimates of the proportion with defective memories, partly because of the different types of memory defects and different methods of measuring it. However, most studies agree that there is little or no decline with age in short term memory storage capacity (using the digit span test). Four studies did find large age differences in free recall of words, but 2 of them found no age differences in recognition or words in a list (Woodruff & Birren, 1975). As for long-term memory, various community surveys have found less than 20% of the aged who cannot remember such things as the past President of the United States, their correct age, birth date, telephone number, mother's maiden name, address, or the alphabet (Botwinick, 1976; Pfeiffer, 1975). Thus it is clear that the majority of aged do not have such serious memory defects.

2. All five senses do tend to decline in old age. Most studies agree that various aspects of vision, hearing, and touch tend to decline in old age. Some studies of taste and smell have not found a significant decline but evidence indicates increases in taste and smell thresholds with age (Riley and Foner, 1968). Studies of structural atrophy in the tongue and nose with old age support the experimental evidence of decline in taste and smell (Birren, 1959).

3. The majority of persons past age 65 continue to have both interest in, and capacity for sexual relation. Masters and Johnson (1966) found that the capacity for satisfying relations continues into the decades of the 70s and 80s for healthy couples. The Duke Longitudinal Studies found that sex continues to play an important role in the lives of most men and the majority of women through the seventh decade of life (Palmore, 1974).

4. There is a reduction in breathing efficiency (60% decrease from 20 years to 80 years old). There is a decrease in maximum breathing capacity and in oxygen consumption. For a given level of ventilation, an older person must work harder due to decreased thoracic wall compliance and less elastic recoil.

5. The majority of old people are happy most of the time. Studies of happiness, morale, and life satisfaction either find no significant difference by age groups or find about 1/5 to 1/3 of the aged score "low" on various happiness or morale scales (Riley & Foner, 1968). A recent national survey found that less than a fourth of persons 65 or over reported that "This is the dreariest time of my life"; while a majority said "I am just as happy as when I was younger" (Harrus, 1975).

6. Physical strength does tend to decline in old age. Studies of various kinds of muscular strength show declines in old age compared to young adulthood of 15 to 46% (Birren, 1959).

7. Only 4.8% of persons 65 or over were residents of any long-stay institutions in 1970 (U.S. Census, 1970). Even among those age 75 or over only 9.2% were residents in institutions.

8. Older drivers have about the same accident rate per person as middle aged drivers, but a much lower rate than drivers under age 30 (National Safety Council, 1976). Older drivers tend to drive less miles per year and apparently tend to compensate for any declines in perception and reaction speed by driving more carefully. (Gerontologist August, 1977).

9. The majority of older workers can work as effectively as younger workers. Despite declines in perception and reaction speed under laboratory conditions among the general aged population, studies of older workers (the 12% who are able to continue employment) under actual working conditions, generally show that they perform as well as younger workers, if not better than younger workers, on most measures.

10. About 80% of the aged are healthy enough to engage in their normal activities. About 5% of those over age 65 are institutionalized and another 15% among the non-institutionalized say they are unable to engage in their major activity (such as work or housework) because of chronic conditions. This leaves 80% who are able to engage in their major activity (National Centre for Health Statistics, 1974).

11. The majority of old people are not "set in their ways and unable to change". There is some evidence that older people tend to become more stable in their attitudes, but it is clear that most older people do change and adapt to the many major events that occur in old age such as retirement, children leaving home, widowhood, moving to new homes, and serious illness. Their political and social attitudes also tend to shift with those of the rest of society, although at a somewhat slower rate than for younger people (Cutler & Kaufman, 1975; Glenn & Hefner, 1972).

12. Old people usually take longer to learn something new. Experiments have consistently shown that older people take longer than younger people to learn new material (Botwinick, 1967). Studies of on-the-job trainees also show that older workers tend to take somewhat longer to learn new jobs (Riley & Foner, 1968).

13. The reaction time of most old people tends to be slower than that of younger people. This is one of the best documented facts about the aged on record. It appears to be true regardless of the kind of reaction that is measured (Botwinick, 1967).

14. Most old people are not pretty much alike. There appears to be at least as much difference between older people as there is at any age level; there are the rich and poor, happy and sad, healthy and sick, high and low intelligence, etc. In fact, some evidence indicates that as people age they tend to become less alike and more heterogeneous on many dimensions (Maddox & Douglas, 1974).

15. The majority of old people are seldom bored. Only 17% of persons 65 or over say "not enough to do to keep busy" is a problem (Harris, 1975). Another survey found that 2/3 of the aged said they were never or hardly ever bored (Dean, 1962). The Duke Adaptation Study found that 87% of those 65 or over said they were never bored in the past week.

16. The majority of old people are not socially isolated and lonely. About 2/3 of the aged say they are never or hardly ever lonely (Dean, 1962), or say that loneliness is not a serious problem (Harris, 1975). Most older persons have close relatives within easy visiting distance and contacts between them are relatively frequent (Binstock & Shanas, 1976). About 1/2 say they "spend a lot of time" socializing with friends (Harris, 1975). About 3/4 of the aged are members of a church or synagogue (Erskine, 1964), and about 1/2 attend services at least three times per month (Catholic Digest, 1966). Over 1/2 belong to other voluntary organizations (Hausknecht, 1962). Thus between visits with relatives and friends and participation in church and other voluntary organizations, the majority of old people are far from socially isolated.

17. Older workers have fewer accidents than younger workers. For example a study of 18,000 workers in manufacturing plants found that workers beyond age 65 have about 1/2 the rate of nondisabling injuries as those under 65, and older workers have substantially lower rates of disabling injuries (Kossoris, 1948).

18. Most medical practitioners tend to give low priority to the aged. A series of 12 empirical studies all found that most medical students and doctors, nursing students and nurses, occupational therapy students, psychiatry clinic personnel and social workers tend to believe the negative stereotypes about the aged and prefer to work with children or younger adults rather than with the aged. Few specialize, or are interested in specializing in geriatrics (Brown, 1967; Campbell, 1971; Coe 1967; Cyrus-Lutz & Gaitz, 1972; Delora & Moses, 1969; Gale & Livesley, 1974; Garfinkel, 1975; Gunter, 1971; Miller, Lowenstein & Winston, 1976; Mills, 1972; Spence & Feigenbaum, 1968).

19. Over 3/4 of old people are working or would like to have some kind of work to do. (including housework and volunteer work).

20. Older people do not tend to become more religious as they age. While it is true that the present generation of older persons tend to be more religious that the younger generations, this appears to be a generational difference (rather than an aging effect) due to the older persons' more religious upbringing. In other words, the present older generation has been more religious all their lives rather than becoming more religious as they aged. Longitudinal studies have found no increase in the average religious interest, religious satisfaction, nor religious activities among older people as they age (Blazer & Palmore, 1976).

21. The majority of old people are seldom irritated or angry. The Kansas City Study found that over 1/2 the aged said they are never or hardly ever irritated and this proportion increases to 2/3 at age 80 or over. About 3/4 said they are never or hardly ever angry (Dean, 1962). The Duke Adaptation Study found that 90% of persons over age 65 said they were never angry during the past week.

22. The health and socioeconomic status of older people (Compared to younger people) in the year 2000 will probably be much higher than now. Measures of health, income, occupation, and education among older people are all rising in comparison to those of younger people. By the year 2000, the gaps between older and younger persons in these dimensions will probably be substantially less (Palmore, 1976).

MISSION STATEMENT
VOLUNTEER PROGRAM

The mission of the Volunteer Program in a long term care facility is to enhance the quality of the lives of residents being served under the organization's mandate. This mission is accomplished by creating a linkage between the residents in the facility and members of the community who contribute their time and talent through the structure of the volunteer program.

The Volunteer Program is to compliment the work of staff of the facility in providing a high level of quality in the care of the residents.

PHILOSOPHY OF A VOLUNTEER PROGRAM
IN LONG TERM CARE

A long term care facility has the responsibility of providing service to all areas of need of the elderly who fall within their mandate. The volunteer program within a long term care facility is responsible for enhancing and enriching the lives of the residents by complimenting the efforts and duties of the staff and the supports of family members of residents.

It is the belief of the volunteer program that residents have the right to the personal relationships, time, talent and creativity provided by the volunteer. It is also the belief of the volunteer program that volunteers have the right to sufficient orientation training, supervision, support, evaluation and recognition that may be required in the carrying out of their duties.

GOALS FOR VOLUNTEER PROGRAMS
IN LONG TERM CARE

1. To provide a well developed, accountable volunteer program through which the lives of the residents would be enhanced and enriched.

2. To bring about a more conscious awareness on the part of the community regarding the needs of the elderly through the process of recruitment, orientation, and training of volunteers.

3. To create a linkage between the residents in the facility and the members of the community through the volunteer program to reduce isolation on the part of the resident.

4. To provide a variety of work experiences to volunteers who wish to investigate or explore various career options in the field of gerontology as it relates to long term care facilities.

5. To provide positive educational and training opportunities for volunteers who provide services within the long term care facility.

6. To provide proper evaluation procedures to ensure that volunteer services are being appropriately delivered and evaluative feedback is being given to volunteers and facility alike.

7. To provide recognition for volunteer efforts and contributions being given to the facility.

VOLUNTEER PROGRAM
POLICIES AND PROCEDURES

1. Volunteers will be recruited through the Volunteer Centre of Winnipeg, educational programs, work experience placement programs, the media (television, radio, newspapers), community posters and pamphlets, community organizations, churches, and through volunteer contacts. Qualifications for volunteers include the following:
   an interest in working with the elderly, dependable, consistent, willing to work under the policy and procedure guidelines, neat in appearance, etc. Specific qualifications are described in the individual job description for each volunteer responsibility.

2. All volunteers are to be registered in the volunteer program.

3. All volunteers are requested to wear volunteer name badges and to leave the badge at the facility upon leaving the building.

4. All volunteers are requested to sign the Volunteer Log Book at the reception desk before leaving the building.

5. Orientation programs for <u>new</u> volunteers will be held on a monthly basis, alternating between day and evening programs and all volunteers are requested to arrange to attend an orientation meeting.

6. If a volunteer is unable to attend the facility or keep an appointment with a resident or a program, the volunteer is requested to phone the charge nurse or program supervisor, to inform them the volunteer will not be in. If a resident is ill and does not want to see the volunteer or if a program is cancelled, the Coordinator of Volunteers should be informed as well as the volunteer assigned to the resident or the program.

7. Volunteers are requested to respect the resident's privacy and rights. All volunteers are requested to knock on the resident's door before entering their room, introduce him/herself, and explain the reason for being in the room.

8. Volunteers are requested to wear appropriate clothing while in the facility. All clothing should be washable, neat in appearance, and comfortable. Any volunteers handling wheelchairs are requested not to wear open toed shoes or sandals.

9. All volunteers are requested to check with a charge nurse before running an errand for a resident. A volunteer could be requested to purchase food or items that the resident is not supposed to have or use, and checking with the nurse would prevent further problems in the future.

10. All volunteers are requested to inform the charge nurse before taking a resident off her/his floor.

11. Volunteers are requested to smoke only in lounges where ashtrays are provided, in smoking cafeterias or other designated areas.

12. No volunteers are allowed to accept money or valuable gifts from residents or resident's family members for services rendered. The only exchange of gifts should be token gifts at Christmas, etc. Token gifts would be candy bars, a greeting card, etc. Volunteers are encouraged to check with the charge nurse before giving a resident a gift due to concern re health, mental confusion, or other legal issues.

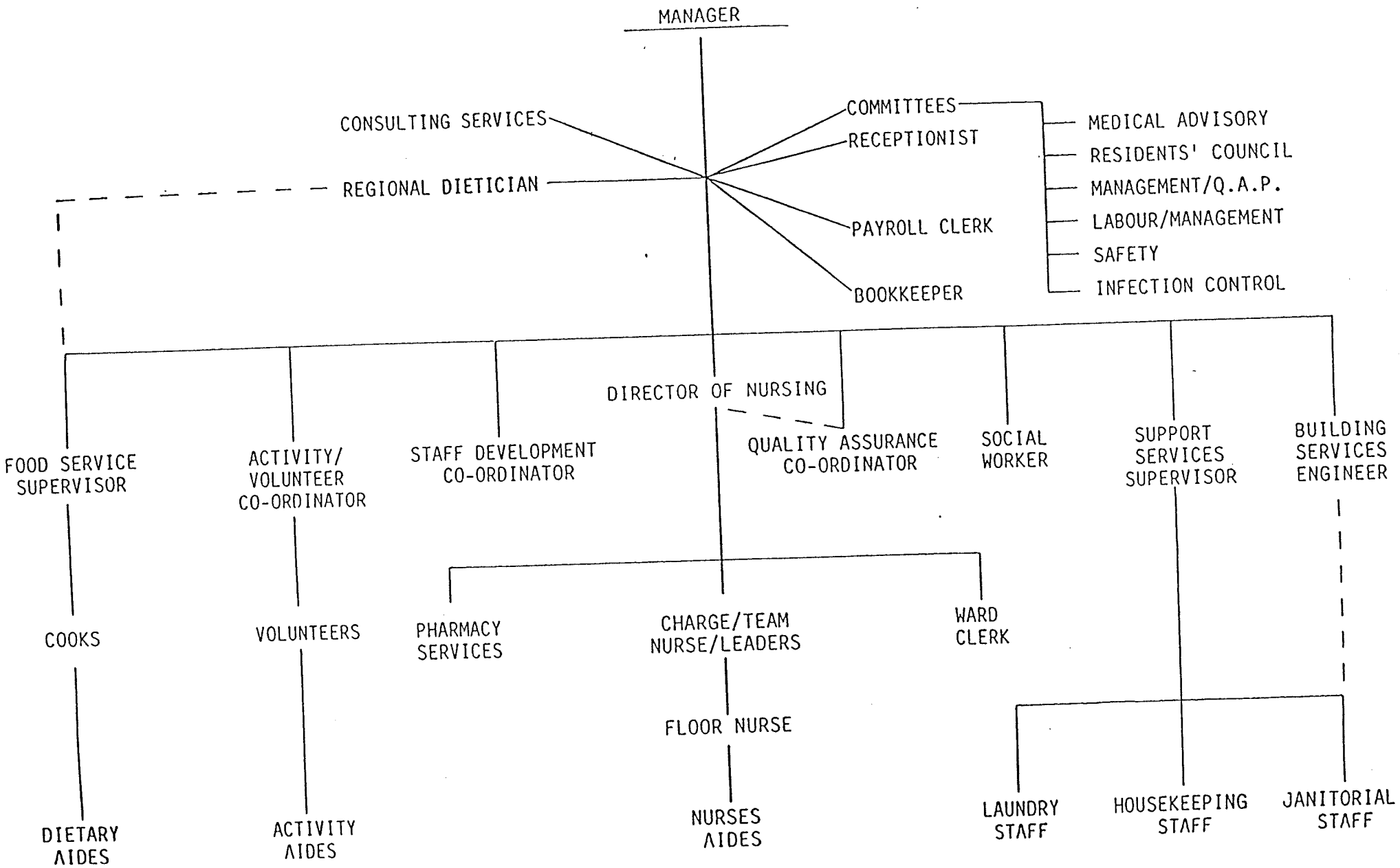
13. All volunteers should refuse to sign any legal documents for residents. Any such requests should be directed to the social worker, the director of nursing, or the manager of the facility.

14. Volunteers are requested to avoid lifting or transfers of residents under any circumstances. Volunteers are not covered by the facility's insurance for lifting and transferring.

15. If a resident falls, volunteers are to seek help from a registered nurse and are not to attempt to move the resident under any circumstances. The volunteer is encouraged to sit by the resident and try to comfort the resident while waiting for assistance. The volunteer is requested to fill out an incident report on the fall if the volunteer had witnessed the fall.

    Incident reports are forms that are available through the Director of Nursing and/or the Coordinator of Volunteers. The form should be completed, signed, dated, and submitted to the charge nurse.

    If the resident should fall away from the facility while out with a volunteer, and is experiencing pain from the fall, the resident should not be moved. The volunteer should ask anyone who is available to phone for an ambulance, stay with the resident until help arrives and notify the charge nurse at his/her earliest opportunity


MANAGER
CONSULTING SERVICES
REGIONAL DIETICIAN
COMMITTEES
RECEPTIONIST
PAYROLL CLERK
BOOKKEEPER
MEDICAL ADVISORY
RESIDENTS' COUNCIL
MANAGEMENT/Q.A.P.
LABOUR/MANAGEMENT
SAFETY
INFECTION CONTROL
DIRECTOR OF NURSING
FOOD SERVICE SUPERVISOR
ACTIVITY/ VOLUNTEER CO-ORDINATOR
STAFF DEVELOPMENT CO-ORDINATOR
QUALITY ASSURANCE CO-ORDINATOR
SOCIAL WORKER
SUPPORT SERVICES SUPERVISOR
BUILDING SERVICES ENGINEER
COOKS
VOLUNTEERS
PHARMACY SERVICES
CHARGE/TEAM NURSE/LEADERS
WARD CLERK
FLOOR NURSE
DIETARY AIDES
ACTIVITY AIDES
NURSES AIDES
LAUNDRY STAFF
HOUSEKEEPING STAFF
JANITORIAL STAFF

SKILLS NEEDED BY THOSE WHO WORK WITH THE ELDERLY

1. ENCOURAGE INDEPENDENCE

In a Personal Care Home, residents can often learn to accept assistance and make a habit of being helpless. SOme might eventually refuse all decision-making.

Among residents, there can be two attitudes. For some, " Everything is done for me ": but for others, " I influence my life. "

As a volunteer, you can encourage residents to be more independent by:

- praising small accomplishments
- encouraging mental stimulation through conversation
- encouraging physical activity within a resident's capability
- planning jointly with a resident instead of making a decision for him/her.
- be a good listener and encourage the resident to talk.

Don't assume that the resident is helpless; try to break through the barrier of " learned helplessness. "

2. FOCUS OF THE TOTAL PERSON AND NOT ON THE HANDICAP OR ILLNESS

Be careful not to categorize a resident or to think of him/her only in terms of his/her disability. Remember that the resident is above all, a person. Help the resident focus on what he can do instead of what his/her limitations are. Be understanding and sympathetic, but be careful not to pity residents.

3. BE A GOOD LISTENER

Be interested in the residents as people. Your interest is the only thing that can successfully encourage them to talk.

If a resident talks about death or some frustration, take them seriously instead of assuming they are confused. Be sympathetic and accepting but also truthful and realistic.

4. TREAT RESIDENTS LIKE ADULTS

Although some residents might be disoriented, be careful that you treat them with the respect they deserve as adults who have lived a full human life.

1. SKILLS IN COMMUNICATING WITH THE VISUALLY HANDICAPPED

Be aware of how you use your voice. Visually handicapped are more attuned to changes in voice pattern - they can more readily pick up feelings of anger, happiness, resentment or acceptance, boredom, etc. through voice inflections. Your tone of voice is often more important than what you say.

Don't be embarrassed about asking the resident to repeat himself/herself. The resident will appreciate the effort you are making to listen.

SKILLS IN HANDLING A WHEELCHAIR

There are a few special skills you should be aware of when dealing with a person in a wheelchair.

1. Go slowly so that your resident will feel comfortable.

2. Be careful when going through doorways, congested areas or near walls not to bump residents arms, elbows or toes. It may be necessary to reposition a residents arms or place his/her feet back on the footplates if they slip off.

3. Apply the brakes when you reach your destination and when the wheelchair is stationary.

4. Don't remain standing when holding a conversation with a resident in a wheelchair. If there is no chair handy, bend your knee to get down to his/her level. It makes both you and the resident in the wheelchair feel more comfortable.

5. Don't come up from behind unexpectedly and begin to push the wheelchair without first informing the resident. It's frightening to be sitting alone and still one minute and then finding yourself suddenly moving the next minute without even knowing why, where or by whom. Introduce yourself tell the resident where you are taking him/her and why.

6. On ramps or slopes, remember to position yourself so that you will be able to gradually ease the wheelchair down the ramp.

2. Sit near the person, facing him or her. Visually handicapped people are not usually totally blind. They can discern some facial expressions which will help them to know you better.

3. Be comfortable with physical contact. The elderly person may touch you on the arm to make certain he/she is gaining your attention. We use eye-contact to establish some sort of rapport in our conversations; they use touch contact.

4. Once a relationship is becoming established, try not to be afraid of showing your feelings. The older person may not be able to see your smile, but he/she can feel a hug or squeeze of his hand.

SKILLS IN COMMUNICATING WITH THE HARD OF HEARING

The hard of hearing are not deaf and so with a little patience and some learned skills on your part, you can carry on a conversation with a hard of hearing elderly person that can be meaningful to both of you.

1. Face the person. A hand on his/her hand will gain his/her attention.

2. Make certain that the lighting is good so that the elderly can see your face and lips.

3. Do not shout.

4. Use positive body language and facial expressions. (Hand movements, leaning forward, smiles, nods etc.)

5. Often, the individual has greater loss in one ear that the other and if you know which side to speak on, you can improve communications. (Most older people will let you know from which ear they hear better, but if they don't and you are not sure, don't be afraid to ask them where they would prefer you to sit.)

6. When working with the extremely hard of hearing, carry a pad and a pencil with you so you can write messages. (Try to make sure they can read . Some older people might be to embarrassed to tell you they can't read, so you will have to learn how to study their facial expression for signs of understanding.)

SKILLS IN UNDERSTANDING PATIENTS WITH IMPAIRED SPEECH

Stroke victims amd accident victims can often have severe speech disability. By patience and learned skills you can help them to get their ideas across.

1. Be patient. Give this type of resident enough time to say the words he/she is trying to speak.

2. When you understand a phrase or even a word, repeat it and the resident will let you know if you are on the right track.

DEPARTMENTAL MANUAL

SUBJECT		No.	PAGE
PERSONNEL RESPONSIBILITIES			
DEPARTMENT	**APP'D. BY**	**EFFECTIVE**	**SUPERCEDES**
FIRE SAFETY & EMERGENCY			

VOLUNTEER WORKERS AND COMPANIONS

FIRE IN YOUR AREA

1. RESCUE RESIDENTS IN IMMEDIATE DANGER.
2. CLOSE ALL WINDOWS AND DOORS TO ISOLATE FIRE TO IMMEDIATE AREA.
3. PULL THE ALARM.
4. CALL THE RECEPTIONIST AT 20 AND GIVE LOCATION AND EXTENT OF FIRE.
5. ASSIST NURSING PERSONNEL REMOVING RESIDENTS ADJACENT TO AND ACROSS THE HALL FROM THE FIRE. DO NOT CROSS THE PATH OF A FIRE.
6. REASSURE RESIDENTS AND BE PREPARED TO EVACUATE.
7. LEAVE LIGHTS ON.

FIRE NOT IN YOUR AREA

1. REPORT TO RECEPTION AREA AND WAIT FOR INSTRUCTIONS.
2. DO NOT LEAVE THE BUILDING. YOUR HELP IS NEEDED.

USE STAIRS - ELEVATORS ARE NOT SAFE IN A FIRE SITUATION

CENTRAL PARK LODGE
VOLUNTEER HOURS LOG

DATE	NAME OF VOLUNTEER	TIME IN	TIME OUT	TOTAL HRS	DEPT.

VOLUNTEER ORIENTATION EVALUATION FORM

DATE:_____ AM:_____ PM: _____

Please answer the following questions by writing the appropriate number in the space after each question:

(1) Unsatisfactory	(2) Somewhat Satisfactory	(3) Satisfactory	(4) Very Good	(5) Excellent
Not Helpful	Somewhat Helpful	Helpful	Very Helpful	Extremely Helpful

How helpful did you find the information presented to you in relation to the facility? _____

How helpful did you find the information presented in relation to the residents? _____

How helpful did you find the orientation session regarding understanding your role as a volunteer? _____

How would you rate the environment for the orientation session? _____

How satisfactory did you find the presentation of the orientation session? (Was it easy to follow or understand?) _____

How satisfactory was the length of the orientation session? _____

Remarks:

Please answer the following questions:

1. Was there other information you feel would have been helpful to include in the orientation?

   _____

   _____

   _____

2. Were the refreshments that were served adequate? _____

   Suggestions: _____

3. What was most helpful about the orientation session? _____

   _____

4. What was least helpful about the orientation session? _____

   _____

   _____

5. General Comments: _____

   _____

Thank you for completing this form.